



‘Mad, bad, or possessed’? Perceptions of Self-Harm and Mental Illness in Evangelical Christian Communities

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Abstract

Mental illness within evangelical Christian communities is frequently stigmatised, with many attributing it exclusively to demonic possession, lack of faith, personal sin, or other negative spiritual influences. This study explores perceptions of self-harm in the context of evangelical Christian faith communities using the novel qualitative story completion task. A convenience sample of 101 UK-based evangelical Christians completed a third-person fictional story stem featuring a devout female Christian who self-harms. A contextualist informed thematic analysis was carried out focusing on perceptions of cause, cure, and treatment. Most stories positioned spiritual causes of mental illness (that is, demonic possession or personal sin) as harmful to the individual by rendering individuals as stigmatised objects or as socially displaced. The stories also provided insight into negative perceptions of females experiencing mental illness within evangelical communities. The stories suggested that these views often led to stigma and shame, which ultimately exacerbated illness and led to reduced help-seeking. Conversely, stories depicting the integration of relational care alongside spiritual resources frequently led to recovery. That the stories represented the need for relational support, within a spiritually syntonic framework, for recovery from mental illness highlights the limitations of a dichotomised approach to pastoral care. Methodologically, the study demonstrates the usefulness of a seldom-used tool within the pastoral psychology context – the story completion task – for accessing sociocultural discourses and wider representations surrounding stigmatised topics or populations.

Keywords Christian · Evangelical · Mental illness · Self-harm · Stigma · Qualitative · Story completion

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Introduction

The Western Judeo-Christian framing of mental illness as exclusively the result of sin, demonic infiltration, lack of prayer, or other negative spiritual influences works to situate mental suffering somewhat negatively as the fault of the individual or as a consequence of spiritual or demonic forces which can be remedied by spiritual means (Scrutton, 2020a; Webb, 2015). While the role of Christianity and religion more broadly for supporting psychological wellbeing has been identified (Lloyd & Waller, 2020; Stanford, 2007), scholars have also found a prevalence of stigmatised beliefs and negative perceptions about mental illness within a Christian setting (Hartog & Gow, 2005; Lloyd & Hutchinson, 2022; Lloyd, 2021a). The effects of such negative perceptions are direct and appear to influence greater avoidance, devaluation, and social distancing from individuals with mental illness. This, in turn, gravely influences these individuals' recovery, quality of life, and help-seeking behaviours (Alonso et al., 2009; Angermeyer et al., 2020; Böge et al., 2018; Cook & Wang, 2010; Reavley & Jorm, 2011; Stull et al., 2020; Thornicroft et al., 2007). Given Nearchou et al.'s (2018) outline of how public and personal stigma around mental health leads to internalised shame, anger, and significantly lower levels of support-seeking, an understanding of wider social perceptions towards mental health within a religious population, specifically a Christian one, is vital in order to begin to address the consequences of harmful perceptions and stigmatised attitudes.

Mental illness in the evangelical Christian context

The need to understand mental health literacy and social perceptions of mental health is especially prominent in evangelical communities, whose theological praxis often situates mental health as vertically representative of the inner soul or spiritual life (Lloyd, 2021a). Lloyd et al. (2021) contend that this is owing to fundamentalist beliefs and literal interpretations of Scripture, which readily position all mental illnesses as tangible signs of demonic or other spiritual involvement. Whilst there are some variations to this definition, Bebbington (2003) defines evangelicalism as a Christian transdenominational movement emphasising spiritual change through being 'born again', the authority of the Bible, personal responsibility to proselytise, and the central importance of the death and resurrection of Jesus. Within the UK, 38% of the population currently identify as Christian (Curtice et al., 2019), with an estimated two million identifying as evangelical (Evangelical Alliance, 2020). These figures underline the central importance of understanding perceptions of mental illness in these communities.

Within evangelicalism, scholars have identified specific features of the religion that could lead to the stigmatisation of mental illness – the chief area of which is spiritual reductionism related to the causes of mental illness (Lloyd & Waller, 2020; Lloyd, 2021a; Scrutton, 2020b). Spiritual reductionism is a potentially harmful perception among Christians as it is the 'belief that all mental distress can be connected to or conceptualised solely through a spiritual aetiological framework' (Lloyd, 2021a, p. 7). Another harmful perception of mental illness within an evangelical environment assumes that it is caused exclusively by the sin of the individual or their own lack of faith (Hartog & Gow, 2005; Lloyd, 2021a; Nie & Olson, 2016; Scrutton, 2020a). Scrutton (2020b) contends that these positions are problematic in that they deflect attention away from social, physical, psychological, political, and economic drivers of mental illness.

Emerging empirical research has begun to illuminate how Christians with lived experiences of mental illness may experience these theological conceptualisations of mental illness. These perceptions are echoed in dominant Christian literature, as illustrated by Webb et al. (2008), who, in their examination of 14 Christian bestsellers, found that mental disorders such as depression and anxiety were primarily represented as being caused by demonic influence, namely attacks from the devil, the enemy, or ‘Satan’ (p. 704). Similarly, in a study carried out by Stanford (2007) in which a survey designed in the United States was used to explore the responses of 293 Christians, over 30% of participants with mental ill health experienced negative interactions such as stigma and abandonment, driven by perceptions and teachings that their mental ill health was caused solely by demonic entities or personal sin (Stanford, 2007). In line with this, in a more recent and larger-scale survey undertaken in the UK (of 446 participants) by Lloyd and Waller (2020), the authors reported that 31% had experienced teachings that exclusively spiritualised their mental illness, equating this as causally connected to spiritual factors. More recently, drawing on a qualitative methodology with 293 evangelical Christians who had previously or were currently experiencing mental illness, Lloyd and Hutchinson (2022) found that many participants had experienced relational dismissal, misunderstanding, and stigma owing to their mental illness – often within a community that prioritised spiritual interventions over relational care. While all of these studies have been useful in illuminating experiences of mental illness in relation to the Christian faith, due to the traditional methodologies employed (such as self-reporting or interviews), none have been able to access more implicit social perceptions or move beyond social desirability bias. This is especially important when researching stigmatised topics or populations.

Perceptions of self-harm in an evangelical context

Whilst previous researchers have focused on mental illness in often homogeneous terms by grouping qualitatively different forms of mental illness (Stanford, 2007), there is currently a lack of scholarly attention on specific forms of mental illness, notably self-harm. Self-harm is susceptible to stigmatised perceptions (Aggarwal et al., 2021) and is severely underreported. Additionally, those who self-harm demonstrate diminished help-seeking (Nearchou et al., 2018). This behaviour is conceptualised as engagement in destructive behaviour with the deliberate intention of hurting one’s body (Al-Sharifi et al., 2015). This may be done with or without the intention of suicide and most often relates to the mutilation of one’s body through actions such as cutting, scratching, burning, hitting, puncturing, bone-breaking, abnormal or disturbed eating habits, or self-poisoning (Mullins-Sweatt et al., 2013). Within the United Kingdom, rates of non-suicidal self-harm cases have dramatically increased between 2000 and 2014, with 230,000 male and female participants between the ages of 16 and 74 reporting a likelihood to engage in non-suicidal self-harm or self-cutting (McManus et al., 2019; Young et al., 2007). Whilst developing medical and psychological interventions for self-harm is of significant value, there is a growing need to understand how self-harm is perceived within a Christian context. Illuminating these perceptions is considered a vital component of understanding and then addressing stigmatised attitudes within these communities. However, whilst increasing research has suggested that some Christians may perceive exclusively spiritual aetiological understandings of mental illness as unhelpful (Lloyd & Hutchinson, 2022; Lloyd & Waller, 2020; Lloyd, 2021a), little is currently known about how the wider Christian community perceives self-harm.

The present study

The lack of research concerning self-harm in evangelical Christian populations sits alongside evidence that mental ill health may frequently be stigmatised, dismissed, or spiritualised in these communities (Lloyd, 2021a). Furthermore, these findings are situated alongside literature that suggests that women in evangelical Christian communities who are living with mental illness may be disproportionately vulnerable to silencing and marginalisation (Weaver, 2014). In this context, this study explores, firstly, how self-harm is perceived and, secondly, how these notions might intersect with a female identity. Specifically, we were interested in understanding the intersections between self-harm and evangelical Christian faith by exploring how a (hypothetical) devout female Christian who self-harms in some way is responded to by a (hypothetical) evangelical church community.

Method

Research design overview

Data were collected using story completion (SC) – an innovative qualitative method for exploring participants’ socially located assumptions about a given topic (Braun et al., 2019). In this study, the topic of mental illness and, specifically, self-harm was explored using SC among an evangelical Christian population in the UK. We aimed to explore how evangelical Christians perceive and make sense of self-harm and mental illness more broadly.

Story completion has an extensive history, first emerging in psychoanalytic or clinical settings (Rabin & Zlotogorski, 1981), where it was used as part of an intentional projective technique (an ambiguous stimulus is used in order to access unconscious ‘truths’ or meanings). Until recently, however, SC had been disregarded in qualitative research (for an extensive historical review of this method, see Moller et al., 2021). Story completion diverges from more traditional self-report techniques such as interviews or focus groups, which dominate the field of qualitative research (Moller et al., 2021) and have several strengths if used sensitively. Clarke et al. (2017) argue that SC may be particularly useful in exploring stigmatised or marginalised groups as it may give access to less socially desirable responses. These are significant merits when undertaking qualitative research.

Significantly, in SC, participants are not asked to discuss or describe their own experiences, perceptions or meanings but are invited to envision how a given scenario might unfold (see Braun et al., 2019). Participants are asked to write a short story after being presented with either a first- or third-person story cue or prompt (an opening sentence). As SC necessitates that participants draw upon sociocultural sense-making resources or discourses, it is a valuable technique in exploring people’s assumptions. Moreover, since SC does not ask people to explicitly state their own experience, it permits access to a range of meanings around a given topic.

While some participants in the present study might have had direct experience with self-harm and others not, all were asked to imagine a particular scenario (see the recruitment and data collection section). Thus, it is worth noting that SC requires participants to use their imagination. In this study, we did not distinguish between imagination and perception. Instead, based on the work of Fettes (2008), we acknowledge that imagination

represents the ‘cognitive capacity of the mind’ (p. 420), which is rooted in an individual’s perceptions, personal history, and culture. By asking participants to access their imagination through qualitative enquiry, we could access what Fettes (2008) refers to as ‘possibility thinking’ (p. 421), which represents both what is and what might be. Thus, by asking participants to use their imagination through SC, we could access a key ingredient of how individuals perceive and order the world.

Ontological and epistemological assumptions

Morrow (2005) encouraged qualitative researchers to make clear the philosophical and theoretical assumptions or paradigms underpinning their research. Broadly speaking, SC can be positioned within a wide range of epistemological frameworks as it is essentialist (‘realist’); the emphasis rests on discovering particular psychological meanings imagined to be linearly connected to stories. This position, however, necessitates an interpretative jump in which the researcher assumes that the personal feelings and motivations (of the story writer) are directly and unproblematically attached to story writing. Alternatively, SC can be framed through a social constructionist lens, wherein the focus shifts to the particular discourses participants draw to construct their story (Burr, 2015; Kitzinger & Powell, 1995). In a constructionist framework, the stories are not imagined as capturing any singular psychological reality per se but, rather, are presumed to socially create that reality through language (Burr, 2015). A third epistemological framework possibility for SC, delineated by Clarke et al. (2017), overlaps somewhere between a realist and a social constructionist framework in that it is concerned not only with individual and wider social perceptions but also with how these are socially mediated and embedded. This third approach is designated ‘contextualist’. Contextualist paradigms are approximately analogous, and interpretivist-qualitative paradigms are also related to critical realism (Willig, 2019) in that the focus remains geared towards participants’ perspectives (analogous to essentialist accounts, which attempt to expose inner psychologies) but also takes account of how these perceptions are socially embedded and enabled. Hence, social context and discursive life are appreciated. This is the approach taken in this study.

Recruitment and data collection

The study was approved by the University of Derby Online Learning Ethics Committee (ETH2021-0074). For study inclusion, participants needed to be at least 18 years old and identify as an evangelical Christian living in the UK. None of the participants were pastors or members of clergy. An advertisement was placed onto online Christian social media groups with the following text:

This study aims to explore perceptions of self-harm in the church community. Please consider taking part in this short, online creative study in which you will complete a short story. Anyone who is an evangelical Christian and lives in the UK is eligible to take part.

Data were collected electronically using Microsoft Forms software in 2020 and 2021. Participants were invited to read and confirm the consent documentation before providing basic demographic information relevant to the study. Participants were then provided with and responded to an identical third-person story stem featuring a devout female Christian who self-harmed. The stem construction was guided by existing literature which suggests

that Christian communities may conflate mental illness and personal sin (Lloyd, 2021b; Wilder, 2012). Hence, the stem aimed to capture understandings related to the coexisting of Christian faith and mental ill health through the term ‘devout’. Moreover, as a secondary goal, the inclusion of a female name in the story stem meant that, through our analysis, we could explore and illuminate how female identity might intersect with perceptions of self-harm and mental illness amongst evangelical Christians (Weaver, 2014).

The stem was brief and written in the third person with enough detail to ‘orient the participant to the focus of the story’ (Clarke et al., 2019, p. 10). The choice to include a third-person story stem was guided by Braun et al. (2019) who advise that third-person story stems may permit access to less socially desirable responses. It is theorised that because the participant is situated outside the story, there are fewer inferences of personal experience (Braun et al., 2019). A single-story stem was used to limit demand on participants and to maximise the chances of obtaining quality data. The final stem presented to participants was: *Summer, a devout Christian, would sometimes self-harm. She...* Participants were invited to read the story stem and to write what might happen next. They were asked not to spend too long thinking of a story but, rather, to respond with whatever came to mind, thereby providing readily available meanings. To ensure adequate data quality, all participants were asked to spend a minimum of 10 min writing the story or to produce roughly 200 words or 10 lines. The study instructions and story stem were first piloted with two participants prior to main study recruitment to ensure that the instructions were understandable.

Participants

Data collection was terminated following a review of completed stories which suggested a nuanced and rich dataset had been collected. Upon study closure, a convenience sample of 124 participants had been recruited. At this stage, 19 participants were later removed from the dataset due to non-story completion. Moreover, four participants were removed whose stories contained fewer than ten words. The final study

Table 1 Sociodemographic Characteristics of Sample ($n = 101$)

Characteristic	
Age	$M = 46.87$ years
Gender	$SD = 14.23$ years 27 = Male 72 = Female 2 = Nonbinary
Frequency of Church Attendance	3 = Daily 3 = Never 5 = Yearly 7 = Monthly 29 = Twice weekly 54 = Weekly
Experience of Mental Illness	94 = Yes 6 = No 3 = Unsure

sample was 101 SCs (see Table 1 for participant demographics). The stories included in the final sample ranged from 10 to 726 words ($M = 158$ words).

Data analysis

Participant responses were downloaded into a Microsoft Excel document and scanned by researchers to ensure that all parts had been completed. Responses with incomplete story stems were removed ($n = 23$). All remaining data ($n = 101$) were subject to a contextualist informed thematic analysis (TA) using Braun and Clarke's (2006) approach to TA comprising six phases of coding and progressive theme development.

As TA is not theoretically fused to any specific theoretical framework and offers a theoretically versatile method for analysing qualitative data, Braun and Clarke (2006) recommend that researchers explicitly discuss their theoretical approach to TA. As discussed, the present study was theoretically grounded within the contextualist approach, which was focused on participants' perspectives (comparable to the essentialist frameworks) but also appreciated these as embedded within participants' wider social context (analogous to social constructionism) and, therefore, as reflecting their particular social positioning. Consequently, the data (stories) in the present study were read as giving access to participants' assumptions, perspectives, and social understandings of self-harm within an evangelical Christian context. Thus, the analysis presented in this study is not situated as representing participants' own experiences or responses to self-harm within an evangelical Christian context. As previously noted, participants were asked to use their imagination when completing the stories. Based on the work of Fettes (2008), we do not view imagination and perception as binary within the context of this study. Instead, through SC, we were asking participants to use their imagination. As imagination is deeply influenced by personal history, culture, and one's ability to think about the nature of the world both as it is and how it might be, we were able to use imagination to gain access to perceptions of self-harm.

The researchers opted for a horizontal analysis – which mapped themes in aspects of the stories – as well as a vertical analysis, which identified patterns in how the stories progressed (Clarke et al., 2017). The authors began by forging familiarity with the data. This included multiple rounds of reading and re-reading the available data in order to make initial notes and analytic annotations. This phase permitted an initial immersion in the data (TA phase 1). In this initial analysis, eight themes and 32 sub-themes were generated. Second to this, the authors began a process of systematic and inductive data coding, which identified core features of the data (phase 2). These were then examined for repetitions and broader patterns of meaning, sometimes denoted as 'candidate themes' (phase 3). This was followed by a process of refinement so that a coherent story of themes was presented (phases 4 and 5). This stage involved several reflective meetings between both authors where candidate themes were discussed and examined in relation to our research question. During this process, three major themes and seven subthemes were generated. The writing of this manuscript constituted the final phase (phase 6) of the analysis, which involved gathering salient data extracts alongside the analytic narrative. In all of the excerpts of data provided, spelling and typographical errors have been corrected. All the extracts are identified by participant number (for example, P1).

Reflexivity

The process of reflexivity or the ability of the researcher to hold in awareness how their own perspective, experience, or bias might be projected into analytic interpretation has a valued history of ensuring research rigour in qualitative research (Willig, 2019). The first author in this study (CL) was raised in an evangelical Christian home which emphasised charismatic forms of spirituality, theology, and miraculous healing. As a practising chartered psychologist, an academic, and a Christian, he is now motivated to explore the negotiation that ensues between faith, lived experience, and mental illness and how particular theodicies and theologies may influence how an individual might respond to their own and others' mental health. He brings a range of intersectional perspectives in relation to this research, namely as a Christian, psychologist, theologian, and scholar who is critical of theologies that excessively spiritualise mental health conditions. The second author (MCP) was also raised in an evangelical Christian environment. She maintains a Christian faith and holds an understanding of the language and meanings expressed by Christian groups. Her scholarly research has focused on the psychology of religion with the aim of understanding religious experiences and conversion. In her scholarly work, she aims to develop psychological understandings of how religion impacts the individual and their society without disregarding or diminishing religious experience.

Analysis

The research aimed to capture how evangelical Christians perceive and make sense of self-harm as well as social representations of the causes, treatment options, and wider social response to mental illness. Ninety-seven stories portrayed the nature of self-harm as cutting, with only two stories referring to other forms of self-harm (overeating and biting). The stories mostly described Summer as cutting on either 'her arms [or] legs, causing them to bleed' (P40), but she was most commonly described as cutting her arms. Across the stories, Summer was described as young, which positioned self-harm as connected to youth and the imagined emotional instability of youth. Only two stories explicitly portrayed Summer as an adult; most specifically outlined her youth by describing her as being a member of a 'youth club' (P76 and P98) or 'youth group' (P37).

Participants also described Summer's personality as outgoing: 'bubbly... the warm, friendly person' (P23). These external characteristics, however, were often portrayed in conflict with Summer's internal world, which frequently positioned Summer as experiencing shame and guilt. The story arcs described a point of intervention at which Summer's self-harm was either discovered or where she sought support, and the stories detailed her process of recovery and the treatment she received, if any.

We present the stories in the analysis that follows as they relate to evangelical participants' perceptions of self-harm through the following themes: (1) causes of self-harm, (2) stigma and shame, and (3) treatment. These themes, along with their subthemes, are further conceptualised in Fig. 1.



Fig. 1 An Outline of Themes: Evangelical Perceptions of Self-Harm

Theme 1: Causes of self-harm

Spiritual causation Descriptions of the causes of Summer’s mental ill health and self-harm provided useful insights into the participants’ perceptions of mental illness as either solely caused by spiritual elements, specifically demonic possession (P79, P49, P57, P10, P44, P47, P77, P26, P79), or by a psychological cause (for example, trauma). Stories describing the causes of Summer’s self-harm overwhelmingly positioned it as being caused by spiritual struggles or demonic entities. One participant wrote: ‘She didn’t understand and sometimes prayed for a demon to come out’ (P77). In this extract, the participant outlined the idea that Summer’s self-harm was caused by demonic possession.

Another participant positioned this slightly differently, describing that it is the opinion of members of the congregation of Summer’s church that self-harm is caused by possession:

She once heard a few people in the row behind her make a joke about self-harm and in one small group, when self-harm came up in discussion, someone made a comment about demon possession, which everyone agreed with and moved on. (P49)

This example illustrated how some congregations may strongly perceive mental ill health – specifically self-harm – as being caused by demonic possession. By associating

self-harm with something as inherently negative as demonic possession, these excerpts outlined attitudes and perceptions of stigma associated with mental illness within the evangelical community. Moreover, by representing members of the congregation as engaging in stigmatising behaviour, such as mockery, it appears that a solely demonic aetiology for self-harm may be represented as unhelpful or as lacking explanatory power.

Stories positioning demonic aetiologies as causative in self-harm also frequently necessitated spiritual interventions and treatments, as illustrated in the two excerpts below:

[She] feels a great deal of guilt about this and frequently confesses and asks for deliverance from it. She often wonders if she is possessed or has done something wrong. (P44)

Told her parents, who arranged for the pastor to come and cast out the spirit of self-destruction. (P4)

These excerpts clearly illustrate the perception that Summer's self-harm is being caused by demonic possession as the participant described Summer praying for deliverance from the demon. Such terminology, common within evangelical contexts, suggests that the affliction is solely due to demonic oppression or possession and, thus, that the individual should pray that the entity is removed along with the affliction. This was highlighted later in P44's story:

She is suspicious of psychiatric help because she feels that all she should need is God. Prayer should work and she should just be able to believe what the Bible tells her and be okay. (P44)

By describing Summer as suspicious of psychiatric help, this story highlighted perceptions of a contradiction between a spiritual and psychological aetiology for Summer's self-harm. It also illustrated how this dualism extends to treatment as the participant described that Summer should instead focus on spiritual aid. Through presentations of the guilt associated with a demonic aetiology and the resulting reluctance to seek treatment, the stories outlined the possible harms of comprehending mental illness through a solely spiritual lens.

Self-harm as non-Christian Summer's self-harm was portrayed as secretive and contradictory to a Christian life, as P80 wrote:

[She] kept this totally apart from her Christian life. Never the two should meet. It was like she had a dual personality; one face for Sundays and one for the rest of the week. (P80)

By referring to Summer's self-harm and her Christian life as a 'dual personality', the participant represented Summer's mental illness and subsequent self-harm as conflicting with Christianity and a Christian identity. As a result of this perceived incompatibility, these two aspects of Summer were represented as becoming compartmentalised. The presentation of mental ill health and of Christianity as dichotomised led to portrayals of Summer struggling to make sense of her experiences of self-harm, as if this meant she was not a 'good enough' Christian. One participant stated: '[She] often wondered why she self-harmed and if it was a 'Christian thing' for her to do' (P21). This participant

represented Summer as experiencing doubt and conflict, concerned that her experiences of self-harm and her Christian faith could not coalesce. Another participant described Summer feeling that, ‘as a Christian, she knew it was the wrong thing to do’ (P40).

This further illustrates the perceptions that her self-harm was un-Christian or morally wrong. The resulting themes illustrate how these perceptions, as well as the identification of spiritual causes of her self-harm, led to representations of public and personal forms of stigma and shame within the stories. In the stories, this shame ultimately stemmed from representations of self-harm as being demonic or as a result of Summer being a bad Christian and led to further mental illness and impaired help-seeking behaviour.

Theme 2: Shame and stigma

Public stigma: Congregational judgement Stories frequently portrayed Summer’s fear of the congregation discovering her self-harm. As explored above, multiple stories outlined that if Summer were to disclose her self-harm to the congregation, she would be depicted as a ‘bad Christian’ (P42, P85, P90, P97). In some instances, the social judgement of her self-harm was represented as leading to punishment:

She didn’t talk to anyone about it as she feared their judgement and being labelled as a problem person; she would have to step down from her activities at church such as playing in the worship group. (P17)

By suggesting that Summer would be labelled a ‘problem person’ and would be forced to step down from her role in the church, this story outlined the perception that her experiences of mental illness compromised the integrity of her Christian faith. It also described the church as responding to her self-harm by punishing or removing designated roles from Summer and, consequently, indicated there was the potential of public shaming for her self-harm. The depicted punishments ranged from being told ‘to leave’ (P20), being ‘taken off the youth leadership team’ (P12), or being told to only come back to church ‘when you’ve sorted your stuff out’ (P1). Such portrayals of the consequences of her self-harm illustrate the potential for public stigma around mental illness and the harm this might cause the individual. Moreover, by labelling Summer as a ‘problem person’ who needs to ‘sort’ herself out, the stories illustrate a perception that mental illness is the fault of the individual and that they are, therefore, solely responsible for rectifying their unfavourable behaviour.

The tendency to make the individual responsible for their mental health struggles was exemplified in another excerpt, which further outlined the potential for public shaming through congregational judgement. The story outlined, in specific detail, the judgement Summer would receive when seeking spiritual counsel from a minister:

It didn’t go quite as she had hoped. He listened for a short while before starting to question her about her spiritual life. ‘How often are you reading your Bible, are you having regular prayer times, is there some secret sin in your life that you are trying to hide from God?’ Summer felt worse and worse, but when the minister offered to pray for her, she hoped it would help. Instead, he seemed to be confessing on her behalf that she had failed in her spiritual life and that she would try to give more time to God. When Summer left, she was bereft. (P39)

Here, Summer’s attempt at help-seeking from her minister was met with a shaming attitude, specifically by placing Summer at fault for her mental illness. The story above

exemplified the perception that, should Summer be more active in her spiritual journey, she would not be afflicted with self-harm. Moreover, the story represented the harm caused by a forced spiritualisation of her experiences, whereby her self-harm was principally connected to sin or a lack of relationship with God. For Summer, however, these experiences were positioned as in contradiction to her own belief system and thus further exacerbated a climate of shame. In many stories, instances of congregational judgement and public shaming led to an internalised belief that because Summer self-harmed, she was a bad Christian and her self-harm was due to her own limitations.

Representations of public shame were depicted as being held not only by spiritual leaders but also by the congregation, which labelled Summer as being ‘mad, bad, or possessed’ (P85). The congregational judgement and perception that Summer’s self-harm was due to her own spiritual shortcomings are confirmed in the excerpt below:

She never admitted her struggles with her church though as she felt ashamed at not being ‘victorious’ and an ‘overcomer’ in faith – learning just to cope on a day-to-day basis with hope and trust in the future through good days and bad. (P68)

Attitudes that positioned Summer as not being ‘victorious’ against her mental illness acted to isolate her from her community as well as to render her responsible for her mental illness. These stories might be indicative of perceptions of self-harm as a behaviour that is shameful, un-Christian, and, essentially, due to the individual’s personal shortcomings.

Private stigma: shame and guilt Across the stories, self-harm was positioned alongside Summer’s feelings of shame and guilt:

The self-harm brought shame which just worsened the situation like a downward spiral with no break in the chain. (P46)

Strike, strike, strike, strike. Yes, the pain feels good, keep going until you see blood. She kept going, she saw blood, she stopped. The wave of guilt hit Summer like a train. (P53)

These poignant excerpts depicted the internalised feelings of guilt and shame that appeared after Summer’s self-harm, causing a cyclical relationship of more self-harm. Feelings of guilt and shame were depicted as being caused by the acts of self-harm; however, in many stories, the guilt and shame Summer felt were also strongly tied to her Christian identity. The stories below indicated how a Christian identity might be represented as incongruent with self-harm and how, by engaging in self-harm behaviours, Summer was angering or disappointing God:

Always felt guilty because she’s a Christian – why should she self-harm? God would be disappointed. However, this was something she struggled with from a young age, and because of the shame she attached to it, she kept it a secret – even from her family and friends in church as she thought she would be judged and not heard. (P96)

Felt a huge sense of guilt every time as if she wasn’t good enough to be part of her community and that she was angering God by self-harming. (P17)

These stories illustrated feelings of guilt associated with self-harm. Here, Summer internalised such immense shame that she was unable to seek spiritual support from her congregation.

This anger and frustration with herself makes her feel worse, more guilty and more condemned, meaning she is more likely to self-harm and less likely to seek help from anyone in the church. (P44)

P44's reference to Summer feeling condemned highlighted the strong sense of wrongdoing that the participant believed Summer would have felt. This outlines how stigma around mental illness, especially within religious environments, might be understood as leading to internalised shame; this is something that may exacerbate symptoms and discourage individuals from seeking support.

While many stories depicted how religion causing shame and guilt was harmful to Summer's state, some juxtaposed the judgemental and punishing congregation with a God that was most often portrayed as 'understanding' (P25, P38, P71) her self-harm and emotional pain: 'She could not reconcile the image of a loving Jesus with the cold truth of a church that didn't want to understand' (P12). This excerpt illustrates how the image of a loving and understanding God might be inherently separate from the behaviour of the congregation. Despite the clear social stigma associated with mental health, as depicted in most of the stories, the distinction between God and the congregation in some of the data indicated that belief in God might be helpful to Summer's mental health if it did not evoke stigma and guilt.

Theme 3: Treatment

Positive interventions: Relational support Participants depicted Summer's journey to recovery as beginning with an intervention or some form of support which exposed the self-harm she had previously hidden. Considering the themes which have been discussed – Summer's self-harm being determined as antithetical to her Christian faith and as demonic in nature – it is unsurprising that the stories did not depict Summer actively engaging in help-seeking behaviours. Instead, the stories often portrayed interventions emerging from a community member building a trusting relationship with her:

She caught her at the end and asked, 'is everything ok?' Summer freaked out. . . . But it all tumbled out. Her leader was kind and listened, comforting with some truths she knew about God. (P85)

Felt completely judged by the other adults in the church but the youth pastor seemed to understand more. She listened and prayed with her and gave her strategies she knew had worked in the past. (P31)

These excerpts correspond with earlier findings regarding perceptions of the congregation as judgemental and unsympathetic towards self-harm. It also outlined how she was able to receive support from a religious figure which was portrayed in a positive, relational sense, where the individual approached Summer with care and helped Summer to actively pursue treatment.

Positive, relational interventions were further illustrated in the description by P13:

It took weeks of check-in calls and fortnightly coffee meets with the lady from pastoral care before she felt able to open up. And our friend listened carefully, thanking her for her honesty. (P13)

Representations of compassionate and person-centred interventions also appeared to contribute to Summer's recovery:

She expects judgement and criticism from the leader but instead receives love and understanding. The leader admits that she used to struggle with self-harm, and over the next two years, she guides Summer into giving [it] up completely. (P100)

Although the stories varied in the exact source of the intervention, it was overwhelmingly from a female Christian (for instance, ‘A youth leader, Claire’ (P22), a Christian woman who opened up about her own self-harm (P9), ‘Emma, a Christian who also self-harmed’ (P30), ‘a girl her age’ (P92)). The female often had experienced self-harm herself and was able to offer support in a peer support capacity. Here, the importance of identification and compassionate intervention that placed Summer at the centre of her recovery was highlighted as a means of breaking the stigma around mental health and allowing for open conversation and inroads to recovery.

Negative interventions: Loss of agency While some stories portrayed positive, relational forms of intervention as leading to recovery, other stories represented negative forms of intervention. Negative interventions were portrayed as instances where Summer was positioned as a passive participant in her intervention or where interventions were imposed upon her by adults, as described in the excerpts below:

Understanding her episodes, her family reaches out to the church community to pray for her, who feels it’s a demonic activity. They recommend both clinical treatments and exorcism. (P26)

Told her parents, who arranged for the pastor to come and cast out the spirit of self-destruction. (P4)

By referring to her self-harm as ‘episodes’ (P26) and due to a ‘spirit of self-destruction’ (P4), these excerpts indicated a lack of compassion towards Summer’s mental health. Moreover, these representations placed Summer in a position to be blamed for her self-harm. It is evident that such approaches hold negative and stigmatising connotations. In addition, the excerpts above show Summer as holding a distinct lack of agency in her recovery. Specifically, stories depicted her as not seeking intervention directly but rather as having it arranged for her through her family or faith leaders. Consequently, it seems that many of these stories included negative interactions, with Summer devoid of agency.

Recovery: Integration of religious and psychological support P41 describes Summer’s journey to recovery as including her taking an active role in seeking support, which consisted of professional care which was fused with religious support rather than instead of it.

Summer accessed help and, thankfully, after years of support, counselling, prayer, medication and love from the church, she emerged still strong in her faith and much better able to handle her mental health challenges. While still on medication. (P41)

The emphasis on her ‘emerging still strong in her faith’ suggests that despite her self-harm and journey into recovery, she was able to retain her belief. Two other excerpts describe Summer receiving religious and psychological support:

It took some time but Summer realised that being a Christian was not incompatible with being mentally ill. There were sisters in Christ she could trust and who wouldn’t

assume it was because she wasn't praying enough or that she lacked faith. (P48)
 Eventually, after many years, [Summer's] prayers are now being answered through the help of a Christian rehab programme. Some of her own determination to work through the pain of her past and [accept] support from her friends has thrown a protective wall of love around her. (P19)

The emphasis on Summer's retaining her faith and receiving spiritual support was not portrayed as a replacement for medical and professional support in all the stories. Instead, some stories emphasised how the quality of her recovery was enhanced by religious support, especially when Summer sought layers of support through a physician or mental health service (P45, P15, P52, and P63) and other professionals and support groups (P32, P43, P58, P59, P72, and P59), as well as psychologists who were either Christians themselves or sympathetic towards Summer's faith (P77, P90, P2, and P74).

Her new group appears to be nonjudgemental, and [Summer] finds she is harming herself less. One of the sisters in her group is a nurse, and she is drawn to her and eventually confides she has been harming herself. The nurse encourages her to seek professional help but also encourages her to call her when she feels tempted to harm herself. The nurse asks permission to ask the group for specific prayer. Summer agrees and feels supported, that the group is non-judgemental and cares very much about both her physical, emotional, and spiritual wellbeing. (P86)

As the stories continued to describe Summer's journey to recovery, they portrayed her recovery as strongest when it allowed for an integration of her faith as well additional layers of mental health support. Moreover, some of the stories described an ideal, holistic model of recovery which did not compartmentalise her physical, emotional, and spiritual wellbeing.

Discussion

This study suggests that a potential mechanism exists through which spiritual aetiologies of mental illness as caused by demons, personal sin, or lack of faith may lead to a perception of diminished or inauthentic Christian faith – the collision of a social understanding that Christian living should embody health, with negative social understandings of self-harm as solely indicative of spiritual ill health. The study found that such perceptions, while useful for understanding the role of spirituality among perceptions of mental illness, may ultimately lead to diminished treatment-seeking and unhelpful interventions which view the individual as at fault for their illness and position them as a passive recipient of spiritual intervention.

Our study contributes to an understanding of perceptions of self-harm in evangelical communities in three principal ways. Firstly, the stories illuminated that when self-harm was positioned as solely caused by demonic or other spiritual aetiological forces, it was seen as negative, often resulting in more stigmatisation and decreased attention to relational care. This suggests that evangelical Christians may perceive exclusively spiritual accounts of self-harm and mental illness in negative ways. Secondly, analysis of the stories suggested that when psychological illness was attributed to an individual's personal sin, rendering self-harm and mental illness as incongruent with a Christian identity, the individual was robbed of agency in relation to their recovery and placed in a passive position. In this position, Summer's recovery was jeopardised and she was pushed into a subject

position of passivity and helplessness. This is a useful finding for pastoral care and may inform future practice by prioritising the need for a strengthening of genuine pastoral and relational care alongside spiritual interventions, which value agency and autonomy. Finally, the study has highlighted that females with mental illness within evangelical communities may be perceived as passive, youthful, and, at times, emotionally volatile. It is clear that such perceptions are harmful and should be actively challenged within pastoral settings.

Gender and self-harm

The placing of Summer in a passive position, as well as the perception that she was responsible for her own mental illness, may be explained by both the gendered aspect of the story stem and the participants' religious context. Perceptions of Summer as a younger female may reflect dominant Western sociocultural assumptions that self-harm is a mental health issue that is more frequently reported among younger females than males (Landstedt et al., 2009). Although self-harm appears to be more prevalent in females, this trend is likely skewed due to the greater likelihood of females reporting their self-harm (Griffin et al., 2018). In addition, authors of supplemental literature have found no significant gender difference for self-harm across a lifetime (Hawton & Harriss, 2008; Kirchner et al., 2011). As such, the tendency to portray Summer as young and perhaps emotionally unstable may be due to greater reporting of self-harm among females, which bolsters perceptions of self-harm as being associated with younger women, thus meaning that less attention is given to men in this area.

Perceptions of Summer may also have been motivated by participants' religious and ideological setting of evangelical Christianity, a space in which doctrine and community have at times been associated with the marginalised perceptions of women as weaker and more subservient (Eteng, 2015; Knickmeyer et al., 2010; McFarland, 2010). Furthermore, evidence illustrates how spiritualisation, or denial of adverse experiences within evangelical spaces, appears to have a greater effect on female congregant members due to the enforcement of patriarchal gender roles and assumptions of female submissiveness (McFarland, 2010). In their investigation of the experiences of abused women within an evangelical context, Knickmeyer et al. (2010) discovered that female congregant members who had been abused did not actively seek support due to pressure to promote and protect the ideal of the 'good Christian woman'. This picture may be of one who is without emotional disturbance or mental ill health. Thus, it is evident that religion-based experiences and expectations of mental illness may be compounded or altered by perceptions of gender within evangelical communities.

The negative consequences of a spiritualised aetiology

Scholarly claims highlighting the harms of positioning mental health as underpinned exclusively by demonic aetiologies or personal sin (Hartog & Gow, 2005; Lloyd & Hutchinson, 2022; Lloyd & Waller, 2020; Lloyd, 2021a; Webb et al., 2008) is a perception that appears to be mirrored by the stories elicited in this study. In portrayals of the causes of self-harm, the stories often outlined that, when demonic aetiologies or personal sin were positioned as the sole cause of self-harm, the individual experienced increased levels of both public and personal stigma. Specifically, the stories illustrated participants' perceptions that stigma was perceived as having both a causal and a maintaining role in self-harm, acting to diminish help-seeking behaviours. By describing shame and stigma as frequent outcomes

of a solely demonic or spiritual aetiology, the participants appeared to comprehend and represent the dangers of a solely spiritual understanding of self-harm.

The result of accounts that portray mental illness as being caused by demonic forces and personal sin in religious settings has clearly been identified as a negative strategy for understanding and treating mental illness. Specifically, the belief that mental illness is caused by malicious, sentient beings is not only associated with greater levels of stigma within religious communities (Nearchou et al., 2018) and delayed help-seeking (Lloyd et al., 2021) but may also, according to Nie and Olson (2016), result in feelings of insecurity and unsafety, which may act to exacerbate mental health side effects. The stories illustrated a similar trend by describing instances of exorcism and forced prayer as increasing feelings of public and private shame, robbing individuals of their agency and ultimately blocking recovery from mental health difficulties. While substantial literature has outlined the positive effects of religion on mental illness (Borrill et al., 2011), it is also evident that, when harmful narratives are dominant, religious communities may blame the individual for their mental ill health, for example, through personal sin or a lack of religious dedication. The results of such narratives could be shame and guilt, which appear to nullify the positive influences of religion on mental health such as social and spiritual support (Lloyd et al., 2018; Nearchou et al., 2018).

Agency and treatment

The relationship between demonic aetiologies of mental illness, religious shame, and lowered support-seeking is supported by Scrutton (2015), Hartog and Gow (2005), and Nearchou et al. (2018), who found that solely spiritual views of mental illness act to discourage religious individuals from seeking psychological treatment. Moreover, individuals may avoid treatments which are not based on prayer or scriptural study (Stanford, 2007). Such a view acts to further divide the realms of psychological care and spiritual care. However, as the boundaries of religious support on mental health continue to be explored, the psychological literature indicates that providing spiritual support in a relational manner without initiating shame can be especially effective in reducing mental illness (Assi et al., 2020; Lazar & Bjoreck, 2008). Furthermore, when individuals are encouraged to seek wider forms of support beyond spiritual interventions such as secular support (medication, counselling and so forth) and are respected for doing so, it is likely that improvements in their mental health will be heightened (Wesselmann et al., 2015). Similarly, in the context of the stories, once the individual was positioned with agency and relational support, validated in accessing both psychological and spiritual support through mental health advisors and pastoral care, wellbeing and recovery were described as being present.

Study limitations and future research

The story completion methodology used in this research is both novel and insightful in its attempt to move past social desirability bias and access wider and often implicit social perceptions of self-harm. However, the methodology may only represent *perceptions* of self-harm and mental illness among Christian populations and not direct experiences.

Whilst this is important, findings should be conceptualised as offering an additional layer of understanding to current and further research in this area.

Further research may helpfully use story completion to explore representations of intersectional variables (gender, sexuality, age, ethnicity, and health status). This may include asking participants to complete two story stems with the aim of comparing stories on different characteristics of interest – for example, one male and one female. Alternatively, to further explore the intersection between mental health and gender, a gender-neutral name could be employed. This might be especially pertinent in light of the present study's findings, which suggested that women who self-harm may be perceived as emotionally volatile, youthful, or lacking perceived maturity. Despite the potential limitations of the present study and the need for further research, the present paper makes a significant contribution to the field of pastoral care by adding to the growing literature on Christianity and mental health by showing the perception within a large sample of Christians that solely spiritualised approaches towards mental illness may lead to increased shame, exacerbate symptoms, and hinder treatment-seeking.

Overall, these findings suggest that evangelical Christians may increasingly perceive wholly spiritual or imposed aetiological understandings of self-harm and neglecting pastoral care and relational nurture in harmful ways. Importantly, pastoral care that retains individual agency and is implemented in relational and spiritually syntonic forms may be perceived as more beneficial. By employing the novel story completion task, we have been able to access socially located assumptions about self-harm, which may not have been possible using traditional qualitative methodologies such as interview-based studies. Furthermore, by accessing these assumptions, we have provided a nuanced picture of how self-harm is conceptualised and how it might be responded to within an evangelical context. These findings provide an initial understanding of group stigma around self-harm as well as a useful basis for further research to attempt to address some of the stigma processes which have been illuminated through the methodology of our study.

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Declarations

Ethics approval This study had full ethical approval from the University of Derby Ethics Committee. This study was conducted in accordance with the ethical standards as laid down in the 1964 Declaration of Helsinki.

Consent and consent to publish Informed consent was obtained from all individual participants included in the study. All participants consented to their anonymised data being published.

Competing interests The authors have no competing interests to declare that are relevant to the content of this article.

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