CRANES CLUB

PROJECT REPORT

Healthy Minds:

A portrait of mental health experiences in the European Unificationist community.

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This study is dedicated in memory of our brothers and sisters we have lost by suicide.

You are not forgotten.

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CONTRIBUTORS

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Catriona has a medical degree from Glasgow University, Scotland. After meeting the Unification Movement in the USA, she resumed her career (on joining her husband) in Germany, as a civilian Family Practitioner with the US Army. Now retired, she is active in the field of mental health in a local support group and has a special interest in increasing awareness of this issue in our faith community.

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Ariane is a second generation Unificationist who lives with her fiancé in Germany. She obtained her degree of Bachelor of Psychology from the University of Bielefeld (2017) and Master of Psychology from the Justus-Liebig University in Gießen (2019). She is currently training to be a psychotherapist-an intensive course which extends over several years. As part of this training she has worked in the department of acute psychiatry and is at present assigned to the department for anxiety and obsessive-compulsive disorders in the University Clinic in Marburg.

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FOREWARD

About the project

Healthy Minds was a project conceived of by second and first-generation Unificationist members of Cranes Club Europe in 2017. The project was designed with four objectives. The first objective involved a needs analysis in which the mental health issues faced by members of the UC community are effectively assessed. This is the primary focus of this report. The second objective of the project was to conduct a literature review with the aim of developing a Principled perspective on mental health. A review of Rev. Moon's words about mental health was written by CV and published on the Applied Unificationism blog in 2018. A copy of the review is also available at the end of this report (see: APPENDIX VII – Healthy minds and mental illnesS: a brief review of Rev Moon's words). Building upon the foundation of these initial aims, the third objective was to raise awareness and enhance the education of members on relevant mental health issues. Our final ambitious objective was to build a support network for sufferers and carers of mental health issues. For a number of reasons outlined in the *Discussion* section, this final objective has been collapsed into the third objective. Each of these objectives have a value in their own right but combined in a systematic way they have the potential to improve the overall wellbeing of our European UC movement.

How to use this report

This report was designed as a public document that should be accessible to all members of the European Unificationist community. This includes those in leadership positions, pastoral positions, or indeed no position at all. Directly or indirectly, mental health affects us all and a change in culture requires every individual to take ownership over their understanding of difficult topics. It should be clearly stated that this report is not designed as a critique, but rather a valuable quantitative and qualitative reflection of the mental health experiences of our beloved brothers and sisters. Furthermore, the results here should not be considered definitive, but rather a snap-shot of the community at a specific point in time.

For the sake of transparency and professional excellence, this report includes an in-depth account of the entire project presented in a standard psychology/social-sciences report format. Throughout the report references to sources have been cited in the text, appearing in brackets with the name of the author and the year of publication. A comprehensive list of full citations is provided at the end of the report, helping to show the reader where the information has come from. The report includes an introduction section that describes why mental health issues should be assessed in the Unificationist community. Following this is a comprehensive overview of our methods (the way in which the team collected the data). Next is a detailed break-down of the results of the study, which includes key figures. The primary research questions addressed in this report, the prevalence of mental health conditions and their relationship to potential risk factors (age/generation, sex, migration), were assessed using a statistical test known as the Chi-squared test. As much as possible, extra information (in blue boxes) has been provided in the results section to help the reader understand the meaning of different technical terms and understand transparently how the conclusions of this study came about. The remaining data gathered in this report was not assessed using statistical tests, and therefore inferences made about them should

be considered as observations only. Finally, the discussion provides an interpretation of the results, importantly describing what the results mean and how they can be used for the future development of the European Unificationist community. The appendices of this report include information about the ethical commitment of the research team, an overview of the project's finances, key information about the four main mental health conditions identified in this study (depression, anxiety, schizophrenia/psychotic disorders, and bipolar affective disorder), as well as a review of the words of Rev. Moon about mental health.

The effort to produce a comprehensive report has resulted in a significant word count! We would like to encourage everyone interested in the mental well-being of the European Unificationist community to take the time to read it – perhaps, with a cup of tea. However, we also acknowledge that many readers may find particular aspects of the report to be technically tedious or simply do not have approximately 1 hour to spare. For these individuals we have created a short form executive summary of less than 1000 words that should illustrate the key take home messages.

Personal reflections and acknowledgments

'Everyone is striving to attain happiness and avoid misfortune.'
Exposition of the Divine Principle, page 1, line 1.

I cannot say how many times I have read this passage. Surely, like many of you, it has been thousands. At specific times in my life this idea has been particularly salient as it felt near impossible to achieve. Happiness is hard to attain at the best of times but contending with depression has felt like climbing Everest, in flipflops, and blaming myself for it the entire journey. My first experience of depression was early in my life, my first contact with mental health services was when I was 19 years old. It has taken me a long time to realise, or rather accept, that flipflops were never my footwear of choice.

It goes without saying that each one of the contributors to this study has in one way or another been affected by mental health issues. Quite likely anyone who is reading this will have been too. I have been humbled throughout this project by the many experiences I have been privy to hear. So many times, after presentations I have been touched on the arm, pulled to the side, and met with eyes so full of suffering that I felt my heart near implode. Talking about mental health can be so desperately difficult, but people have been so incredibly brave to do so.

I want to take the time to express my deepest gratitude to particular individuals and groups. Firstly, I want to thank Cranes Club Europe for providing a platform upon which this project could come together. I hope that the outcome of this project can serve as a future example of what is possible when professional individuals from a Unificationist background come together to serve their community. So many second generation have had many opportunities that many first generation did not, and this is one way in which we can share that wealth. I am grateful to Michael and Fumiko Balcomb, Matthew and Natasha Huish, and Dieter and Ana Schmidt, who so happily welcomed this initiative and supported us with as many resources as possible, including access to UC membership records and platforms to promote the project, without which achieving our aims would have been very difficult. I am grateful to Désirée Körtvelyessy who so sweetly contacted us to help in any way that she could. Her translation skills in the early stages of this

project were much appreciated. I am grateful to Johann Hinterleitner, who supported us later in the project helping to translate the findings of this report into German. Furthermore, I thank Karl Leja who helped with formatting the tables and figures in the German report
I am eternally grateful for my team of women who made this project possible. For In-Sun, who so diligently reached out to UK members in every possible way and who was a rock when it came to the sifting through of the hundreds of questionnaires we received. For Ariane, who was instrumental in the development of the questionnaire, its distribution in Germany, and for the preliminary processing of all our data – all this alongside completing her Master's degree. It goes without saying, she is a powerhouse without which this project may very well have run out of gas. I want to thank Catriona, who represents first generation in our team. It was very natural for her to assume a motherly role, she was a source of never-ending compassion and very much anchored us all together. But, beyond that she offered her years of expertise working in the medical field, assisting the development of the questionnaire, reaching out to members, and applying her sharp intellect to the mammoth task of reviewing Father's words on mental health. Ladies, at times it wasn't easy, but we made it - thank you, from the bottom of my heart. Lastly, I want to thank everyone who took the time to participate in this study – in doing so you are saying that it is time for this issue to be heard. To those who have suffered with mental ill-health, our beloved sisters and brothers, aunties and uncles, mothers and fathers, we hear you.

Elisa Uhnak-Brann

EXECUTIVE SUMMARY

Introduction

Every year one in four people experience some form of a mental health problem. It is therefore highly likely that within the folds of our Unificationist community, each of us knows someone suffering from a mental health condition. Currently, the extent of mental health issues within the UC community is not known. This is the first ever study that has been conducted to record active members' experiences of mental health. The study aims to capture the experience of the broader European UC community by focusing on two of Europe's largest UC populations, Germany and the UK. The primary aim of the study is to clarify the extent to which membership face mental health issues and what the nature of these issues are. This includes the prevalence of specific mental health conditions, experiences of treatment, and characterising why some individuals choose not to seek professional support. Finally, this study aims to capture how these individuals perceive the role of their faith and community in their mental health, as well as general attitudes concerning the causes of mental ill-health.

How the study was conducted

A total of 273 active UC members over the age of 18 participated in a questionnaire that addressed the specific aims outlined above. An English and German language version of the questionnaire was open to participants from October 2018 until September 2019. Distribution of the questionnaire was supported by the European FFWPU Continental Director (Michael Balcomb), and then National Leaders of the UK (Matthew Huish) and Germany (Dieter Schmidt). Financial support (€500) was awarded to the project by Cranes Club Europe an Unincorporated Association (www.cranesclubs.eu), which was used to support research efforts. All the investigators were volunteers and were not paid for their time or contribution to the project.

Findings

This in-depth report found that mental health issues are a very real concern for the European UC community. Approximately 1 in 3 UC members have received professional help for their mental health and around 1 in 5 UC members has a diagnosable mental health condition. The prevalence of different mental health conditions roughly mirrors that observed in wider society. This study found that first and second generation were just as likely to seek professional support or receive a mental health diagnosis. A similar observation was made for men and women. Migrant individuals were just as likely to seek professional support as natives but were less likely to receive a diagnosis of depression. Individuals that experienced mental health issues but who did not seek professional support were more likely to be second generation. This observation may be driven by second generation not viewing their circumstance as being serious.

Informed by the qualitative data, the discussion also raises important concerns with respect to these different groups and observations. For instance, the risk of anxiety in women may be driven by trauma and physical female experiences such as pregnancy; the reluctance of men to seek professional support may be driven by specific issues surrounding masculinity; migrant individuals may face challenges with respect to cultural differences and language barriers.

This study found that treatments offered by mental health professionals, such as talking-therapy and medication, can potentially be very useful for many individuals struggling with mental health issues. The role of faith and community support for these individuals is, however, a complex picture. Faith has the power to offer such individuals a deep sense of purpose and direction that can be very helpful. Conversely, judgement and mistreatment within the UC community can have a damning effect. The limited capacity of pastors was highlighted and is an important point of reflection for the future.

This study was limited in terms of the voices it could portray. What is more, these findings are not definitive, but rather a snap-shot of the European UC community at a specific point in time. Efforts to improve mental health awareness and understanding within the UC community as a whole could potentially provide some of its most vulnerable members with an invaluable sense of validation and much needed support. The role of Mental Health Officer is suggested as a means to better support those in leadership or members in general on the topic of mental health. Compassion, care and understanding are essential for a healthy community and are essential qualities at the heart of the blessed family ideal. Culture change within the European UC community may take time, but it is possible.

Limitations

This study was limited in terms of the voices it could portray and these should be reflected upon. Specifically, the sample was limited to current members from larger European UC communities, which may not reflect the experiences of smaller communities or that of former UC members. Furthermore, the study did not consider the impact of other conditions (e.g. neurodevelopmental conditions) or social issues (e.g. racism). It should also be emphasised that these findings are not definitive, but rather they are a snap-shot of the European UC community at a specific point in time.

Future directions

Mental health should be considered for the future strategic development of the UC community. Efforts to improve mental health awareness and understanding within the community as a whole could potentially provide some of its most vulnerable members with an invaluable sense of validation and much needed support. Individuals with serious mental health concerns should be encouraged to seek professional support. Doing so has been shown to be very helpful. The role of pastors and pastoral care should be reflected upon. These individuals should be better supported with specific training with respect to mental health and crisis management. Raising awareness of members and better equipping leadership in the area of mental health is important for positive culture development within the European UC community. The role of Mental Health Officer is suggested as a means to implement this. Addressing the issues of mental health within the UC community is very important. Compassion, care and understanding are essential for a healthy community and are also essential qualities at the heart of the blessed family ideal.

GLOSSARY

Key terms and definitions used throughout the report:

TERM	DEFINITION
Unification church (UC)	For the sake of simplicity this term is used to refer to the religious organization created by Rev. Sun Myung Moon, which is currently referred to as the Heavenly Parents Holy Community (HPHC).
First generation (FG)	An individual who joined the UC.
Second generation (SG)	An individual born to parents who had received the blessing.
Jacob's child (JC)	An individual whose parents joined the UC and were blessed after they were born.
Migrant	An individual not living in their country of birth.

INTRODUCTION

Every year 1 in 4 people experience some form of mental ill-health (McManus, et al., 2009). This issue is fast becoming a key topic on the agendas of many governments in Europe (Botezat, et al., 2015) and growing emphasis is being placed on this area by society (Rhydderch, et al., 2016), especially amongst younger generations (Korkodilos, 2016). Within religious communities, the issue of mental health is not unfamiliar. A meta-analysis (the gold standard of research reviewing methods) of mental health and religiosity found that regardless of religious affiliation or mental health condition there is a consistent relationship between the two (Hackney & Sanders, 2003).

The nature of the relationship between religion and mental health is complex. Analysis has shown that many people struggling with mental health issues find solace and support within the communities and belief framework provided by religions. A 2006 report from the UK charity Mental Health Foundation reports on studies that demonstrate how aspects of religious beliefs (e.g. spirituality) may allow a person to reframe or reinterpret events that are seen as uncontrollable, in such a way as to make them less stressful or more meaningful (Cornah, 2006). For example, the most successful way in which spiritual individuals cope with stress is by adopting a collaborative approach, in which the individual collaborates with 'God'. Similarly, perceiving negative events as externally caused and positive events as internally caused is widely regarded as an 'optimistic' attributional style and is generally associated with better mental health.

Conversely, research has also shown the negative impact of religion on mental health. For instance, having negative religious core beliefs (e.g. believing that "God ignores me") is predictive of psychological distress (Rosmarin, Krumrei, & Andersson, 2009). Another study investigated the impact of religious experiences on development demonstrated that strict and fearful religious parenting styles resulted in children who either continued to be religious but showed higher levels of guilt (a symptom of depression) or became non-religious and showed an aversion to religious ideas (Hansen, 1998). From this, it appears that there is a cyclical relationship between mental health and religion.

Currently, the extent of mental health issues within the UC community is not known. This is the first ever study that has been conducted to record active members' experiences of mental health. The study aims to capture the experience of the broader European UC community by focusing on two of Europe's largest UC populations, Germany and the UK. The primary aim of the study is to clarify the extent to which membership face mental health issues and what the nature of these issues are. This includes the prevalence of specific mental health conditions, experiences of treatment, and characterising why some individuals choose not to seek professional support. Finally, this study aims to capture how these individuals perceive the role of their faith and community in their mental health, as well as general attitudes concerning the causes of mental ill-health. A discussion of the results, including limitations of the study are provided, and considerations for the future are offered concerning how to equip the European UC community to better understand and support membership on the issue of mental health.

METHODS

Sample

A total of 313 anonymised individuals completed the questionnaire from across two of Europe's largest UC communities, Germany and the UK[*]. Thirty-five questionnaires were discarded as they did not meet the criteria for community association (i.e. the individual was not a member of either the German or UK communities, or did not currently identify as a member of the UC). A further five duplicated questionnaires were removed[†], resulting in a final sample of 273 questionnaires, consisting of approximately equal numbers from Germany and the UK (Germany = 132, UK = 141). The sampling error at a 95% confidence level was 0.053. This indicates that we are 95% confident that the results of this sample reflect the true population with a small margin of error, 5.31%. Calculations for sampling error were conducted based on a total true population of 1359 members. This figure was taken from the combined total number of all active members over the age of 18 (including regular, associate and registered membership) in UK and Germany in 2017. Membership figures were obtained from the European FFWPU General Affairs Office.

Data collection

Individuals over the age of 18 were invited to participate in the questionnaire by way of an online form or by filling in a paper copy. All participants were offered an incentive for taking part (two prize draws, €100 for the German questionnaire and £100 for the UK questionnaire) and were informed of the purpose of the study before administration.

A variety of strategies were used in an attempt to reach a representative and broad population. The German language version of the questionnaire was distributed amongst the German UC community via email through a central database of contact information held by the German UC General Affairs. It was open to submission from Oct-2018 until May-2019. No central database was available for the UK. Therefore, the English language version was made available to subscribers of the UK FFWPU newsletter, and given to the 10 UK community pastors, to be distributed amongst their local network of members. Further to this, paper copies of the questionnaire were collected at the UK Annual General Festival held in June 2019. The UK version of the questionnaire was open to submission from Feb-2019 until Sep-2019.

Reminders were sent to community leaders in both Germany and the UK periodically throughout the dates stated above. Access to the questionnaires was also made available to a number of closed-groups on Facebook (groups with administered membership). Lastly, a number of presentations were given to promote the project and participation. These included five in Germany (German Whitsun Festival, and Düsseldorf, Gießen, Munich, and Berlin communities, presented by CV and AS), and three in the UK (Scotland community, presented by CV, a Council of Communities meeting and the 2019 Annual General Festival, presented by EUB).

Distribution of the questionnaire was supported by the European FFWPU Continental Director (Michael Balcomb), and then National Leaders of the UK (Matthew Huish) and Germany (Dieter Schmidt). As this project was conducted by volunteers not part of a formal research body, there

[*] A questionnaire was regarded as incomplete if the individual did not continue to the end of the questionnaire.

[†] Multiple submissions that contained near identical information were considered duplicates. In the exceptional case that duplicate entries contained discrepancies, answers were combined.

was no ethical committee to provide approval. As a result, an ethical commitment was drafted that included important points to protect the anonymity and rights of participants, and to outline a code of conduct for the researchers (see APPENDIX I - Ethical Commitment). Financial support (€500) was awarded to the project by Cranes Club Europe an Unincorporated Association (www.cranesclubs.eu). This money was used for the purposes of research (see APPENDIX II – Finacial Overview). All the investigators were volunteers and were not paid for their time or contribution to the project.

Questionnaire measures

A questionnaire was devised consisting of four sections. The first section included a demographic form that was used to characterise the sample, this included information such as sex, age, place of birth, and generational status (i.e. first generation, second generation, Jacob's child).

The second section included questions concerning formal diagnosis and treatment of mental health conditions by a medical professional. A medical professional was defined as an individual with professional qualifications to diagnose and/or treat mental health conditions, such as a medical doctor, psychiatrist, or a registered psychologist, psychotherapist, or counsellor. These questions were designed to capture participants' experiences with mental health services, which is taken as an initial (not exhaustive) measure of illness severity. Many individuals will likely suffer some form of mental health distress in their life, but do not necessarily require professional support. It is assumed that individuals who do seek such professional support or who are required to by law reflect a more vulnerable population who would not be able to manage their mental health condition without it.

The third section included questions concerning experiences of mental health issues for those who had not had not sought any professional support for their mental ill-health. As there are no existing records on mental health conditions in the UC community, it was considered that simply asking individuals whether or not they had sought help or received a formal diagnosis may result in an underrepresentation of the prevalence of mental health issues in the sample. For those who had not sought professional help, we asked them to characterise their experience based on whether or not their mental health issue interfered in their daily life. This is a common dividing line used for the characterisation of mental ill-health for research and clinical purposes (Hall, 1995). Interference in daily life was described as difficulty keeping/finding a job or partner, regularly attending and coping with school, etc. To illustrate this, one example could be an individual may have experienced periods of depression in their life that may have resulted in the break-down of a relationship or the termination of their job. Another example of this could be an individual may have experienced a period of anxiety that may have resulted in them being unable to complete exams or to withdraw from a course of education all together. There is a degree of subjectivity in these questions, as two individuals may perceive similar experiences differently. What is important however, is that these questions capture the individual's perception of their *own* experience. Further to questions about mental health, participants were asked about their decision not to seek professional support. These questions characterize the beliefs these individuals have about their mental health issues, as well as positive coping mechanisms they may use to manage them.

The final section of the questionnaire included questions that more broadly characterise beliefs about the causes of mental health conditions and experiences of support from members of the UC community (i.e. pastors).

RESULTS

Descriptive statistics

The average age of the sample was 42.45 years old (SD = 19.16), and this consisted of slightly more female participants than males (see Table 1). Given the small sample size of the Jacob's Children group (n = 5) it was decided to collapse this group into either one of the larger generational groups based on likely life experience[‡]. Following this the sample consisted of 125 'first-generation' members (45.79%, mean age = 62.32 years old, SD = 7.17, female = 63, male = 62), and 148 'second generation' members (54.21%, mean age = 25.68 years old, SD = 4.09, female = 87, male = 62). A descriptive analysis of all variables is shown in Table 1.

MEAN and STANDARD DEVIATION

In statistics, 'mean' or 'average' describes the result you get by adding two or more values together and dividing the total by the total number of values. It is used to reflect a *typical* value for a given set of values. The 'standard deviation' (SD) reflects how much *variation* there is either side of the mean.

Example: For a group of 10 people the *average* age is 25 and the *standard deviation* is 5. This means the 'typical' person of the group would be 25, but there are individuals aged 5 years more (30) and 5 years less (20) in the group.

Table 1 Descriptive analysis of sample. All percentages have been rounded up to the nearest whole number.

	Total	First Generation	Second Generation
Sample, *n*	273	125	148
Average age in years (SD)	42.45 (19.16)	62.32 (7.17)	25.67 (4.09)
Sex			
Female (%)	150 (55%)	63 (50%)	87 (59%)
Male (%)	123 (45%)	62 (50%)	61 (41%)
Migration			
Migrant (%)	107 (39%)	65 (52%)	42 (28%)
Native (%)	166 (61%)	60 (48%)	106 (72%)

[‡] It was considered that the life experiences of JC born after 1980 would likely resemble that of the second-generation group, having received a primarily UC upbringing (e.g. attending Sunday School and specialist workshops), whilst individuals born before 1980 would not and therefore may more closely resemble the life experiences of the first-generation group.

Prevalence and characterisation of mental health conditions

Distribution of different mental health diagnoses

Of the 273 participants, 34% (n = 92) reported having sought professional support for their mental health, of which 63% (n = 58) reported having received a mental health diagnosis. This gives an estimated overall prevalence rating of mental health conditions within the UC as 21%, approximately 1 in 5 people. Individuals reported a range of diagnoses, as described in Table 2. The most frequent diagnoses fell under the category of 'common mental health conditions', including depression (50%), followed by anxiety (36%). Most individuals reported having received a single diagnosis, however 26% reported having received multiple diagnosis, with the most common being depression and anxiety combined.

No formal statistical comparison between the UC prevalence ratings and observations made in the general population can be made. Nevertheless, as an *estimate* the prevalence of different conditions can be observationally compared with recent publicly available estimates for the general population (see: Table 2). It is important to note that data obtained from the current UC sample reflects lifetime prevalence (i.e. individuals reported on whether they had *ever* experienced a mental health issue), whereas publicly available data published on the general population most often reported on annual prevalence (i.e. individuals reported on whether they had experienced a mental health issue in the last 12 months). With these limitations in mind, observational comparisons between the UC populations and general population appear to show similar prevalence rates for common and sever mental health conditions.

Table 2 Overview of mental health diagnoses received by UC members. The total number of cases per diagnosis and their percentage are described. UC population prevalence values (how common the mental health condition is within the UC population, represented as %) is provided alongside estimates of prevalence values for the general population. Sources for general population estimates: ◊McManus et al., 2014, ♦2009; ±NHS Digital, 2019. *No prevalence estimations were found for 'adjustment disorder'.*

	Total	UC population prevalence	General population prevalence
Sample, n (%)	58 (100%)	21%	~25%
Common mental health conditions			
Depression	29 (50%)	11%	10%±
Anxiety	21 (36%)	8%	7%◊
Severe mental health conditions			
Schizophrenia/			
Alcohol addiction	1 (2%)	0.4%	1-2%♦
Eating disorders	1 (2%)	0.4%	6.7%♦
Personality disorders	1 (2%)	0.4%	2%◊
Not specified	12 (21%)		

SAMPLE, N

In statistics, a lowercase 'n' is used to denote 'sample size', the number of individuals in a group.
An uppercase 'N' is sometimes used to describe the total sample or population size.
Example: group X describes a small sample consisting of 5 people (n = 5), which is a subset of the total sample/population of 100 people (N = 100).

Risk factors for seeking professional support and receiving a mental health diagnosis

Three descriptive factors were assessed in the sample as potential risk factors for mental ill health (as measured by receiving a mental health diagnosis). Seeking professional support did not necessarily mean individuals received a diagnosis (see Table 3). The three risk factors considered included: generation (first vs second generation), which was also taken as a general marker of age, with each generation being either over or under 40 years old respectively; sex (female vs male); and migration (migrant vs native), which describes whether or not the individual has migrated away from their native country of birth. With respect to seeking out professional support there was no significant effect of sex, χ^2 (DF=1, N=273) = 0.40, p>.05, age, χ^2 (DF=1, N=273) = 0.55, p>.05, or migration χ^2 (DF=1, N=273) = 0.08, p>.05. Similarly, with respect to receiving a mental health diagnosis there was no significant effect of sex, χ^2 (DF=1, N=92) = 0.30, p>.05, age, χ^2 (DF=1, N=92) = 1.66, $p>.05$, or migration, χ^2 (DF=1, N = 92) = 0.27, $p>.05$.

CHI-SQAURE (χ^2) TEST

The chi-square (χ^2) test is a statistical test used to measure how well a model compares to actual observed data. The model used is a hypothetical estimate which assumes there is no difference between groups. This is compared to the actual data observed.

$$\chi^2 = \sum \frac{(O - E)^2}{E}$$

where: O=Observed value(s) E=Expected value(s)

The data is used to calculate a chi-square statistic (χ^2) which, together with the degrees of freedom (DF), can be used to determine the significance of any differences found between the expected model and observed data. A p value of <0.05 reflects significance.

Calculating a chi-square statistic requires data to be random, raw, mutually exclusive, drawn from independent variables, and drawn from a large enough sample.

Table 3 Overview of sample based on risk factors.

	Total sample, N	Sought professional help, n	Diagnosed mental health condition, n
Generation			
1st	125	45	31
2nd	148	47	27
Sex			
Female	150	53	33
Male	123	39	25
Migration			
Migrant	107	35	21
Native	166	57	37

Risk factors were also assessed for specific mental health diagnoses (see Table 4). A significant effect was observed with respect to migration and receiving a diagnosis of depression, χ^2 (DF=1, N=58) = 8.33, p<.05. A chi-squared test of sex and anxiety was observed as approaching significance, χ^2 (DF=1, N=58) = 3.61, p>.05. No other significant effects were observed.

*Table 4 Overview of specific diagnosis based on risk factors. 'SZ' denotes Schizophrenia and psychotic disorders, 'BD' denotes bi-polar affective disorder. ±Other complex conditions described in Table 2. χ^2 denotes chi-squared statistic. Significance set at p = .05, *significant effect, ♦approaching significance.*

	Total sample N	Depression n	χ^2	Anxiety n	χ^2	SZ n	χ^2	BD n	χ^2	Other± n	χ^2
Generation											
1st	125	14	0.14	10	0.04	2	0.07	2	0.05	2	-
2nd	148	15		11		3		2		2	
Sex											
Female	150	17	0.32	15	3.61♦	2	0.49	2	0.06	2	-
Male	123	12		6		3		2		2	
Migration											
Migrant	107	6	8.33*	6	1.56	2	0.00	3	2.33	2	-
Native	166	23		15		3		1		2	

Experiences of treatment

Individuals who had sought professional help (regardless of whether or not they received a diagnosis) were more likely to be offered talking-therapy only, compared to a combination of talking-therapy and medication. Furthermore, individuals who were offered medication were more likely to be offered this form of treatment in conjunction with talking-therapy compared to being offered only medication. These observations highlight the preference of professional bodies to offer talking-therapy over medication. Being offered medication alone was very unusual.

Of those offered treatment, individuals were more likely to accept treatment if it did not include medication (see Table 5), which may suggest the sample had a slightly increased aversion to taking medication for their mental health. Whether or not this attitude differs from the general population, or from UC attitudes towards medication more generally, is not known as these figures are unavailable. It should also be noted that a considerable portion of the sample (25%) did not report on whether or not they were offered treatment.

Table 5 Overview of treatment offered and accepted by individuals who sought professional support for their mental health. Total sample of individuals who had sought professional help ('total sample'), n = 92.

	Offers of treatment n (% of total sample)	Acceptance of treatment n (% of those offered treatment)
Talking-therapy only	35 (38%)	28 (80%)
Talking-therapy and medication	27 (29%)	18 (67%)
Medication only	6 (7%)	4 (67%)

Individuals who reported accepting treatment were more likely to report their experience as 'helpful' (n = 22) compared to 'unhelpful' (n = 14) or 'neither helpful nor unhelpful' (n = 14). When

these reports are assessed based on each treatment option (Figure 1), we observe that individuals who were offered medication alone were the only group to report their experience of treatment less favourably.

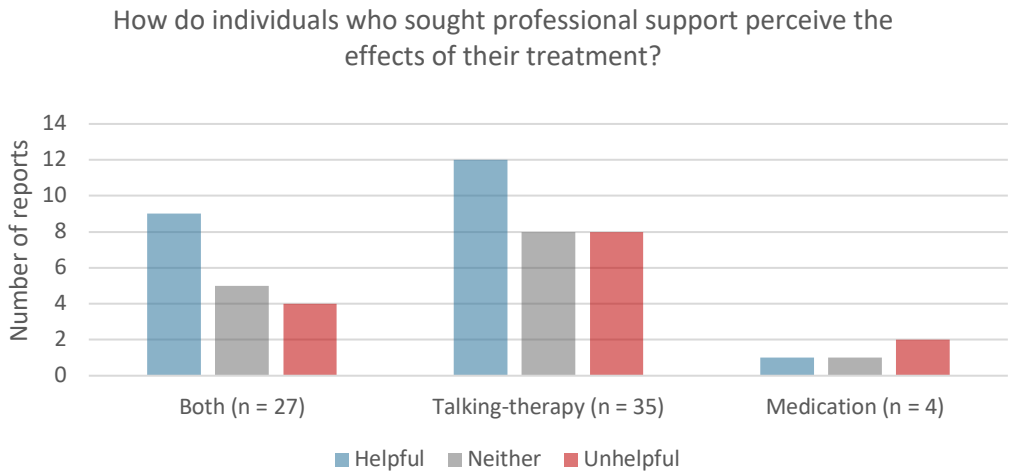

Figure 1 An overview of how individuals perceived the mental health treatment they received. Figure reports on individuals who had sought professional help and had accepted the offer of treatment given to them. The category 'both' describes individuals who were treated with both talking-therapy and medication. Reports for 'helpful' include individuals who reported their experience of treatment as either 'helpful' or 'very helpful'. Similarly, 'unhelpful' includes reports of either 'unhelpful' or 'very unhelpful'.

Impact of UC community and faith for those with diagnosed mental health conditions

Pastor awareness and perceived attitude

Of the 58 Individuals who had been diagnosed with a mental health condition, 47 responded to questions about their pastor's awareness of their mental health condition. More than half of these individuals reported that their pastor was not aware of their mental health condition (n = 25). Of the individuals who reported that their pastor was aware of their mental health condition (n = 22), 13 went on to rate on a scale the extent to which they felt their pastor had a supportive attitude in response to them disclosing their mental health condition. The scale ranged from 1 to 5, reflecting very unsupportive to very supportive respectfully, with 3 indicating a neutral response. On average, individuals with a mental health diagnosis reported their pastor's attitude to be 3.3, just slightly more supportive than neutral.

Impact of faith

Of the 58 Individuals who had been diagnosed with a mental health condition, 52 responded to questions about how they perceive their faith to have impacted their condition, being asked to rate it as 'positive', 'negative', or 'both', and provide further explanation as to why. The majority of individuals described the impact of their faith as being both a positive and negative factor (n = 26, 50%), followed by 'positive' (n = 18, 35%) and then 'negative' (n = 8, 15%) (see Figure 2).

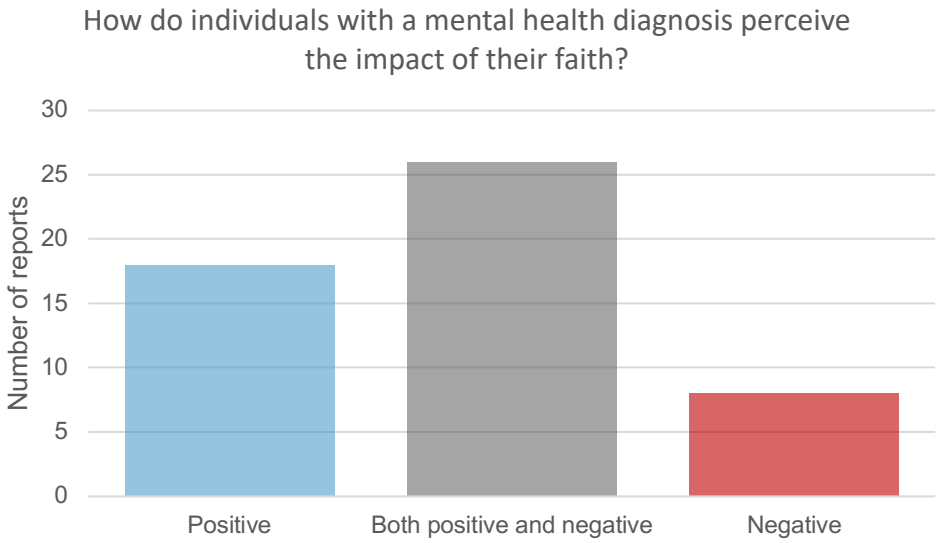

Figure 2 An overview of how individuals with a mental health diagnosis perceive the impact of their faith on their condition.

Participants' qualitative responses describing their choice were assessed to understand what themes were driving their reports (Table 6). The prevalence of individual positive themes was determined based on their frequency amongst individuals who reported their faith as being either 'positive' or 'both positive and negative' (n = 44). Similarly, the prevalence of individual negative themes was determined based on their frequency amongst individuals who reported their faith as being either 'negative' or 'both positive and negative' (n = 34). Although overall it appears that more individuals reported their faith as being a positive impact on their mental health condition, individuals who reported it as being negative were more likely to provide an explanation as to why (see Table 6).

The most commonly referenced positive theme was that the individuals' faith provided a sense of direction and purpose (11%). Other positive themes included helpful faith practices (7%), positive aspects of UC teachings (7%), and helpful support from the UC community (5%). The most commonly referenced negative theme was experiences of judgement and/or mistreatment within the UC community (18%). Other negative themes included negative aspects of UC teachings (12%), a culture of taboo surrounding difficult topics (9%), unhelpful support from UC community (9%), pressure associated with mission (9%), a sense of isolation from wider society (9%), and feelings of disappointment and/or perceptions of hypocrisy associated with the UC (9%). The extent to which different views were held according to risk factors outlined in previous sections (generation, sex, migration) was not assessed.

Table 6 Overview of themes described and representative examples concerning the positive and negative impact of individuals' faith on their mental health condition.

Theme	Representative examples
Positive:	
Sense of direction and purpose	*'Without UC I would have been totally lost'*
Helpful faith practices	*'…prayer… helps a lot'*

	'…my applied faith has had a positive effect on me…'
Helpful support from UC community	*'My Pastor and spouse together have supported me and brought healing activities into our community often.'*
UC teachings (positive)	*'My faith and belief in the spirit world, was a strong factor in avoiding suicide'*
Negative:	
Judgement and mistreatment within UC community	*'There is not as much tolerance as one would pretend'* *'Ill-treatment'*
UC teachings (negative)	*'…[UC] belief did not always give clear answers and therefore I did not always know what to think'* *'Sense of worthlessness and extreme statements'*
Culture of taboo	*'…not communicative or ready for open discussions'* *'…sexuality has also been made very difficult or impossible due to the taboo of any sexual desire'*
Unhelpful support from UC community	*'…a lot of members seem to have a negative view on medications and strongly urge me to avoid them'* *'…there are hardly any skills that people can provide sufficient emotional support'*
Pressure of mission	*'We sacrifice, serve and love others, (often) at the expense of our families and selves'*
Sense of isolation from society	*'Membership in the UC was / is often the reason for differentiation from friends / colleagues outside the UC, therefore hardly any close social contacts'*
Feelings of disappointment and/or perceptions of hypocrisy associated with UC	*'…that was a contradiction to the teaching, which I could not accept'*

Other mental health issues

A total of 49 individuals (18% of the total sample) reported experiencing a mental health issue that impacted their daily life but had not sought professional support. Whether or not this represents a high or low prevalence is unclear given that there are no general population figures to compare this too. The extent to which specific risk factors contributed to not seeking professional support was assessed. A significant effect was observed with respect to generation/age, χ^2 (DF=1, N=49) = 7.13, p<.05, and migration, χ^2 (DF=1, N=49) = 4.62, p<.05. No other significant effects were observed (see Table 8).

Reasons for not seeking professional support

Thirty-six individuals gave explanations as to why they had not sought professional help, and their qualitative responses were reviewed and categorized into specific themes outlined in Table 7. The most frequently referenced theme was that the individual did not view their mental health issue as being serious enough to warrant professional support (31%). It is important to note here that none of the individuals who gave this reason for not seeking professional support reported another explanation. For example, individuals who viewed their mental ill-health as not serious enough to warrant professional support did not report that they were able to recover on their own or with the support of their social network.

The next most frequently referenced theme related to a lack of resources (25%). This included not having enough money or time to seek professional support but was mostly characterized by the individual lacking knowledge about mental health or how to go about seeking support. Following on from this were themes of self-sufficiency, in which the individual felt able to resolve their mental health issue themselves or with the support of their social network (19%), as well as shame and stigma associated with needing or seeking support (19%). Other themes included lacking motivation to seek support (11%) and not trusting or believing professional support to be adequate (11%).

Table 7 Representative examples of reasons given for not seeking professional support for poor mental health.

Theme	Representative examples
Circumstance not viewed as serious	*'I didn't consider professional help necessary in the situation.'* *'I don't really want to get help because it's probably not bad enough and I don't dare to ask for help.'*
Lack of resources	*'Getting help is expensive and takes time...'* *'…I was too young to realize I needed help'*
Self-sufficient recovery	*'I just put [it] down to depression and waited for it to pass, which it did.'* *'I thought I could make it right with the help of social support and it was like that.'*
Shame and stigma	*'It's hard to ask for help, at times it is rather stigmatized'* *'I felt a lot of stigma attached [to seeking help/mental health]'*
Lack of motivation to seek professional support	*'No interest.'* *'…I have not sought "professional help" primarily because of laziness.'*
Lack of belief/trust in professional support	*'I would not address things that have to do with the church, because I do not expect it to be understood and that limits everything.'* *'No adequately competent professional [was] found'*

Themes concerning reasons for not seeking professional support were further assessed based on the three risk factors previously mentioned (generation, sex, and migration), however no

statistical inference was conducted for this (see Table 8). Observationally, not viewing one's mental ill-health as being serious enough and lacking resources (e.g. money/information) were predominantly reasons given by second generation. Lacking belief/trusting in professional support was an exclusively male perspective. Lastly, no migrant individuals reported self-sufficiency with respect to not seeking professional support for their mental ill-health.

*Table 8 Characterisation of individuals who have not sought professional help for their mental ill-health and overview of reasons given. χ^2 denotes chi-squared statistic. Significance set at p = .05, *significant effect*

	Total sample N	Individuals who have not sought professional support	χ^2	Reason for not seeking profession support n (%)					
				Not viewed as serious	Lack of resources	Self-sufficient recovery	Shame and stigma	Lack of motivation	Lack of belief/trust
Total	273	49		11 (31%)	9 (25%)	7 (19%)	7 (19%)	4 (11%)	4 (11%)
Generation									
1st	125	14	7.13*	1 (1%)	1 (1%)	2 (2%)	2 (2%)	1 (1%)	2 (2%)
2nd	148	35		10 (7%)	8 (5%)	5 (3%)	5 (3%)	3 (2%)	2 (1%)
Sex									
Female	150	25	0.37	7 (5%)	7 (5%)	4 (3%)	4 (3%)	2 (1%)	0 (0%)
Male	123	24		4 (3%)	2 (2%)	3 (2%)	3 (2%)	2 (2%)	4 (3%)
Migration									
Migrant	107	13	4.62*	5 (5%)	3 (3%)	0 (0%)	1 (1%)	1 (1%)	2 (2%)
Native	166	36		6 (4%)	6 (4%)	7 (4%)	6 (4%)	3 (2%)	2 (1%)

Beliefs and attitudes about mental health

The researchers were interested to understand what UC members perceive to be the general cause of mental health conditions, irrespective of whether or not they themselves had experienced mental ill-health. A total of 253 individuals responded to this question. The majority (n = 166, 65%) reported that they believe mental health conditions are the result of both spiritual and other factors, including factors such as genes, environment, and upbringing. This was the case regardless of whether or not an individual had experienced any mental ill-health themselves. After this, individuals were more likely to attribute mental health conditions to mainly other factors (e.g. genes, environment, upbringing) (n = 63) compared to mainly spiritual (n = 14). The least opted opinion was 'unsure'. Having a more binary view of causes of mental ill-health (e.g. perceiving it as being the result of either mainly spiritual or mainly other factors) was more common for individuals who had experienced mental ill-health (whether or not they had sought professional support).

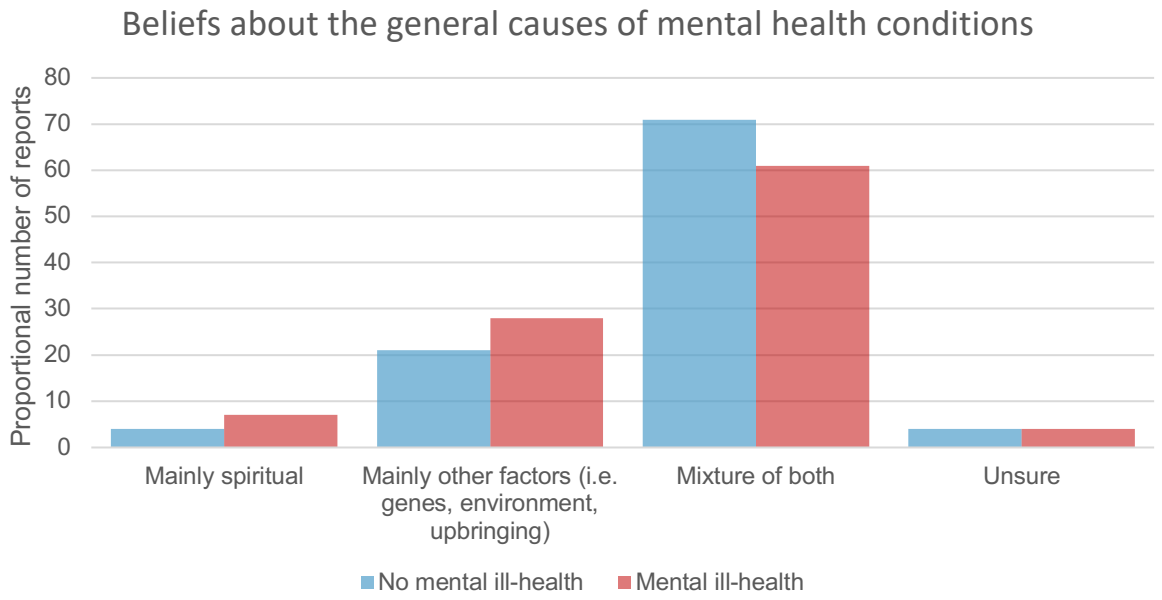

Figure 3 An overview of what UC members perceive to be the cause of mental health conditions. Data shown in blue depict attitudes of individuals who reported no experience of mental ill-health, whilst data shown in red depicts all individuals who have experienced mental ill-health, whether or not they sought professional support.

DISCUSSION

This report set out to characterise the mental health experiences of two of Europe's largest UC communities, UK and Germany. The outcome of this is a rich data set that allows for a nuanced understanding of individual experiences of seeking professional support and treatment for serious mental health concerns. Further to this we have been able to capture why it is that some individuals in the UC community who experience mental health issues do not seek professional support. Lastly, all these experiences are given colour with the support of meaningful qualitative accounts that characterise experiences and attitudes within the UC community. The following discussion is arranged in such a way that the most insightful outcomes of this study are highlighted. Lastly, important limitations of this study are addressed and suggestions for the future are given.

Prevalence of mental health issues within the UC are similar to that of the general population.

The results of this study found that approximately 1 in 3 individuals within the European UC community have received professional support for their mental health, and approximately 1 in 5 have a diagnosable mental health condition. In both Germany and the UK it is estimated that 1 in 4 individuals will experience some form of mental ill-health in any given year (Jacobi et al., 2014; McManus et al., 2009). Prevalence data reported in the results section for the wider population are based on publicly available data from thousands of individuals and were not acquired by the investigators of this study. Differences in sampling and analysis approaches means a direct statistical comparison between data obtained in this study and the general population was not possible. With this in mind, that authors infer prevalence ratings within the UC community *observationally* reflect that of greater society. Importantly, mental health issues are not unique to the UC, but equally being a member of a blessed family does not make one immune to it. Mental health is a very real and serious issue that faces a considerable portion of the UC community.

First and second generation are just as likely to have mental health issues

This study found that both first- and second-generation UC members report seeking professional support and being diagnosed with mental health conditions to the same extent. This suggests that being born into a blessed family is not a protective factor against mental ill-health. Moreover, it is plausible that the sample obtained captured data of individuals within the same family, and therefore may also reflect a hereditary component of mental health conditions.

Many mental health conditions have been shown to have a genetic component (Barnett & Smoller, 2009; Lohoff, 2010; Rees, O'Donovan, & Owen, 2015). This means that some conditions could be biologically inherited from one generation to the next. Beyond genetics, there is also evidence to suggest that other factors may contribute toward the inheritance of mental health conditions within families. These include factors such as parental experience and exposure to certain environments (Toth, 2015).

The results of the current study were obtained from anonymised data therefore it was not possible to determine how many individuals from the same family took part. When designing the questionnaire, the authors included questions that attempted to do so, however, these were

ultimately removed from the analysis as their accuracy could not be determined. For instance, two parents from the same family may report one child as having a mental health issue, but due their anonymity their reports would have been counted twice, as if two children had a mental health issue.
The authors decided to include the observation of inheritance as a possible contributing factor in the development of mental health issues as this may be helpful for understanding the issue for the purposes of future strategic planning of the European movement. If one individual in a family is struggling with mental health issues, it may have a knock-on effect on other family members. Such families may benefit from seeking professional support early, which could be improved by the support of their pastor or local community. This could be by way of improved education on the topic of mental health and by being able to guide congregants to professional support.

Men and women are just as likely to have mental health issues

This report found that mental ill-health effects both men and women in the European UC community. Men and women are equally as likely to seek out professional support and be diagnosed with a mental health condition. This appeared to be the case across all diagnoses, be it common conditions, such as depression and anxiety, or severe conditions, such as schizophrenia/psychotic disorders and bi-polar affective disorder.
The results of this report observed that with respect anxiety, the difference in prevalence of this condition amongst men and women approached significance. This could mean that our sample may have been underpowered. In other words, had the total number of responses to the questionnaire been greater (e.g. >300) we may have observed the effect of sex and anxiety as being significant. Despite not reaching significance, a decision to include this observation in the final report was made as it may be helpful for understanding how specific issues may contribute to the development of certain mental health conditions. Although men and women are just as likely to experience anxiety, how they came to develop this condition could be different.
In society at large, anxiety has been reported to be more common in women than men. A recent meta-analysis found that the prevalence of anxiety disorders is high in women across the globe, and that contributing factors associated with anxiety include (but are not limited to) experiences of trauma as well as physical vulnerability (e.g. as in pregnancy) (Remes et al., 2016). Evidence suggests that anxiety disorders are not only more prevalent but also more disabling in women than in men (McLean et al., 2011). Whilst these themes were not directly assessed in the current report, individuals were given an opportunity to freely comment at the end of the questionnaire, and indeed, amongst women who reported a diagnosis of anxiety there were also reports of traumatic experiences. For example, one individual described what she perceived to be the cause of her personal anxiety and how she felt unable to seek support from those around her:

'Childhood experiences, sexual harassment. [I] had no way to entrust stress to parents or other supportive adults.'

Whilst this example is not necessarily representative of all women with anxiety, it is very important to acknowledge that such traumas exist in the community and that women may be at particular risk of experiencing them.

Native and migrant members have different experiences of depression

The results of this questionnaire illustrate the high instance of migration within the UK and German UC communities. For every 5 individuals, approximately 2 of them will be a migrant, meaning they are not living in a country they were born in. This is perhaps unsurprising given the Unificationist tradition of international marriage. The results of this study found that migration was not a risk factor across most mental health conditions. Migrant UC members are just as likely to seek out professional support for their mental health as native, non-migrant members and for the most part are as likely to receive a mental health diagnosis. The exception to this was in the case of depression.

The findings of this study found that migration status does effect whether or not you receive a diagnosis of depression. Why this is the case is not clear. Migration is often accompanied by a range of changes that could be either beneficial or detrimental. An individual may experience positive change moving to a country where they have better economic opportunities, however they could also experience hardship in the form of racism or homesickness (source: migrant.health, 2018).

The fact that migrant UC members are going to the doctors with mental health issues, but not receiving a diagnosis of depression may suggest there are specific issues associated with communication, namely cultural differences and language barriers. Compared to anxiety, schizophrenia and bi-polar affective disorder, all of which may have easily identifiable symptoms (e.g. panic attacks, hallucinations and delusions), depression may be more difficult for non-native speakers or individuals with a different cultural upbringing to communicate.

The UK government has made a point to issue guidelines to migrants concerning mental health (source: Gov.uk, 2019). These include recognising that depending on your cultural background different symptoms of mental health conditions may present as physical (e.g. pain) rather than emotional (e.g. depression). Further to this it is emphasised that individuals should use a professional interpreter to explore mental health issues rather than a family member. Most health care systems, including the UK NHS, employ professional interpreters for this purpose. Migrant UC members should be made aware of this finding, as inappropriate assessment of a mental health condition could mean they will not have access to appropriate treatment.

Experiences of mental health treatments are mostly positive

UC members should not fear seeking professional help

The findings of this report demonstrate that seeking professional support does not necessarily mean one will receive a mental health diagnosis. This may be an important point to emphasise to the considerable number of UC members who have struggled with their mental health, but not sought professional help. Whilst there is no shame in struggling with one's mental health, being 'labelled' with a mental health condition can be seen by some as self-defeating. Such individuals should be reassured that seeking out help does not necessarily mean you will receive a label, and you will be more likely to give yourself the opportunity to receive helpful treatment. The majority of people who received treatment (regardless of whether or not they received a mental health diagnosis) described their experience as helpful.

Talking to a professional is helpful

The majority of individuals described their experience of talking-therapy as helpful. This finding is of interest as it demonstrates that talking to an individual professionally trained in therapeutic techniques is a useful means of mental health support for UC members. As evidenced by reports from those who have not sought professional support for their mental health, there can sometimes be a fear/suspicion that therapists will be unable to understand issues associated with Unificationist lifestyle choices or be equipped to provide adequate help. The evidence from this study shows this appears not to be the case. Spirituality and religion are practices that are increasingly being embraced within the field of psychological therapy (Masters, 2010). UC members experiencing mental health struggles should be encouraged and supported to seek professional therapy as many individuals have found it helpful.

Taking medication can be helpful

Overall, many individuals also described their experiences of taking medication as helpful. This was particularly the case for those who were offered talking-therapy alongside medication. Being offered only medication was very unusual; a total of four individuals had this experience. Nevertheless, when this occurred half of these individuals (n = 2) did not find treatment helpful. Why this is the case is not known. As evidenced by this study, medication is usually offered alongside talking-therapy. This is because UK and German health care systems acknowledge that mental health is complex, and not merely biological. Talking-therapy is designed to support individuals to assess their relational and behavioural struggles, and it can also be an important means of support for individuals who are on a journey to finding an appropriate medication for their needs. It is perhaps interesting to note that the individuals who were offered only medication were also all UK nationals. It is an unfortunate reality of the UK National Health System (NHS) that there are considerable discrepancies in access to treatments depending on where you live, and this includes mental health services. A 2018 report by the BBC found that the NHS missed mental health targets of offering patients talking-therapy across 28 areas of England. This included the South London area of Merton and the city of Manchester (Triggle, 2018), both areas in which there are active UC communities. Given the unusual instance in which individuals are only offered medication and not talking-therapy, it is plausible these individuals unfortunately fell through the cracks of an imperfect system. Individuals who are only offered medication should be encouraged to communicate with their doctor if they would like to receive talking-therapy. Alternatively, they should be socially and potentially even financially supported to seek private care.

Pastors are mostly unaware and can offer limited support

The results of this study found that most individuals believe their pastor to be unaware of their mental health condition. Why this is the case is not clear and may not necessarily be negative. Mental health issues are personal, and it should not be considered necessary for anyone to share such personal information with their pastor if they do not wish to. The reason why the investigators chose to include this question was to have a characterisation of the level of awareness about mental ill-health within a given community. Traditionally speaking, the primary

role of a pastor has been to offer advice and counsel to their community. That more than half of individuals believe their pastor is unaware of their mental health condition may suggest a lack of trust towards pastors (i.e. individuals being unwilling to disclose this information), and in parallel a lack of awareness on the side of the pastors (i.e. pastors not knowing and/or not asking).
This idea is further reinforced by the perceived attitude of pastors by those who had informed them of their mental health condition. Whilst a variety of responses were reported, ranging from very supportive to unsupportive, the average of these responses was that pastors are generally neutral, neither supportive nor unsupportive. This may suggest that pastors are unable to provide appropriate mental health support or may have a false understanding about this topic. Why this may be the case was not explored further in this study. The role of a pastor within the UC community is arguably multi-faceted. A 2017 job advertisement for the role of a community pastor in the UK[§], described pastoral care as being just one of the many tasks these hard-working individuals perform. Conversely, experience of pastoral care and/or qualifications in counselling are not necessarily requirements for taking on this role. This is an important point of reflection for UC leadership. Whilst it is unrealistic to expect that every pastor become a mental health professional, it is reasonable to expect pastors receive a basic education and skills training about how to deal with a mental health crisis. Not only would this better prepare pastors for their role it would possibly also instil a deeper sense of trust and/or understanding from membership.

Role of faith and community on mental health can be positive and negative

For individuals who had been diagnosed with a mental health condition, the majority of them described the impact of their faith as being both positive and negative. Elaborations as to why this is the case illustrate a noticeable dichotomy in experience. Positive reports demonstrated that faith offers individuals a deep sense of purpose and direction in their life, and that community support, particular practices (such as prayer) and beliefs are in some cases lifesaving. The following quote illustrates this:

"My faith and belief in the spirit world, was a strong factor in avoiding suicide when feeling exceptionally low…"

This highlights the incredible strength that a religious lifestyle can offer to someone struggling with serious mental health issues. At its best, faith is an invaluable tool for coping with difficulty which can be further enhanced by the positive support of one's community.
In contrast, many individuals also reported that their faith had a detrimental impact on their mental health. Reasons for this were also more varied, including issues such as feelings of pressure associated with mission, feelings of disappointments and/or perceptions of hypocrisy associated with the UC, a sense of isolation from society, as well as a culture of taboo surrounding difficult topics. However, the most commonly cited negative theme was experiences of judgement and or mistreatment within the UC. Reports describe at best misdirected efforts of support from the community and at worst worryingly unhelpful comments and treatment. The latter point is well characterized by the following quote:

[§] Advertisement for the role of Bromley community pastor (UK), 2017: https://um-uk.org/archives/seeking-a-new-pastor-for-the-bromley-community/

'I had church people tell me it was just evil spirits that I was hearing and seeing, and I was basically corrupted when actually this was not the case, I had multiple severe physical illnesses which left me with severe mental health problems coping with them [sic]. The church made me feel judged and made me shut away from everyone because of how people reacted towards me. I am still a member of the church but am very distant from everyone and everything to do with it.'

This illustrates how ignorance around the topic of mental health can impact the treatment of those with mental health conditions and dramatically affect how they choose to relate to the UC community. This insight is perhaps uncomfortable to acknowledge considering the strong emphasis of the UC on ideas such as 'living for the sake of others' and 'one family under God'. It is perhaps made even more painful given that this study also showed the potentially positive impact of a supportive community. Why it is that some individuals feel supported by their community and others do not is an important question that this current study cannot provide definitive answers for. What this study does show is that judgement and mistreatment are serious concerns that the European UC community should reflect upon if they are committed to the care and support of some of their most vulnerable members.

Why some individuals do not seek professional support for their mental health

Second generation may not recognize mental ill-health as serious and have limited resources

The results of this study found that generation/age was a risk factor in not seeking professional support for mental health. No statistical test was conducted to determine the direction of this effect; however, observation suggests that second generation UC members were more likely to report having experienced a mental health issue but not sought professional help compared to first generation. Why this might be the case is not directly clear.

One possible explanation for this could be duration of illness. Older first-generation members may have experienced mental ill-health over a longer period of time and therefore be more likely to have sought professional support at some point. On the other hand, for younger second-generation the duration of their mental ill-health may be shorter. Consequently, they may not *yet* have sought professional support. This observation is supported by the qualitative data obtained in this study.

When asked to report on why they had not sought professional support, the most frequently identified theme for second generation was that they did not consider/recognise their mental health issue to be serious enough to warrant professional support. Whilst this may suggest that the severity of second-generation mental health issues may be less, it is important to note that all these individuals described their mental health issue as being severe enough to interfere in their daily life. Furthermore, none of these individuals made reference to managing their mental ill health with the support of their social network. Therefore, despite struggling with their mental health to the point they had difficulty, for instance, finding or keeping a job or partner, or regularly attending and coping with school or work, these individuals were unable to recognise the seriousness of their mental ill-health and consequently did not seek professional, or even social support to help themselves. In effect, these individuals are suffering in silence.

Mental health conditions are strongly associated with beginning in early life. In the UK half of all mental health problems have been established by the age of 14, with this figure rising to 75% by the age of 24 (NHS England, 2017). It is also widely noted that many individuals delay seeking help for their mental ill-health. A survey by the World Health Organisation found that for instances of anxiety, individuals delay seeking help by between three and 30 years (Wang et al., 2007). Consequently, diagnosis and importantly treatment of mental health conditions is often hindered by the fact that many individuals delay seeking professional support. That so many second generation do not recognise the severity of their mental ill-health is potentially very serious. These individuals should be encouraged to take their mental ill-health seriously and seek appropriate professional support.

The second most common theme as to why second generation do not seek professional support for their mental ill-health was due to a lack of resources (e.g. money/knowledge). Given the average age of second-generation respondents was 25 years old, it is possible that these individuals may be in lower paid employment and/or under more financial pressure compared to older first generation, making it difficult for them to prioritise paying for private therapy - especially if one does not consider one's situation to be serious enough to go to a doctor. Similarly, youth may suggest limited life experience or knowledge about how to go about seeking mental health support. These individuals should be socially and/or financially supported to seek help. They should be reassured that talking-therapy can be affordable, with many charities and employers providing schemes to enable low-income individuals to get appropriate care.

Men may be less trusting of professional support

This study observed that men and women were just as likely to report experiencing a mental health issue but not seek professional support. This suggests that both men and women may have similar challenges (e.g. lacking resources) or compensatory strategies (e.g. social support) when dealing with their mental ill-health. However, the theme of having a lack of belief/trust in professional support was shown to be an exclusively male opinion.

Why men do not seek mental health support is a complex issue that may, in part, be rooted in specific ideas around masculinity. For example, the traditional idea that men are expected to be the breadwinners and to be strong, dominant and in control, may make it harder for men to reach out for help and open up. One study found that adherence to traditional masculine norms has been shown to be negatively associated with the willingness of men to seek professional help for mental ill-health (Berger et al., 2013). Moreover, it has been suggested that men would be more inclined to seek help if therapies catered more for men's preferences (Liddon, Kingerlee, & Barry, 2018). For example, recent evidence suggests that young men in particular may feel more comfortable seeking professional support online, by way of online-therapy (Ellis et al., 2013).

Promoting discussion around the topic of masculine norms within the UC community may help to encourage men to seek support for the challenges they face. Furthermore, it should be considered that some men may find particular styles of therapeutic treatment more helpful than others.

Could culture and community have protective effects on mental health for migrants?

The results of this study found that migration was a significant risk factor in not seeking professional support for mental health. No statistical test was conducted to determine the

direction of this effect; however, observation suggests that compared to natives, migrant individuals were considerably less likely to report having experienced a mental health issue in their daily life for which they had not sought professional help. Why this is the case is not clear. Considering the previous points made concerning cultural differences (see: Native and migrant members have different experiences of depression), it is possible that migrant individuals are less likely to perceive or describe their experiences as mental health symptoms and would therefore not believe they need professional support.

However, this may not fully explain why migrants are so much less likely to experience a mental health issue that interferes in their daily life. We do not have a definitive answer for this. It is conceivable that being actively part of a community in which there are many other migrants who may share your experiences and offer support could have a protective effect on mental health. Future investigation would be required to determine definitively why it is that migrant individuals do not report mental ill-health as interfering in their daily life.

Mental health: a call for clarity

Prior to conducting this study, the investigators were aware of particular beliefs held by some UC members about mental health conditions, namely that they were the result of 'spiritual possession'. Consequently, this study was interested to understand the extent to which this belief was common amongst UC members. The results showed that the belief that mental health conditions are mainly caused by spiritual factors is an opinion held by a minority of individuals. This opinion was less common than the belief that mental health was mainly caused by other factors, such as genes, environment, and upbringing.

The overall majority of respondents believed that a combination of both spiritual and other factors cause mental health conditions. This latter finding is difficult to unpack as participants were not asked to elaborate on how or why they believe spiritual and other factors intersect to cause mental health issues. On the one hand, it is possible that these individuals have specific informed opinions that we failed to capture. On the other hand, it is possible that some individuals were not sure and that choosing the option of 'both' was equivalent to 'unsure'. This response approach had been anticipated by the investigators and an option for 'unsure' had also been included, but exceptionally few individuals chose it.

Moreover, whilst individuals who had experienced mental ill-health responded most frequently that the causes are the result of both spiritual and other factors, they believed this less often than individuals who had not experienced mental ill-health. They were also more likely to have a binary view that mental ill-health was either caused by spiritual or other factors, with the latter being more common. The broader distribution of responses observed in individuals with first-hand experience of mental health issues further suggests that individuals who had not experienced mental ill-health and responded 'both' may be saying so because they are not sure. Ultimately, the results of this study do not provide any definitive explanation as to what UC members believe to be the causes of mental ill-health, aside from that they generally believe both spiritual and other factors are at play. To understand this more deeply would require further investigation. A recent review of the words of Rev. Moon from one of the primary UC texts (Cheon Seong Gyeong) identified very few instances in which mental health was referred to. Furthermore, texts that were identified included contradictions. This review was published on the Applied Unificationism blog and is available to read below (see: APPENDIX VII –). Briefly, there

is little explanation or advice concerning mental health issues from the founder of the UC movement or from primary Unificationist texts. Whilst individuals should be encouraged to form their own opinion, a clear stance about mental health from the upper tiers of the movement would have the potential to validate many individuals' experiences of mental health issues and encourage a culture of informed awareness, compassion and care.

Unheard voices: important limitations of this study

There are a number of limitations of this study that should be addressed. The first is that this questionnaire was only made available to UC members in either the UK or Germany. These two communities were chosen as they represent the largest UC populations in Europe and therefore afforded the study the best possible chance of capturing a large enough sample. Furthermore, given the sensitivity of the topic, the investigators were committed that members should have the opportunity to fill in the questionnaire in their native (or most frequently) used language. Much care and consideration were taken to translate the questionnaire and coordinate its dissemination amongst members. Limited resources (such as available volunteers, time, and money) meant it was not possible to translate the questionnaire to further languages. That the results of this study reflect the European UC community as a whole is an assumption. How smaller communities or different European cultures experience and/or perceive mental health may be different.

The primary aim of this study was focused on the issue of mental health, however it did not consider the experiences of those with neurodevelopmental conditions, such as Autism Spectrum Disorder (ASD). Whilst ASD is not a mental health condition, there is considerable evidence from wider society that such individuals may be particularly vulnerable to mental health issues. A recent meta-analysis found that many mental health conditions, ranging from common to severe, are generally more common in individuals with ASD than the general population (Lai et al., 2019). This is an important point of reflection and any future investigations should include this aspect in their study.

In a similar vein, this study failed to consider the impact of social issues on mental health, such as racism. The investigators had considered collecting demographic information concerning individuals' ethnicity, but early feedback that was obtained suggested that some individuals feared that disclosing their ethnicity would make them identifiable and circumvent their anonymity. This was a concern for the investigators as protecting participants' anonymity is the foundation for reliable research and forms the bedrock of the investigators' ethical commitment (see: APPENDIX I - Ethical Commitment). Nevertheless, in the comments section at the end of the questionnaire, some individuals did express themes of racism as a contributing factor to mental ill-health. Future research should be sensitive to this issue.

Initially, the investigators had hoped to be able to capture the broader experiences of former members and second generation who have distanced themselves from the movement. This was based on first hand observations that some individuals who choose to no longer associate with the UC community may be particularly vulnerable to experiencing mental health issues. Attempts were made to reach out to former members and indeed some made efforts to contribute, for which we are very grateful. The decision to not assess this data was twofold. Firstly, there is no reliable estimate for the total population of former members that could be used to determine an

appropriate sample size (see previous section: Sample). This is important as this enables one to determine whether or not the responses obtained are a reasonable representation of the broader population and therefore not biased. Furthermore, the practicalities of reaching out to former members proved difficult as there were limited sources from which contact information could be obtained. Consequently, the number of responses from former members were limited. Understanding the experiences and opinions of former members is important for the future betterment of the current UC community and could also serve to offer some former members a sense of comfort and/or closure. Future research should consider all the voices this study failed to capture.

Future directions

Education and awareness

The outcomes of this study suggest that much could be gained by raising the general awareness and understanding of mental health issues amongst UC members. This is not a specific critique of the UC community as arguably false impressions of mental health are notable in wider society as well. Initially, members of the Healthy Minds team would be willing to present the findings of this report as well as share educational resources about different mental health conditions to local communities as well as at leadership meetings. However, improving the level of understanding within the community will likely take time and sustained efforts. It should be considered that specific attention should be provided to this at a continental level. For instance, the role of 'mental health officer' an individual who is provided formal education on the topic of mental health and has the responsibility to promote this theme amongst members should be considered and integrated into the European Blessed Family department. This individual could then act as an adviser to national leaders and pastors, as well as support other community leaders such as in HARP or STF. It is not suggested that this individual become a 'church therapist', but rather a spokesperson and educator. An example of an awareness raising activity that could be adopted is the promotion of a European wide 'mental health awareness week', an already existing initiative supported by multiple mental health charities who provide many useful resources and activities (for an example see: Mental Health Foundation UK).

Openness to professional support

As evidenced by the results of this study, the most helpful and sustainable way of supporting UC members with mental health issues is by encouraging them to seek professional support. Efforts should be made to demystify false impressions surrounding seeking professional support. These include reassuring individuals that seeking professional support is not a sign of weakness and does not necessarily mean you will be labelled with a mental health condition. Furthermore, that professional therapists would not be able to understand particular lifestyle choices associated with being a UC member is not necessarily the case.

There have been suggestions for the recruitment of 'in house' therapists, for example, paying and supporting a UC member to qualify in the field of mental health and provide therapy to members. There are a number of reasons why this well intended suggestion is limited. Firstly, the prevalence of mental health in the UC community is great and would be understandably too much for one individual to cater for. Secondly, the broad geographical distribution of members

and language barriers would make it difficult for any single individual to fulfil this role. Thirdly, there are potential issues associated with confidentiality and clear relational boundaries between an individual and their therapist are very important. Finally, having an 'in house' therapist would only serve to reinforce the false belief that professional bodies are ill-equipped to understand the issues of Unificationists. For these reasons, the authors of this report encourage members to be open to already existing professional support.

Members should also be reassured that choosing or needing to use medication is potentially a very helpful way of helping oneself to recover or manage a mental health condition and should not be vilified. For some individuals, particularly those with severe conditions, it can take considerable time to find a medication that best suits their needs, which can be disheartening and result in relapses as a result of discontinuing treatment. These individuals deserve the support of a community that does not exacerbate this issue through judgement, but rather encourages them to continue their journey to better health.

The findings of this report show that a lack of resources, including access to information about getting support or having the funds to seek it are genuine concerns for UC members. The authors suggest that part of the remit of the 'mental health officer' would be to provide information on how to access affordable support. This could be having a list of recommended therapy clinics or services, or guidance on how to talk to your doctor about mental health. For example, it should also be noted that the costs of psychotherapy in Germany are covered by the health insurance companies if there is a diagnosable mental illness. Where possible national councils could also consider providing full-time members facing mental health challenges with paid counselling, under the remit of occupational health. Furthermore, an emergency 'well-being fund' could be set up to provide members facing financial hardship with the funds to seek urgent mental health care.

Support for Pastors

The results of this study highlight a strong need to better equip pastors to support members of their community struggling with mental health issues. That pastoral care is one of many tasks these individuals must juggle suggests they may not be able to allocate enough time to tend to their community in such a way that vulnerable members may need. Furthermore, that individuals with mental health conditions perceive their pastors to have a neutral attitude towards them suggests that pastors may simply not know what to do or how to properly help. This is an important point to acknowledge, especially considering this study found that 'pressure of mission' can be a contributing factor to a decline in mental health. If pastors are being put in a position to support, but lack the resources or training, both the community members and pastors are at risk. It is the opinion of the investigators that providing basic training in mental health and crisis management to pastors should be a requirement of the position. One example of this would be to pay for pastors to attend a training in 'mental health first aid', which is a lay-based program of health education, which is evidence-based and wide-spread in English-speaking countries and is also now available in Germany[**]. Furthermore, we would suggest that the formal definition of what a pastor in the UC does should include pastoral care as a one of the *primary* tasks. If this is

[**] More information can be found by visiting the website of Mental Health First Aid International, www.mhfainternational.org

not possible, it should be considered that individual nations consider adopting the role of 'mental health officer' into their Blessed Family departments. These individuals should be available to offer support to an individual and their family during a mental health crisis if it is requested.

Summary

This in-depth report found that mental health issues are a very real concern for the European UC community. Approximately 1 in 3 UC members have received professional help for their mental health and around 1 in 5 UC members has a diagnosable mental health condition. The prevalence of different mental health conditions roughly mirrors that observed in wider society. This study found that first and second generation were just as likely to seek professional support or receive a mental health diagnosis. A similar observation was made for men and women. Migrant individuals were just as likely to seek professional support as natives but were less likely to receive a diagnosis of depression. Individuals that experienced mental health issues but who did not seek professional support were more likely to be second generation. This observation may be driven by second generation not viewing their circumstance as being serious.

Informed by the qualitative data, the discussion also raises important concerns with respect to these different groups and observations. For instance, the risk of anxiety in women may be driven by trauma and physical female experiences such as pregnancy; the reluctance of men to seek professional support may be driven by specific issues surrounding masculinity; migrant individuals may face challenges with respect to cultural differences and language barriers.

This study found that treatments offered by mental health professionals, such as talking-therapy and medication, can potentially be very useful for many individuals struggling with mental health issues. The role of faith and community support for these individuals is, however, a complex picture. Faith has the power to offer such individuals a deep sense of purpose and direction that can be very helpful. Conversely, judgement and mistreatment within the UC community can have a damning effect. The limited capacity of pastors was highlighted and is an important point of reflection for the future.

This study was limited in terms of the voices it could portray. What is more, these findings are not definitive, but rather a snap-shot of the European UC community at a specific point in time. Efforts to improve mental health awareness and understanding within the UC community as a whole could potentially provide some of its most vulnerable members with an invaluable sense of validation and much needed support. The role of Mental Health Officer is suggested as a means to better support those in leadership or members in general on the topic of mental health. Compassion, care and understanding are essential for a healthy community and are essential qualities at the heart of the blessed family ideal. Culture change within the European UC community may take time, but it is possible.

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APPENDIX I - ETHICAL COMMITMENT

As this project was conducted by individuals and not part of or funded by an institution or organisation, there was no ethical framework it was required to adhere to. In spite of this, all researchers involved felt it important to outline a clear ethical commitment to ensure the integrity and quality of any of the research conducted as part of the Healthy Minds project.

Consequently, all those involved in the design, collection and analysis of data were required to agree to the following ethical commitments:

1. To ensure the quality of the research by using the appropriate means of analysis and rigour;
2. To ensure the integrity of the research by openly communicating the nature and findings with honesty and transparency;
3. To seek informed consent from all those participating in questionnaires and/or interviews;
4. To respect the confidentiality and anonymity of participants;
5. To ensure that participants take part voluntarily and not as a result of social pressure;
6. To ensure the care and respect of all participants.

As the Healthy Minds project is an independent venture being conducted by Cranes Club Europe volunteers the findings and inferences made will be independent and impartial to the formal views of the European UC community.

APPENDIX II – FINACIAL OVERVIEW

Healthy Minds was awarded a grant of €500 by Cranes Club Europe at the 2018 Annual General Meeting, held in Paris. The following is a breakdown of how these finances were used to support the project.

Item	Description	Amount (€)
Prize drawer money	To encourage participation, questionnaire respondents from each country were given the option to enter into a prize draw for a monetary prize of €100/£100.	209
Education/training	EUB, CV, and IT attended a seminar on "Health and Healing in Minority Religions" hosted by Inform (Information Network Focus on Religious Movements), an independent charity based at King's College London. Cost included registration fees.	103
Website	For the duration of the project (2018-2020), a website was setup so that participants would have access to information about the project.	41
Translation	Payment to individuals for their work translating materials from English into German.	134
Other/Misc	Food/drink for meetings, international transaction fees, other.	13
TOTAL		500

APPENDIX III – ABOUT DEPRESSION

What is depression?
It's normal to feel sad or miserable sometimes. But if your mood stays low for weeks at a time, keeps returning, or interferes with your life, it could be a sign of depression.

Depression is not the same as being sad and is not a sign of weakness or a character flaw. It is an illness and can have a serious effect on a person's life and the lives of those around them. In severe cases it can make everyday life extremely difficult, and even lead to suicide.

How common is depression?
Depression can affect anyone and is one of the most common mental health problems. In the European Unification Church community, depression affects around **1 in 10 people**.

What does depression look like?
Depression affects everyone differently, but there are some common symptoms:

- Feeling sad or low for long periods of time n Feeling hopeless or helpless
- Feelings of guilt
- Being anxious or worried a lot
- Feeling irritable
- Feeling tired all the time and having no energy
- Having no motivation or being unable to concentrate
- Losing interest in things that you normally enjoy
- Losing interest in sex
- Changes in your appetite - eating too much or too little
- Having trouble sleeping, or needing to sleep more than usual n Moving or speaking more slowly than usual
- Thoughts of suicide or hurting yourself
- In severe cases, a person with depression might experience symptoms of psychosis (e.g. hallucinations, such as hearing voices).

It's important to note that a person with depression might not experience all of these symptoms - for example, someone can be suffering from depression without feeling particularly sad.

How is depression treated?
A combination of lifestyle changes, talking therapies and medication is often the most effective way to treat depression.

More information about depression can be found on the website of the following heath organisations and charities:

In English…

- NHS mental health services https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/
- Mind (The UKs largest mental health charity) www.mind.org

Auf deutsh…

- *Deutsches Bündnis gegen Depression e.V.* www.buendnis-depression.de
- Sehr umfangreich ist auch Informationsangebot im Internet: unter www.psychiatrie.de

APPENDIX IV – ABOUT ANXIETY

What is anxiety?
It is normal to feel anxious or worried in situations that we see as threatening. In fact, a certain level of anxiety can be helpful in making us prepare for important events such as exams or job interviews, or by helping us escape from dangerous situations. Anxiety becomes a problem when it lasts a long time, becomes overwhelming, or affects the way we live our day to day lives. There are many different kinds of anxiety conditions including: generalised anxiety disorder (GAD); panic attacks; obsessive-compulsive disorder (OCD); social anxiety disorder, and phobias.

How common is anxiety?
Problems with anxiety are common. In the European Unification Church community, anxiety affects approximately **1 in 10 people**. In fact, it is common for individuals to experience both anxiety and depression. People of all ages and backgrounds can experience problems with anxiety.

What does anxiety look like?
People who have problems with anxiety may experience a number of different psychological and physical symptoms:

Physical Symptoms
- Muscle tension
- Light headedness
- Dry mouth
- Sweating
- Trembling
- Hyperventilating
- Nausea

Psychological Symptoms
- Feeling worried
- Fearing the worst
- Feeling irritable
- Finding it difficult to concentrate

Everyone experiences anxiety differently. There may be feelings or physical symptoms listed here that you have never experienced. On the other hand, you may have experienced anxiety in ways other than these.

How is anxiety treated?
A combination of lifestyle changes (getting more exercise, eating healthily and sleeping well), talking therapies (such as cognitive behavioural therapy), and in some case medication are all considered effective ways to treat anxiety. Depending on what kind of anxiety you are experiencing you may be recommended different treatments.

More information about anxiety can be found on the website of the following heath organisations and charities:

In English…
- NHS mental health services https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/
- Mind (The UKs largest mental health charity) www.mind.org

Auf deutsh…
- *Deutsches Bündnis gegen Depression e.V.* www.buendnis-depression.de
- Sehr umfangreich ist auch Informationsangebot im Internet: unter www.psychiatrie.de

APPENDIX V – ABOUT SCHIZOPHRENIA AND PSYCHOTIC DISORDERS

What is schizophrenia?
Schizophrenia is an illness that affects thinking, feelings and behaviour. It is a major cause of disability and can affect people from all cultures and ethnic groups. Having schizophrenia does not mean that a person has a 'split- personality'. The media often stereotypes people with the condition as dangerous or violent - this is actually rare, and people with schizophrenia are more likely to be victims of crime.

How common is schizophrenia?
Schizophrenia affects around **2 in 100 people** in the European Unification Church community. Men are slightly more likely to develop the illness than women. Most people with schizophrenia first develop the condition between the ages of 16-35.

What does schizophrenia look like?
The symptoms of schizophrenia can be very dramatic and frightening for people experiencing them. They can include seeing or hearing things that are not really there - known as hallucinations, or developing unusual, often frightening beliefs, known as delusions. Schizophrenia can also cause confused thinking which can make it difficult to follow the meaning of people's speech. These experiences are sometimes known as 'positive symptoms' or psychosis. In addition to these symptoms people often have difficulty with motivation and concentration and may withdraw from social situations. These are known as 'negative symptoms' of schizophrenia.

If someone experiences psychosis does it mean they have schizophrenia?
Just because someone experiences psychosis does not mean that person has schizophrenia. It is possible for people to experience psychosis in other mental health conditions, including bipolar affective disorder and depression, as well as in other health conditions, such as following childbirth or dementia.

How is schizophrenia treated?
There is no cure for schizophrenia, but in most people, symptoms can be either completely controlled or improved a lot by treatment. Many people with the illness go on to live a stable life, work, and have relationships. A group of medicines called antipsychotics are often used to reduce symptoms of psychosis. Psychological treatments can also help, and most people will be offered a combination of medicine and talking therapies. Other kinds of support such as Family Intervention therapy can be very useful too. In severe cases, people with schizophrenia may need to spend time in hospital until they recover from symptoms of psychosis. Others may need a lot of support in their day-to-day lives on a longer term basis.

More information about schizophrenia can be found on the website of the following heath organisations and charities:

In English…

- NHS mental health services https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/
- Mind (The UKs largest mental health charity) www.mind.org

Auf deutsh…

- *Deutsches Bündnis gegen Depression e.V.* www.buendnis-depression.de
- Sehr umfangreich ist auch Informationsangebot im Internet: unter www.psychiatrie.de

APPENDIX VI – ABOUT BIPOLAR AFFECTIVE DISORDER

What is bipolar affective disorder?
Bipolar affective disorder (sometimes simply called 'bipolar disorder') is a complex illness which can vary a great deal in nature and severity between people. People with bipolar disorder have problems with their moods, experiencing extreme highs and lows.

How common is bipolar affective disorder?
Bipolar affective disorder occurs in approximately **1 in 100** people in the European Unification Church community. Factors such as life stress, lack of sleep and recreational drugs can trigger mood episodes.

What does bipolar affective disorder look like?
If you have bipolar disorder you will experience periods or 'episodes' of highs known as mania (feeling hyperactive or having a highly elevated mood, e.g. euphoria) or hypomania (a less intense form of mania, your energy level is higher than normal but not as extreme as mania). In addition to the highs, you will usually experience periods of severe depression. You may also have problems with thinking and perception, which can include symptoms of psychosis. This can include thinking things that are not true (delusions) and seeing or hearing things that are not there (hallucinations).
Because of the different symptoms, individuals with bipolar disorder can sometimes be given a wrong diagnosis. For instance, if that individual goes to the doctor when they are experiencing a period of depression they may wrongly be diagnosed with depression and not bipolar. If you think you might have bipolar it is often recommended you keep a 'mood diary', tracking how often you experience highs and lows. Sharing this information with your doctor can be very helpful.

How is bipolar affective disorder treated?
For many people with bipolar disorder medication is a key part of staying well. There are a large number of medications that can help. Some work by preventing the extreme highs or lows caused by the condition; these are known as mood stabilisers, and often need to be taken daily for long periods. Other medications may then be used to treat episodes of high or low moods when they happen. Different medications suit different people and finding the best medication for an individual can take time, with trials of different medications and doses. Talking treatments such as psychoeducation can also be helpful. This approach helps people to understand their illness, learn to recognise early warning signs of highs and lows and develop the skills needed to stay as well as possible.

A combination of medication and psychoeducation is often most effective.

More information about bipolar affective disorder can be found on the website of the following heath organisations and charities:

In English…

- NHS mental health services https://www.nhs.uk/using-the-nhs/nhs-services/mental-health-services/
- Mind (The UKs largest mental health charity) www.mind.org

Auf deutsh…

- *Deutsches Bündnis gegen Depression e.V.* www.buendnis-depression.de
- Sehr umfangreich ist auch Informationsangebot im Internet: unter www.psychiatrie.de

APPENDIX VII – HEALTHY MINDS AND MENTAL ILLNESS: A BRIEF REVIEW OF REV MOON'S WORDS

Review published on the Applied Unificationism blog on April 16th, 2018. Written by Catriona Valenta. (source: https://appliedunificationism.com/2018/04/16/healthy-minds-and-mental-illness-a-brief-review/)

Healthy Minds and Mental Illness: A Brief Review

This article describes background research for a proposed project initiated under Cranes Club Europe.
The project, "Healthy Minds," aims to assess the mental health needs of the Unificationist community — its prevalence, attitudes and support available. I review:

- Reverend Sun Myung Moon's (SMM) words about mental illness (MI). Quotes were found mostly in the *Cheon Seong Gyeong*; the source speech was then identified on Tparents.org, which hosts a comprehensive database of SMM's speeches translated into English listed by year and month.
- The basic premises of the Divine Principle (DP) and Unification Thought (UT). Do they offer insights which may be helpful for sufferers and therapists in our movement?
- An attempt is also made to integrate the words of SMM and the content of DP and UT into the more conventional psychiatric view of MI.

The words of Rev. Moon
Although he did not say a great deal about mental illness, quotes from the 1950s until the last years of his life confirm that SMM saw MI as a "spiritual problem," i.e., as the result of the influence of evil spiritual beings. The speeches from which these quotes are taken were given to various audiences; the earlier ones are to smaller groups of followers in Korea, the later ones in the United States not only to leaders, but also to the broader audience of members who would regularly gather to hear him when he spoke. I am unable to find comments about mental illness in any of his speeches to the general public.
If his view of MI seems very limited, the spiritual aspect is arguably the only one about which SMM could have had any informed knowledge. Furthermore, it is important to bear in mind that although an expert on love, SMM often made statements about fields in which his knowledge was lacking, and some of his comments may not even have been meant to be taken literally (for example, when he says, "with just a look, you can cure leprosy and other disorders").

Divine Principle as a model of health
The core teachings of DP, upon which Unification Thought (UT), the teachings/philosophy of SMM systematized by Dr. Sang Hun Lee is based, are:

- The Principle of Creation, God's ideal
- The Fall
- Restoration

The ideal of the three blessings and a *Cheon Il Guk* made up of individuals who have fulfilled them, is a basic pillar of the Principle of Creation. "Mind-body unity" must be achieved by developing and maturing the three core functions of the mind, intellect, emotion and will, if one is to fulfil the first blessing. But in mental illness one or all of these three parameters are disrupted.

Disturbances of emotional response make it extremely difficult for those with mental illness to develop mature and loving relationships; some lucky individuals with psychotic illness may find a supportive life partner, and have children, but many will not. And the disturbance of will resulting in a lack of "will power" brings up the vexing issue of responsibility and is the reason why many mentally ill are seen as having character and moral flaws and weaknesses. And, of course, while the life of a mentally ill person is greatly affected by the choices he or she makes while exercising free will and responsibility, the ability to make good choices is greatly influenced by illness. It tends to be a vicious circle.

The question is: are we emphasizing a lifestyle that is only attainable by some? Or is mental illness "just" an extreme manifestation of "fallen nature" — we are all mentally ill and the path of restoration is open to and "walkable" by all? This is indeed an unresolved and debatable issue, and even Western psychiatry with its DSM (Diagnostic and Statistical Manual) classification system of mental disorders is not united as to whether mental illness is a distinct entity or something at the end of a spectrum (as in some cases of hypertension and diabetes, for example). Nevertheless, to classify all as having degrees of "mental illness" does not deal with or explain how or when the border is crossed into a clinical problem — be it psychosis/delusions or "clinical depression."

Unification Thought suggests the root causes of mental illness (with the key to "healing" / "cure" denoted in parentheses) to be:

- The Fall (the Blessing)
- Evil spiritual influence (*ansu* and liberations at Cheongpyeong)
- "Fallen" dysfunctional families (family therapy)

In effect, the treatment of (cure for) mental illness is none other than the "path of restoration" that all of fallen humankind should walk, with "family therapy" an additional tool used in some form by most Unification counsellors and therapists. Popular approaches are "intergenerational family trauma therapy" and "family constellation therapy."

Underlying these particular approaches is an assumption that even deceased family members have an enormous effect on our behaviour by exerting a spiritual influence on family dynamics. But instead of (or in addition to) trying to "liberate" spirits by *ansu*, an attempt to relieve or mitigate spiritual influence is made by utilizing the above-mentioned therapies. This approach is also widely used by non-UC therapists (who may not acknowledge or understand the influence of the spiritual dynamic, at least not as understood by Unificationists).

While undoubtedly almost any family could benefit from therapy (especially anywhere communication is improved), efficacy of this specific type of family therapy — at least alone — in severe mental illness has not been properly evaluated, and it is generally not accepted as legitimate by mainstream psychiatry.

Additionally, it must be stated that it is an oversimplification to consider that mental illness can be solved simply by creating healthy families and may foster an attitude which places an

unwarranted burden of guilt on the family members of the mentally ill. Herein is a regression to the thinking exemplified by the now debunked "refrigerator mother" theory of R. D. Laing (referring to mothers of schizophrenic patients). The mentally ill can be found in the most "ideal" of families.

Conventional psychiatry will admit that much remains puzzling and unsolved about mental illness, but generally acknowledges the following etiological factors, whereby any combination may play a role in any individual case:

- *Biological:* including a strong genetic component. The case for a strong biological component and genetic susceptibility in MI is pretty watertight, given what we have learned from advances in genetics and neurochemistry, as well as insights into the functioning of the brain in health and disease, gained from new technologies such as MRI (magnetic resonance imaging).
- *Environmental*: poor social support, substance abuse (especially cannabis), city living, background of migration.
- *Psychological*: trauma, neglect, (grossly) dysfunctional family background.

The Unification perspective puts emphasis on two further components:

- *Original sin,* which, according to *Divine Principle*, "is ingrained in our lineage and is the root of all sins." The exact mechanism by which original sin exerts its influence is disputed even within Unificationist circles (e.g., whether it is "in our DNA" or a collective inheritance of shame and guilt resulting in dysfunctional families), but the Blessing ceremony, a ritual whereby original sin is forgiven and dissolved, is generally accepted as the *sine qua non* for resolving this issue.
- *Spiritual influence:* It is essential to recognize that this is a core belief of the majority of Unificationists and is reinforced by the words of SMM. It is not at all surprising that a large part of the work of "healing" in our movement has been centered on the work of the medium for Dae Mo Nim (ascended mother of True Mother) and the Cheongpyeong providence which SMM endorsed. It is beyond the scope of this brief review to assess the validity or extent of spiritual influence. Western psychiatrists (with rare exceptions) do not acknowledge this dimension, and some Unificationists struggle with the emphasis placed on it.

It is an ambitious undertaking to develop an understanding of mental illness based on our belief system (a "Principled perspective"), and perhaps at most, we can attempt to integrate the understanding brought by insights from SMM through his words and teachings — DP, UT — with the very best, evidence-based findings and understandings of scientific, mainstream psychiatry. SMM himself recognized in a 1987 **speech** to Unification medical professionals that Western medicine has an essential role to play; we ignore or reject Western medicine at our peril.

Thus, a perspective which integrates and satisfies all differing points of view might postulate a biological malfunction — abnormalities in neurotransmitters and neuronal pathways — as being the final common mechanism producing the clinical manifestation recognizable as MI in a genetically susceptible individual.

Multiple varying factors — environmental, psychological, and (at least for most Unificationists) "spiritual influence" — contribute to this final common pathway.

Therapeutic intervention may be offered at various stages, the emphasis in any given situation depending on the clinical picture, the beliefs and wishes of the patient, and the knowledge and skills of the therapist.
Thus, medications address the biological dysfunction at the neurotransmitter level; individual counselling helps optimize personal behaviour and lifestyle choices; family therapy addresses dysfunctional family dynamics; and spiritual liberations tackle negative influences at that level.

Conclusion

A study of Unificationist teachings (words of SMM, DP and UT) leads to some mixed conclusions. On one hand, DP/UT offers an idealistic and hopeful view of humankind's potential, as well as insights into the dynamics of the spiritual world; on the other hand, this view sets a very high standard (individual "perfection," the first Blessing) which is difficult enough for an individual of "sound mind," but as discussed above, may be unattainable for (and place unhealthily unrealistic expectations on) one who is seriously mentally ill.
We also need to acknowledge that embedded in the very core of the attitude of Unificationism to MI is the belief that its origin and course is greatly influenced by an evil spiritual world, and that this understanding is reinforced by the views of the founder, SMM. How much this premise is accepted by individual Unificationists varies, and any attempts to confirm or refute spiritual influence are fraught with challenges. However, it is entirely reasonable to demand evidence that spiritual liberations in Cheongpyeong bring about a level of clinical improvement equivalent to wisely used psycho-pharmaceuticals.
It should remain the domain of the individual patient, his family and therapist to decide how much of a role each aspect will play in an individual case, but imperative that any decision-making is based on informed choices; what is practiced and recommended must be effective and ideally supported by solid evidence. There must be mutual respect, understanding and cooperation among therapists employing differing approaches, and a great deal of work needs to be done to improve understanding between Unificationists (patients and providers) and conventional psychiatrists.
Western psychiatrists have a hard time with the notion of spiritual influences, but those who are "humane" and ethically-minded will at least respect the religious beliefs of their patients, no matter how eccentric they may find them. Unfortunately, the attitude towards Western psychiatry among Unificationists is often one of suspicion, prejudice and even a degree of ignorance. We need to acknowledge, for example, that the lives of many have been dramatically improved by the judicious use of medication.
The many counsellors and therapists within the Unification movement working in the field of mental health must strive for professionalism and the highest standards, recognize their limitations, and be prepared to refer as necessary. Ideally, any UC therapist or counselor would have a solid scientifically-based education and understand the findings and implications of what modern medicine teaches us about the workings of the brain, to which he/she can bring his/her particular aspect of therapy, delivered with a compassionate and parental heart.