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Training Ministry Leaders Towards Supportive Psychotherapy Referrals to Tyndale Wellness Centre

A Research Portfolio

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of the requirements for the degree of

Doctor of Ministry

Tyndale University

by

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ABSTRACT

This Doctor of Ministry integrated portfolio presents a summary of key insights, themes and findings arising from an exploration of Christian leadership, with particular reference to the authors' own ministry context as Director of the Tyndale Wellness Centre (TWC). The exploration includes a contextual analysis, literature review, biblical reflection, and the author's personal reflection on lived experiences that led to a servant-leader philosophy of Christian leadership. The analysis informed the design and implementation of a field research project: *Training Ministry Leaders Towards Supportive Psychotherapy Referrals to Tyndale Wellness Centre*. The project addressed an identified need to help Christian ministry leaders learn how to support their members with mental health problems and refer them for psychotherapy. A training program was developed and piloted with nine ministry leaders and the outcomes analyzed. Findings indicated an overall increase in participants' understanding of mental health, the importance of self-care, the nature of spiritually integrated psychotherapy and how to make supportive referrals. A recurrent theme in the research analysis was participants' concern about clergy mental health as much as that of their members. Recommendations are made for further study and for possible uses of adapted versions of the training program in other contexts.

DEDICATION

To the memory of my dear parents

who loved, served and lived to the glory of God.

"Much to be thankful for"

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LIST OF ABBREVIATIONS

APA: American Psychiatric Association

CAMH: Centre for Addiction and Mental Health

CAST: Complex Adaptive Systems Theory

CBT: Cognitive Behavioural Therapy

CRPO: College of Registered Psychotherapists of Ontario

DMin: Doctor of Ministry

ENFJ: Extroversion, Intuition, Feeling, Judging

FLC: Family Life Centre

GTA: Greater Toronto Area

MBTI: Myers Briggs Type Indicator

MHFA: Mental Health First Aid

NLT: New Living Translation

TCPS: Tri-Council Policy Statement

TCS: Tyndale Counselling Services

TWC: Tyndale Wellness Centre

RP: Registered Psychotherapists

SIP: Spiritually Integrated Psychotherapy

CHAPTER 1:

INTRODUCTION

This Doctor of Ministry (DMin) Portfolio titled "Training Ministry Leaders Towards Supportive Psychotherapy Referrals to Tyndale Wellness Centre", contains three major sections which together, met the requirements of the DMin program I completed between 2020 and 2023. The first section is the context assessment titled *Tyndale Wellness Centre - A Journey of Change and Complexity*, the second is my philosophy of Christian leadership titled *Philosophy of Christian Leadership - My Journey to Servanthood* and the third section is the field research project report on *Training Ministry Leaders Towards Supportive Psychotherapy Referrals to Tyndale Wellness Centre.* While each section is distinct, together these chapters tell a story of the key lessons and insights I learned, how I developed as a leader during the DMin program, some of the resources and processes that contributed to my development, and an application of my learning through the field research project.

Tyndale Wellness Centre - A Journey of Change and Complexity

Had I not done the context analysis of Tyndale Wellness Centre (TWC), I would have missed out on deepening my understanding of the key people, places,

values, legislation, etc., that impacted and were impacted by it. Furthermore, the analysis helped me to see how I as Director fit into the context, influenced it, as well as how it has influenced me. One major idea that helped me grow as a leader in this context is described by Heifetz and Linksy as the "balcony view" and the "dance floor" (Heifetz and Linsky 2017, 53). In the balcony view, I intentionally took my mind off the day-to-day activities to get a sense of the overarching, combined components of the context, in order to observe and understand how the parts were inter-related and what was needed to make effective changes, (e.g., add or improve processes and stakeholder relationships). On the dance floor, I was present and interacted with the stakeholders in the everyday processes, to get a better sense of their needs and the responsibility of the context to them. I have learned that the balancing of the balcony view and dance floor is not static, as I needed to constantly respond to the influences on the context including influences on me as the leader. This concept was demonstrated in this portfolio through the interplay between the context analysis, my philosophy of leadership, and the research that it generated. It was also seen in the research project where the training program provided an overview of the main issues and then allowed room for participants to assess their own contexts in light of those issues, to arrive of what they needed to support their members and make referrals for psychotherapy.

The context analysis also helped me to delineate the stakeholders of TWC and to notice the consolidative impact of the stakeholders on the context. In addition to comprising a wide range of individuals, stakeholders included several

organizations and legislation related to TWC's primary service of psychotherapy. Additionally, as a department of Tyndale University, there is direct reporting relationship to a Tyndale cabinet member, thus including the institution as a major stakeholder. The stakeholders also included the hundreds of clients TWC serves each year, the persons who referred them and the staff that served them. As shown in the research project, the context analysis highlighted and strengthened the opportunity to meet the needs of stakeholders who were ministry leaders, to help support their members with mental health issues, including referring them for psychotherapy to TWC.

As the context leader, introspection on my personal, professional and spiritual life and of the interrelationship with the context provided the information needed for me to evaluate my fit as a leader, and the factors within the context that have supported and challenged my leadership. This was directly related to the second section of this portfolio on my philosophy of Christian leadership.

My Journey to Servanthood

Arriving at a philosophy of servant leadership, was a very deep, introspective journey which took me back to some of the earliest memories of my life. Throughout this journey, I saw examples of an integrated understanding of church and community Christian leadership modelled by my parents, who demonstrated ministry beyond the church setting, cared for people in general and specifically those with mental illnesses. Their collaborative ways of living in

community, general adaptability, and the way they always made room to grow new leaders at any stage of development were also evident. I now see how all these influenced my own life and leadership. The introspective journey showed how both my spiritual formation journey and my leadership journey were shaped very early in my life, and both continued to grow and develop over time, even throughout this DMin program.

In retrospect, it seemed that the examples from my parents and family life, my personal formation and life experiences, the opportunities I had for leadership and service over the years, and my training and personality, have all been designed and developed to equip me to serve in this TWC context in this season of life. This journey has solidified in me the concept that "leadership is first and foremost about being a servant … and ultimate power is about ultimate submission" (Dickens and Nelson 2015, 32).

Training Ministry Leaders Towards Supportive Psychotherapy Referrals to Tyndale Wellness Centre

The impetus for the field research project stemmed from an opportunity identified in the TWC context analysis, my interactions with Christian ministry leaders regarding mental illness and psychotherapy for over a decade, the increase in mental health issues in the general community especially as impacted by the COVID-19 pandemic, and my personal long-standing desire to work with churches in helping to address the issues of mental illness in their members.

The research process provided an opportunity to interact with nine ministry leaders connected with the TWC context who were interested in learning more about mental health/illness and about the referral process for psychotherapy. In a pre-questionnaire at the start of the research process, the participants identified awareness, processes, and resources as their three primary needs followed by self-care, confidentiality, support for pastors, and networking. A three-session training program was then developed and implemented that directly addressed all of these identified needs except networking, which was accommodated through the conversations of participants during the training. The outcomes of the training program were analyzed through a post-training questionnaire and through qualitative analysis of the research conversations, recorded videos and transcripts.

Findings of the research showed an increase in awareness, knowledge or understanding in most of the areas of need as indicated by the participants. Some participants indicated a need for further resources and clarity to be more knowledgeable and comfortable with working with their members with mental illness and referring them for therapy. In addition to the benefits for the research participants as identified in the analysis of their pre-post questionnaires and in training conversations, the research findings pointed to the potential value of the training program to help other ministry leaders (and various other leaders), to use a collaborative approach to supporting their members and/or employees towards mental health, while paying attention to and caring for themselves. The

limitations of the research were discussed, including some of the processes during the training and recommendations were made for further research to address them.

Overall, the research process showed how nine ministry leaders from eight different ministry settings, with a wide range of differences in demographics, interacted, supported and learned together and from each other, and were willing to be vulnerable about their challenges and concerns even as they shared their successes related to the issues discussed. This model could be leveraged in subsequent trainings to maximize opportunities to share resources, support one another, share concerns, etc., among other churches and parachurch ministries.

The action research method and the design of the training program allowed for a strong level of collaboration and adaptiveness during the research, both of which are integral to my preferred way of leading.

Some parts of this integrated portfolio are linked to the practice of psychotherapy that has technical language, some of which is included the portfolio. I have included below the definitions or descriptions of these terms to help readers who may not be familiar with them.

Definition of Key Terms

College of Registered Psychotherapists of Ontario (CRPO): The regulatory college for the practice of psychotherapy in Ontario. It is governed by Psychotherapy Act, 2007 and the Regulated Health Professions Act, 1991 (RHPA), with a mission "To develop standards and procedures to regulate

psychotherapists in the public interest, striving to ensure competent and ethical practice within a professional accountability framework" (CRPO 2022).

Confidentiality: Due to the personal and sensitive information clients bring to psychotherapy, (including their personal health information), under normal circumstances, no information about a client is disclosed to anyone outside of the agreed upon persons involved in the care of the client without the written permission of the client or representative.

Consent: When a client agrees to commence and continue therapy based on the information that is provided for them to make an informed decision. "Client consent must be informed, be voluntary, be specific, i.e., based on specific relevant information, not vague generalities, and not involve misrepresentation or fraud" (CRPO 2021).

Controlled Act of Psychotherapy: "Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood … that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning" (CRPO 2021).

Counselling: CRPO defines counselling as consisting of "advising/advice-giving, instruction, assisting in resolution of dilemmas, assisting in improvement of coping strategies" (CRPO 2021). These activities may be part of psychotherapy, but by themselves they do not represent the controlled act of psychotherapy.

Duty to Report: The duty of clinicians to report to different governing bodies when they become aware of information that signifies that a client or another is or may be at risk of serious harm. The most common incidences in therapy are children at risk of abuse and or neglect. "Under section 125 of the Child, Youth and Family Services Act every person who has reasonable grounds to suspect that a child is or may be in need of protection must promptly report the suspicion and the information upon which it is based to a Children's Aid Society. This includes persons who perform professional or official duties with respect to children, such as health care workers … In 2018 the age of protection was raised to include youth up to 18 years old" (Ontario Association of Children's Aid Societies 2021).

Ethno/cultural: This refers to ethnicity (where persons come from) and/or the culture they identify with.

Intrapreneurship: "Intrapreneurship is acting like an entrepreneur within an established company. It is creating a new business or venture within an organization. Sometimes that business becomes a new section, or department, or even a subsidiary spinoff" (Somers 2018).

Mental illness: Is "a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (for example, major depressive disorder, schizophrenia, bipolar disorder)" (APA 2018, 4).

Members or ministry members: Persons who are served by the ministry, not including the ministry leaders.

Ministry leaders: Persons who play leadership roles in Christian churches and/or parachurch organizations.

Privacy: The protection of clients' personal information (oral and written) in the process of collection, use, storage, disclosure and destruction. TWC's Privacy Policy provides information on how client information is collected and used, when disclosure of information is allowed, how information is kept private, how clients can access their records and privacy breaches (Tyndale 2021). Privacy is governed by the Personal Health Information Protection Act 2004 (PHIPA) and the Personal Information Protection and Electronic Documents Act (PIPEDA).

Spiritually Integrated Psychotherapy (SIP): The integration of spirituality into other psychotherapeutic modalities (e.g., Cognitive Behavioural Therapy), to address the concerns of the client about the various areas of life. Like other therapeutic interventions, the therapist and the client are both involved in the process, exploring ways spirituality helps and/or hinders the wellbeing and recovery of the client (Moreira-Almeida, Mosqueiro and Bhugra (2021) and (Carstarphen 2015).

Supportive Psychotherapy Referral: Persons making the referral have a working understanding of the following: mental and mental illness, why and when they should refer their members to psychotherapy, the referral process, the process

for the members they referred, some ethical and legal considerations in psychotherapy, and how they can support their members who are in therapy.

CHAPTER 2:

TYNDALE WELLNESS CENTRE: A JOURNEY OF CHANGE AND COMPLEXITY

This chapter provides a contextual analysis of the Tyndale Wellness Centre (TWC), including information and insights into the development of TWC, the services it offers and its staff and clients. It also highlights the geographic and extended contexts and relationships that influence its services. My role as the Director of TWC is reflected throughout the chapter, but more specifically under the subheading, "Context of the Leader" and in the analysis of the department. The contextual analysis shaped the development of the research project reported in Chapter 4 of this portfolio by providing the information needed to better understand how the mission of TWC intersected with the needs of the community, and the resources available or needed to help Christian ministry leaders in providing support and making psychotherapeutic referrals to their members.

Overview

"The fact that leadership has become a courageous act in the swirl of constant change means to us that the day belongs to the nimble and the adaptive"

(Dickens and Nelson 2015, 23). This statement from Dickens and Nelson in their work on *Leading in Disorienting Times* (Dickens and Nelson 2015, 23) captures the numerous changes that have taken place at Tyndale Wellness Centre (TWC), over the last few years, and which were exacerbated by the impact of the COVID 19 pandemic. Dickens and Nelson also state that "Perhaps good leadership means being willing to have the confidence to move forward even when all the answers needed are not yet available" (Dickens and Nelson 2015, 26). As the Director of TWC, I have been privileged not only to lead TWC but to be part of its growth and development through various stages. I have noticed that since its inception, adaptability has been a defining characteristic of how it functions. TWC is also a product of adaptability, demonstrated by its early development and through its ongoing ability to help ensure that Tyndale fulfills its mission to students and the community, even during times of uncertainty.

TWC is a department of Tyndale University, a "Christian university in Toronto offering a wide range of programs at the undergraduate, seminary & graduate levels…built on over 125 years of history" (Tyndale 2022). This department was formed in 2021 from the merger of two separate and related departments, Tyndale Counselling Services (TCS) which provided psychotherapy and related services to Tyndale students and the Family Life Centre (FLC) which provided similar services to members of the public. The merger was designed to result in a more cohesive way of working by streamlining and expanding the scope of services to those both inside Tyndale and in the broader community. As

a department of Tyndale, TWC is supported by several other Tyndale departments, including Human Resources, Marketing, Business Office, and Information Technology Services (IT). All of them were integral in its formation and the numerous changes needed for the department to function effectively.

The main service of TWC is the provision of psychotherapy to Tyndale students and their families (Student Services) and to members of the public, i.e., persons who are not current students at Tyndale (Community Services). Services are provided mainly by Registered Psychotherapists (RPs) who are members of the regulatory College of Registered Psychotherapists of Ontario (CRPO), or intern therapists who work under the licence of a clinical supervisor. CRPO provides the following information:

> The Regulated Health Professions Act, 1991, sets out fourteen controlled acts that are inherently risky and should only be performed by a properly qualified professional to ensure client/patient safety. The controlled act of psychotherapy is one of these legally restricted acts. It is defined as: Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning (CRPO 2021).

This statement highlights the specificity that surrounds the practice and the corresponding detailed attention that is involved in maintaining the required standards. For example, one key change brought about by the implementation of the controlled act of psychotherapy is that the term counselling, as practiced by TWC prior to the controlled act, has been replaced with psychotherapy. TWC also provides webinars and seminars to organizations that offer mental health and

wellbeing services, and professional development services to mental health clinicians.

In fulfilling its purpose, TWC serves the immediate geographic community of Willowdale in North Toronto where it is located. However, with advances in technology and the ongoing demand for its services, TWC has expanded its services nation-wide and now sees its service context as Canada, not just the Greater Toronto Area that it served prior to the use of online services. In analysing the stakeholders of TWC, I found numerous and varied relationships, both internal and external to Tyndale, that were associated with the functioning of the ministry. These relationships varied in purpose and function, some being supportive, others challenging and demanding of resources, but all important to the ministry. These relationships are further explained under appropriate sections of this paper.

Although referring to church contexts, James Watson's *Community Research Guide for Church Leaders* is applicable to TWC:

> The parable of the good Samaritan (Luke 10:29-37) provides a helpful definition of neighbour as the person with whom we can come into contact and relate to in a meaningful way, regardless of differences in culture, appearance or social status. Different churches will find it helpful to define their community in different ways. Some churches may be able to identify a geographic region on a map as being their urban neighbourhood, town or rural region. Other churches may have to identify their community as networks of relationships or "people groups," perhaps with certain languages or cultural identities as the primary features of these relational networks. (Watson 2008,1)

This definition of neighbour fits the ministry of TWC, with its context being a combination of geographic location and numerous relationships of persons and organizations that together contribute to maintaining its stable functioning (Steinke 2006). The physical location of the TWC office is more related to the operational location, while the service location is the "networks of relationships or 'people groups'" (Watson 2008,1) who access the services primarily online instead of the previous in-person format.

The networks related to TWC are diverse and numerous, involving individuals, groups and both small and large organizations. For example, clients seeking psychotherapy as individuals, couples or families are the primary customers. They are part of a network that includes their substitute decision makers, sponsors, caregivers, health practitioners, insurance companies, lawyers, employers, etc. Another example is the network of regulatory colleges and professional associations that govern the practice of psychotherapy and professional development of therapists. Consequently, they strongly influence the overall direction and day to day activities of TWC.

Brief History of Tyndale Wellness Centre

In this section I outline the historical development of TWC and how it is situated as a department of Tyndale University. This outline also includes insight into the numerous changes during the development of TWC that were related to

the psychotherapy services provided to members of the public (non-Tyndale students).

In 1996 Tyndale formally began to provide counselling services to students through the Tyndale Counselling Services (TCS). Over its 25 years of operation, this service expanded in the quality of service, numbers of counsellors who supported the services and numbers of students it served. During those years, different persons associated with TCS shared their vision of expanding the counselling services to members of the public (non-Tyndale students). In 2014, with Tyndale's move to the Bayview campus and the accompanying additional space, TCS began to plan for services to the public and this culminated in a pilot project launched in January 2015. During the summer of 2015, Tyndale formally moved the services to the public under the newly formed Family Life Centre (FLC), with an official launch in October 2015. Dickens and Nelson explained how and why this was done: "One way we moved forward was to place all of the freestanding entrepreneurial centers under one umbrella… It is called the Tyndale Open Learning Centre" (Dickens and Nelson 2015, 16). FLC was considered one of those entrepreneurial centers in the sense of offering something new that emerged within the broader institutional context.

Until June 2019, the FLC psychotherapy services were contracted out to TCS, while the overall leadership was handled by the inaugural FLC Director. In June 2019, I transitioned from the role of TCS manager into full responsibilities as FLC Director. TCS and FLC continued to share many services and resources:

physical space, equipment and software, collaborative management, supervisors, administrative support, psychiatrists, therapists (all FLC therapists served student clients as part of their contracts) and both entities were governed by the same regulatory bodies of psychotherapy and membership organizations. In January 2020, FLC expanded its services with a remote office in Scarborough, Ontario, a location rich with diverse ethnic groups. In May 2021, Tyndale Wellness Centre (TWC) was formed as a new department of Tyndale University through the merger of TCS and FLC and I was appointed as Director. As noted, the merger was created to provide a more integrated service and optimize the resources of the previous departments into a streamlined whole. Going forward in this chapter, I will refer to the past services of FLC and TCS as TWC, except when making necessary distinctions.

This brief history gives a glimpse into the ever-changing context, the shifting organizational structures as part of the larger institution, and the adaptability that has always been necessary to ensure the flourishing of TWC. Change and the corresponding adaptability continue to be features of TWC.

TWC as a Tyndale University Department

This section provides insight into how TWC is situated as a department within Tyndale University, with a common vision and purpose yet some differences in governance based primarily on the services it offers.

Spiritual Context

As part of a Christian university, and with spiritually integrated care as part of its focus, TWC is aligned with the broader institutional context of Tyndale University which is:

> …rooted in the Protestant Reformation with its conviction concerning the Lordship of Jesus Christ and the normative authority of Scripture. In the tradition of the Evangelical awakenings, we proclaim the message of a personal faith in the crucified Christ and a transformed life through the Spirit. Born out of the world missionary movement of the 19th century, we continue to serve the global Church in all its cultural diversity. We embrace the biblical call to seek justice and peace and to serve the poor, the vulnerable, and the oppressed. (Tyndale 2008)

This is important for TWC in recruiting staff who are expected to adhere to Tyndale's mission and statement of faith. It is also important for clients, as they can use this information in making informed decisions about having services in this Christian based organization.

A Regulated Health Practice within an Educational Institution

Psychotherapy is the primary service of TWC and is a regulated health profession functioning within an educational institution, Tyndale University. The practice of psychotherapy is governed and guided by laws and guidelines that do not necessarily apply to education. The laws include The Regulated Health Professions Act (1991), Personal Health Information Protection Act (2004), The Psychotherapy Act (2007), The Controlled Act of Psychotherapy (2017), Health Care Consent Act (1996), Mental Health Act (1990), Child, Youth and Family Services Act (2017), Fixing Long-Term Care Act (2021) and Missing Persons Act

(2018). The Personal Information Protection and Electronic Documents Act (2019) is crucial for TWC and Tyndale, because the personal health information collected by TWC is transmitted and stored electronically using Tyndale's resources. Although the tight scrutiny for the protection of client's health information is understood and deeply valued, the accompanying documentation process is very time-consuming. In addition, there are regular program and related process updates, monitoring and training to ensure data security, and corresponding detailed conversations and documentation with Tyndale management to provide clarity, while maintaining client confidentiality. One positive result is that Tyndale provided a customized database (PRISM) which improved the security of client data, streamlined the data collection and storage processes and facilitated the provision of online psychotherapy, supervision and professional development services.

An example of how the differences in regulations for education and health services impact TWC's functioning was the closure of the university in response to COVID 19. As a mental health practice, TWC is seen as an essential service and thus could have continued its operations during the pandemic in different ways and under different guidelines than the educational side of the university. However, because the educational institution had to be physically closed, TWC's in-person services were also closed. Another example is that opportunities for COVID vaccines were more readily available for health professionals than for educational workers. Because TWC is located within Tyndale University

facilities, laws that govern education directly and indirectly impact TWC's practice, all forming part of the complexity of offering TWC services. This summary shows how both the highly regulated networks, and the associated complex nature of operations at TWC, contribute to the distinctive nature of this ministry context as well as the integrative, collaborative nature of its functioning within the wider Tyndale institution.

TWC Services

TWC services are centred around providing mental, emotional, and relational care, whether directly through psychotherapy, or indirectly through professional development of clinicians and other professionals within the field. It also provides psychoeducation on personal and relational care to Tyndale staff, schools, churches and other organizations. Other services to organizations are categorized as corporate wellness activities. The main services are individual, couple and family therapy to students and members of the public followed by clinical supervision and webinars.

Until the end of March 2020 which aligned with the COVID pandemic, psychotherapy and other services at TWC were offered almost exclusively in person. In September 2019, all staff were trained in providing online therapy, thus, when the COVID pandemic began, there was a relatively smooth transition for clinicians to offer online therapy. Most of the challenges arose from ensuring security of clients' personal health information. This was a laborious task.

Tyndale's IT department, however, made many changes in a fairly short time frame to the PRISM database to ensure the security needed.

Psychotherapy

As noted above, psychotherapy is a Regulated Health Profession, and it is governed by the College of Registered Psychotherapists of Ontario (CRPO) under the Psychotherapy Act (2007) which provides strict guidelines for practice in the treatment of the disorder or issue the client brings. The therapy process itself begins when a potential client or representative contacts TWC administration or a specific therapist, provides a reason for seeking therapy and confirms the availability of a therapist. For student services, clients are placed with therapists using a structured placement process. This involves a student completing an online placement request form, the first in a number of steps which lead to TWC matching the student client with the most suitable therapist available.

A potential community client may access the brief, free consultation offered by the therapist contacted. This consultation provides the potential client with basic information about the process and the therapist, and the potential client provides personal information to create an electronic file in PRISM data-base. PRISM-generated links are sent to the client to provide detailed information about therapy and TWC, for the client to provide personal details and consent to begin therapy and to pay for the session. For all clients (whether student or community clients), depending on the presenting issues for therapy, and if children or third

parties are involved, additional forms for consent may be required. Certain discoveries made during therapy or prior to the first session may prompt external interventions based on therapist's duty to report to authorities regarding harm to children, client's harm to self and others (CRPO 2023). Normally the number of therapy sessions is limited by the fulfilment of goals, time available, finances, health condition, etc. The exceptions are mainly when clients are mandated by the courts, workplaces, academic programs, etc., to participate in a set number of therapy sessions to meet pre-arranged objectives.

Two distinctive therapeutic approaches used at TWC are Spiritually Integrated Psychotherapy (CRPO 2021) and Family Systems Theory (The Bowen Center, 2021). Spiritually Integrated Psychotherapy (SIP) is an established therapeutic modality which is approved by CRPO and is practiced in a way that respects the diversity of the clients. According to Pargament (2007):

> When people come to psychotherapy, they do not check their spirituality at the door. Spiritually integrated psychotherapy assumes that spirituality is often interwoven with the problems that clients bring to psychotherapy, the solutions to those problems, and the client's larger social and cultural context … and that the spiritual dimension of problems calls for clinical attention. (Pargament 2007, 176-178)

Although I have heard negative comments from some Christians about today's post-modern culture, I have found it actually provides room for issues of faith to be openly and organically integrated in the mental and emotional healing conversations in ways previous eras might not have allowed. As SIP becomes more widely known, many faith organizations including TWC's ministry partners,

appreciate a clinical space where faith can be integrated into healing. This is consistent with the American Psychiatric Association's view that "religion and spirituality often play a vital role in healing" (APA 2018, 2). TWC's approach of connecting psychotherapy and spiritual care also reflect the words of Vanhoozer et al., "to engage culture as part of Christian mission and theology" (Vanhoozer, Anderson and Sleasman 2007, 48). The Family Systems Theory approach practiced at TWC purports that "Knowledge of how the emotional system operates in one's family, work, and social systems offers new, more effective options for solving problems in each of these areas" (The Bowen Center, 2021). This approach enhances the quality of therapy through a holistic approach, taking into consideration the larger systems that are part of client's world and how they are inter-related with problems and solutions for the client.

Culture and Psychotherapy

One definition of culture provided by Merriam Webster is "the customary beliefs, social forms, and material traits of a racial, religious, or social group" (Merriam Webster 2022). Vanhoozer, Anderson and Sleasman state that "cultural anthropology proceeds from the insight that humans live in worlds they create for themselves, worlds in which they invent and discover meaning" and that "any adequate definition of culture … has to keep both aspects - system and practice - in mind" (Vanhoozer, Anderson and Sleasman 2007, 35, 38). In many ways, it can be said that psychotherapy embodies the above. Therapists and clients

participate in an interrelated system that connects them in their respective contexts. Therapists must be aware of, and be guided by, clients' knowledge, understanding and response to their cultural contexts and not simply make assumptions. Together, client and therapist discover how these interrelated components have formed the client's and therapist's understanding of life and the issues they bring to therapy and generate outcomes that are useful for the client. A stance of openness and curiosity is needed from the therapist, as others in the exact situations may have very different experiences of the issue. Therapists must ensure their own cultural norms do not cloud their understanding and work with the client's situation. All this happens within the therapy context where there are established rules to follow. As therapy progresses, both therapist and client experience changes, and the therapeutic relationship changes to reflect new understandings of the work they are doing together. This is the aim of therapy - to generate change towards health, and it is supported by the statement: "Culture is a way of life, and what is living changes and develops. It is only a slight exaggeration to say that one cannot step into the same culture twice" (Vanhoozer, Anderson and Sleasman 2007, 37). Like culture, the therapeutic relationship is always changing; it is never the same throughout or between sessions.

Berger and Luckmann argue that "reality is socially constructed and … the sociology of knowledge must analyse the process in which this occurs" (Berger and Luckmann 1991,13). The psychotherapy culture at TWC reflects a system of multiple, socially constructed worlds that intentionally integrate family systems

theory and spirituality, focusing on the clients in their socially constructed worlds by therapists in their socially constructed worlds, both personally and professionally. This is a time-consuming, complex way of working but has many positive implications for the outcome of the work. For example, for a white, female therapist, the police in her neighbourhood may mean safety, while for her black, male, youth client, in the same neighbourhood, the police may mean a threat to his very life, although he is a law-abiding person. Bringing oneself totally into the work means one is always influencing and being influenced by what is done or not done, asked or not asked, etc. Clinical supervision is a requirement of the work, in that therapists have a safe space to be accountable, to get insights into their progress and blind spots, and to explore the "Safe and Effective Use of Self" in therapy (CRPO 2021).

TWC Psychotherapy Through the Lenses of *Everyday Theology*

There are ways in which TWC applies some concepts from Vanhoozer, Sleasman and Anderson into its work, for example, "culture communicates, culture orients, culture reproduces, and culture cultivates" (Vanhoozer, Anderson and Sleasman 2007, 41). Psychotherapists are "constantly communicating messages, both overtly and covertly, on a variety of levels and through a variety of means" (Vanhoozer, Anderson and Sleasman 2007, 41). For example, the concept of "culture communicates" is evidenced in the way God's love is constantly communicated through a client-centred, non-judgmental stance,

regardless of the clients' issues, faith, culture, etc. and the interventions the therapists use. Christian faith messages are overtly communicated to clients who agree to have their faith included in their therapy and covertly through the silent prayers of therapists. The goal is to communicate love and respect for everyone as image bearers, i.e., "God created human beings in his own image" (Genesis 1:27 NLT). The culture of TWC assumes that all persons regardless of their actions, position in life, etc., deserve to be treated with dignity and respect because of the image of God they bear. This culture positively contributes to the therapeutic relationship.

"Culture orients" is another concept from Vanhoozer, Anderson and Sleasman that is manifested at TWC: "Cultural statements are vision statements, and cultural texts have the ability to seize our imaginations" (Vanhoozer, Anderson and Sleasman 2007, 42). Tyndale's mission statement (Tyndale 2008) focuses on service both to the church and the world and TWC's work is clearly part of this overarching goal of enhancing the wellbeing of persons both within the church and the world in general. With therapists working from a systems perspective, there is an array of possible positive outcomes when one person makes even a small change in behaviour or thought. One common way this is shown at TWC is through therapists extending grace and understanding to all clients. Although some clients find this difficult to understand, it often provides the means to begin their change process. Also, when clients make a small change, it often impacts their family members.

"Culture reproduces… spreads beliefs, values, ideas, fashions, and practices from one social group to another" (Vanhoozer, Anderson and Sleasman 2007, 43). TWC therapists are ministering in a non-Christian profession but use aspects of their profession to spread the gospel by becoming deeply engaged in the intimate lives of their clients and effecting changes the clients can integrate and live out in their day to day lives. The new beliefs, values, etc., being reproduced are manifested as therapists spread God's message of love, grace and healing to those in mental and emotional anguish, help those who are captive to addictions or unhealthy relationships find relief, and help all to see that the time of the Lord's favor has come (Luke 4:18-19 NLT). An effective therapeutic relationship results in a transfer and/or awakening of a sense of change and hope that might otherwise not emerge.

Vanhoozer, Anderson and Sleasman (2007, 74) describe the "world behind the work" meaning the background upon which the work is built. Some factors that have distinctively shaped psychotherapy at TWC are the mission of Tyndale, the genesis of TWC, the seminary training of many therapists and their call to ministry, the socioeconomic conditions and mental/emotional/relational health issues of the population, a culture that supports mental health, etc. Many of our therapists' lived experiences propel them "to comfort those who are in any affliction, with the comfort with which we ourselves are comforted by God" (2 Cor 1:4 ESV).

By integrating faith into psychotherapy, and showing the love of God to all clients, therapists witness "the world-in-front… how the text … interacts with our world, especially in terms of its influence and ideals" (Vanhoozer, Anderson and Sleasman 2007, 350). Some clients readily understand this integration process as it is part of their everyday lives. For others, it is a new way of being that they want to continue. Like any other intervention, clients provide consent for faith integration in the work, and often anecdotally report in direct conversations with their therapists the mainly positive outcomes from this integration.

Using psychotherapy, we see and respond to the world of our clients "through Redemptive History–Colored Glasses" (Vanhoozer, Anderson and Sleasman 2007, 356). TWC therapists know and act out of the truth that ultimately God is the Healer and Jesus came to redeem the lost and bring hope, etc., and although some things can be accomplished by the self, ultimately the integrated self includes a relationship with God. As "the salt of the earth" and "light of the world" (Matt 5: 13-14 NIV), it is crucial that therapists play that role both with Christians, with whom we are part of the body of Christ, as well as with non-Christians who need the presence of salt and light in their lives. In this way, we partner with Jesus who did "not come to call the righteous, but sinners" (Matt 9:13 NIV).

"Becoming a Cultural Agent" (Vanhoozer, Anderson and Sleasman 2007, 360) at TWC includes making a redemptive change. As one example, in 2018-2019 some TWC psychotherapists participated in an international research study,

A multi-site study of Christian-based spiritually integrated psychotherapy: Focus on East Asian Canadians" (University of Toronto, Canada, 2018), regarding integration of Christian faith in psychotherapy. Although the published findings were delayed due to the COVID pandemic, preliminary responses from clients indicated the benefits of including faith in therapy. Out of their own lived experiences, therapists effectively communicate the hope and change that only a relationship with Jesus Christ brings. Therapists too, find themselves "in a world in decay and yet with the shadow and promise of glory, a world that God is reconciling to himself" (Vanhoozer, Anderson and Sleasman 2007, 360). Willingly, they partner with God in that redemptive process by sharing the grace, acceptance, forgiveness, hope, etc., that they themselves have experienced, with those who seek their help.

These examples show how TWC has been a cultural agent, integrating theology into its everyday psychotherapy practices. These practices acknowledge and meet spiritual concerns of clients as part of their clinical care and highlight TWC's distinctive feature of being able to address both the spiritual and psychological needs of clients.

Professional Development

For therapists to provide services that meet the needs of clients and satisfy the requirements of the regulatory bodies, professional development is an ongoing and necessary part of their practice. Professional development services offered at

TWC include an annual one-week intensive training for all new staff and regular clinical supervision to all TWC therapists, interns in the MDiv Clinical Counselling programme, and therapists from other agencies or in private practice. TWC provides biweekly webinars to interns from the MDiv Clinical Counselling program and ad hoc training to Tyndale faculty, staff and students, as well as to clinicians from the public. TWC is a founding member of the Christian Mental Health Practitioners Network that offers clinical training from a Christian perspective. As noted above, TWC research has included participation in *A multi-site study of Christian-based spiritually integrated psychotherapy: Focus on East Asian Canadians* (University of Toronto, 2018).

Corporate Wellness

The corporate wellness function of TWC includes consultations to churches and other organizations to address issues of conflict and reconciliation, transitions, etc. Seminars and workshops are provided as required (e.g., boundaries for leaders, stress management and relationships).

TWC Staff

Most of the forty staff members are past or current Tyndale students, mainly from the MDiv Clinical Counselling programme. Therapists have minimum of graduate-level training in a psychotherapy related field and, except for some intern therapists, all are members of the College of Registered Psychotherapists of Ontario (CRPO) or the Ontario College of Social Workers

and Social Service Workers (OCSWSSW). Psychiatrists are members of College of Physicians and Surgeons of Ontario (CPSO). Intern therapists provide services under supervision as stipulated by CRPO. Four members of the team are trained clinical supervisor mentors, three are clinical supervisors in training and, in addition to their roles as therapists, provide clinical supervision for the team.

TWC staff adhere to the Christian faith and Tyndale Community Standards. Therapists share a common understanding of their profession as their calling or ministry to help those in need. Some have served as missionaries in different countries or are currently ministry leaders within their own congregations. Their varied professional backgrounds include teaching, administration, project management, law, social work, prison chaplain and IT. They are trained to work with persons of all faiths or no faith. Therapists' ethnocultural backgrounds include Black, Chinese, Korean, Middle Eastern, South Asian and White. They offer services in six languages: Arabic, Cantonese, English, French, Korean and Mandarin. They are males and females, in their twenties to sixties, single, separated/divorced or married persons and parents of young to adult children. Many therapists have intercultural experiences through missions or other work, or by birth outside of Canada and are from a cross section of Christian denominations. The team is intentionally diverse to better support the diverse community that TWC serves.

Until September 2022, some therapists volunteered their services to the students at TWC and gained clinical hours and supervision in return. Currently,

except for intern therapists and one volunteer, therapists are self-employed, contracting their services with Tyndale. They all provide services to students at a fixed rate per session and some are contracted to serve members of the public and are reimbursed a fixed percentage of the fees they collect. Supervisors are reimbursed at a fixed rate per session. TWC is intentional about helping therapists to make their work a financially viable career option. Therefore, it provides some marketing / promotional services for the practice and fees for service are revised as needed, while considering affordability for clients and the market rate.

The administrative team consists of the Director and Assistant Director (who are also trained clinicians at the Supervisor Mentor levels), the Administrative Supervisor and two Administrative Assistants. This team initiates and supports the processes that hold the department together. TWC works closely with Student Life and the Centre for Academic Excellence to support Tyndale students' wellbeing and guards against dual relationships and conflicts of interest when serving members of the Tyndale community. Other Tyndale departments and persons supporting the work at TWC include the Business Office, Marketing and External Relations, Information Technology, Human Resources, Privacy Officer and Facilities Management. TWC's work is also supported by other practitioners outside of Tyndale to whom therapists regularly refer. These include medical team, psychologists and therapists with skills outside the scope of practice of the TWC team, as well as agencies that can support long-term therapy at little or no fees for our community clients.

The above description demonstrates that TWC staff have the professional credentials, capacity and skill required to safely practice psychotherapy as prescribed by regulatory organizations, and to carry out other related services. TWC's work is supported by the therapists' diversity, shared faith and values, and the complex inter-related network of persons, organizations, legislation that are relevant to the services TWC provides.

TWC Clients

As noted above, clients at TWC include those identified as Tyndale students and their immediate families who are part of the therapy (student clients), and non-Tyndale students (community clients) who access therapy as individuals, couples and families (representing the vast majority of TWC's clients), and organizations that sponsor some of these clients. Clients also include therapists in private practice or in agencies whose therapists access supervision, as well as organizations TWC supports through seminars/webinars/workshops on various topics.

There are some common factors among clients accessing therapy whether as students or from the community. For example, prior to the COVID-19 pandemic, they accessed in-person services mainly at Tyndale's Bayview Avenue campus. When online therapy began in April 2020, there was an attrition of clients who could not or did not want to use that modality, but over time, there was a positive adjustment. The primary issues for therapy include anxiety and

depression, consistent with the national survey that indicated that "Mood and anxiety disorders are among the most common types of mental disorders in Canada and have been shown to have a major impact on the daily lives of those affected" (Government of Canada, 2015).

TWC expects that the demand for therapy will remain at least fairly steady for some time, as the Centre for Addictions and Mental Health states:

> Canada was already in the midst of a mental health crisis prior to COVID-19. The pandemic has both magnified and added to this crisis and highlighted how crucial mental health promotion and care are to our overall well-being … COVID-19 is both magnifying and contributing to Canada's mental health crisis… The negative mental health impacts of COVID-19 can be expected to last for some time and will place added burden on Canada's already overwhelmed mental health system. (CAMH 2020, 1 & 12)

Student Clients

Tyndale has been providing counselling/psychotherapy services for students since 1996 serving thousands of students with various issues. Student clients are mainly those who voluntarily access therapy and those whose academic programmes have therapy/counselling as a requirement. An analysis of student clients for the academic year 2021-2022 showed that the reported ethnicity of student clients was: Unspecified, White, Chinese, Black, Korean, Multi-ethnic, Other (See Fig 1.1). Student clients ranged in age from 17 to over 65 years with close to 57% of the students between 26 and 49 years old (See Fig 1.2). General anxiety, family of origin, depression, stress and boundaries were the

top five presenting issues for therapy. Family of origin is part of an academic programme requirement in counselling which accounts for its ranking in presenting issues. During this same period, student clients accessed 3703 therapy sessions which are usually 50-60 minutes in duration. Since the academic year 2022-2023, a few students have accessed in-person therapy at the TWC office location but most of them have used the online services.

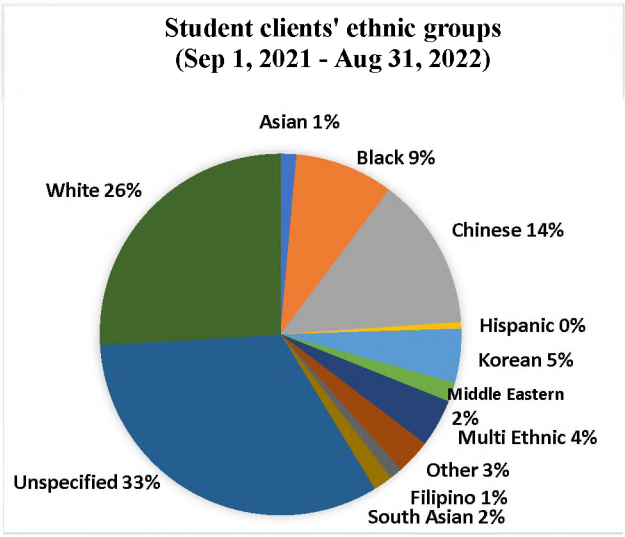

Figure 1.1 Student Clients' Ethnic Groups\

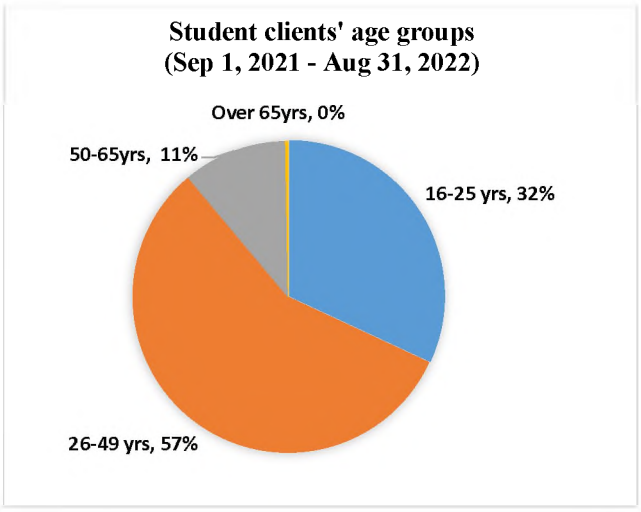

Figure 1.2 Student Clients' Age Groups

Up to 2022-23 academic year, therapy services for students included free sessions and paid sessions at minimal fees based on the course load. At the time of writing, students taking more than one course were required to have extended health benefits either through the Tyndale benefits plan or alternate coverage. This resulted in a change in fee structure with no free sessions, fees closer to the market rate and students reimbursed by their insurance for a percentage of the fee. However, where there were financial challenges, TWC was committed to help find resources to ensure students receive the services they needed.

Community Clients

Prior to the COVID-19 pandemic, TWC community clients lived primarily in the GTA and travelled for services to Tyndale's Bayview Avenue campus, and for a few months to TWC's secondary office which was located in Scarborough.

Following the introduction of online therapy in April 2020, many of these clients did not want to use online services, but within two years the number of client sessions per year tripled as online services became the norm. The primary issues for community clients were anxiety and depression.

Between September 1, 2021, and September 30, 2022, TWC community clients identified as White, Chinese, Unspecified, Korean, Black, Multi-ethnic, Other, South Asian, Asian, Middle Eastern, Filipino, Hispanic, Japanese (See Fig 2.1), with highest numbers being clients 26-49 years old (62%) and the lowest numbers over 65 years old (13%) (See Fig 2.2). During this same period, community clients had 4662 hours of therapy which are usually 50-60 minutes in duration.

Potential clients are informed that "all staff members are committed to the Christian faith and agree with the Tyndale University 'Statement of Faith'" (TWC 2022), therefore, some people may not choose TWC services because of the Christian faith. Some non-Christian clients however, report choosing TWC based on referrals from their doctors, friends, etc., and others report choosing therapists based on clinical skills and not religious affiliation. Over the years, the religious affiliations reported by clients have ranged from various Christian denominations, different religions, no formal religion and agnostics/atheists.

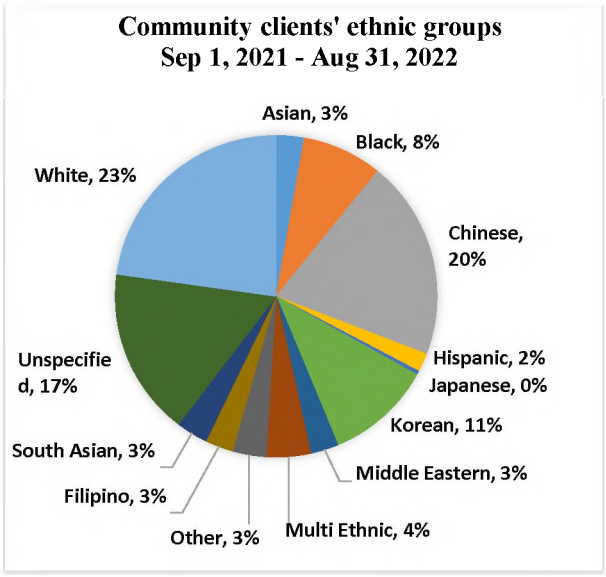

Figure 2.1 Community Clients' Ethnic Groups

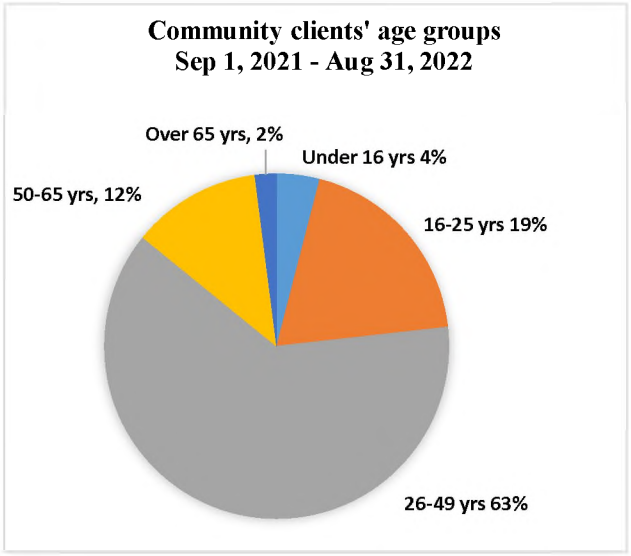

Figure 2.2 Community Clients' Age Groups

Fees for service for community clients are competitive and most clients pay the full fees. Some clients have full or partial insurance coverage or are co-sponsored by individuals or organizations, while others access the sliding scale

for fees. Because therapists are compensated as a percentage of the fees they collect, they usually have a limited number of clients they will see at reduced rates. This is a challenge for TWC as an organization since serving the underprivileged is part of its values. In wrestling with this challenge, I resonate with Das (2016), "Is it possible that something profoundly changes when people in the name of Christ are willing to step out of their comfort zone and self-centeredness and put their … resources on the line by sacrificially helping those who are broken and poor, and then introducing them to the King of the kingdom of God?" (Das 2016, 2). As the need for and cost of psychotherapy increases, so has financial compensation to therapists within the industry, resulting in staff retention challenges as therapists have more financially lucrative options. As a profit centre within Tyndale, TWC also wrestles with finding creative ways to balance reasonable therapy fees with reasonable remuneration for therapists. The ongoing balancing act is somewhat reduced as we collaborate with more Christian ministries that help to fund therapy for their members. Many staff members attest to "a call" and compassion for the hurting that outweighs the compensation, reflecting that "Compassion is a divine attribute fundamental to God's nature" (Das 2016, 12).

The above indicates the growth in services to community clients and TWC's ability to adapt and meet the needs. It also highlights the interrelated challenges of compensation to therapists and affordability of therapy for some

community members and the dilemmas that TWC faces in trying to find satisfactory resolution.

TWC Geographic Context and Relevant Relationships

I now turn to an examination of the geographic context of TWC. This is important as TWC's work began in this geographic community and continues to have strong relationships with local Christian ministries (some of which sponsor clients), has access to resources within this community for clients (e.g., referrals to medical care), and continues to serve many clients who live and/or work within the community. Although advances in technology have allowed TWC to provide services throughout Canada, the geographic location remains relevant, as many of the partner ministries are physically located in this neighbourhood and we anticipate that the in-person connections will continue to increase within this community. Additionally, as Tyndale University plans to grow its presence in the community with the Tyndale Green project (a proposed plan to build an affordable housing community on the Tyndale campus), TWC is planning for a more robust presence with expansion of the wellness services it offers. Currently, with online therapy, the geographic boundaries are now those of Canada, and these are only limited because of legislation and potential professional liability issues which we anticipate will continue to be the case.

The relevant relationships that I will examine refer primarily to other persons and organizations that are instrumental to TWC but are not necessarily located within Willowdale or limited by TWC's geographic boundaries.

TWC Geographic Neighbourhood

Tyndale is located in the Willowdale neighbourhood, a community within the Willowdale electoral district Ward 18, North York, Toronto, Ontario. It is bound on the north by Steeles Avenue, on the East by Bayview Avenue, on the west by Bathurst Avenue and on the south by Highway 401 and the West Don River. These boundaries place Tyndale University just outside the northeast corner of the official boundaries of Willowdale, although Tyndale is involved with and interacts as a part of the Willowdale community. Willowdale has a natural connection to TWC as a previous FLC Director was part of a local congregation in the neighbourhood. This connection was strengthened by Tyndale's direct involvement in the aftermath of 2018 Yonge Street van attack (Carter 2022), collaborating with churches in the community to offer grief support and crisis counselling. The relationships grew with the use of a church facility in the neighbourhood for some TWC programs, TWC's involvement in the Willowdale Church Coalition and NeighbourLink North York. A natural progression was agreements with churches in the community to provide therapy for their members and regular referrals from other churches. Pastors in some of

these churches participated in the research project recorded in Chapter 4 of this portfolio.

Statistics Canada in 2016 census placed the Willowdale population at 118,801 growing by 8.3% since 2011 (Statistics Canada 2016). Seventy-three percent of the population is 15-64 years and 16% is over 65 years old. The most common non-English mother tongues include Iranian, Korean, Cantonese, Mandarin, Persian, Russian, and Filipino (Statistics Canada 2016). A connection is made between wealth and ethnic groups as "this once-sleepy suburban neighbourhood is one of the hottest real estate markets in Toronto right now, partly due to demand from wealthy Persians and Chinese" (Pigg 2015). A closer look at Willowdale reveals alternate narratives to the dominant narrative of wealth and stability. The alternate stories portray poverty and loneliness with residents outside the mainstream culture, as reported by community workers (Neighbourlink 2022) and from personal observation of homelessness and poverty when commuting through the neighbourhood. The body of Christ in Willowdale is working to meet these needs. For example, Neighbourlink North York has as part of its mission that "we believe transformation happens when we come together … to address poverty, social isolation, discrimination, violence … we will seek opportunities and develop programs that benefit the most vulnerable among us" (Neighbourlink North York, 2022).

In the *Community Research Guide for Church Leaders*, Watson states: "We seek to understand the community that surrounds us so we can: know how to

relate to our neighbours more effectively, recognize where God is already at work around us, and partner with the Holy Spirit in ministering within our community" (Watson 2008, 2). In knowing and trying to meet the needs of Willowdale, TWC offers psychotherapy in many of the languages of this community. Many therapists have cultural connections with the clients and TWC supports the activities of Neighbourlink North York.

The Network of Relationships

TWC's network of relationships includes relationships that are varied and far reaching, both in distance and impact. According to Chua, Madej and Wellman, "The internet not only enables people to maintain and strengthen existing ties, but it also aids in forging new ties" (Chua, Madej and Wellman 2009, 5). The resources developed during the COVID pandemic have expanded the network of clients' relationships as clients access services with the use of telephone and / or internet services and are not restricted to physical locations. This new process maintains and strengthens ties through increased accessibility for most of the population, saving time and transportation costs and forging new ties by allowing more participation in therapy, training or meetings, simultaneously from different locations for those who would otherwise not participate. For example, an in-person family session that involved all members attending in a TWC office could be difficult to achieve, but can now have all members attending from different places in Canada.

With the increased use of electronic media for daily life during the pandemic (e.g., school, church, court sessions, psychotherapy), there have been advances in technology to secure privacy and confidentiality. At Tyndale, the TWC database has a dedicated server that can only be accessed by members of the team. Zoom is the video software used for therapy and its PIPEDA/PHIPA Compliance Guide (2021) shows that Zoom technology meets the requirements for Canada's privacy laws. Therapists in their respective locations need home offices suitable for confidential conversations and all TWC staff sign an agreement to provide services that meet the requirements of TWC.

Other relationships for TWC services are mentioned throughout this chapter and include the College of Registered Psychotherapists of Ontario (CRPO) (the primary regulatory body for psychotherapists), other membership organizations (e.g., Ontario/Canadian/American Associations for Marriage and Family Therapy), professional liability insurance companies, professional development organizations, marketing and promotional services, and client referral sources. Bidirectional referrals and collaborations with medical professionals help provide complete care for clients. Other common relationships are the Children's Aid Society (CAS) when working with child protection matters, lawyers, employers and insurance companies (to provide progress reports on employees' health) and occasionally, a subpoena for client records and a court appearance. Some mental health professionals and organizations that do not

practice, but support the integration of faith and psychotherapy form an informal network by referring clients to TWC for spiritually integrated therapy.

This description of the formal and informal network of relationships of which TWC is a part, illustrates the complexity of the nature and functions of TWC as well as the potential influence it can have in the community. As Watson argues, "Communities can be transformed through the ministry of churches that understand their community and are guided and empowered by the Holy Spirit" (Watson 2008, 2). By understanding the community and relationships, TWC has continued to tailor its services to meet the needs of clients and develop strong relationships with many people and organizations, whether or not they are faith-based. Furthermore, an active, informal but often silent network of relationships is with persons who support the work of TWC in prayer, and within the broader context of Tyndale where relationships are reflected in the organizational structure, mission, leadership, departments, academic programmes, staff, physical space, etc.

Context of the Leader

In understanding the context of the ministry, it is also important to understand the context of the leader. As the TWC Director, I report to the Tyndale Vice President for Student Development who represents the department on the Tyndale cabinet. Therefore, to better understand how I fit into TWC context and the broader institutional context, in this section, I provide a synopsis of my own

leadership journey and what has influenced me. More details about my personal context as a leader are included in Chapter 3 of this portfolio on *Philosophy of Christian Leadership*.

I asked the Lord into my life when I was a child, and as a pastor's kid, I was exposed to ministry in the church and was involved in different leadership activities. These helped to form my interest and work in leadership roles in various settings from elementary school to college then in further training and a career in management, and in leadership in church settings. My parents' ministry to the community through their involvement in education, agriculture and social engagement introduced me to ministry outside the walls of the church, and their open acceptance and care for the mentally ill developed empathy in me.

My professional training includes a Bachelor of Science (BSc) in Economics and Management, a Master of Divinity (MDiv) in Clinical Counselling, and professional designations as a Registered Psychotherapist (RP) with the College of Registered Psychotherapists of Ontario (CRPO), Registered Marriage and Family Therapist – Supervisor Mentor (RMFT-SM) with the Canadian Association for Marriage and Family Therapy (CAMFT), Certified Couple and Family Therapist (CCFT) with the Ontario Association for Marriage and Family Therapy (OAMFT) and Clinical Fellow and Supervisor Mentor with the American Association for Marriage and Family Therapy (AAMFT). These have helped me to better understand the clinical and operational sides of the functioning of TWC.

Having been exposed to leadership within Christian ministry settings as well as within wider communities, and with relevant training and experience within the fields of management and psychotherapy, I was better able to understand and empathize with the needs of clients as well as the Christian ministries within my context regarding providing psychotherapy for their members. This too contributed to the field research project with nine Christian ministry leaders to help them in supporting their members with mental health issues and referring them for psychotherapy as needed (See details in Chapter 4.)

Timelines and Assessments

In reflecting on my personal context as a leader, I used Reese and Loane's timeline guide to provide a synopsis of my leadership journey and the impact on my role in the TWC ministry context. My "foundation" (Reese and Loane 2012, 76) included loyalty to family, ministry, a strong and public Christian faith, leadership training and involvement at various levels, coupled with overarching themes of opportunity, support and passion and a strong national culture and heritage. In the "preparation" phase (Reese and Loane 2012, 99), I experienced considerable spiritual growth, intertwined with and resulting from career transition, immigration, some traumatic losses, new dependence on God, and support from family and friends. These left me with strong convictions and experiences of the healing power of God through relationships. Having personally experienced the benefits of therapy, I was better able to relate to both roles of

clients and therapists. The "contribution" and "multiplication" phases (Reese and Loane 2012, 125 and 146) overlapped with my roles at TWC as I solidified and helped to move the organization forward. These roles were strongly influenced by other leadership roles in my church, relationships with other churches and leadership in the Ontario Association for Marriage and Family Therapy (OAMFT). Completing this Doctor of Ministry program was a very helpful part of my leadership journey, primarily for discovering new tools to lead well such as understanding myself as a leader, leading an intrapreneurship and investing in the next generation of leaders for succession planning.

In terms of self-understanding, based on the Myers Briggs Type Indicator (MBTI) report (2020), my extroversion, intuition, feeling and judging (ENFJ) personality preference confirmed traits of being compassionate, empathetic, friendly, diplomatic and placing a high value on harmony. These preferences were important for me as a leader in a psychotherapy setting since many of these traits are useful for a safe therapeutic relationship. In addition, my tendency for seeing the big picture, conscientiousness, perseverance and getting things done in a timely and orderly manner all helped with day-to-day leadership of this ministry. As a leader in a complex system, my personality preference allowed me to hold the tension of "not knowing" while trying to maintain healthy relationships when chaos persists. In this mentoring / finishing well stage of my life, empowering others is enhanced by my natural tendency to help others grow and develop their

potential and these, along with creativity, are needed to help establish a secure future for TWC.

Donald Clifton's StrengthsFinder Assessment (Clifton 2018) was another useful tool in self-understanding and revealed that belief and ideation were two areas that were consistent with my preference and goal of living out my core values with integrity. These I saw as integral in leading in a Christian-based work setting. Life experiences and my personality preferences supported my openness to change, which were crucial as I allowed others to expose my blind spots and as I learned from the mistakes I made on this leadership journey. A challenge for me was to balance my intuitive side with more detailed thinking. This was important to ensure that projects were manageable, and others were able to understand the ideas/concepts I had. Being open to and appreciative of criticism was a work in progress for me, as was having strict boundaries with my work.

My History with Tyndale and Position at TWC

In this section, I give a synopsis of my history with TWC and provide details about my current role, to show the duration and levels of my involvement with the context. Here I also show the connections, collaborations and inter-relatedness with the larger Tyndale institution, as well as some distinctions in the type of services and functioning of TWC.

My connection with Tyndale began in 2000 when I registered in the MDiv Counselling program at Tyndale Seminary. I completed my internship at Tyndale

Counselling Services (TCS) and then volunteered for several years. During that time, I shared with the director my vision of how TCS could provide counselling services to the public. Over time, I realized that several persons shared that same vision. In 2014, TCS hired me as the consultant to prepare for services to the public, and in summer 2015, I joined TCS as the manager with my main task to oversee the services to the public, as outlined in Chapter 2 on the Tyndale Wellness Centre Context. As noted above, in 2019 I accepted the position of FLC Director and in 2021, the director of TWC.

At the time this study took place, I was responsible to ensure TWC operated in accordance with the mission of Tyndale (Tyndale 2008). My official position purpose was to provide strategic leadership and oversight of TWC and its mandate and to provide effective management enabling TWC to become a sustainable department of psychotherapy and pastoral counselling in support of Tyndale's mission.

I was accountable to, or liaised with, both internal and external stakeholders. Internal stakeholders included the Tyndale cabinet through my direct manager, several departments (e.g., Human Resources and Business Office), students and staff clients and TWC staff. My personal contribution to this leadership was intertwined with and enhanced by the incredible insight, dedication, wisdom and balance provided by the Assistant Director and Administrative Supervisor and supported by the Administrative Assistants and Clinical Supervisors. The collaborative leadership of this group not only fit my

preferred leadership style, but also afforded a sense of assurance for contingency and succession planning.

Clinical staff were committed, understanding and worked very hard in supporting their clients. They provided an overriding sense that we were part of the same team, which was supported by our shared, open faith. I learned daily from the combined faith, knowledge and wisdom of that diverse group of people who allowed me to provide leadership and oversight. In turn, I felt supported by Tyndale leadership, and this was conveyed through the strong relationships with my different managers over the years.

One of the unique features of TWC is that it functions as an intrapreneurship within Tyndale University, i.e., it operates as an entrepreneur within the structures of Tyndale. Within that type of business structure, I led TWC into finding its own operating strategies and to function as a profit centre that fit within the mission and overall structure of the larger non-profit Tyndale institution. My business training, and management and leadership experience helped me to ensure this arrangement was sustainable.

With the range of responsibilities associated with the leadership of TWC (from overall strategic planning to training in legal and ethical issues in the practice of psychotherapy, and direct relationships with some of our Christian ministry partners), it was necessary for me to have ongoing awareness of the larger contextual issues as well as details that affected the internal and external stakeholders. The range of responsibilities reminded me of the Gospel according

to Luke which records Jesus rhetorically asking to what He could compare the people or describe "this generation" (Luke 7:31). Jesus already knew the answers. Having been with the people, he understood them and saw life through their eyes. While he consistently had what Heifetz and Linsky describe as the ultimate "balcony view" (Heifetz and Linsky 2017, 53), Jesus took the time to understand what was happening around him and responded accordingly. "Achieving a balcony perspective means taking yourself out of the dance, in your mind, even if only for a moment. The only way you can gain both a clearer view of reality and some perspective of the bigger picture is by distancing yourself from the fray" (Heifetz and Linsky 2017, 53).

From the TWC balcony perspective, I learned to step back from the day to day demands of keeping the TWC system going and see the interplay between TWC, Tyndale University, staff, clients and the numerous subsystems or "networks of relationships or 'people groups'" (Watson 2008,1) that kept them in place or threw them out of sync. In those moments, I learned I was often at my most creative when I had a better idea of the overall picture. For example, an unexpected decrease in the number of students utilizing therapy in fall 2022 semester, generated major concern about how to encourage more students to utilize therapy. In stepping aside mentally, an analysis of the issue by the leadership team took into consideration the reduction in student enrollment numbers at Tyndale, the impact of COVID on students (CAMH 2022) and how that might have impacted their willingness or ability to initiate therapy. In

addition, there were issues around students navigating the newly introduced extended health care benefits and the related payment methods and confidentiality issues for students. These considerations changed how TWC saw its role in the issue and the related promotional strategies it employed. I learned that balcony moments were often planned and can involve other administrative team members, for example, during preparation for monthly meetings with my manager where I provided updates on the ministry. DMin assignments that were related to this ministry also provided opportunities for reflection that were useful to my balcony moments.

Heifetz and Linsky state, "If you want to affect what is happening, you must return to the dance floor" (Heifetz and Linsky 2017, 53). My dance floor in the TWC context included spaces of personal and professional experiences and training, interactions with staff and the conscious and subconscious expressions of their impacts on my leadership. This combination of experiences allowed me to better understand and respect the various other persons and groups on the dance floor, both internal and external, supporters and dissenters. I learned that at any space on the dance floor, I may get caught up with specific dance partners at the expense of the larger context. My challenge was to maintain humility, respectfully empathize and maintain healthy boundaries with each dancer while assessing and purposefully integrating appropriate information in the overall development of the ministry. "The process must be iterative, not static. The challenge is to move back and forth between the dance floor and the balcony, making interventions,

observing their impact in real time, and then returning to the action. The goal is to come as close as you can to being in both places simultaneously" (Heifetz and Linsky 2017, 53). That was a work in progress for me as a leader. My training in systems thinking for marriage and family therapy, and other members of TWC leadership team, helped me navigate the delicate balance between balcony and dance floor.

In the context of leading in the unprecedented times associated with the COVID pandemic, as well as other important changes that occurred within Tyndale and TWC and the associated uncertainties, I learned that ongoing flexibility, openness to change and willingness to take calculated risks were requirements of my role. I have embraced Janyne Peek's statement that "Organizational decisions need to reflect freedom from that's-the-way-it's-always-been-done rationalization to alignment with its vision, values and goals" (Peek 2002, 19). This mentality has been beneficial to the ministry as its dynamic nature demanded new and innovative responses for it to be successful while remaining true to its values and mission. It was not always the natural way of being for me, but I learned that it takes intentional focus, time with God, personal support, collaboration and constant awareness of the impact on the system to make this a reality. It was my preferred way of leading.

Analysis of Strengths, Challenges and Opportunities at TWC

With the rapid changes throughout the world in general, especially since the COVID pandemic in 2020, it came as no surprise that there were also ongoing changes at TWC. This has helped me to understand that a contextual assessment is never static but needs to be ongoing, resulting in an iterative assessment of TWC during the period of my DMin program (which corresponds with the COVID pandemic period mentioned above). This assessment drew on data from reports, observations and conversations within the ministry setting, clinical-related statistics from the PRISM database, the literature regarding context analysis and important relational networks, relationships with allies and potential collaborators, regulators, and relevant documents. In this chapter I highlight strengths, challenges, and opportunities and the related implications for the ministry that contributed to the field research in Chapter 4.

Although TWC is not a church, there are some components of a Community Opportunity Scan (COS) (Diaconal Ministries Canada 2019) that were applied in its contextual assessment of both internal and external programs. These included identifying needs, affirming gifts and assets, evaluating existing programs and creating new ones as needed, and engaging in community partnerships. The assessment included various sources of information (e.g., ongoing feedback from clients and Tyndale staff and established relationships with Christian ministries), and resulted in new services (e.g., transition to online

services), and the research project with ministry leaders for supporting and referring their members to psychotherapy (see Chapter 4).

TWC's Strengths

The service of psychotherapy was expected to increase in demand as people became more familiar with its value, particularly as the world worked through the impacts of the COVID pandemic as noted above in the CAMH report (CAMH 2020, 1 & 12). A strength of the TWC leadership team and staff was their combined knowledge, expertise and experience in all areas of the work that helped in continuing to effectively provide therapy in the short and long terms. The ministry was stable in areas of finances, personnel and professionalism, and the business model created some degree of buffer from major financial loss. Tyndale's ongoing support of the ministry through its various departments had enhanced stability and promoted long term planning. TWC also benefitted from the longevity, integrity and presence of Tyndale as "a Christian university in Toronto… built on over 125 years of history" (Tyndale 2022) and intentionally used the name Tyndale Wellness Centre to leverage the reputation of the organization.

Foresight and adaptability were two ongoing strengths of TWC, as demonstrated in all therapists being trained to work online even six months before the COVID pandemic. This facilitated all the adjustments needed to transition fully to online services and kept the ministry functioning and growing even in the

midst of the pandemic. The change to online therapy resulted in reduced overhead costs for TWC (e.g., reduced office space), while it increased clients' accessibility to services through reduced travel time and no limitations on office space. For in-person service, therapy offices were easily accessible.

The commitment of staff members was another strength of TWC. That was demonstrated in the low turnover of staff compared to other related agencies of which I was aware. Also, the diverse, qualified and committed team of psychotherapists had a steady flow of clientele, which placed many of them consistently at maximum caseload. With access to an ongoing source of potential new therapists from the MDiv Clinical Counselling internship program, the prospects for continuity of service were good. A valuable resource and hallmark for clients and therapists at TWC was the access to psychiatric consultations within a relatively short period. The associated automatic collaboration between psychiatrist and psychotherapist was a unique service that TWC provided and resulted in a more comprehensive care of clients.

TWC's collaboration with Christian Mental Health Practitioners Network provided information, referrals and support in professional development from different, yet related professionals and that enhanced the quality of services provided. Additionally, the mutual connection found in the Willowdale Church Coalition helped to secure TWC's presence within the Willowdale community. With the language skills and availability of therapists, TWC was well poised to continue serving this community into the future.

Another strength of TWC was that most clients paid full fee for therapy, whether self or other sponsored or through insurance coverage, which provided opportunity to support clients, and income security for therapists. TWC also offered opportunity for reduced fees which partially met the needs of those clients who were unable to afford full fees. There was a growing number of corporate clients, including churches and parachurch organizations that partnered with TWC to provide therapy for their ministry staff and congregants, and some that supported professional development for their therapists. These arrangements included requirements for confidentiality for clients, necessary consents, financial contribution of clients, when possible, convenient billing and payment processes, etc., and for therapists, verification of professional development services.

Indicators of the strengths of TWC came from client feedback that showed they were generally satisfied with the services. We also noted interest from some ministry leaders in having mental health care for their congregations or communities, through their questions about the referral process (who, how, when, etc.), getting help in educating persons on mental health issues, and the importance of therapy. Many of those ministers had connections with Tyndale through past faculty or staff, or they were students or graduates and valued the Tyndale reputation. Those connections and expressions of interest suggested other areas of potential strength in which TWC could provide service, and informed the development of the field research project (Chapter 4).

The final TWC strength mentioned in this paper, is that Tyndale University strongly supported the work of TWC through its various departments and through some funding for the operations of the students' services. In turn, TWC supported Tyndale's mission to serve the church and the world (Tyndale 2008) and through its services, provided exposure to the academic opportunities at Tyndale.

Challenges at TWC

Between 2020 and 2021 during my role as director of the then FLC, I was heavily involved in managerial and some administrative roles, reducing time for creativity in leadership, and I was concerned about potential burn out, reduced efficiency and effectiveness and possible related negative outcomes. One constant of that period was the ongoing adapting and responding to demands of the ministry rather than following a strategic plan which was a feature of leading during those earlier days of the COVID pandemic. This resulted in considerable, additional stress on leadership and staff which was not sustainable, and while there has been some relief, some of those challenges remain.

An ongoing concern was the relatively low salary Tyndale could offer to staff in leadership roles when compared to offers from other related organizations. The potential of losing many clinicians to more lucrative practices was a constant concern, and the number of interns who wanted to join TWC as staff was reduced

as they preferred to do private practice which potentially was more lucrative and less restrictive, or to work with other psychotherapy organizations.

Another challenge was that TWC community services (unlike student services) did not have a dependable source of external funding and relied on the profits from its services to cover expenses. The service was fully a profit-driven business and could only continue to function if it was profitable. The service to students was partially supported by Tyndale, with a future vision for overall profitability of the department as more students utilize their extended health benefits to access therapy. Previous attempts to secure external grants to support TWC were reportedly unsuccessful, partly because applications from TWC were usually viewed as coming from the established Tyndale University, therefore denying to access these monies. External funding could help to offset fees for clients who cannot afford the service. Even with competitive fees for service and some provision of reduced fees, TWC's primary service of psychotherapy continued to exclude a sizable part of the population for whom psychotherapy fees were prohibitive. This stood in opposition to TWC's values and systemic understanding of the importance of serving this vulnerable segment of the community.

A further challenge was that psychotherapy has legal and ethical responsibilities and associated time-consuming documentation required by the regulatory college. These activities demanded vigilant scrutiny by therapists and their supervisors and were often stressful for all involved. Since client cases

belonged to the department, the final responsibility was with the organization to ensure all requirements were met and maintained and this demanded ongoing attention to the details of each case to maintain good client care and mitigate potential ethical or liability issues associated with the practice.

Additionally, the professional cost of being a psychotherapist was relatively high. Annual licencing and ongoing professional development were required by the college, in addition to other professional association membership and professional liability insurance costs. Maintaining a home office (space and equipment) and professional services for their businesses were additional costs. Some therapists who were clinically competent found it difficult to operate as business owners and expressed frustration when they took a long time to build caseload. This was understandable since income and client hours were among the reasons for them being with TWC.

Of equal importance was the mental and emotional toll in the form of secondary trauma that affected some therapists as they bore witness to the difficult stories of their clients, bringing with it a risk of burn out. Protective factors for therapists included reducing their caseloads or seeking psychotherapy for themselves to manage the impact of the work on their wellbeing, both of which were costly for the therapists.

Other challenges that were being addressed arose from providing psychotherapeutic services to Tyndale employees. Anecdotal reports and other feedback from Tyndale faculty and staff who accessed therapy at TWC indicated

some concerns about potential dual relationships and conflicts of interest. That challenge was considered and was being managed through the use of TWC's database in the placement of students with appropriate therapists, and Tyndale staff as they selected therapists from the website. Another issue was that the insurance coverage that Tyndale employees had for psychotherapy services was very low, limiting the services some could afford at TWC.

A particular challenge was the need for greater awareness of what psychotherapy means and its role in promoting human wellness. Psychotherapy was a relatively new terminology within the Canadian health context and Ontario in particular. Until 2014, when the Registered Psychotherapist credential was introduced in Ontario, "counselling" was the acceptable word used to cover similar treatments of mental, emotional, relational health matters. Many people did not understand what psychotherapy is and how they could access and benefit from using it. Because the college expected therapists to use language that accurately reflected their work, some potential clients who did not understand it may have self selected to not use the service if they were not provided with enough information to make an informed decision. In my assessment, TWC could have done more to educate the public, our constituency, and potential clients about the terminology. This concern was a factor in the selection of my research project as discussed in Chapter 4.

A related issue, in my experience and from therapists' feedback at TWC, was that although many persons were familiar with Christian counselling, many

did not know that faith issues could be integrated into psychotherapy, and some believed it opposed faith. Others associated psychotherapy with severe mental illness and therefore did not believe the service was appropriate for them. Additionally, TWC often heard from pastors and other church leaders who indicated that because of religious and cultural beliefs, another segment of potential clients believed that mental illnesses were demonic in nature and therefore sought prayers and/or deliverance only, instead of including psychotherapy. These persons were often more open to receiving the service if they were supported by their pastors to do so. This crucial issue, with its major impact on congregants, their immediate and expanded families, church leaders and collectively the wider community, was the area of focus for my research project. As reported in Chapter 4, I designed a training program that provided essential information to ministry leaders about psychotherapy and mental illness as collaboratively we determined what they needed to support their members and to refer them for psychotherapy services if needed.

Opportunities

From my assessment, growing psychotherapy services at TWC was a viable opportunity supported by several factors. As noted above, there was a considerable increase in demand for therapy that was directly connected to the negative impact of the COVID pandemic on mental, emotional and relational health of the population, as reported by CAMH (2020, 1 & 12). The TWC

statistics reported above confirmed this increase in demand. The easy access to online services presented another opportunity for growth. Growing the practice was also supported by the availability of interns that TWC could recruit from Tyndale's master's program, to help staff the services.

Anecdotal reports from the Willowdale Church Coalition also suggested that the need for psychotherapy services in the Willowdale community had been growing, particularly as citizens dealt with the impact of the COVID pandemic. The reported needs covered the spectrum of residents from more affluent persons living alone in condominiums and experiencing loneliness and anxiety, to those who were unemployed and/or had relationship issues because of family dynamics associated with COVID. The client referrals TWC received from this community reflected their reports and were similar to conversations with the general public. These needs were also present in churches that requested mental health webinars or other interventions for their staff and congregants and their associated referrals to TWC. There was opportunity to strengthen ties within the Willowdale coalition, to collaborate with more churches to serve the mental, emotional and relational needs of the body of Christ and the immediate geographic context of Tyndale, and beyond.

With potential clients located throughout Canada, TWC had an opportunity to grow its services through advertising. At that point, advertising was limited to word of mouth, individual therapists advertising on *Psychology*

Today, the Tyndale website, advertisements of specific webinars, and the close relationships that had been established with some organizations.

Supporting faculty and staff at Tyndale to access psychotherapy services was another opportunity for TWC to serve its own immediate community. Some Tyndale community members already accessed the services and the provision of online services and having a secure database increased accessibility and confidentiality. To further increase access to service and in light of the potential for dual relationships that existed at Tyndale, this could involve organized external referrals to other psychotherapists.

In early 2021, a focus on expanding the leadership of FLC was realized in the merger of FLC and TCS as noted above. The related opportunity at the time of writing was to develop a strategic planning process that would include an advisory council, service expansion, succession planning and keeping contingency planning vibrant and relevant.

Providing education on psychotherapy within the faith community remained an important and relevant opportunity, in response to the challenges noted above. In general, helping people to understand the psychotherapeutic process and its benefits and limitations would allow individuals, their sponsors and support system to make supportive and informed decisions for service. Providing education on the spiritual integration component was a niche area for TWC to serve the church, other faith communities and faith-seekers. This also provided opportunities to share the gospel with professionals working in non-

Christian settings, as we sought to explain the value of faith in improving the well-being of clients. Since some churches were already requesting a spiritually integrated service, TWC could do more in meeting this need. This opportunity to educate the faith community about psychotherapy was another motivator for the research project described in Chapter 4.

Responding to the Context Analysis Through Field Research

The above assessment of the TWC context included the mission of the ministry, the wider geographical and online contexts and relationships, the services offered, a description of clients served and the staff providing services, and an analysis of strengths, challenges and opportunities. Stemming from this assessment was the development of a field research project titled "Training Ministry Leaders Towards Supportive Psychotherapy Referrals to Tyndale Wellness Centre" (see Chapter 4). The project was designed to generate positive movement towards increasing the effectiveness and outreach of TWC by training ministry leaders to support and make informed referrals of their members who were struggling with mental health issues. The research project was supported by the following factors:

As noted above, TWC offered a unique service and was well-positioned for ministry growth. For twenty-six years, TWC had consistently provided quality, professional counselling / psychotherapy to Tyndale students, and later, to members of the public in the Greater Toronto Area and beyond. Therapy at TWC

addressed mental, emotional, social, relational and spiritual issues through Spiritually Integrated Psychotherapy (SIP), a hallmark service that provided a holistic approach to healing. The relatively quick access to psychiatric consultations, and the resulting therapist/psychiatrist collaboration in client care, further enhanced clinical quality and client access to services. The choice of Christian psychotherapists who were well-qualified to address diverse client populations, who offered a wide range of available time slots, and who provided both in person and online services, all added to the accessibility of service at TWC.

Furthermore, TWC built a network of relationships with pastors and church leaders in the Greater Toronto Area and beyond. As a part of the Willowdale Church Coalition (comprising members representing different ministries / denominations), TWC had developed strong connections with church leaders in this geographical context and expanded other connections as the message of its services was passed on through electronic media. Pastors and other Christian ministry leaders continued to request information from TWC about mental illness and mental health care, the psychotherapeutic process, helping families in relationship crises, the integration of faith in therapy, how to help their congregants access therapy at TWC, the related costs and how they could help to cover therapy costs, as well as questions about their involvement as pastors during therapy. Also, many churches in the Greater Toronto Area were associated with specific ethnic/cultural groups and their congregation included persons who were

immigrants and needed specific language and cultural supports for therapy such as those available at TWC. In the years prior to the writing of this report, some church leaders even approached TWC about setting up their own counselling centres. After hearing what was required for a centre to meet the government regulations, they decided that referring to TWC was the better option. Many of the pastors in these settings had previous connections with Tyndale and trusted its services as a Christian faith-based institution. This network of connections with community faith leaders, and their expressed needs and questions, were contributing factors in the design of the research project.

Many TWC clients were Christians, and whether self referred or referred by ministries or others, they too had questions about therapy, concerns about replacing faith with therapy, mental illness versus demonic oppression, etc. Many also had the financial constraints. Some persons were concerned about confidentiality if they were referred by their churches and some church leaders were unaware of the confidential nature of therapy. Since TWC had a history of helping individual clients and churches successfully navigate the system at TWC with the desired outcomes, the research project (Chapter 4) built on these established relationships and protocols in the design of the research on "Training Ministry Leaders Towards Supportive Psychotherapy Referrals to Tyndale Wellness Centre". Nine ministry leaders drawn from TWC's network participated in the action research, in light of its potential value to their ministry and themselves. As further elaborated in Chapter 4, this assessment of the ministry

context of TWC was a major impetus in the development and design of the field research project.

Conclusion

This contextual assessment of TWC provided a glimpse into its ever changing and evolving structure and the ongoing need for adaptive and flexible leadership to respond to these changes in a timely and effective manner (especially as demonstrated during the COVID pandemic). It has also identified TWC's organizational complexity as a highly regulated health sector entity embedded in a larger educational institution, with multiple lines of accountability and reporting. The analysis of this complexity and the evolving changes have highlighted the need for adaptive thinking and a systems perspective in all aspects of leadership and the general functioning of the department.

This assessment also highlighted the highly integrative and collaborative nature of this ministry as seen in the numerous and varied persons, groups and organizations that were directly and indirectly included in the TWC network of relationships. These included regulatory bodies, community organizations, churches, other Tyndale departments and individual clients. It outlined TWC's place in a network of internal and external relationships that needed ongoing attention and maintenance.

The assessment highlighted several key strengths of TWC, which included its highly skilled, multi-cultural staff, the use of SIP, easy access to psychotherapy

through online and in person services for clients, access to psychiatry services and related integrative clinical care, and support from Tyndale as the parent organization.

My own training and experiences in leadership and as a psychotherapist, plus active involvement in church ministry, helped to shape a long-lasting desire to help bridge the gap between psychotherapy and church ministry. This also spurred my interest in developing the training program component of the research project (see Chapter 4).

In addition to the intersection of my personal desire and my leadership of TWC, the research project was born out of several other important factors that arose from this context analysis. They included the fact that TWC had experience and resources needed to help meet the increased demand for mental health services, its long-established relationships with churches in the Willowdale community and beyond that were interested in meeting the mental, emotional and relational needs of their members, the niche service of TWC in offering SIP that satisfied the need for faith integration to members of the Christian faith community, the frequent inquiries from pastors about the services TWC provided and some already established agreements to provide psychotherapy to their members. A major factor was that Christian ministry leaders repeatedly expressed to TWC their interest in knowing more about psychotherapy and how their members, who represented various ethnocultural groups and a variation of beliefs about psychotherapy, could have access to the services provided by TWC.

In Chapter 4 of this portfolio, I have provided information on how I developed and implemented a field research project involving nine ministry leaders, in which I provided them with a training program on mental health/illness, self care, supporting their members who have mental illness, tenets of psychotherapy, barriers to psychotherapy and referring their members to TWC. The training program was designed to enhance their knowledge on the issues associated with mental illness and psychotherapy, and in turn, to help them in supporting their members with mental health needs and refer them to TWC for psychotherapy as needed.

Having been part of the TWC ministry context since 2005, this assessment was instrumental in helping me to identify and understand the many ways in which the context has shaped my philosophy of leadership (see Chapter 3), and how my philosophy has shaped it. Some factors of influence were the internal and external relationships, clientele, the faith and values that demonstrated acceptance of and service to all people, as well as the opportunities for collaboration and adaptiveness that were needed and practiced in the ministry. These also prompted me to reflect on the qualities that were needed to lead effectively in this context. I have discussed these in Chapter 3 on my philosophy of Christian leadership.

CHAPTER 3:

PHILOSOPHY OF CHRISTIAN LEADERSHIP

MY JOURNEY TO SERVANTHOOD

My philosophy of Christian leadership is servant leadership, supported by collaborative and adaptive emphases. It is a philosophy where I strive to continuously represent Jesus' example of servanthood as I help to facilitate change in others (persons and/or organizations) and in myself. This philosophy is rooted in my faith in Christ, the values and beliefs that formed me, my personality, and life experiences. It is also influenced by the changes and training that moved me towards a collaborative approach in leading and being flexible and adaptive, a stance that is suitable for leading not only through normal circumstances but in difficult and tumultuous times.

My journey towards establishing and articulating my philosophy of Christian leadership was marked by a deep and extended reflection on the ongoing prominence of God in my life and the impact of my family of origin. Using the insights from that reflection, I developed a model (see Fig 3 below) that represents the flow of influences towards my philosophy of servant leadership. The model shows that many of the principles and practices that I have embraced

throughout my life, were the ones my parents practiced, and that I witnessed growing up.

As a psychotherapist and a Christian, I understood the importance and impact of my family of origin. However, I never explored the area of Christian leadership in my family and ministry and was pleasantly surprised by the revelations of the interconnections, not just for me, but for my siblings. These connections reinforced my confidence in the leading of God in my life and my call to lead using biblical principles as the basis of leadership.

In the previous chapter of this portfolio (Chapter 2: Ministry Context: Tyndale Wellness Centre – A Journey of Change and Complexity), I provided details of my service at Tyndale Wellness Centre (TWC) in a leadership capacity since 2015. In this chapter, I describe the development and application of my philosophy of leadership by reviewing some early factors that shaped me, scriptures that informed my beliefs and practices of Christian leadership, and leadership concepts and theories that continue to guide, inform, and fit with my philosophy of leadership.

The application of this philosophy at TWC included having collaborative relationships within the Tyndale institution and with other Christian ministry leaders in the community as together we care for the body of Christ by providing psychotherapy services. The process and management of caring and serving involved finding creative ways to adaptively respond to the multiple regulations

and stakeholders involved in the practice of psychotherapy. This included responding to the needs of the church community through a field research project (see Chapter 4). The research process provided some ministry leaders with the opportunity to collaboratively determine what they needed to serve their members and / or refer them to TWC for psychotherapy services, to help in meeting their mental, emotional, relational and spiritual needs.

In reflecting on my own journey, I was reminded that the scriptures had always been an integral part of my life. Therefore, in developing my own philosophy of leadership, I was naturally drawn to biblical passages for guidance. Some of these scriptures included Jesus the servant, (Matthew 20:28) prophet (Mark 6:4), priest (John 1:29), and king (Revelations 19:16). Not only did Jesus revolutionize the world, but after his ascension, he continued to change the world through his disciples and the formation of the church (Acts 1). The history of the early church as seen throughout the New Testament scriptures provided me with insight into the complexity of that era and the varying roles of its leaders, reflecting the diverse roles of their leader, Jesus. As a Jesus follower, my leadership has also represented the different roles of Jesus at different times. This is explained later in this chapter.

When I thought of Peter, who was the key leader in the early church, and I was readily drawn to this fisherman (Matthew 4:18), impulsive and quick to speak and act, sometimes inappropriately (John 18:10), a risk taker who also was seen as having faith (Matthew 14:29) and declared profound truth about the Lordship

of Jesus (John 6:69). As he moved into the leadership stage of his life, Peter's personality, past profession, lived experiences with Jesus and the other disciples, and the lessons he learned through the previous three years, helped him to lead the early church. In some ways, I have identified with Peter (e.g., sometimes impulsive, then having to apologize, and taking risks e.g., in immigration and ministry). Also, like Peter, I have seen how my leadership has been influenced by my personality, relationships, lived experiences, relationship with Jesus, etc., (see Fig 3).

The issues in the very early days of the church included replacing Judas who betrayed Jesus (Acts 1:21), continuing to preach the Good News, managing three thousand new members who were added to the church in one day (Acts 2), providing leadership for the day-to-day needs of some members, like caring for the widows (Acts 6) and living and managing through ongoing persecution of Christians (Acts). In that era of complexity and difficulty Peter and the other leaders of the early church were dedicated servant-leaders, who demonstrated adaptive and collaborative leadership as they spread the gospel and met the needs of the church members. In my leadership philosophy and experiences, I have seen where servanthood fits well with adaptive and collaborative leadership practices. This includes depending on the Lord for guidance and instruction, while being willing to move ahead without having all the answers, and working with the others God provides for the tasks.

Christian Leadership Philosophy

In defining and articulating a Christian leadership philosophy, I looked at different components: a leadership philosophy, a Christian leader, a command from Jesus about leadership and Christian leadership.

> A leadership philosophy contains value-based ideas of how a leader should be and act and the sources of their power. Any leadership philosophy is a way of thinking and behaving. It is a set of values and beliefs. A philosophy is a series of reference points or a foundation upon which processes, decisions, actions, plans, etc. can be built, developed, and applied. Ultimately, a leadership philosophy connects leadership with humanity, morality and ethics, and crucially, trust. (Accipio 2022)

When I asked myself, or those who have known me for most of my life, about why and how I lead, clear connections were made with my early life. I experienced this through frequent recollections of my parents' voices and actions, interactions with my siblings and friends and seeing how I behaved as a leader in response to those influences. The early influences developed over time as I learned and grew and experienced the church and the world in different contexts, had a wider interaction with different cultures and belief systems, and increased in wisdom and knowledge through personal and professional life experiences and relationships and through further training and opportunities to reflect. An example of my parents' influence is that they provided leadership in the church (as pastor and secretary), as community leaders (as chairman and secretary of the local elementary school board for many years), and provided food, clothing and finances to many in our community who were in need. Since living in Canada, I have served both my local church and the Ontario Association for Marriage and

Family Therapy as a board member and treasurer. I have also provided meals and clothing for persons living on the streets in Toronto and Brampton. It is clear to me that my leadership philosophy was influenced by the values and connections of faith and humanity that I learned from my family of origin.

Malphurs and Mancini define a Christian leader as "a servant who uses his or her credibility and capabilities to influence people in a particular context to pursue their God-given direction" (Malphurs and Mancini 2011,17). God has guided me into various contexts to serve using the resources and capabilities He entrusted to me. At TWC, my openness about my faith and God's direction for my life was made explicit to the team. In other leadership contexts, it was more about using leadership tools and applying my Christian values, e.g., respecting and loving people and being faithful and diligent in service. In all cases, integrating my Christian faith was an essential part of my leadership belief system and actions and is ultimately the reason, the motivation and the power behind my years of leadership, to follow Jesus as an example.

To understand what following Jesus as a leader entails, I explored where Jesus described himself as a servant-leader and commanded His followers to do the same:

> You know that the rulers of the Gentiles lord it over them, and those who are great exercise authority over them. Yet it shall not be so among you; but whoever desires to become great among you, let him be your servant. And whoever desires to be first among you, let him be your slave - just as the Son of Man did not come to be served, but to serve, and to give His life a ransom for many. (Matthew 20:25-28 NLT)

Here I saw Jesus contrasting Gentile leaders who dominate those they lead with how he led through service, to the point of giving his life. This is a command which also shows that Jesus cares about how we lead and equally about those we lead – ultimately serving them as He served us.

John Burns (2014) in *Leadership River* argues that Christian leadership facilitates transformation and sanctification in the journey of individuals and organizations, both in their material and spiritual domains. He compared this to a river where some parts change while others remain constant. While I readily agreed with Burns that in Christian organizations I could facilitate transformation and sanctification, I did not agree that I could facilitate sanctification in secular contexts. My reason was that I understood sanctifying to mean "the act of making holy … the transition from the realm of the profane to that of direct association with God" (Toon 2018, 37) and that was often, not consistent with the goals or views of some secular organizations. For example, at TWC, leaders must embrace Christian values and the centre's sanctifying purpose is made explicit through its mission which includes service to church and the world for God's glory (Tyndale 2022). This purpose is carried out by staff who choose to help move clients on a journey to healing so they can better fulfil their purposes in life. In some of my previous secular contexts, my Christian leadership influence was implicit. It was reflected in my values and associated actions, (e.g., stewarding resources, treating persons respectfully and kind, and living in a way that at least some persons see a difference in me), but never stated or expected to be sanctifying.

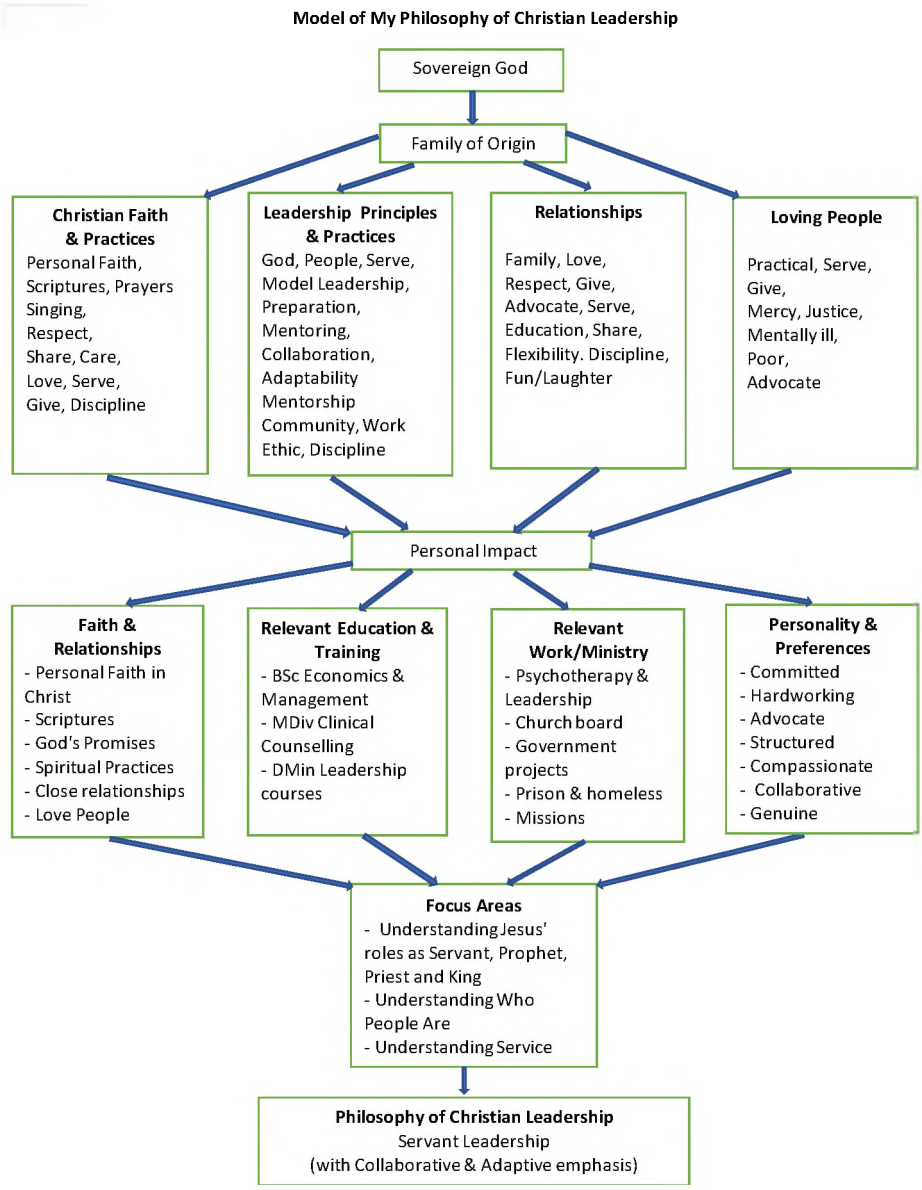

Figure 3 Model of My Philosophy of Christian Leadership

The Early Years

The early years represent a reflection on the period in my life from early childhood to early adulthood and include my early spiritual formation, where I

saw how God always had my heart and attention. In hindsight, my understanding and practice of leadership during this period were based on the opportunities and examples around me, contributing to an early formation of a philosophy of Christian leadership. Fig 3 above shows some of the influences in my early life.

Early Spiritual Formation: He's Always Had My Heart

My spiritual formation began in my formative years and was influenced by different people, practices, a promise and my personality, (see Fig 4). Growing up in a Christian home and with my parents as church leaders, there were many examples and practices of reading and memorizing scriptures, prayers, praising in song, and explicit teaching about Jesus as Saviour, resulting in my accepting Jesus as my Lord when I was a child. At thirteen years old when I was baptized, the pastor read to me, "Let no man despise thy youth; but be thou an example of the believers, in word, in conversation, in charity, in spirit, in faith, in purity" (1Tim 4:12 KJV). This became both a promise and a motivation that matched my sense of independence and somewhat fearlessness about demonstrating my faith. My knowledge of and confidence in God continued throughout my life and was reinforced by the text, "I can do all things through Christ which strengtheneth me" (Phil 4:13 KJV), one of the many verses that as children we memorized in Sunday school. I was supported by the meaning of my name, "resolute protector" and the opportunities for leadership in Sunday School, primary (elementary) school, in my family and in the community.

Figure 4 Early Spiritual Formation

Early Formation of a Philosophy of Christian Leadership

In this section, I will outline some of the early leadership examples I was exposed to, and how they were reflected in my leadership at TWC. My first exposure to Christian leadership was from observing the collaborative leadership of my parents in family and ministry, their approach to gender roles, and their living and working in community – an integration of faith and daily living. I was born and grew up in rural Jamaica, where my father was a church leader, then a pastor for almost sixty years, chair of the local primary school board, and member of agricultural organizations representing our farming community. Behind the scenes, it was my mother (as the more educated in the couple) who did most of his administrative jobs, and as youngsters we were aware of her role, which she fully embraced. At TWC, I noticed some of these early influences emerging in how I led. For example, I embraced, noticed and highlighted the valuable

contribution of the administrative team in a context where the emphasis tended to be on the clinical services offered.

Leadership was also experienced in the family as shared responsibilities among the children. For example, as owners of a farm, hard work had to be done in a timely manner. The responsibilities extended into the community as families shared in the planting and reaping seasons, in building houses, etc., demonstrating the value of collaborative work and the benefits of shared labour instead of hiring paid labour. All of these provided great lessons in financial management, stewardship, and in building and maintaining relationships. Many stories of life and faith were shared during these times. My parents did not separate their faith from the other components of their lives, as preaching the gospel and planting the crops were within the same community in which we lived. Their leadership roles also included training young leaders which included giving opportunities to lead and participate in church activities. Leadership was also demonstrated as my parents used their respective skills for the overall benefit of the family, to allow us to find ways to better ourselves and not become dependent on them as providers. This reflects Burns (2014) views on facilitating the change instead of doing for the other. I observed many parallels in my role at TWC. One that stood out was that psychotherapy is an intentionally facilitated process to help clients find healthier ways to resolve or cope with their respective issues, allowing them to maintain their changes which includes getting the support of others in their

contexts (e.g., their families, pastors and other church members) and not becoming dependent on therapists.

The principle of adaptive leadership was demonstrated in my family through the unusual but necessary action of my mother leaving home to work abroad, while my father remained at home to care for us children. In the 1970s when that was unimaginable and unacceptable to many, especially with my father as a leader in the church, my parents chose that bold solution which provided the finances they needed to ensure we received a good education, something that was very important to them.

Leadership was also strongly encouraged and supported at elementary school where students helped teachers with small tasks, managed the library, read the Bible for devotions, etc. Similar opportunities were encouraged throughout secondary school where I had my first major leadership role as the Student Council president. This was my first experience of leading in a non-Christian context, representing the student body even in some matters I did not personally support. This contrasted with simultaneously leading the Student Christian Fellowship in which we had shared beliefs and direction, and which supported me in my Student Council role.

As I reflected on that stage of my leadership journey, I saw where Christian leadership for me included six distinct but interrelated themes (see Fig 5). The first was a call which is two-fold (Drury, 2013). One part is a general call which I share with all Christians (e.g., a call to justice, mercy and humility (Micah

6:8), to preach the gospel (Mark 16:15)), plus a specific call to the ministry, which for me was progressive and became clearer over time and included my work with helping churches provide mental health care for their members. Secondly, a commitment which means staying on the path God is leading, knowing that "the Lord your God is indeed God. He is the faithful God who keeps his covenant for a thousand generations" (Duet 7:9 NLT). Thirdly, there was a challenge to be a good example of Christ, strengthened and sustained through the promise that "God, who began the good work within you, will continue his work until it is finally finished on the day when Christ Jesus returns" (Phil 1:6 NLT). The fourth theme of a Christlikeness is being like Christ in e.g., humility and obedience (Philippians 2), love (John 3:16) and continuing the work of the kingdom (Mark 16:15). The fifth theme of companionship refers to persons who journey with and support the leader (e.g., Paul and Timothy (Colossians 1:1, Philippians 1:1), Jesus and his disciples (Matthew 17:1, Matthew 11:1). The sixth theme of conclusion was determined by the inputs of the other five themes and includes knowing when our time has ended in any ministry context and the natural ending of our work life. Jesus demonstrated the perfect conclusion of his work through his declaration on the cross, "It is finished" (John 19:30 NLT). The Apostle Paul provides another example: "The time of my death is near. I have fought the good fight, I have finished the race, and I have remained faithful" (2 Tim 4:6-7 NLT). In the examples of Jesus and Paul, succession planning was seen in Jesus' work with his disciples for approximately three years and Paul's work

with Timothy (e.g., in 1 Thessalonians). I recalled my father mentoring young men for the ministry, and my own role as president of Student Christian Fellowship which included mentoring a successor. In my context at TWC and with my life stage, succession planning was a necessary and explicit role.

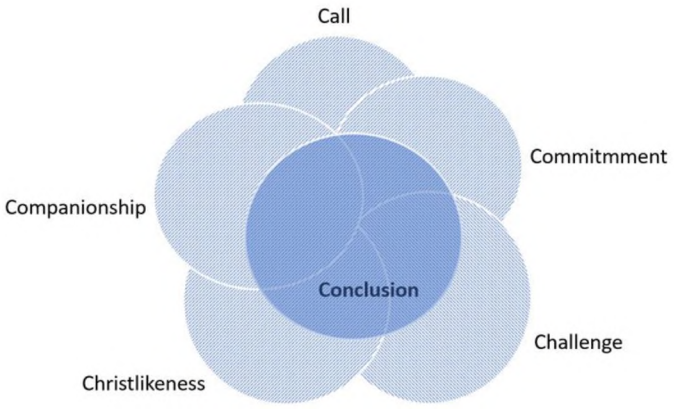

Figure 5 Early Christian Leadership Philosophy

My early experiences also included learning from ministry leaders who failed, as reported in the news and through community conversations. Upon reflection, I saw themes of pride, lack of accountability, ownership of ministry, lack of spiritual practices, and misuse of power instead of loving those being led. Now seeing these through the lens of a psychotherapist, it seems some of these failures may also have been accompanied by themes of unresolved childhood trauma, imposed unattainable expectations and standards from ministries, lack of healthy oversight, support, training, etc. Sadly, the fallen were sometimes ostracized by the same persons who may have contributed to their downfall. This

observation supports the need for personal leadership, accountability and mentorship. Brown (2015) identifies bungees as issues that keep people from moving ahead in their lives. He notes that they are of different types, e.g., those that are obvious or subtle, and those that result in lack of competency and lack of self-awareness. He argues that "leading yourself well requires you to identify and address bungee cords in your life and leadership" (Brown 2015, 824). Removing bungees may have prevented some of the downfall of past leaders. I believe that concept remains applicable to leaders.

Leading at TWC provided ample opportunity for discovering and addressing bungees. Regular supervision at all levels included the practice of reflecting on how the work impacts clinicians and how they impact the work. Not only was this a requirement of the regulatory college but also a reflection of the care and concern that was needed for team members to ensure they served in a healthy manner. This gave me confidence when I reported on the work of the department to my manager and to pastors and others who were interested in using the services, as I had a good sense of what was happening throughout the department including the staff.

The above recollection and assessment confirmed that my early formation of a servant-leader was enveloped in the truth "that God, who in Jesus makes all things possible, creates a place of rootedness and security from which the radical nature of servanthood is possible… where all the aspects of their lives are touched by what He calls us to be and do … because their identity is assured" (Dickens

and Nelson, 2015, 37). My early years provided for me the rootedness and security that has been foundational to my practice of leadership.

A Maturing Philosophy

My early twenties to early forties was a period of experiencing leadership in a variety of settings. At age twenty-one, my first job was as a farm manager. Later studies in economics and management provided the skills for leadership roles in projects for the Dutch and Jamaican Governments. In these three contexts, I was the both the youngest and a female manager/director working directly with mainly with older men. Although the matter of gender was raised by many, it never seemed important to me, perhaps influenced by shared gender roles in my family. Working with the Jamaican government tested my childhood faith and integrity as a few leaders expected the usual abuse of funds, nepotism, etc., associated with government spendings. After being in that position for several months, I learned that I was chosen for that position partly based on my skills and experience in collaborating with government leaders and partly because I was able to find creative solutions in a timely manner during my work with the Dutch government. In hindsight, I label that as collaborative and adaptive leadership, which continued to be evident in my work at TWC with its many stakeholders and in thriving through the COVID pandemic. My commitment to collaborative work with Christian ministry leaders was evident in the arrangements to provide

psychotherapy services to their members, and then, through the design of the action research project (see Chapter 4), which gave voice to their needs.

In the later years of this period, I was growing a family and migrated to Canada in the mid 1990s. Life after immigration could be called crucible years with an emphasis on self leadership through multiple losses and hardships, including breakdown in my family life and starting from the bottom in jobs. My family continued to be a strong support and God provided good friends, a great church, opportunities for ministry and opportunities to use my managerial skills. In hindsight, both adaptive and collaborative skills were key to survival. For example, with basic training, I started a small business and partnered with friends in another successful business venture. Scriptures I learned from my youth (e.g., Proverbs 3:4-5, Isaiah 55:8, Jeremiah 29:11) which talked about God's ways, provision and leading, guided me in business and in passing on my faith to my sons. Being a mom and being involved in the lives of my sons gave me great joy during those difficult times.

Ministry involvement during this maturing period included prison ministry and feeding people who were homeless which built compassion and empathy. These, plus my experiences with family law during separation and divorce, have provided tools for my work as a psychotherapist and leading TWC. I believe "God causes everything to work together for the good of those who love God and are called according to his purpose for them" (Romans 8:28 NLT).

Leadership Context Overview

In Chapter 2, I provided details of Tyndale Wellness Centre (TWC) which has been my primary context for leadership since 2015. The chapter also described TWC's context as part of Tyndale University, the geographic context and the numerous and varied stakeholders associated with the work.

In addition to my work with TWC, other contexts of significance included my work as a therapist in private practice and in a Catholic-based agency, both of which provided experience and relationships that have been instrumental to managing the work arrangements for staff at TWC. The arrangement is described as a hybrid of private practice (for contract staff) and agency practice, as the clients belong to TWC. In my work at Catholic Family Services – Peel Dufferin, I experienced working with multiple cultures, leading programmes, chairing the policy committee, helping prepare the agency for audits, collaborating with other social service agencies, managing their secondary office, as well as providing supervision to therapists. All of those experiences provided some tools useful in my similar roles at TWC.

I had other leadership roles at my church in missions, family life ministry, as a member of the board of deacons and as treasurer. These church leadership experiences provided me with a better understanding of how churches in the Greater Toronto Area function, enhanced my relationship with church leaders who used the services at TWC and gave me a better understanding of the needs of their ministries regarding access to psychotherapy.

The above examples of my leadership experiences helped in developing my leadership philosophy. They provided different contexts, exposure to and the practice of different leadership styles, and experiences of working collaboratively, having adaptive responses in difficult times, being accountable to and for others, working with different cultural groups, and at all times being able to show God's love to the people I worked with. My experience of serving in leadership in my church helped me to better understand some of the areas that would be important in the development of my action research project (Chapter 4), especially with the decision to include topics such as legal and ethical protective factors in serving members and self care of ministers.

Growing My Philosophy of Christian Leadership - Servant Leadership

It was in the spring of 2021 that, as part of the DMin program, I was introduced to the course on Philosophy of Christian Leadership. Prior to that, I had a good idea of my leadership style, but never had an articulated philosophy of leadership, and not from a Christian perspective. An intentional development of my Christian leadership philosophy started then, and continued to develop as I prepared to include it in my DMin integration portfolio. Because of the reflective nature of the development, I have concluded that this philosophy will undergo more iterations throughout my lifetime.

This growing process included my reflection on Jesus' example of servanthood and how I experienced and integrated those examples in my

leadership context. As I reflected on the premise that "leadership is associated with a certain context" (Burns 2014, 68), I acknowledged that some components of my leadership philosophy have been expressed differently depending on the context, but the core remained, namely, being a Christ-like leader. This meant, imitating and representing him as I serve as a leader. I agreed with Greenleaf, et. al. that "The servant-leader is servant first" and "It begins with the natural feeling that one wants to serve, to serve first" (Greenleaf, et. al. 2002, 29-30). Scriptures show that Jesus came to serve. "He did not think of equality with God as something to cling to. Instead … he took on the humble position of a slave and was born as a human being" (Philippians 2:6-7 NLT), He looked out for little children (Matthew 19:13–14), provided for the poor, and healed the sick (Luke 17:12–19). "For the Son of Man came to seek and save those who are lost" (Luke 19:10 NLT).

Although I love Jesus and always embraced his servant-leader role, getting to a place where I could comfortably settle on servant leadership as key to my leadership philosophy was a long journey. This was partly because I did not personally take the time to study what that would mean for me. Also of significance was that the historical connotation of "servants" for me, as someone who grew up in a postcolonial setting, still embodies many of its stings. In addition, in many social and religious settings, and in some Christian church denominations, I saw gender imbalance and injustice, where women were expected and/or forced to serve men, sometimes in the name of proper biblical

interpretation. My upbringing did not closely reflect those conditions, so I chose not to be associated with the term servant. However, as I understood Jesus' message both in His word and life, I developed a new appreciation of being a servant, not just being "spiritual" to serve Jesus, but to serve fellow humanity in various ways. I embraced leading as serving the organization and the people who are part of it. I have also come to understand servant leadership as a collaborative leadership approach that does not rule over others (Matthew 20:25 NLT) but seeks to engage and empower them through service.

The Servant Leader as Prophet, Priest and King

Embracing the concept of servanthood has helped me to appreciate that while being a servant, Jesus also served as prophet, priest and king, showing that the roles are not mutually exclusive, but together, represent the fullness of his ministry. I in turn represent Jesus in those roles of prophet, priest and king as I represent him as a servant. When Jesus' authenticity was questioned, he highlighted his role as prophet: "A prophet is honored everywhere except in his own hometown" (Mark 6:4 NLT). Burns describes the prophet's role as serving "as a check and balance to the king and to the priest" (Burns 2014, 72). Reflecting the prophet component of my leadership role included promoting and sharing about the work at TWC and serving as the check and balance between the requirements of the Regulated Health Professions Act (which covers TWC's practices) and Tyndale an educational institution.

Regarding the role of priest, Burns argues "The priest's role was to be an intermediary, representing God to the people and the people to God" (Burns 2014, 72). John the Baptist declared Jesus as "The Lamb of God who takes away the sin of the world" (John 1:29). In representing Jesus as priest, my duties at TWC included the use of Spiritually Integrated Psychotherapy (described in Chapter 2) to introduce and / or emphasize Jesus as an integral part of one's wellbeing. With staff, it was an ongoing reminder and modelling of our Christian faith into the daily activities.

Using king David as an example of shepherd-leader and king, Burns states that "shepherd-leader foreshadow the later teaching of Christ regarding servant leaders" (Burns, 2014, 72). Like many persons, my own preference was to know that managers and other leaders care first and foremost for the persons within the organization, more than they do for the processes and financial gains. The caring nature and accountability of therapy and the corresponding isomorphic nature of supervision and mentoring lent itself to an understanding of the shepherd-leader (king) role at TWC, with established self-care, faith integrated practices and accountability at all levels of the department, as we ensured the wellbeing of clients and team members.

As shown above, reflecting Jesus's roles as the prophet, priest and king functions in my leadership at TWC demanded a combination of skills and approaches depending on the circumstances and the level at which they occur. This complexity was supported by the statement "Servant leaders do not act from

a passive position… do not simply wait to be told what to do. Their call to vocation generally and leadership particularly has within it a deep sense of purpose, living a call which is characterized by urgency and courage" (Dickens & Nelson, 2015, 29). My leadership at TWC was leading an intrapreneurship, which by its nature demanded active, innovative, ongoing action towards goals and purposes that fit the culture and mission of the university. The trust of the larger institution in the ability of the department to meet its objectives was advanced through the servant leadership nature of that complex role.

The argument about courage and urgency from Dickens and Nelson also contrasted with many sermons and conversations where servant leadership did not include confrontation or going outside the status quo. I wondered if in part, we tend to emphasize the meek and mild parts of servant leadership because of our discomfort or fear of what we would do if we were actually in charge or have the power. Burns states that:

> Christians are sometimes uncomfortable with the discussion of power because of its corruptive potential and apparent antithesis of doing everything from a motivation of love. Yet love without power may merely generate good feelings. Power without love can lead to tyranny… a Christian model of leadership recognizes … a wise, meek and judicious use of power. (Burns 2014, 97)

I see Jesus as the ultimate balance of power and love, the suffering servant who is fully God, ("I and my Father are one" (John 10:30 KJV)), yet fully submitted to his Father ("I am the true grapevine, and my Father is the gardener" John 15:1 NLT)). Unfortunately, servants can become subversive or counterproductive and

cause organizational failure and undue hurt and loss. It seems that it is the use of power, rather than its presence or absence, that determines success, and servanthood and power can complement each other in a successful Christian leadership.

Having spent time researching, reflecting and looking at applications of servant leadership in my life and ministry practice, I agreed that "Christ is the supreme example, and Christian saints… have also taken up the servant-leader vocation for the last two thousand years" (Burns 2014, 116). I am privileged to be among them.

In exploring servant leadership, some of its characteristics I identified with include obedience to the Lord, loving those I lead, empowering others, being good stewards of all resources, providing guidance and direction for those in my charge. In addition, I identified with being open to learn from others and making the necessary changes in my life, confronting, defending, and intervening when needed, as well as always seeing people as image bearers of God and treating them accordingly. These traits were supported by various spiritual disciplines, accountability and an openness to learn and grow. In addition to the biblical texts cited above that showed Jesus' servant leadership approach, in the next section, I will outline other scriptures that have guided me in the understanding of servant leadership.

Biblical Reflection and Impact on My Philosophy of Christian Leadership

Based on my personal experiences, insights from the scriptures and observing the lives of Christian leaders, I agree that "Christian leadership requires faithfulness to God's calling and mission, and it requires the joint effort of gifted and Spirit-filled leaders and followers" (Burns 2014, 73). The Bible provided me with solid examples of what God requires of leaders and followers who used His provisions to successfully lead. I have highlighted some scriptures that have special relevance to my life stage, TWC context, and my servant-leader philosophy of leadership.

I Thessalonians Reflections

I have learned a lot from Paul's first letter to the Thessalonians which details some of his principles for leadership. The first theme is one of collaborative leadership and teamwork in which Paul expressed gratitude to God for the team, highlighted their accomplishments and valued them as team members (1Thes1:2- 8). Paul led the Thessalonian church from afar. He guided the processes instead of doing them himself, acknowledged the roles of others and named the outcomes which provided encouragement for the church. At TWC, evaluation of processes and positions provided formal opportunity for me to highlight contributions, in addition to day-to-day acknowledgements. More details of collaborative leadership are explained below.

Another theme from 1Thessalonians is that of mentorship, as seen in 1Thessalonians 3:1-6. Paul invested in Timothy and referred to him as his son and told him, "You have heard me teach things that have been confirmed by many reliable witnesses. Now teach these truths to other trustworthy people who will be able to pass them on to others" (2 Timothy 2:1-2). In preparing him to visit the Thessalonians, Paul publicly validated and affirmed Timothy giving details of how he saw him, his contribution to the ministry and expectations of what he could accomplish on the trip (1Thessalonians 3:2-3).

In addition to the themes of collaborative leadership and teamwork and mentorship, my third focus from 1Thessalonians is that Paul acknowledged the difficulties faced by the Thessalonian church: "you suffered persecution from your own countrymen" (1Thes 2:14) and then he instilled hope by reminding the church, "for he called you to share in his Kingdom and glory" (1Thes 2:12). Paul was a realistic leader who did not discount the sufferings, having firsthand experience of suffering and knowing the effect it had on others. But he did not leave them there; he also emphasized that there was another part, the hope they had to share in God's glory. While I have not experienced what I would define as persecution, it was a sense of hope that kept me through personal difficulties. In psychotherapy as well as in my leadership, helping people acknowledge their sufferings and offering hope are key components of their growth.

Other Biblical Reflections

I have had the privilege of serving in a therapy centre characterized by diversity in staff as well as clients who access therapy because of varying degrees of concerns in their mental, emotion, cognitive, relational or social functioning. The following are three themes that helped me to see people as God sees them and recognize how I can partner in His work with His people.

A Leader Understands and Treats People as God's Image Bearers (Genesis 1:27-31)

To serve well, it was crucial for me to understand and treat people as God does. From Genesis 1, I understood that God intentionally breathed His life into humans, created both male and female, gave them responsibility to care for what He created and declared that He did a great work. Jesus supported that theme when He quoted "'You must love the LORD your God with all your heart, all your soul, and all your mind … 'Love your neighbor as yourself'" (Matthew 22:37-39 NLT), showing the link between loving God and the people He created. Jesus used the story of the Good Samaritan in Luke 10 to describe a neighbour. That is, not necessarily having shared beliefs, family, religion, etc., but having humanity in common. Jesus exemplified this love for and ministry to persons who were not accepted, including some who were even ostracized by society in those days. Examples included the Samaritan woman whose race, gender and lifestyle made it inappropriate for Jesus to talk with her (John 4). Jesus called and dined with Matthew, the despised tax collector (Matthew 9). For the woman caught in the act of adultery, Jesus stayed and talked with her, setting her free when others

wanted her killed (John 8). Having set Mary Magdalene free from demons, Jesus allowed her to be first witness of His resurrection (Mark 16:9). He chose to heal ten lepers although He knew only one would show gratitude (Luke 17:11-19) and he cast demons out of a young man (Matthew 17:14-20). Jesus also associated with and had followers among those who were wealthy and influential e.g., Joseph of Arimathea and Nicodemus (John 19:38-40). From the general community he had an inner circle of Peter, James and John (Matthew 17:1) to large crowds (Matthew 4:25). In emulating Christ, as a servant-leader, I have paid attention to his love and acceptance of all people and with his help have continued to grow in those areas.

Embracing persons of ethno/racial diversity has always been part of my life, with my family background of mixed races directly linked to slavery and colonialism. My birth country (Jamaica) with its mixed-race population and resulting motto of "out of many, one people" provided an open messaging of acceptance for all. As a child, our family hosted many white missionaries from North America, contributing to my early exposure to diverse cultures from an early age. Caring for the needy was a regular part of our family life. Supporting the mentally ill and their families and issues of social justice were exemplified in the words and actions of my parents (see Fig 3, My model of philosophy of Christian leadership). These examples led me to an early understanding that I am not better than anyone, and no one is better than me; we are just doing different jobs. This was an internal mantra that helped me through a conversation with a

man on death row in a maximum-security prison, to feeding the homeless, to being in cabinet meeting with a Prime Minister and socializing with members of the diplomatic corps. All of us are people created by God and are equally valuable to Him. As a follower of Christ and as a leader, I must respect His image in everyone.

Numerous public events since 2020, have increased my awareness of racial discrimination, both past and present, in North America. The exposure of the atrocities of the Canadian church towards the Indigenous Peoples of Canada and the controversies about the responses of some evangelical churches regarding racial discrimination against black persons, have emphasized serious issues within the church. I agree with Boubakar Sanou that "Ethnic, tribal, and racial identities are a challenge not only to society in general but to the Christian church in particular. As bearers of cultural differences, ethnic and racial differences are often seen as a difficulty to overcome rather than a gift from God to be treasured" (Sanou 2015, 94). Paul reminds us that the body of Christ has diverse parts and functions, but all are equally important (1Cor 12), thus loving Christ means loving all His body, all His children.

In therapy, therapists sit with suffering saints and equally with persons charged with or convicted of child pornography or molestation, rape, murder, etc., extending God's redemptive power and love. This is also in keeping with the code of ethics of the CRPO that supports the "Autonomy & Dignity of All Persons - To respect the privacy, rights and diversity of all persons; to reject all forms of

harassment and abuse…" (CRPO 2022). This posture of love and acceptance for all and being with them through their difficulties reflects Jesus' servant heart, which influenced my leadership philosophy.

Leading With Humility and Obedience
(Philippians 2:5-8)

I found this a very important and yet difficult passage, as we as mere humans are instructed to have the same attitude of humility and obedience as Jesus (who is God) (Philippians 2:5-8). Yet being created in His image as stated above, He gives us the power to follow Him. When Jesus called "follow me" (Matthew 4:19, 8:22, 9:9), those following were required to give up their rights and possessions, to be with Christ in his work. That is still the requirement (Matthew 10:38).

Merriam Webster defines humility as "freedom from pride or arrogance" (Merriam Webster 2021). Peter contrasts God's response to pride and humility; opposing the proud and giving grace to those who are humble (1Peter 5:5 NLT). I saw humility as the precursor for obedience, in that once I recognized who God is and who I am, it was clear that obedience flowed more out of love and reverence than out of duty. The creation story helped me to realize that God is all powerful, and the crucifixion drew my heart into His incredible abundant love. Psalm 90 paints a contrasting picture of God and people. "Before the mountains were born, before you gave birth to the earth and the world, from beginning to end, you are God. You turn people back to dust, saying, "Return to dust, you mortals!""

(Psalm 90:2-3 NLT). These and other scriptures evoked an honest and necessary response of humility. To remain there, Brown suggests that "every Christ-follower and Christian leader needs to take responsibility to partner with God in his or her growth, development and transformation" (Brown 2015, 332). This partnership can be developed through spiritual practices, which I will address in the next section on the formation of the leader.

In referring to Philippians 2:5-8, David Gray states, "To present-day Christians, the message may seem simple enough to comprehend and understand, at least from a scriptural perspective. Yet applying the principles in secular pursuits, such as climbing the corporate ladder, may seem incomprehensible to others" (Gray 2008, 8). From my experience in secular settings, work principles were not explicitly biblical, therefore humility from the biblical perspective was not expected. However, success was highlighted and often meant competition among team members. At TWC, as a team we recognized how humility is a necessary stance as we worked with a multicultural/multiethnic team and served clients with diverse needs, beliefs, behaviours, etc. Psychotherapy practices demand a stance of humility to learn from each client how to better serve them, rather than impose beliefs or strategies. In making plans for the department, humility included being intentional in connecting with staff about their issues and perspectives and being open to change.

Leading Authentically/With Integrity – As God Sees Me (Psalm 24:3-4)

Northouse states that "People's demand for trustworthy leadership make the study of authentic leadership timely and worthwhile" (Northouse 2019, 197). Psalm 24:3-4 encouraged and challenged my desire to lead authentically and with integrity. Clean hands and pure heart suggested both action and motive, seen and unseen, private and public; a wholistic and overarching stance of genuine heart and living. Examples of this struggle include David in Psalm 51 where he acknowledged his guilt, sin and rebellion, and in Romans 7:14-24, where Paul shared his struggle to do what is right and attributed it to his sinful nature. According to McDonald, "The model that Paul displayed in Romans chapter seven illuminates the importance of awareness, aligning the inner and outer self, which builds a sense of trustworthiness between leader and follower, allowing the message to be well-received" (McDonald 2019, 13). The question of authenticity/integrity and pure hearts and clean hands suggested the absence of sin or the acknowledgment of the struggle with it, and like Paul, the dependence on God to free us from the sin (Romans 7:25). Northouse provides further insight stating that "Authentic leadership develops in people over a lifetime and can be triggered by major life events, such as a severe illness or a new career" (Northouse 2019, 198). For David, the authenticity may have been triggered by the overwhelming burden of his sin, which he then confessed. For Paul, it was

realizing "Who will free me from this life that is dominated by sin and death? Thank God! The answer is in Jesus Christ our Lord" (Romans 7:24-25 NLT).

1 John 1:8-10 shows that we have all sinned and God wants to and will forgive us. To be an authentic leader, I needed to be constantly aware of my sinfulness and be vulnerable and willing to seek God's forgiveness. Knowing that God does not separate our spiritual experiences from our regular life experiences, and His willingness and ability to help me in the ascension into His presence, I was assured that His completed work of salvation and my obedience to His word through the help of the Holy Spirit, are enough.

While authenticity is an internal work, it affects those with whom we associate. As Northouse argues, "Leaders and followers are tied together in productive ways that go beyond the stereotypical leader-follower relationship. This results in strong leader member relationships, greater understanding and higher productivity" (Northouse 2019, 201). In my context, leading a group of psychotherapists with authenticity did not leave much room for prolonged, disingenuous practices. The reasons were that clinicians were trained and encouraged to notice, ask and reflect in a cyclical manner, have various means to get their questions and concerns known to leaders and know that the clients will be impacted by behaviours and attitudes. I witnessed a positive outcome of authentic leadership at TWC during the early days of the COVID pandemic where, in the midst of the uncertainty and instability of that season, along with other members of the leadership, I conveyed genuine openness about not knowing

what to do in many cases and cautioned the staff about the ongoing challenges. This authenticity and openness resulted in cooperation from staff who were engaged in the collaborative efforts being made and therefore realized it was for the good of all involved. An understanding that we were all in it together emerged. These processes showed that "adaptive work creates risk, conflict, and instability because addressing the issues underlying adaptive problems may involve upending deep and entrenched norms. Thus, leadership requires disturbing people— but at a rate they can absorb" (Heifetz and Linsky 2017, 20).

Succession Planning

I linked Paul's example of mentoring (in 1Thessalonians above), with succession planning, which has been part of all my leadership roles as I transitioned into different positions or moved to other organizations. I saw this crucial role of a leader as showing respect for the organization, as leaders are often more transitional than the positions they fill. At my life stage of ending well, succession planning included identifying potential successors like Paul recommended Timothy, and providing an accurate view of the status of the department. *The McKinsey Capacity Assessment Grid* (Venture Philanthropy Partners 2022) was a comprehensive tool I began to use with the TWC Assistant Director as part of succession planning for the department.

Succession planning includes and is often dependent on successful mentoring. Malphurs and Mancini argue that "the primary leadership issue in an

organization may not be the lack of leaders but the lack of a development process to discover and deploy them" (Malphurs & Mancini 2011, 163). I have found this process to be intentional, time consuming, and requiring an approach where the leader is not insecure about their own leadership position. Some biblical examples of mentorship include Jethro and Moses (Exodus 18), Moses and Joshua (Numbers 27:12-23) and Naomi and Ruth in the book of Ruth. In reflecting on the TWC context, the mentorship program for clinical leadership at TWC was formalized as part of professional development, but administrative mentorship was less formal. This proved to be very disruptive to the department when an administrator left and there was no immediate, appropriate replacement for the position. To help in resolving the issue, TWC began cross-training of administrative staff and providing regular supervision to get a better understanding of the goals and performance of each person and the issues they faced.

The Redemption Story

The redemption story connected me as a leader and those I led in a common place of sin, vulnerability and the love of God. A synopsis of my understanding of the redemptive story is that God the Creator and sustainer of all creation (John 1:1-4, NLT), made people in His image (Genesis 1:26-27, NLT) to worship Him, (Genesis 1:28, NLT). The fall of humanity resulted in sin and death (Romans 5:12 NLT) and broken relationship with Him (Romans 3:23 NLT). God

loved the world (John 3:16, NLT) and provided restoration through Jesus (John 3:16, Ephesians 2:1-10 NLT). Jesus' redemptive work restores us into right relationship with Him and together we form the Body of Christ, with different roles and abilities (1 Corinthians 12, NLT). We are to love each other (John 15:17, 1 Corinthians 13, NLT) and reach others with the good news of the kingdom of God (Mark 16:15, NLT) as demonstrated by Jesus (Matthew 4:17, Luke 4:43, NLT).

Gordon King (2016) argues that the kingdom of God is seen in how God's presence changes people's lives and that kingdom lifestyle is the "fruitful participation in God's work of personal and social transformation" (King 2016, 48). At TWC, I have had the privilege to participate in this personal and social transformative process through psychotherapy services to our clients, helping them to find hope and healing in the hurting places of their lives.

Current Formation

Current formation refers to formation at the time of writing in 2022-2023. Like all other aspects of my life, formation practices developed and changed over time as I experienced and learned more, and as my roles demanded new changes in me. My work with Clinton's (1993) *Time-Line* helped me to be aware of the different time frames in my life and that they required different ways of being present with myself, my God and my relationships. As I led from a perspective of finishing well, there was a sense of planning to pass the baton. I also realized that

there were many new areas of interest I wanted to develop and actively engage in, and therefore, formation practices benefitted both my current and future roles. Palmer's statement that "Seasons is a wise metaphor for the movement of life" (Palmer 1999, 96) resonated with me and I became excited about equipping a successor for this ministry and welcoming new seasons in my own life, just as each season of the calendar year lets go of its activities and makes room for the next. I acknowledged that formation is an ongoing process and shared the opinion of Dickens and Nelson that "Servant leaders lead from their own ongoing development… leadership is, first of all, a question of character and substance long before it is a question of technique or skill" (Dickens and Nelson, 2015, 46-47).

Spiritual Formation Practices

Insights from the literature including Ruth Barton (2018) *Strengthening the Soul of Your Leadership*, Reese and Loane (2012) *Deep Mentoring*, Steve Brown (2015) *Leading Me*, and Heifetz and Linsky (2017) *Leadership on the Line*, along with personal and others' experiences, have taught me that a central part of being able to lead well is to maintain one's overall wellness (e.g., physical, mental, emotional, spiritual). As a psychotherapist, I saw the interrelatedness and impact of illness in different spheres of health, the complexities that developed in relationships and the larger systems' impact. Within ministry settings, many have experienced or witnessed the impact when leaders succumb to burn out,

unresolved past trauma, lack of accountability, etc., and we can learn from these unfortunate circumstances. Sometimes overwork can be the result of how we have been socialized or from trying to keep up with the demands of our roles, while other times it may be that we might need to prove to ourselves, others and God, that we deserve to be in the leadership positions we hold. In evaluating these aspects of my own life, I noticed there were some practices that helped me personally and as a leader.

Rhythm of Rest

Spiritual practices of prayer, reading and meditating on scriptures, fasting, and sharing the gospel have been regular practices for most of my life, sometimes more consistently than other times. At the same time, being busy was seen as a positive trait and it seemed that those who were most busy were most respected, especially if they were always busy doing ministry. In earlier times I associated a day of rest with the Seventh Day Adventist faith that kept the Sabbath day. Since then, many Christian leaders have shared the benefits of taking a sabbath rest. This became compelling and applicable to me through the work of Barton:

> There is nothing more crucial to the staying power of the leader than establishing rhythms that keep us replenished—body, mind and soul. There is nothing more crucial than rhythms that help us make ourselves available to God for the work that only he can do in us—day in and day out. Week in and week out. Year in and year out. All organisms follow life-sustaining rhythms. If we believe that we are somehow above or beyond or immune to our need for such rhythms, we will find ourselves in danger. (Barton 2018, 122)

These convictions motivated me to begin my journey of establishing the rhythm of rest. Through spiritual direction, I learned to utilize the practices that brought me in closer communion with God and brought me pleasure, such as long walks in nature and listening to worship music as part of my rest. Although it was sometimes a struggle to maintain this rhythm of rest, I saw the benefits in my personal well-being and was better able to speak out of a place of experience when I encouraged others to practice resting.

One thing that helped me to return to rest was the reminder that, while on earth as a Jew, Jesus kept the Sabbath. As a leader, he prioritized rest even when there were ministry needs around him. The gospel of Mark 6 recounts that, "The apostles returned to Jesus from their ministry tour and told him all they had done and taught. Then Jesus said, "Let's go off by ourselves to a quiet place and rest awhile … So they left by boat for a quiet place, where they could be alone" (Mark 6:31-32 NLT), although there were many needs around them. This led me to the realization that having healthy boundaries was necessary for a rhythm of rest, as there would often be other issues and persons that demand my attention. Part of my care was entrusting others into the care of God and not trying to resolve every issue that may arise during my rest.

Leading the Internal Self

Knowledge of self impacts how one leads. I have witnessed how leading from a place of hurt and unforgiveness results in harm to oneself and to others. On

the other hand, Brown argues that "Leading yourself well needs to flow from a deep wellspring and reservoir of God's love" (Brown 2015, 78), where we can experience His grace, love and compassion. Seeing myself through the eyes of the one who loves me enough to die for me (John 3:16) allowed me to walk through successes, giving the glory to God who deserves it, and through failures with grace and self-compassion. Leading the internal self sometimes requires the assistance of others (e.g., spiritual director, psychotherapist, mentor, and/or pastor) as they play different roles in helping to identify and care for the hurt places and making appropriate changes.

Understanding myself played a major role in my self-leadership, and therefore in leading others. Several instruments and assessments helped me get a better understanding of myself. I agreed with Brown that "One practical step you can take to steward your time and impact is to get a clearer picture of how God has wired and shaped you" (Brown, 2015, 1734). Clifton's *StrengthsFinder Assessment* revealed my Signature Strengths of ideation, connectedness, belief, strategic and positivity (Clifton 2018). This combined with my MBTI of extroversion, intuition, feeling and judging (ENFJ), provided many insights in how God has formed and used me in my everyday work as a Christian leader in secular or faith organizations throughout the years. For example, positivity, which I believe was developed out of my early belief that "I can do all things through Christ" (Phil 4:13), and encouragement from my family, helped me to walk with clients and staff through very difficult circumstances as well as through my own

difficulties. Connectedness enhanced the collaborative work which was necessary at TWC, and ENFJ personality type facilitated the big picture "balcony view" (Heifetz and Linsky 2017, 53) that I needed to manage ongoing changes in an organization. Developing a view of my integrated self has helped me to see my strengths and areas for growth and ways these areas overlapped in aspects of my personal and professional life, thus impacting my leadership roles. My challenge was that of owning the ongoing awareness of my strengths as well as my blind spots and finding ways to create balance, which included having others identify and fill some of my personal gaps. Doing that created a safe space for other team members to do the same.

Team Care

At first, I wondered about including team care as a spiritual practice. As I thought about it more, it resonated with the principle of shepherd-care, without which the team members may be less able to survive the rigors of daily work and the shepherd-sheep relationship may be strained. The process of attending to the wellbeing of others in my care enhanced the team relationships and provided an example for others to do so. My team care practices included recognizing and demonstrating care for each other through regular "check in" and a devotional segment in meetings to acknowledge and care for our spiritual lives. Like other mental health care facilities, TWC observed that working and leading during the pandemic era highlighted further the need for self-understanding, balance and self

care, as burnout became a major health challenge for workers in this sector. Wilbiks, et. al. recommend that healthcare employers provide "targeted mental health interventions, in order to maintain the mental health of their employees" (Wilbiks, et al. 2021, 205). My role included guiding the team to determine and access what was needed to manage well, individually and collectively, while supporting others.

Key Leadership Theory and Practice

Complex Adaptive Systems Theory (Plowman, et. al., 2007) was the major leadership theory I identified with as I practice leadership. I have naturally used components of it in various positions I have chosen, or was assigned, over the years including my position as TWC Director. Collaborative Leadership (DiFranza 2019) fits well with complex adaptive leadership and when these two theories are used together, leaders can utilize the available resources, share the responsibilities and benefits and can truly rely on God's leading in addition to reading the signs of the season in which they lead. Both approaches to leadership seemed to have naturally developed in me over time from my early experiences and were supported by my personality type, sense of self and my relationship with God. Components of these can be seen below, in the application of my leadership philosophy.

Complex Adaptive Systems Theory (CAST)

According to Tim Sullivan:

> A complex adaptive system has three characteristics. The first is that the system consists of a number of heterogeneous agents, and each of those agents makes decisions about how to behave… The second characteristic is that the agents interact with one another. That interaction leads to the third—something that scientists call emergence… The key issue is that you can't really understand the whole system by simply looking at its individual parts. (Sullivan 2011)

Leading through the lens of complex adaptive systems, demands a stance of not determining the next steps through established plans. Instead, the leader must be sensitive to the activities of the different agents within the context, how they interact with each other and follow the natural outcome that emerges from the complex interactions, instead of from each agent. From my experience, these concepts are applicable to both processes and people. In both cases, the leader's responses demand a delicate balance of intentional restraint to allow enough time for observation of interactions to better understand what is happening, while knowing when to intervene to prevent an over-run of chaos within the organization.

"Ask almost anyone over thirty about the difficulty of creating major change in an organization and the answer will probably include the equivalent of 'very, very tough' … down deep we underestimate the enormity of the task, especially the first step: establishing a sense of urgency" (Kotter 2012, 35). Kotter's statement became reality for me in 2020, especially at the early stages of

COVID pandemic when the sense of urgency was forced upon leaders and when flexibility, willingness to change, being comfortable with not knowing and over communication were keys to survival. Dickens and Nelson write about "a world characterized by unpredictability and global interconnectedness. These two forces alone create a complexity that defies any attempt to place things in neat and tidy categories. It is a world of constant change in which only the nimble and quick responders appear to be able to thrive" (Dickens and Nelson 2015, 9). This description closely reflected my experience of the early pandemic period, beginning in early 2020. In those days, life at TWC was chaotic, as we were working between the applicable guidelines and instructions from the Ministry of Health and those of Tyndale, helping forty staff members transition to working remotely from their homes with skeleton administrative support staff, creating policies and guidelines to ensure that privacy was maintained, educating clients on online psychotherapy, etc. All these were occurring simultaneously, and we had no knowledge of how and when things would change, just knowing they would. This situation required more of me than the logical, rational, cause and effect thinking that worked with some of the simpler tasks that I have had as a leader. It reflected the characteristics of complex systems.

While I referred to the complexity in 2020, the Bible provides examples of leaders who faced times and systems of unpredictability, complexity, sensitivity to change and constant change and exemplified faith and obedience intertwined with their actions. These examples have increased my own comfort with the

theory and practice of CAST and my faith in God to meet the needs of the ministry he has called me to. When God called Abraham to go to a strange land, there was not much information and Abraham did not know where he was going (see Genesis 12). God called Moses to leave Midian and his shepherding job to lead the children of Israel out of Egypt, even after Moses ran away from Egypt forty years before to save his life (Exodus 3 and 4). Moses, a shepherd, was called to face the mighty Pharaoh. Jesus, before He left earth commanded his disciples not to leave Jerusalem until the Father sent them the Holy Spirit. They waited there, unaware of what that would be like and the impact on their lives and the world (Acts 1). A common experience these leaders faced and overcame were "complex challenges" that "contain multiple variables and interconnected parts" (Dickens and Nelson 2015, 82).

These leaders' experiences, including reliance on the Lord through difficult circumstances, resonated with my preference and experiences as an adaptive leader. Personally, complex adaptive leadership began with acknowledging and embracing the complexities, the lack of control and my personal limitations, while collaboratively engaging the resources of others and the assurance that God knows and will provide. This was demonstrated in the successful transitions that TWC made during the pandemic, some of which were temporary and others, permanent changes, but all of which moved the department to levels of operations that would not otherwise be achieved had we not been forced to act urgently, although not always smoothly.

CAST also fits the psychotherapy process where therapists enable their clients in a process with unpredictable outcomes and do not control the changes in their clients. Therapists, in their roles as staff, tend to reflect the therapeutic values and do not respond well to being controlled, but prefer to be guided with room for contribution. Additionally, with numerous and far-reaching changes in the mental health industry, long term planning at TWC was often not feasible. Given my experiences with complex systems, I have found that effective leadership included the willingness and ability to make decisions needed to move forward before having all the answers. The concepts of CAST were also applied in my action research project (see Chapter 4), where as a researcher I helped the participants to identify the numerous co-occurring issues in their respective ministries and to choose ways they could move ahead to support their members without having all the answers.

Collaborative Leadership

Earlier in this chapter I mentioned that my parents demonstrated collaborative leadership in our family and also saw this present in the way the Apostle Paul led using 1Thessolonians. I also noted in Chapter 2 that collaborations within and outside of Tyndale have been instrumental in the successes of TWC. In this section, I will provide more details of collaborative leadership at TWC. DiFranza states that:

> Collaborative leadership is a management practice in which members of a leadership team work together across sectors to make decisions and keep

> their organization thriving. This style of leadership has become common among managers today, replacing the standard top-down leadership method of the past, in which high-level executives made decisions that trickled down to employees without offering any insight into how or why those decisions were made. (DiFranza 2019)

Working with others to find best practices and solutions, whether at work, in family or among friends was my natural way of being and it provided a sense of rich, interconnectedness that enhanced the finished product or process. From a leadership perspective, collaborative leadership in general, provides ongoing assessment of personnel skills and interests which are useful for short, medium and long-term application of resources. It also represents respect shown to others by hearing how they experience various situations and giving them an opportunity to provide input into matters that affect them or others. Team members can experience and feel like true members of the team, and they have opportunity to grow their own skills and be recognized for their contribution to the overall work being done.

At TWC, this collaborative approach was applied and demonstrated over the years in the relationships between the past TCS and FLC departments, in the professional relationships with my Tyndale managers, between TWC and other departments, between TWC and the many Christian ministries whose members accessed psychotherapy and with other organizations for which TWC provided professional development services. Within TWC, I used a collaborative leadership approach which allowed members of the leadership team to contribute their expertise, and where possible, come to a joint decision, while acknowledging my

role as final decision maker. The practice of psychotherapy itself is a very collaborative process where the therapist leads the process of hearing each client using the guidelines of therapy and together, formulate a treatment plan which is iterated towards achieving the goal. Even then, the clinical judgment of the therapist is used to guide the next steps when clients are unable or unwilling to make decisions that would be in the interest of theirs or others' wellbeing.

There are some limits to collaborative leadership, however, when working as part of an institution. In some cases, the decisions are already made, and the collaboration is about responses to the decision. I have found that even in those cases, the principles of collaborative leadership still hold, as team members get an opportunity to share their views. I have learned that "your most important task is not to make sure that the group comes up with the 'right' ideas or plans, or to produce single-handedly the vision or goals that it needs to follow. Your main job is to establish, maintain, and safeguard the collaborative process that allows everyone to participate fully in the group's work" (Rabinowitz 2022). Simultaneously, as a department, collaboration, of necessity was built into aspects of leadership, as services were needed from other Tyndale departments for TWC to function well. Again, the COVID pandemic demonstrated the effectiveness of collaborative leadership as TWC partnered with departments, (e.g., IT, to provide innovative tools for its services).

In the field research project, the collaborative leadership approach proved very useful in prompting and receiving information from ministry leaders on how

they understood and experienced mental health issues, barriers to mental health care, etc., and what they needed to care for their members, including referring them for psychotherapy. The findings revealed what TWC was already doing that worked well for them and indicated some areas that needed to be addressed to enhance the existing collaborations (see Chapter 4).

Conclusion

My philosophy of Christian leadership is servant leadership, supported by collaborative and adaptive practices. My journey to articulating this philosophy involved reflection on my early years of family, faith and leadership formation. In the earlier years, the formation was a natural response and emulation of what was presented as an example at home, school and church and also a personal relationship with Jesus. As time went on, I made more intentional choices as life became more complex, as leadership opportunities called for a lived faith, and as I experienced difficulties and needed to find my way in life. In those times, I experienced life and leadership as "unpredictable, emergent, evolving and adaptable" (Patton, Westley and Zimmerman 2007, 7). I drew on internal and external resources, with the Word of God always a guiding force, the awareness of His presence, and the support of family and friends in the decisions I made, including where and how I practised leadership.

In 2022, after a period of wrestling with my past and present experiences and waiting on the Lord, and in conversation with my DMin advisor, I noticed the

extent to which my family of origin influenced my faith in God, my understanding and love of people, my career paths in psychotherapy and leadership, ministry practices, etc. In addition, after prayerfully reviewing aspects of the life of Jesus, I gained a better understanding of his life as a servant, in all its complexity and this resulted in me comfortably embracing the servant leadership philosophy. At the time of writing, I am learning more about its implications and applications in my life and my leadership context, while noticing the many ways I have been applying this philosophy throughout my life and in my leadership roles. I am satisfied that it fits well for me.

In contextualizing my leadership philosophy, TWC provided an opportunity to both explicitly and intentionally put my servant leadership philosophy into practice. This was realized through the mission of Tyndale, the relationships within and outside the organization, and in shaping a leadership culture that supported and encouraged collaborative and adaptive leadership styles and promoted open and practical service to others in the name of Jesus. I saw how this approach contributed to the reasons the relationships between TWC and other Christian ministries continued to grow, and why some ministry leaders agreed to partner in the research project recorded in Chapter 4.

One of the crucial parts of my leadership philosophy has been staying with and being immersed in the truth that, "From Jesus' perspective, leadership is first and foremost about being a servant … and ultimate power is about ultimate submission" (Dickens and Nelson 2015, 32). Jesus Himself taught us that

"Whoever wants to be a leader among you must be your servant, and whoever wants to be first among you must be the slave of everyone else." (Mark 10:43-44 NLT). I learned that God who is the ultimate leader is also my father, friend, and the one with ultimate control over everyone and all things. Therefore, serving under His rulership, as His servant, has been a privilege and a relief that I am not in charge of his work. "Therefore, (I) will not fear, even though the earth be removed, and though the mountains be carried into the midst of the sea" (Psalm 46:2 NKJV).

This servant leadership mindset played a major role in my selecting the research project (see Chapter 4). The choice of that specific project was based on my conviction, supported by the Tyndale mission, that TWC should serve the church, and specifically, serve ministry leaders who in turn, serve their members. With the purpose of the research being to ultimately provide support and mental health care to persons who needed it, the process of training ministry leaders towards that end meant collaboratively working with them to get their input into what they needed to supportively refer their members for psychotherapy.

CHAPTER 4:

RESEARCH PROJECT: TRAINING MINISTRY LEADERS TOWARDS SUPPORTIVE PSYCHOTHERAPY REFERRALS TO TYNDALE WELLNESS CENTRE

This chapter of the portfolio reports on an action research project that I carried out in response to needs and challenges identified in the contextual assessment of the Tyndale Wellness Centre (TWC) (see Chapter 2), specifically, the need to assist Christian ministry leaders in supporting their members with mental health issues and referring them for psychotherapy at TWC as needed. In this chapter, I present information on how I conducted the research with nine ministry leaders, developed a training program, collected data, analyzed outcomes, and arrived at findings that have potential to help serve other Christian ministries and expand the reach of TWC. This research was influenced by my philosophy of servant leadership which includes my personal conviction that God called me to serve persons with mental health challenges and specifically to help churches support their members through mental illness and to refer them to psychotherapy services.

As noted in previous chapters, TWC offers psychotherapy to Tyndale students and the wider community with a specific focus on ensuring that the Christian community in particular is included among those it serves. Psychotherapy is offered using a systems approach and includes Spiritually Integrated Psychotherapy (SIP) with clients who are open to using it. Within the Christian faith community, I have encountered various responses to mental illness, from fully accepting its reality to skepticism and rejection. This in turn has resulted in a range of responses, from freely accessing psychotherapy, to fear and the belief that it is demon possession which needs deliverance only.

Several ministry leaders connected to TWC shared their burden of witnessing their members experience mental illnesses and relationship issues that they, as ministers, felt ill-equipped to handle. Hence, this research project was designed to address those expressed needs by providing a training program to nine ministry leaders on mental health issues, self-care, supporting their members who are experiencing mental illness, barriers to mental health care and understanding psychotherapy, culminating in how and when to make referrals for psychotherapy. I intentionally included all these topics in the training program because understanding the broader context of mental illness, the barriers to care, the need for self-care when caring for others, etc., helps leaders provide support for persons with mental illness, and know how and when to make referrals for psychotherapy. In addition to the input participants made through discussing the

topics I presented, their direct input into the training program came through their answers to the question of what they needed to make referrals for psychotherapy.

The nine leaders in Christian ministry who participated in the research study represented various segments of the ethnocultural community of the clients at TWC. The findings indicated that participants who engaged in the training program gained a better understanding of mental health issues, reported being more comfortable talking with their members about these issues, better understood how spirituality and psychotherapy work together, and gained a better understanding of psychotherapy services at TWC and how to refer their members for these services. Findings also showed that ministry leaders expressed as much concern about mental health in clergy as about their congregants.

The Problem of Mental Illness and the Opportunity to Collaborate in Healing

At TWC, we understood psychotherapy as doing the work of the kingdom of God. King (2016) describes this kingdom as God's presence to transform lives. As staff, we witnessed this through the personal, familial and community transformation of clients. As Christians providing the service of SIP, we were aware of our partnership with the Holy Spirit to comfort the sad, lonely and depressed, to bring the Good News of healing and/or to manage various mental health symptoms, to provide ways to set persons free from the bondage of addictions and unhealthy habits, etc. (Isaiah 61:1-2 NLT & Luke 4:18). Services

provided at TWC were carried out appropriately in relationship with others who were part of the lives of the clients (e.g., family members, pastors, medical practitioners) who were often the ones who referred clients to TWC.

Christian ministry leaders in our network were often involved in the care of their members and were therefore likely to be aware of their needs for psychotherapy and to provide them with other supportive care outside of therapy. The American Psychiatric Association states that "religion and spirituality often play a vital role in healing" (APA 2018, 2). This connection between psychotherapy and spiritual care, was part of what it means "to engage culture as part of Christian mission and theology" (Vanhoozer, Anderson and Sleasman 2007, 48). This understanding, along with other factors including the Canada-wide increase in need for mental health care (CAMH 2020), my role as TWC director, my personal calling to work with churches to provide psychotherapy to their members, and a research requirement for the DMin program, provided the motivation to pursue this research topic of Training Ministry Leaders Towards Supportive Psychotherapy Referrals to Tyndale Wellness Centre.

Responding to the Mental Health Need

The goal of the research was to help Christian ministries provide more informed support and referrals for their members to psychotherapy services to help improve the members' wellbeing. Since psychotherapy is one segment of the integrated care needed by persons with mental illness to recover, research

participants needed an overview of the factors related to the referral process. Therefore, I designed and provided a training program that included information on mental health and mental illness, ways ministers can self-care while supporting their members, how ministries can support their members with mental illness, barriers to accessing psychotherapy, psychotherapy in Ontario, including how psychotherapy and faith intersect and the referral process to TWC for psychotherapy. This training program integrated data from questionnaires, interviews, information and observation of the referral process at TWC, my professional experience, related literature, and notes taken during the training sessions and review of video recording and script of the sessions.

Supervision, Permission and Access

In the planning phase of this research, the Tyndale Provost was my direct manager and I got permission to conduct this research and provided her with updates. During the research phase, I reported to the Vice President of Student Development and kept him informed of the progress. Apart from these formal lines of accountability, I was also accountable to the research participants during the research and indirectly to the persons they refer.

Following the *Tyndale Research Ethics Board Policy*, the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2)* for Canada and the DMin project guidelines, I obtained the necessary approval from

the Tyndale Research Ethics Board to conduct this research. I then began the formal recruitment of participants as outlined below.

Research Context

In Chapter 2 of this portfolio, I provided a contextual analysis of TWC including my involvement since 2005 as an intern, a manager in 2015, a director in 2019 and as TWC director in 2021. Over those years, TWC formed strong alliances with various Christian ministries within the GTA and particularly within the Willowdale community and learned about their members' needs for psychotherapy and related services and their limitations and desire to provide those services in their facilities or to refer to organizations like TWC. One of their specific requirements, the integration of faith in psychotherapy which TWC offered, was identified during those conversations as being important to them.

By 2021, TWC's increased capacity to meet the demand for online psychotherapy services associated with the COVID pandemic, and its increased clientele and relationships with ministries throughout Canada, intertwined with my personal convictions and calling that God wants me to help churches support their members with mental health issues and this opportune timing to conduct this research.

Models and Other Resources

My role in this research was enhanced by my philosophy of leadership described in Chapter 2. This intersected with the stage of my ministry life which I

identified as "finishing well and contributing to the Kingdom" (Clinton 1993, 2) using the resources God has provided. Part of that life stage for me was to ensure that TWC continued to grow in the direction God has planned for it. I saw how this research project contributed to the growth as I helped ministry leaders better understand mental health issues, the services provided by TWC, how they could refer their members to those services to improve the members' wellbeing, and potentially for TWC to strengthen relationships with those ministries and establish new ones using the training program used in the research project.

My Christian Leadership Philosophy Highlights

In Chapter 3 (Philosophy of Christian Leadership: A Journey to Servanthood), I provided details of how my philosophy of Christian leadership developed into servant leadership with an adaptive and a collaborative emphasis. I highlighted how this philosophy influenced and enhanced my leadership capacity at TWC, as well as its influence on this research. The scriptures, spiritual practices, my early family experiences and exposure to Christian ministry and leadership, heavily influenced my philosophy and these taught me that the people being led are the main focus of leadership and that from a Christian perspective, we must see them as God does.

The following four features of my leadership philosophy influenced this research. First, my early understanding that all people are made in the image of God (Genesis 1:27-28) led me to honour God's image in all humanity. Therefore,

for this research, I intentionally focused on a diverse, multiethnic population. Secondly, as a Christian leader, I endeavoured to lead through humility and obedience (Philippians 2:5-8) following Jesus' example. To allow for the voices of participants and to reflect the outcomes that emerged in this action research, I, as the researcher, guided the research process from a stance of openness and willingness to learn, instead of imposing my own views on the participants. Thirdly, living and leading authentically and with integrity, which includes "clean hands and pure heart" (Psalm 24:4), were ongoing practices I tried to maintain. I reflected these values in this research by being open and honest with participants and accurately reporting the findings. Finally, the story of God's redemption showed the extent to which God went to ensure we could experience his love for us. As recipients of his love, the research participants and I worked together on ways to help their members experience God's love through psychotherapy.

Other Resources

Complex Adaptive Systems Theory (CAST), like action research, emphasizes working with participants to facilitate outcomes instead of pre-determining the direction. Plowman et. al. (2007, 354) argue that leadership in a complex system encourages innovation and interprets instead of creating change. I applied these principles in this research as I asked questions, challenged statements and helped participants move outside their comfort zones to determine what they needed to help make supportive referrals for psychotherapy.

I also found some principles of collaborative leadership very useful in the research project. One such principle from Rabinowitz (2022) was that my main task in the research was to protect the collaborative process by giving each person the opportunity to participate in the group work and to allow the group to produce the answers and not to look for the right answers.

To help the research participants understand some of the concepts of psychotherapy and therefore, to help them in making informed decisions about supporting and referring their members, I obtained permission from the American Psychiatric Association (see Appendix 7) to use two documents that formed part of the training program: *Mental Health: A Guide for Faith Leaders* (American Psychiatric Association 2018) and *Quick Reference on Mental Health for Faith Leaders* (American Psychiatric Association 2018) and I also used *MHFA Basic* (Mental Health First Aid Canada 2021). These resources provided the groundwork for understanding mental health, mental illness and their prevalence. I also drew on *Overcoming Stigma* (Grappone 2017), *Addressing Stigma* (Canadian Mental Health Association 2022) and *Mental Health Program-Supporting Black Youth* (CAMH 2022) to teach how stigmas can be barriers to mental health care. Other resources utilized in developing the training program included *Sanctuary Course* (Sanctuary Mental Health Society 2022) which provided resources for ministries to support members with mental health challenges, *CRPO* (College of Registered Psychotherapists of Ontario 2021) which provided information on psychotherapy practice in Ontario and *Disclosure*

Information (TWC 2022) which outlined psychotherapy at TWC. *Institutional Intelligence: How to Build an Effective Organization* (Smith 2017) provided me with insight and respect for conducting this action research within the broader institutional context of Tyndale University.

The information, consent, questionnaire and interview questions were designed with the input of information from the *Tyndale REB Application for Ethics Review* which approved the research to ensure it met the requirements for research involving human participants and Tyndale's standards. The design (not content) of the research informed consent and questionnaire was influenced by *A multi-site study of Christian-based spiritually integrated psychotherapy: Focus on East Asian Canadians* (University of Toronto 2018). That research protocol was approved by the Research Ethics Boards of the University of Toronto and Tyndale University College & Seminary and data was collected in 2018-2019.

As I planned and implemented the research, I was influenced by Tim Sensing (2011) in putting the research into context, identifying a useful and manageable problem to research and carrying out the research. Judith Bell (2014) was instrumental in helping me to understand my role as a practitioner researcher and influenced my use of pre and post-questionnaires for data collection. Chapman (2018) *Action Research Ethics for DMin Students* helped me to identify the ethical issues I needed to consider and resolve in the process of carrying out research at TWC as the TWC director while also being a student.

In 2009 I was introduced to collaborative leadership through *The Collaborative Leadership Fieldbook* (Chrislip 2002) and it helped me to guide the process of leading the research while promoting input from the participants.

Project Methodology and Methods

This section on methodology and methods, as outlined below, includes research field and scope, recruitment of participants, information about the participants, methodology, ethical matters, methods and data collection, and a summary of the training.

Research Field and Scope

The scope of this research project included specific areas that were addressed and some that were excluded and the reasons for exclusion. The issues explored in this research were identified over two distinct periods. The first period ranged from the early 2000's to 2022 and reflected gaps identified from several sources, namely, my personal and professional experiences, as well as conversations with ministry leaders (over two decades), TWC therapists and clients, and with DMin colleagues and other associates. Literature (e.g., American Psychiatric Association (2018) mentioned above) provided additional information. These issues from this first phase were included in the pre-questionnaire (see Appendix 3) to get initial responses from the participants that could inform the content of the training program (see Appendix 6). The second period included information from participants' pre-questionnaire responses,

follow-up interviews and then through discussions and feedback during the three training sessions, which provided more detailed information that supported the gaps identified in the first period. Drawing from this data, the six main themes that were covered in the training program were mental health/mental illness, self-care, supporting members with mental illness, barriers to mental health care, understanding psychotherapy and making referrals to TWC (see Appendix 6).

The research did not include any information about clients of TWC as that was not part of the research focus. Although ministry leaders were trained to recognize some symptoms of mental illness, they were not trained to diagnose mental illness as, in Ontario, diagnosis is done by medical professionals only. There was no analysis of how the different subsets of the participants (e.g., ethnocultural identity) experienced the research training, although those may be important factors for further research. I did not report on issues that were raised during the training that were not specific to the research topic.

This research field work occurred between June 2022 and October 2022 (see Appendix 10). Training sessions were held online via Zoom for two hours each session on September 19th and 26th and October 3rd, 2022. I prepared invitation and information letters (Appendix 1), research participants' consent forms (Appendix 2), pre/post-questionnaire surveys (Appendix 3) and a training program (Appendix 6). The TWC Assistant Director conducted part of the final training session. To avoid conflict of interest with the personal education of the director, the research intentionally did not require TWC's therapists' direct

involvement. Their involvement with the clients referred by the participants, was part of their regular work.

Recruitment of Participants

Recruitment began with having informal conversations or sending emails to ministry leaders I knew who were interested in the research topic and then to others who were referred by other ministry leaders and TWC staff. I provided general information about the proposed research and heard their levels of interest. After I received approval from the Tyndale Research Ethics Board, I began the formal recruiting process by emailing ten potential participants the *Information, Consent and Questionnaire* (See Appendices 1, 2 and 3) which they all completed and emailed back to me. Between August 15 and 23, 2022, I briefly interviewed seven of the participants via Zoom, to provide clarification of the documents they completed and to get a decision on the use of Zoom for the training sessions. I communicated by email with the other three participants as they could not find a suitable time for an oral interview.

Additional issues that emerged from the interviews were how the research came about, when participants would get the training package, if there would be training to churches after the research, and if participants would receive a certificate of participation. Participants were then sent emails with options for dates, times and number of sessions and they agreed to meet by Zoom on Monday

September 19, September 26 and October 3, 2022, and potentially October 17, for 2 hours to 2.5 hours each session.

Participants

Each of the participants chosen for this research helped to provide variety in culture, age, gender, years of service in ministry leaders and demographics they serve. Participants were two women and seven men, representing eight Christian ministries in the Greater Toronto Area and one north of this region. They identified ethnoculturally as Black, Korean, South Asian and White persons (see Fig 6.1), with first languages of English, French and Korean. They served as lead/senior pastors, young adults pastor, youth/students pastor, family life ministries/congregational life/pastoral care and pastor (see Fig 6.2), for periods ranging from thirty-one years to less than a year. The ethnocultural identity of the persons they served were Arabic, Black, Chinese, Filipino, Indigenous, Japanese, Korean, Latin American, Mixed, South Asian, White and Other (see Fig 6.3). The age groups they served were infants, children, youth, young adults, adults and seniors (see Fig 6.4) with the income levels of those served ranging from high income to low income. Eight participants reported serving persons who were immigrants, all nine served Canadians and two served persons who were refugees.

I knew five of the nine participants prior to the research, some of whom referred members to TWC. Two participants were relatively new pastors from my church and with whom I had no real connection prior to the research. I met one

participant in 2018/2019 as part of a community church organization and we connected on ministry related activities. Three participants are Tyndale graduates: one is a past classmate and we connected on pastoral care issues, another I connected with in 2019 on issues related to mental health care in communities, and the third I connected with when their ministry recently began referring members to TWC. The other three participants were introduced to me by persons associated with TWC who knew of their interests or ministry needs for psychotherapy.

To help protect the privacy of the participants, I assigned codes, from TWC-01 to TWC-10 which I used instead of their names, and I have used they/them as a non-identifying singular pronoun. Although I began with ten participants, participant TWC-02 completed the consent forms and pre-questionnaire and pre-research interview but withdrew from the research as they could not fit the times agreed upon by the other participants. They did not respond to request for post-withdrawal authorization to include their data in the research, so I chose not to include it since they withdrew before the training sessions and it would not help in the pre/post-questionnaire comparative data.

No minors were included in the research and none of the participants were directly involved with TWC although some have referred members. Since no vulnerable persons (children/youth, persons with disabilities, elderly) were directly involved in the research, the proof of recent positive vulnerable sectors

reference checks was not required, but it was mentioned in the training as a protective factor for ministers and their members.

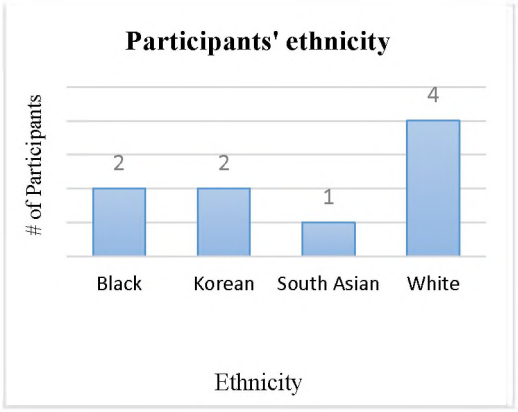

Figure 6.1 Participants' Ethnicity

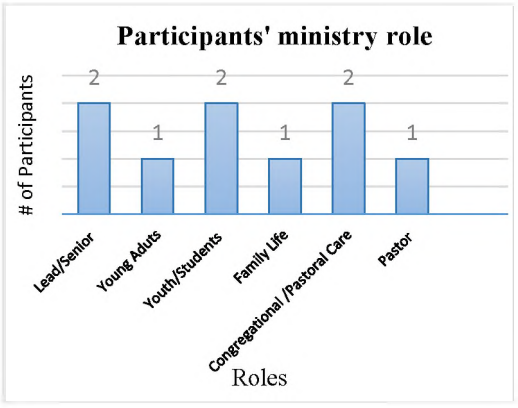

Figure 6.2 Participants' Ministry Roles

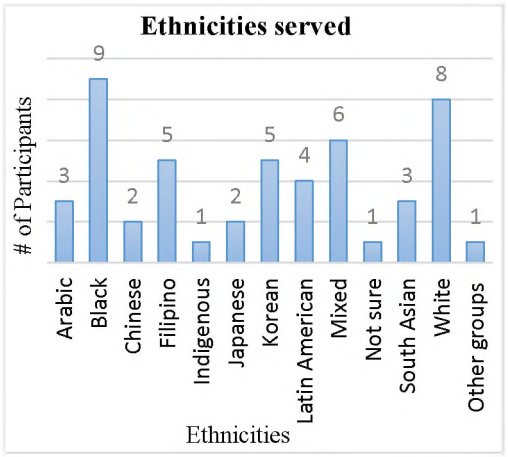

Figure 6.3 Ethnicities Served

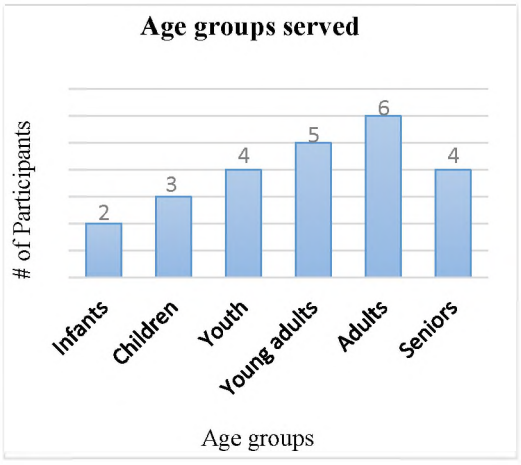

Figure 6.4 Age Groups Served

Methodology

I applied Coghlan's *Action Research Cycle* of constructing, planning action, taking action and evaluating action to the research process (Coghlan 2019, 9), which helped participants and the researcher learn together and continuously reformulate the process. Participants provided input into the initial training from their pre-questionnaire and responses to my initial interview questions (see Appendix 5), and further input in ongoing training from their feedback during each training session and my notes during the sessions and review of videos and transcripts. For example, when the issue of mental illness in ministry leaders was raised by one participant, it emerged as an area of interest for the group, resulting in interaction on care for ministry leaders as part of their role in supporting their members. Coghlan states that "The critical issue for you is to be able to construct and select a project from a position of being close to the issue" (Coghlan 2019, 120). My training and experience at TWC and relationships with some ministry leaders positioned me close to the issues in this research.

Ethical Matters

The research process was guided by the principles of research ethics in *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2* (2018) and the *Tyndale University Research Ethics Policy* (2019).

My regular work hours helped with boundaries around the time used for research as a student and in my regular work as TWC Director. My ministry

responsibility overlapped with this project, therefore I requested permission and oversight from my direct manager to commence the research and provided regular updates. TWC Assistant Director attended and participated in the third training session primarily to get to know the participants who could refer clients to TWC. I did not provide therapy to clients who were referred by participants to TWC. During the research period, I was involved with placing one person referred by a participant with a therapist and this was covered by an agreement made prior to the research.

During the individual interviews and at the onset of the first session, I discussed power differential with the participants, emphasizing the use of collaboration during the research and that I as the researcher would be guiding the proceedings, participating alongside them, not deciding, but recording the outcomes. I did not have formal authority over the participants.

Participants' expectations were identified through conversations I had with ministry leaders and therapists over the years, the answers to the pre-questionnaire and interviews, and mainly through the questions and conversations during the sessions. These were managed mainly by emphasizing the collaborative approach used, trying to balance the input of participants, reminding participants of the limited scope of the research, and providing some additional resources they requested or that I thought would be helpful. I found it was somewhat difficult to manage expectations as some of the participants introduced ideas which initially seemed irrelevant but some were navigated to provide relevant content.

Methods and Data Collection

The methods I used for data collection were questionnaires, interviews, note-taking, observation during the three training sessions, and review of the videos and transcripts of the training sessions that were recorded by Zoom. I used pre- and post-questionnaires as the primary data collection tool for quantitative analysis. I sent the pre-questionnaires by email along with the information and consent forms to ten persons who showed interest in the research, and they all completed and returned them to me by email. (As noted above, one participant later dropped out). The pre-questionnaire included some questions on demographics to help me better understand who the participants were and their ministry roles, and then scaled answers to forty questions (see Appendix 3). I conducted brief pre-training interviews online by Zoom with seven participants, and with two participants (TWC-05 and TWC-08), by email.

During the three training sessions, I gathered qualitative data by making note of the participants' questions, comments and some non-verbal cues, and after each session I carefully reviewed the recorded Zoom video and transcript notes of the session for data analysis.

The post-questionnaire did not include the demographics questions, but all the other questions remained the same. After the third training session I emailed the post-questionnaire, a thank you note and some resources to all nine participants. They all completed and returned the questionnaires by email. I compared the data from the post-questionnaires with the pre-questionnaires to

measure changes in their awareness/knowledge and attitude with regard to the research topic before and after the training. Questionnaires and interview questions are attached as Appendices 3 and 5, respectively.

Summary of Training

Three training sessions were held on September 19, 2022, September 26, 2022, and October 3, 2022, for two hours each. The participants agreed to having online Zoom sessions as they were in different locations, and with busy schedules they found it more convenient to meet online. During the first training session, participants all agreed that I could record the Zoom sessions to help ensure accurate information. I informed them that all the raw data would be appropriately destroyed when the research ended.

For the first training session, I presented the training material I prepared. This information generated questions and conversations which provided more information about what the participants knew and what else they needed to make referrals for psychotherapy. That information influenced the content for the second day of training. That process was repeated on the second day to provide information for the third day of training. For each training session I provided information on the topics either through handouts sent by emails or I shared some documents, websites and PowerPoint presentations on screen via Zoom and asked for direct feedback, sometimes from each participant, to get a variety of input and reduce power imbalance. For other parts of the sessions, the conversation was

driven mainly by questions and feedback from the participants, as well as observations and notes I made during the sessions and from the recordings and transcripts of the previously recorded sessions.

I provided training to participants to help them better understand mental health and mental illness, what psychotherapy at TWC entails, what they needed to know to help support their members, and relevant information if they are making referrals to TWC. While two participants who referred their members to TWC had a good understanding of the referral process for psychotherapy, I assumed the other participants did not have as much information. Therefore, for training, I selected six common themes that arose at TWC, from my personal conversations with Christian ministers and from my professional experience, when persons with mental illness are referred to psychotherapy by churches. The topics were mental health/mental illness, self-care, supporting members with mental illness, barriers to mental health care, understanding psychotherapy and making referrals to TWC. These topics provided contextual information for supporting members and the psychotherapy referral process. I included these themes on the pre-questionnaire, therefore the participants' pre-questionnaire responses provided some guidance for me in terms of the details to focus on during the training. The training material did not include frequently asked questions about fees, how to find a therapist, etc., as those answers were readily available from TWC. (An outline of the topics covered in the training program, participants who attended each session and the training materials can be found in

Appendix 6). Towards the end of each training session, I asked participants to share what else they needed to refer their members to psychotherapy, to get a better understanding of the needs of each participant and to share the needs among the group so they could learn from each other.

Training – Day One

All nine participants attended the first training session. At the start of the session, I provided an overview of the research training sessions, a brief review of the consent signed by participants and explained how the sessions would be conducted, including online behavioural guidelines. To have a better understanding of each of their contexts and how they are associated with the research and to help bring some common knowledge of each other to the group, I asked that all participants introduce themselves and include their years in ministry, their interest and/or experience with mental health issues, what they hoped to gain from the research and what they could offer.

The training on mental illness and mental health, emphasized definitions, examples, prevalence, common symptoms of mental illness, as well as the role of faith leaders in the mental health care of their members. This was needed to help participants better understand what persons with mental illness experience and when their support to members could include making a referral for psychotherapy. I invited the participants to pay attention to the training, to ask clarifying questions throughout the presentation, and to participate in a discussion on the

topic I presented. The second part of the training on day one was on self-care which included information on anxiety and stress, burn out, boundaries, accountability, areas of wellbeing and a breath prayer. I intentionally chose to present this topic to show the importance of caring for self when caring for others and presented it as a prelude to the second day of training. The self-care training was done using a PowerPoint presentation I prepared and shared on-screen. Participants interacted through comments, questions and discussions.

Training – Day Two

For the second training session, seven participants attended. The focus was on supporting members with mental illness, including protective factors and barriers to care. In setting the stage for supporting members, I guided a discussion about protective factors that ministries have in place when supporting their members. Protective factors in this training program referred to the processes, programs, instruments, etc., that ministries have in place to reduce or remove potential harm from members, (especially children, youth and seniors who fall under the vulnerable sectors category, as well as persons who are experiencing mental illnesses and may not be able to think clearly). Professional liability insurance was also included as a protective factor. I included this section to help increase participants' awareness of the need to ensure that vulnerable persons and ministries are protected and to inform them that protective factors are part of the psychotherapy process.

I then shared information on ways a congregation can support members who have mental health issues, using the *Sanctuary Course* trailer (Sanctuary Mental Health Society 2022) as a key resource. This part of the training was vital to show the integrative and comprehensive support needed for persons with mental illness. This focused on helping participants understand that referring their members to psychotherapy was one part of the support for their members with mental illness and provided options for ways they can provide additional support, which can augment the work done in therapy.

For the second part of this training session, I focused on barriers to mental health care using resources from *Overcoming Stigma* (Grappone 2017), *Addressing Stigma* (Canadian Mental Health Association 2022) and *Mental Health Program-Supporting Black Youth* (CAMH 2022), which I shared by screen and later provided as handouts. This tied into the trainings done on day one, as it provided insight into why some members may not want to access mental health care, despite needing it.

Training – Day Three

Seven participants attended the last training session. The TWC Assistant Director attended for part of the session and used a Power Point presentation to provide information on understanding psychotherapy in Ontario (including important definitions and Spiritually Integrated Psychotherapy) and the process of making referrals to therapy at TWC. This helped participants understand some

details of the psychotherapy language and the processes their members would be engaged in if referred to therapy. These could help them to better support their members through the process by sharing with them some of this information.

At the end of this session, participants all agreed they did not see the need for a post interview as they had their questions answered, had limited time, and would complete the post-questionnaire (see Appendix 3). After the last session, I emailed participants the post-questionnaire which they all completed and returned by email by October 21, 2022. The responses helped to measure the changes in knowledge and attitude towards the research goal of making supportive referrals for psychotherapy to TWC.

Data Analysis, Findings and Interpretation

This section includes information on how I analyzed the research data, the findings from the research and my interpretation of the data.

Data Analysis

I analyzed data collected from pre- and post-questionnaires, interviews, participants' feedback, observations, and notes taken during the three training sessions and the review of the Zoom recordings and transcripts of the three sessions. For the demographics information provided by participants on the pre-questionnaires, I used a Microsoft Excel spreadsheet to record the answers from each participant and reported on number of participants that responded for each category (see Fig 6.1 to 6.4 above). For the scaled questions on the pre and post

questionnaires, I recorded the answer to each question for each participant. I used a Microsoft Excel spreadsheet to determine the frequency and mode and compared the answers to identify changes in each answer, pre and post training sessions. The comparative pre- and post-questionnaire data showing the frequency of each answer is found in Appendix 8.

For data collection during each session, I made short notes of key words, phrases and short quotes that were used by each participant, as well as behaviours that I thought were important based on the content of the training and the research goal. After each session, I reviewed the Zoom video recording and transcript to ensure the information I captured was accurate and also to note any additional information from the recordings. I noted how often the key words or phrases occurred, whether they fit with the themes or words I expected or if new themes or words arose using coding techniques such as in vivo and descriptive coding (Saldaña 2015).

I coded the data manually, and because I had not done any research of this type and magnitude before, I underestimated the time and intensity required to code manually. However, I had the advantage of repeatedly revisiting the recorded data and that provided more clarity. For the next steps, I used a Microsoft Excel spreadsheet to compile the data for analysis. In this second stage, I compiled similar and recurrent themes that emerged from the data I collected to formulate the interpretation of the data.

Findings and Interpretation

In planning the training, I thought about how meeting online might affect my findings, both advantages and disadvantages, but the participants and I agreed it would be most suitable for the time frame we had for the research. The Zoom video sessions provided several advantages including having participants attend from separate locations, ease in identifying everyone by name, being able to see all faces readily and making audio and video recordings of the sessions to provide information I may have missed if we met in person and for accuracy of data collection. The disadvantages included that when sharing my screen for presentations, I could not see all participants. Also, throughout the training, I was only able to see above the shoulders of most of the participants, therefore, I may have missed valuable information from body language.

From the pre-questionnaire demographics, I noted that the participants were primarily pastors in churches and throughout the research, they spoke mainly from their contexts as pastors. As participants introduced themselves in the first session, I learned about their wide range of ministry experiences with mental illness and their interest and/or experience in referring their members to psychotherapy and what they wanted to gain from the research experience. For example, TWC-01 had been in ministry for thirty-two years, sometimes used "trial and error" to help members with mental health issues and wanted to learn more during the research training. TWC-10 had been in ministry for three years and had experience working with students and mental health issues and was

"passionate about mental health" which can be used "to show God's love in a practical way." Most of the participants said they were interested in the training components of the research and this was summarized by TWC-06 as "to learn how to better identify and refer" members who need services at TWC.

As noted earlier in this chapter, the training program included contextual information (e.g., mental illness, self-care and barriers to mental health care) needed to help ministers in making referrals for psychotherapy. These are reported below, as part of the relevant findings during the training sessions and from the pre and post-questionnaires for each of the training program themes.

Mental Health, Mental Illness and Self-care

As participants discussed the topic of mental illness, I heard their common concerns about the increase in mental illness in the society and the additional help they needed as ministry leaders to meet the demands. The conversations revealed several contributing factors to their understanding of mental illness. For example, TWC-01 and TWC-09 recalled their cultural backgrounds in which "snap out of it" was how mental illness was dealt with. TWC-03 talked about "a culture of silence" in their church, even in a community where "opioid-related deaths is an epidemic." Another theme was that stigma was attached to the words "mental illness" and alternate words like "the issue" were used. Conversations also revealed that some participants were involved in the mental health care of their members and were having conversations about mental health in the wider

community. (E.g., TWC-06 was part of an interfaith council where "mental health keeps coming up"). Some participants regularly referred their members for psychotherapy.

The issue of mental illness in clergy was raised by a participant who witnessed that a pastor with mental illness was not treated well by his church. A common theme from participants was that clergy members are not exempt from mental illness, should be treated with respect and dignity and given time to recover as would clergy with physical illnesses. TWC-10 emphatically stated that "having mental illness does not disqualify one from being used by God" and along with other participants, they talked about people God used despite their mental health issues. One participant shared their personal experience of mental illness and being supported by their church and congregation through a structured process that worked for them all. They referred to it as having a "culture," not just a process of care. They all agreed that disclosing clergy mental illness to the congregation must be handled carefully, in the interest of the clergy member and the congregation. A related theme was that ministry members are not always sympathetic to their leaders having any difficult emotional experiences. They are expected to be always happy.

When discussing mental illness among non-clergy ministry workers, other themes that emerged were concerns about how some ministry workers spiritualize the issues, and how ministry leaders sometimes are not able to recognize mental illness in persons until it was too late for them to take preventative actions. I also

heard that sometimes, because of dual relationships, leaders may not want to ask those who are not well to stop serving and to get help. Two participants found some solutions through structured discipleship programs during which time they got to know potential leaders by building relationships and then placing them where they were best fit to serve. The group consensus was that this topic was generally a sensitive issue.

When discussing the statement that "people experiencing mental health concerns often turn first to a faith leader" (APA 2018, 2), I found that while some participants agreed with the statement, others mentioned deterrents such as stigma, lack of safety, pastors not being equipped, pastors spiritualizing the issue, and lack of confidentiality in dealing with members' information. A different perspective that one participant shared and that some others supported, was that sometimes pastors do approach members first when they realize the members need help. Another participant mentioned that among youth, "faith leaders are helpful as they are detached enough" to give comfort and not overact like some parents would and his statement was supported by other participants.

On the issue of self-care, participants noted their appreciation for the emphasis on this topic and concurred that it must be a priority as one needs to be well to help others, that it is a community effort and that self-care is vital in order to balance the different components of wellness (e.g., mental, emotional, physical, spiritual).

From the post-questionnaires, participants reported having a better understanding of mental health, were more comfortable talking with their members about mental health/illness and knew better how to self-care when supporting members who have mental illness, than was reported in the pre-questionnaire. These comparative changes were reported in questions 1, 6, 7 respectively on the questionnaire and shown in Appendix 8.

Supporting Members with Mental Illness

In discussing the protective factors their ministries have in place, in general the participants with senior leadership roles and more ministry experience were more actively engaged in and attuned to the matter. Participants named the *Plan to Protect* (Plan to Protect 2021) program, liability insurance and vulnerability sector's reference checks (from local police) as the most common tools they used. I noted that some participants were using additional tools. TWC-03 talked about "challenging the culture of silence" through education and training. In TWC-09's church, before anyone can serve as a leader, they go through a "probation in a controlled environment, with a primary worker." In TWC-07's ministry context, they are testing a software program with different levels of access and where the pastoral staff log the work done with members. TWC-07 also talked about wrestling with "the balance between compassion and taking responsibility" when assessing members who want to work in ministry, as well as the need to "pray that the Holy Spirit gives wisdom" in the decision-

making processes. TWC-06 talked about "screening during discipleship training" and placing members accordingly and developing a church culture of support instead of just having policies. These different approaches provided more options for ministry protection to the group of participants.

After viewing the Canadian *Sanctuary Course* trailer (Sanctuary Mental Health Society 2022), most of the participants affirmed the value of the format (which includes eight sessions, where anyone who is interested can attend, and guided by a facilitator) and the content of sharing experiences, concerns and resources for persons with mental health concerns. TWC-05 shared being impacted by the statement that mental illness is "an element of the human experience" which helped them to normalize it. A few participants who shared their concerns about how to support their members stated that after having the *Sanctuary Course* as an option, they had less concerns.

Three participants spoke about confidentiality as a barrier to supporting members. TWC-01 talked about it from the perspective of a general church culture where leaders talk among themselves about the issues members bring to them, and even by their body language, leaders sometimes inadvertently disclose confidential information. TWC-04 shared that, as a youngster, their pastor shared a personal conversation with their parents without consent and that their "relationship with that pastor was kind of shot." They noted how that has influenced them to be very aware of confidentiality in their role as a youth pastor. A different view on confidentiality as a barrier to supporting members was raised

by TWC-06 during the third day of training. They shared their strong concern that the confidentiality issues in psychotherapy inhibited them from coming alongside their members during therapy and contrasted that with how they support members in medical care. This generated conversation in the group about how to reduce that barrier.

Findings from the post-questionnaire showed that more participants knew at least one member in their ministry with mental illness, and more were comfortable talking with members about mental health/mental illness when compared to the pre-questionnaire. These were recorded in questions 5 and 6 respectively on the questionnaire and shown in Appendix 8. I wondered if the changes were related to an increase in their awareness of mental illness and perhaps seeing things they had not previously noticed, assuming that the members they knew pre and post questionnaire were mostly the same.

Barriers To Mental Health Care

Over the three days of training, the issue of barriers to mental health care emerged as a repeated theme and centered around lack of knowledge in both ministry leaders and members, stigma, racism, culture, generational differences, confidentiality, spiritualizing and lack of access to services. As mentioned above, during this training, I used information from *Overcoming Stigma* (Grappone 2018), *Addressing Stigma* (Canadian Mental Health Association 2022), and *Mental Health Program-Supporting Black Youth* (CAMH 2022). All participants

agreed that information on the seven types of stigma was very informative and helped them better understand stigma as a barrier to mental health care. The conversation on this topic was lively and most participants were very engaged as they agreed with or added to information shared by others to support their points.

Although participants acknowledged racism as an issue in terms of public access to services, only two mentioned it specifically with respect to their contexts. At first, that was somewhat disappointing for me, as a Black woman who has understanding and deep empathy for the racial discriminatory issues of Indigenous and Black persons in Canada and beyond. As the discussion continued, and in the interest of allowing the natural flow of the group conversation, I did not raise my concern about this matter, but I soon became comfortable with the direction of the conversation when some of the participants referred to race as part of culture and focused on it within their ministry contexts. All participants agreed that culture was a barrier to mental health care. TWC-03 talked about growing up in a church culture where mental illness was seen as "demonization and needed deliverance" and is now in another cultural setting where mental illness "is a private matter and referred to clinical care." TWC-07 served in a multicultural setting and noted that different approaches were needed to deal with different cultures. One participant noted that in some cultures, mental health was not even a term used, so the approach to accessing care had to be different from the typical western culture.

Another theme that emerged was generational differences as another barrier to mental health care. TWC-09 said the older generation of immigrants in their culture were "tough minded, from culture and history," so their response was "snap out of it," but as mental illness became a sensitive issue, the older generation became less vocal. TWC-05's view was that the older generation needed permission to be vulnerable enough to access mental health care and younger persons needed to be challenged to "agency and accountability" for their own mental health care.

Many participants agreed that spirituality was sometimes a barrier. TWC-07 noted that when pastors tried to get help for some members, the members used scriptures to justify or explain what was happening to them. The issue of blame was raised by TWC-06 as a common recurring barrier from the younger generation, who attributed their difficult situations to their parents, environments, etc., hence they are "feeling like the victim." Several participants concurred. TWC-01 noted that the word psychotherapy can be a stigma that makes people feel "there is something very wrong with me," so they use the word counselling as it is "relatively calming." To support this point, TWC-07 shared that they usually do not use the word psychotherapy when referring their members for therapy.

In the post-questionnaire responses, all participants agreed or strongly agreed that some members feel ashamed/uncomfortable/hesitant to talk about mental illness, while two disagreed in pre-questionnaire (see Appendix 8). This change might have been influenced by the participants' increase in awareness of

the types of stigma associated with mental illness and therefore being more able to identify it in their members.

Understanding Psychotherapy and the Referral Process to TWC

Some basic information and discussion about psychotherapy at TWC took place during the first and second training sessions, as part of providing context to some of the training on those days. On the third day, Bassma Younan, (TWC Assistant Director), presented the training to the group on understanding psychotherapy in Ontario, key definitions in psychotherapy and the referral process to TWC. Common themes that emerged in the feedback from participants were how to convince their members to utilize therapy, the limits of pastors in offering care to persons with mental health concerns, details of how faith is integrated into therapy, the challenges with members who spiritualize mental illness and those who want the pastors to provide care beyond their capacity.

The presentation on how faith is integrated into therapy generated much discussion, and participants shared their preference for referring to psychotherapists who are Christians, but noted cases where expertise was more important than faith and, in those cases, they would refer to non-Christian therapists. For TWC-07, psychotherapy referrals are to Christians only, as "part of the discipleship pathway" and also noted that some members reported getting stuck with therapists who are not Christians and who suggest solutions that are not biblical. TWC-07 also noted that some members think that "Christian

counsellors will judge them and can't handle the heaviness of their sins" so are initially reluctant to see Christian therapists.

From the post-questionnaire results, I found that all nine participants strongly disagreed that psychotherapy and faith are not compatible, when compared with seven who strongly disagreed as reported in pre-questionnaires. I also found that participants expressed greater levels of knowledge about psychotherapy, the difference between counselling and psychotherapy, clients' rights in psychotherapy, the risks and benefits of psychotherapy and how to refer members to Tyndale Wellness Centre. For example, in the pre-questionnaire, six participants agreed and two strongly agreed that psychotherapy can help persons who have relationship issues, and in the post-questionnaire, four agreed and five strongly agreed. In the prequestionnaire, three participants disagreed, five agreed and one strongly agreed that they knew the benefits of psychotherapy, and in the post-questionnaire, seven agreed and two strongly agreed (see Appendix 8).

What Do You Need to Know to Refer Your Members to Psychotherapy?

At the end of each training session, participants were asked to share what else they needed to know to make psychotherapy referrals. I have summarized the findings below (see also Appendix 9). For the first day, the needs were many and they decreased in number as the training sessions progressed.

Knowing the processes, having awareness, and accessing resources were the top three needs of participants at the end of the first two training sessions. I

found that participants wanted to know how to go about making referrals and to have a structured process to follow, and they needed the resources to make referrals happen. Awareness was linked to process, in that participants wanted to know more about what psychotherapy was, and to have a general awareness of who and what in their respective contexts would support referrals. At the end of second day, awareness included what TWC-01 stated as "making the entire church aware that mental health is an issue."

Confidentiality, networking, support for pastors and self-care, were also identified as necessary for making referrals for psychotherapy. Confidentiality included what TWC-01 highlighted as something that needed to be established throughout the leadership team. Networking included connecting with other ministers to increase confidence in understanding psychotherapy and the related processes for referrals as stated by TWC-08. Support for pastors was crucial as participants articulated that caring for members with mental illness required specialized care, which was in addition to their regular work. Two participants named self-care as the priority. TWC-07 spoke from the context of many years in pastoral care and TWC-10 spoke out of an experience of working with mental illness in youth.

Participants shared that communication was important when identifying and articulating the need for pastoral care and / or when to refer to psychotherapy. Participants voiced the need for change in the culture of churches, to be places where mental health issues are given similar care and openness as medical issues.

More resources and clarity were needed by some participants to become more knowledgeable and comfortable with working with their members with mental illness and referring them for therapy. The need for protocols was specifically related to how to serve members with gender-related issues.

Additional Findings

I found that the issue of clergy mental illness was an unexpected theme that emerged early in the training sessions and continued in diverse ways throughout the training. These discussions arose mainly around supporting members with mental illness and barriers to mental health care.

Another issue that generated interest and ensuing discussion was about family conflict and the lack of direction some ministries experience when one member of a heterosexual couple identifies as bisexual, resulting in family conflict and stress. Some participants shared different strategies and the matter was left unresolved, but with suggestions of having a policy, teaching the scriptures on how God sees gender, ensuring there is conversation at the leadership level about the beliefs and strategies of the church, having legal consultations to know the law, and showing God's love to everyone.

I found the the first training session to be exciting, and somewhat unnerving as I was not sure how the participants would respond, although they all expressed interest in the topic during pre-research conversations. I managed the session by asking each person for their response to specific questions and that

worked well as everyone was engaged. The second and third sessions were more difficult for me. Some participants were less responsive and made short or no comments in some discussions, but I noticed that participants working in pastoral care were more engaged in the conversations. In hindsight, a methodical approach to question and answer as used in session one might have produced more engagement in training sessions two and three.

Finally, the research showed nine ministry leaders, from eight different ministry settings, a wide range of differences in age, experience, who represented different ethnicities and age groups served, interacted, supported and learned from each other and were willing to be vulnerable about their different challenges and concerns while they shared their successes related to the issues they discussed. These were referred to in the findings as participants agreeing with, or raising other issues, sharing how they managed different issues, etc., during related conversations.

Overarching Themes Emerging from the Data Analysis

Nine ministry leaders who were pastors entered the research at different levels of experience as pastors and with varying levels of understanding and experience with mental health issues. They shared common interests in knowing more about mental health issues, how to support their members and how and when to refer their members for psychotherapy. I analyzed the data they provided from pre- and post-questionnaires which they all completed, written or oral

interviews with all of them, notes taken during three training sessions and review of recorded sessions and transcripts, to explore their understanding, beliefs and behaviors related to supporting and referring their ministry members for psychotherapy to TWC, as well as other related issues that emerged. Throughout the training sessions, I took note of my personal responses to participants and the data provided and this helped me notice potential bias that could have skewed my interpretation. My interpretation was influenced by my professional knowledge and understanding and hence, my opinions on mental health, mental illness, psychotherapy in Ontario and the practices, policies and processes at TWC. I was also influenced by the literature used in the study and the recurrent themes and or other outcomes that emerged from the participants' responses and the questionnaire results. I did not study if the changes participants reported in the post-questionnaires resulted directly from the research training sessions only, or if there were other factors that contributed to the reported changes. However, there was nothing in the data that indicated other factors had contributed.

This action research reflected my goal of helping ministry leaders to support and refer their members for psychotherapy. To meet that goal, I designed and used the training program (outlined in Appendix 6), over the three research training sessions that provided information on mental health/mental illness, self-care, supporting members with mental illness, barriers to mental health care, understanding psychotherapy and the referral process at TWC. It was important to give the extensive background training, so that participants could interact with the

information from the perspectives of their respective contexts and through the discussions, conversations and reflections, they formulated what they needed to make referrals to TWC for psychotherapy. The active involvement by all participants in completing the pre- and post-questionnaires, their attendance at sessions except for valid reasons, and the overall level of engagement showed their interest in knowing what was required to support and refer their members to TWC for psychotherapy. I summarized my interpretation in three themes below.

Mental Health, Mental Illness and Self Care

Throughout the training sessions, the participants voiced common concerns about the increase in mental illness and an awareness that they needed help to manage the related issues they faced. For example, TWC-03 shared about opioid-related deaths in their community and the connection with mental illness, TWC-06 talked about being part of the inter-faith council that has concerns about mental health. These experiences and concerns were consistent with that of the general society as stated by CAMH: "Canada was already in the midst of a mental health crisis prior to COVID-19. The pandemic has both magnified and added to this crisis and highlighted how crucial mental health promotion and care are to our overall well-being" (CAMH 2020).

The participants, however, have not been inactive on this issue. They have been using different types and levels of interventions to help with the mental health issues they face within their ministries. TWC-07's ministry has a

discipleship program that has been referring members to TWC for a few years and TWC-03 is using education to help remove the prevailing culture of silence in their community and referring members to TWC. TWC-01 is new to their current ministry and is seeking to develop a culture of confidentiality within the leadership and to normalize issues of mental health throughout the congregation. As participants shared their concerns and interventions, they were introduced to additional ways of supporting their members in addition to referring to therapy. Many of them expressed interest in the *Sanctuary Course* (Sanctuary Mental Health Society 2022), acknowledging that its Canadian-based program made it particularly relevant, the format of eight-weeks and a small group setting was familiar to some participants and this program prevented them from having to reinvent the proverbial wheel.

Consistent with legal and ethical protective factors used in psychotherapy at TWC, (e.g., professional liability insurance and vulnerability sectors reference check), all participants reported having some level of legal/ethical protective factors for themselves and/or their ministries which indicated it was crucial for them. In addition to the regular protective measures, other protective factors included a range of other activities, from what TWC-09 described as "probation in a controlled environment, with a primary worker," to having at least two persons with anyone who falls in the vulnerable persons category as described by TWC-03. These measures indicated that the participants were interested in the

wellbeing of the people they served and in protecting their ministries in the process of serving.

One of the unanticipated findings in this research was the strong concern expressed among participants about managing clergy mental health care in the interest of clergy and their congregants. This acknowledgment of actual or potential need for mental health care was consistent with the prevalence of mental illness in CAMH's report that "In any given year, 1 in 5 Canadians experiences a mental illness" (CAMH 2022). One participant shared their personal experience of mental illness and the supportive environment their church provided, and another shared about mental illness in a pastor and the lack of support from that pastor's church. This theme was consistent with the numbers and types of clients that were being served at TWC, which included pastors and other ministry leaders and workers.

Given the above, it was encouraging to note that participants embraced the concept and practice of self-care. Their interest in the training material on this subject and the subsequent reference to it throughout the research indicated the level of importance to them. From the post-questionnaires, participants reported having a better understanding of mental health, being more comfortable talking with their members about mental health/illness and better understanding how to self-care when supporting members who have mental illness, than they reported in the pre-questionnaires (see Appendix 8 and Appendix 9).

I noted that the questionnaires did not reflect any change in participants knowing many signs of mental illness, and I wondered if I could have provided more information, if they already knew enough and were not interested in knowing more, or if there were other reasons. A follow-up study might provide further insights.

Barriers to Psychotherapy

In response to the training on barriers to psychotherapy, participants processed their own contexts and expanded their understanding of barriers to include those experienced within their own ministries. The fact that participants were able to identify barriers to psychotherapy to include issues that affected them in their ministry roles, and therefore, indirectly affected their members, was an indication of their understanding of barriers and the impact, which in turn could allow them to better serve their members. From the pre- and post-questionnaires, there was a slight reduction in the number of participants who agreed that members were comfortable to talk about mental health/mental illness and more who, on the flip side, agreed that members feel ashamed, uncomfortable or hesitant to talk about mental illness. I wondered if there was any connection between their responses and their increased awareness through the discussion about barriers. In the post-questionnaire, one more participant agreed than in the pre-questionnaire that mental illness is a spiritual / demonic issue. This did not reflect the training conversations nor the research questionnaire where all

participants strongly disagreed that psychotherapy and faith are not compatible. In doing further analysis, I found that the participant, who in the post-questionnaire agreed that mental illness is a spiritual / demonic issue, supported persons with mental illness and strongly defended their statement that mental illness does not prevent someone from serving God. I wondered if there was an error in scaling the question as the participant's other post-questionnaire responses and contributions during the session did not support the above response. In the post-questionnaire, there was a slight increase in number of participants who disagreed that mental illness is a private issue, not to be shared with anyone (see Appendix 9).

Understanding Psychotherapy and the Referral Process to TWC

When information on understanding psychotherapy in Ontario, key definitions in psychotherapy (including Spiritually Integrated Psychotherapy), and the referral process to TWC were presented, the participants focused more on the application of the information than the terminologies and processes. That might have been in part because they knew I would send them the details (e.g., the referral process), or perhaps because many of the conversations in the previous sessions included some information about psychotherapy, or because four of the participants already referred members to TWC and were familiar with the details, and the three participants who were Tyndale graduates may have heard about or used the services as students. The number of participants and the levels of

engagement with the application of the training material provided positive indication that they were incorporating the knowledge to their own contexts. One example was that participants focused on how the Christian faith (not spirituality in general) was integrated into psychotherapy, and asked for examples. They asked pertinent questions when given examples of integration using Cognitive Behavioural Therapy and Narrative Therapy. Another example was that confidentiality was not discussed in terms of its meaning, but as a barrier to pastoral support. In addition, the benefits and constraints of using Christian psychotherapists had more focus than defining a Christian psychotherapist. The findings suggested that the participants had a clear understanding of psychotherapy and the referral process, and this was supported by the post-questionnaire results which showed that more participants expressed greater levels of knowledge and/or understanding about the difference between counselling and psychotherapy, the meaning of confidentiality in psychotherapy, exceptions to confidentiality, duty to report, informed consent, clients' rights and responsibility in psychotherapy, the risks and benefits of psychotherapy and how to refer members to TWC when compared to the pre-questionnaire (see Appendix 8).

In general, the findings suggested that the training program provided information for ministry leaders to better understand mental health and mental illness, how to care for themselves and for their members with mental health issues, protective factors they need to have in place when providing support, some

barriers to accessing psychotherapy, the main concepts of psychotherapy, how spiritually integrated psychotherapy works and the referral process to TWC. After each training session, participants identified what they needed to make referral to psychotherapy and with the subsequent trainings they reported less needs. The post-questionnaire showed overall positive changes in most areas except for "I know many signs of mental illness" which showed no changes, and mental illness is a spiritual / demonic issue as discussed above.

At the end of the research, some participants needed more resources and clarity to become more knowledgeable and comfortable with working with their members with mental illness and referring them for therapy. With the complexity of the issues surrounding mental illness and the practice of psychotherapy, the different needs of each participant, and that the limited training time and scope that did not cover these issues in their entirety, I understand the need for additional resources and clarity. In addition, with two of the nine participants absent for each of the second and third training sessions, they missed some important information. The related information that was used in the training to cover those issues, was sent by email to all participants.

The differences in the personal and ministry contexts of the research participants and the levels of interaction, support, vulnerability etc., they showed during the research, indicated that together, ministry leaders can collaboratively enhance the growth of each other and their ministries in the matters of mental health support for their members and referral for psychotherapy.

Conclusion and Implications for Further Research

From the analysis of the research findings, I concluded that the training program helped participants to acquire the information they needed to support and refer their members to psychotherapy at TWC. In addition, they gained some tools and resources to serve their congregations (e.g., *Sanctuary Course* that could help create awareness and support persons with mental health issues). Awareness, processes and resources were the three primary needs identified by participants as they entered the training program, followed by self-care, confidentiality, support for pastors and networking (see Appendix 9). The training and discussions focused on all of these, except networking. I did not explore networking specifically, but it was accommodated through the interactions of participants during the training and with the option to continue beyond the training.

Additional findings that emerged from the research included the following. Participants appeared as concerned about their own wellbeing as they were about their members' and made the link between their wellbeing and the extent to which they could support their members. This theme of clergy wellbeing included concern for clergy with mental illness and the need for a safe and supportive environment for them. As part of its support to churches, I thus recommend that TWC reach out to ministry partners to see if there is an interest among them in having conversations and training about support for clergy.

Another issue that emerged was that the confidentiality required in psychotherapy restricted pastors from actively participating in the care of their

members during the course of therapy. I thus recommend that TWC partner with ministry leaders to establish ways they can provide supportive care to their members who are in therapy, within the boundaries of the practice of psychotherapy.

The issue of gender identity "confusion" that was raised by participants included concerns about legal issues, protocols, how to balance scriptures and gender issues. Although this was outside the scope of the research, there is room for further exploration of how ministries are working through these issues and the role TWC might play.

The additional themes were introduced primarily by participants who were already referring members to psychotherapy and who most likely already understood some of the training information and were looking for additional information. Emphasis on culture and context was often raised by a participant who was fairly new to their context. Participants who interacted the least during the sessions had less years of experience as pastors, and although not explored, it could be related to them listening and learning from the more experienced participants and/or they may have felt intimidated by them. In light of this observation, if I repeat this training or have similar training, I would be more intentional in trying to achieve a more balanced level of engagement from all participants on each topic.

In the data analysis, these additional findings emerged. Firstly, while I cannot fully attribute changes recorded in pre/post-questionnaire to the training,

the qualitative data gathered throughout the training sessions provided further evidence that change in knowledge, understanding and awareness took place, as noted above. Secondly, the questionnaire results referred to changes in knowledge, understanding and awareness in the overall group and not to specific participants. Because pre- and post-questionnaire results and codes were aggregated in the analysis, the reported findings do not reflect the individual participant's responses, except where they were used as examples. This research did not compare each participant's interactions in the training sessions with their pre/post-questionnaire responses. Further research into the relationship between each participant's interactions in the training sessions and their pre/post-questionnaire responses may provide some insight into further needs of the participants after the research sessions. This could also provide some insight into the relationship between the demographics of the participants and their pre/post-questionnaire responses.

This research project was the result of co-existing factors of my personal calling to work with churches to provide mental health care, opportunities at TWC to provide psychotherapy, the increase in need and demand for mental health care in general and as experienced at TWC, and the expressed desire of some ministry leaders to be better able to support and refer their members for psychotherapy. Together, these factors shaped the information that was provided by the training program to assist this group of Christian ministry leaders to better support and refer their members to TWC for psychotherapy.

Having completed this initial training program for ministry leaders, experiencing their engagement and hearing of some additional areas of interest they had, I believe there is value in repeating it with other groups. This is supported by inquiries from other ministry leaders who have expressed interest in similar training. For example, some of my peers in the DMin program who had insights into the details of this research asked about having this training for their own ministries. I will be following up with them about an appropriate time to have this training as a group or provide them with information on other training options. In addition, one research participant who was involved with an inter-faith group asked whether TWC would provide similar training opportunities for other churches, and I will be pursuing that option. One ministry participant invited me to be part of a mental health focus session at his church during the coming fall. As two research participants were from my church, I will be meeting with my pastor to determine next steps for the church and how I can support the changes needed. Also, there are other ministries that refer their members to TWC that could benefit from similar training. With the level of interaction and support shown among participants during this research, repeating the training with participants from various ministries may help to maximize the opportunities to share resources, support, concerns, etc., among ministries.

To potentially expand the scope of access for this training program, TWC will initiate a collaboration with the newly formed Tyndale Centre for Pastoral Imagination to provide this training for the pastors supported under that initiative.

TWC has also begun conversations about potentially offering the training as part of academic programs, hopefully during the 2023 -2024 academic year. This training could be presented in its entirety over one or two days, similar to other courses offered by TWC to academic programs. Additionally, for some of the specific issues raised during the training (e.g., mental health in clergy), TWC could offer specific workshops for ministry leaders who have an interest in that topic, or could collaborate with other Tyndale events (e.g., annual Preaching Conference) to offer that training.

One issue that arose in this research training was that three weekly two-hour training sessions in September to October was not ideal timing for participants. Therefore, it would be important to consider the length and number of training sessions and the time of the church calendar year if this training was repeated to pastors. In addition, given the benefits and limitations of the online training sessions, it might be informative to conduct the training in-person and compare the results.

In presenting another round of training, and in response to the findings, I would include more information, as well as leave room for conversation, on clergy mental illness and care, ministers supporting their members during therapy, and additional ways ministry leaders can prepare their ministries to support their members with mental illness, specifically, by building confidentiality within ministry leaders and normalizing mental illness within the congregation.

This training has also provided TWC with opportunities to meet specific needs of some ministers who are already referring to the centre, including helping ministry leaders to support their members in therapy while meeting the requirements for confidentiality, or providing information sessions to their congregants about psychotherapy to help remove the stigma associated with that word.

To provide similar training outside of ministry settings, the training material could be easily adapted to meet the needs of other organizations, as the topics of mental health/mental illness, self-care, supporting members with mental illness, barriers to mental health care, understanding psychotherapy and making referrals to TWC are consistent.

While this research project was small and focused particularly on the work of TWC, the findings suggests that other ministry leaders may welcome similar opportunities to wrestle with the issues of living with and/or serving their members with mental health issues and by extension, other members of the communities they serve.

CHAPTER 5:

CONCLUSION

In this conclusion, I provide an overview of how I experienced the DMin program in my personal and professional life, and how the three main components of the integration portfolio (Context Analysis, Philosophy of Christian Leadership and the Research Project) were interwoven into a comprehensive whole.

Why a Doctor of Ministry in Leadership?

In 2019, my then manager Dr. Janet Clark suggested that I do a DMin program, and she outlined the many ways in which it could enhance my work and my personal development. At that point, I had already decided that I was not interested in pursuing a doctoral program, but after some wrestling with the idea, I registered in the program in 2020. Of two areas of interest, Leadership and Spiritual Formation, I chose the leadership option because I believed God called me to lead at TWC and I felt assured I was suitable for the position. More importantly, I believed the DMin was good stewardship of what God already deposited in me and would increase my capacity to lead, which included providing contingency and succession planning for the ministry.

Getting to Know Myself More

Never did I ever expect that the program would help me to get to know myself so well! As I completed the DMin program, I earnestly concluded that the program provided more opportunity for me to get to know myself than I could ever have imagined. Every course from Formation of the Leader in the first year, to the Integration Portfolio (the last course), brought many personal benefits which I will briefly recount.

First, the lectures and literature chosen for each course drew me to intentionality notice what God was doing in me and in my ministry context. This provided enrichment in my relationship with God, acknowledgement of the skills God gave me, and allowed me to lead from a more grateful heart. Secondly, the program embodied a collaborative approach to learning, i.e., helping and being helped by my peers. The classroom interactions (online or in person), the open prayers for each other as we made presentations, and the required peer reviews of our projects demonstrated the body of Christ in action. These activities also enlarged my perspectives and appreciation for differences. Thirdly, the preceding points provided a training ground and practice for the final presentation and hearing requirements of the Integration Portfolio, where I presented my work and responded to questions and comments. Fourthly, completing this DMin Leadership program developed in me a discipline to live iteratively and to gain more knowledge and wisdom. It expanded my innate curiosity and rejuvenated my desire to learn.

As expressed above, the DMin program was much more than a degree. It was more about the journey and the change it brought in me as a person, and in how I see ministry. The program also substantially built on my earlier training and roles in management and in the field psychotherapy, where the knowledge and use of self in that work is paramount. The spiritual dimension, which was a major part of this program, helped to shape my understanding of how God has made, trained and placed me in different places for different purposes. I developed an integrated sense of self, and a sense of feeling at home in my leadership role and in the context to which God had called me to lead.

The Interplay Between Contextual Analysis, Philosophy of Christian Leadership and Research Project – The Balcony View and the Dancefloor

To describe the interplay between the three components of the DMin integration portfolio (Contextual Analysis, Philosophy of Christian Leadership and Research Project), I have drawn on one of the leadership concepts I learned from the DMin Leadership program that has radically impacted me. It is what Heifetz and Linsky refer to as the "balcony view" and the associated "dancefloor" (Heifetz and Linsky 2017, 53). This phenomenon occurs when a leader mentally moves away from the day-to-day activities to observe the bigger picture (which includes the leader as part of what is being observed) to achieve clarity. The leader then mentally goes back into the activities on the dancefloor, and by

interacting with the activities, the leader gains a better understanding of what is happening there.

From a balcony perspective, I experienced this DMin leadership program and the resulting integration portfolio as enabling a major step in my life towards realizing my calling to help churches in supporting their members to access psychotherapy. Many terminologies, strategies, laws, training requirements, etc., have changed since I first heard the call in 2004 to assist ministry leaders. Seeing that call come to pass started with the first session of the research training program, when nine ministry leaders participated in learning how to supportively refer their members to psychotherapy. While this accomplishment was years later than the initial call, the preparation process was worth the wait for me and will hopefully have long, far-reaching impact on many lives. By developing a training program for the research project, the foundation was laid for a ministry that can outlive me. This has helped to anchor my role in succession planning, and personally, in leaving a legacy, which is part of my understanding of good stewardship.

From the balcony, I also sensed the God-ordained timing of my DMin studies in general and the research project specifically. For example, I saw how my experiences in leading in other organizations (e.g., in church and therapy settings), had prepared me to understand leading in the ministry context of TWC. My history with Tyndale University for eighteen years (first as a student and leading up to director of TWC), provided important knowledge, understanding

and continuity for my role. The connection between TWC and the Willowdale community and specifically with Christian ministries within that community, helped in establishing strong relationships that were important to the TWC ministry.

In addition, through developing a philosophy of Christian leadership, this DMin program helped me to understand who God has called me to serve, and how and why I lead as a Christian. This resulted in a sense of peace, clarity, appropriate boundaries, humility and a deeper dependence on God. Finally, the COVID pandemic that occurred as I began my studies provided an urgency and opportunity which made the need for helping churches to support and refer their members, undeniable. It also allowed me more flexible time to complete this degree in three years, which meant I did not lose the window of urgency for working with churches to supportively refer their members to psychotherapy.

The "Dance Floor" - the Three Segments of this Integration Portfolio

Before I provide the details of how I saw the main characters on the dancefloor, it is important to provide some context. Firstly, I realized that there are many others on the periphery of dance floor who provide support for the dancers (e.g., musicians, those who clean the floor, side conversationalists, the audience), each adding to the flavour of the event. For my portfolio, these important persons included my professors, DMin administration, peers, manager, TWC leadership and staff, my advisor, my family and friends, spiritual director,

leadership coach, Tyndale library staff, Tyndale departments that support TWC, clients of TWC, ministry leaders, and others.

Secondly, although each dancer or group of dancers was featured separately, there was an ongoing interplay between them, each affecting and being affected by the other. If one dancer or group took the time or space needed by the other, things became chaotic. Similarly, if one dancer tripped, others came to rescue or had to replace them in the dance. In preparing my portfolio, I found that my initial resistance to servant leadership motif blinded me to some important truths and connections between my past and my research. Once I was open to what God was saying, truths flooded my mind and heart. For example, recognizing the connection between my parents' legacy as ministry and community leaders and supporters of the mentally ill, and my own ministry role, became increasingly clear and provided a sense of being privileged to continue their work.

Thirdly, I saw how each dancer was important and the interrelationship between the dancers created an energy which allowed for the full experience of dancing that could not be achieved by focusing on only one at a time. Here "the whole is greater than the sum of its parts" (attributed to Aristotle), seemed evident. An application to my role as a leader, was that when the TWC leadership team was making plans on how to implement the research training program within a Tyndale program, I did not focus on context analysis, leadership philosophy or the training program separately. However, when we discussed options, my

response automatically included all three areas in a seamless, comprehensive manner, showing the power of their presence even when they are not identified individually. I will now look at what I consider to be each of the dancers on the dancefloor: Context Analysis, Philosophy of Christian Leadership and Research Project.

Dance 1 - Context Analysis

I envisioned the context analysis as comprising different solo dancers using different genres who came together at the end for the final act. When together, they expressed the overall picture of being in sync and being necessary parts of the whole.

From a balcony view of this dance, at first, I saw exegeting my context as a strange concept until I came to understand the need to pay attention to all aspects of my context. For example, in exploring the Willowdale neighbourhood, I found there were numerous ethnic groups, many churches working together, as well as affluence and hidden poverty. Although many of TWC clients were from that community, without this analysis I would not have known so many details about the community, which provided important information for working with them.

In carefully analyzing the context of TWC, I had a better understanding of how its history impacted its functioning, the complexities of being an intrapreneurship within Tyndale University, and the needs and resources of the

staff, etc. I also saw how in my role as the TWC director, my strengths and areas for growth, personality preferences and leadership skills, etc., impacted my leadership. I noticed how my calling fit with Tyndale's mission to serve the church and the world to God's glory, and how I built on the work of the past directors while charting new paths. An important part of this analysis was seeing how an iterative contextual analysis allowed me to implement aspects of my learnings from the DMin program over the duration of the program. For example regarding staffing, I used principles of the *Leadership Pipeline* (Drotter and Charan, 2001) and over communication (Lencioni, 2021). At the time of writing, I was using intercultural development tools from the course on Intercultural Leadership Competency to help therapists build intercultural competency, and *The McKinsey Capacity Assessment Grid* (Venture Philanthropy Partners, 2022) which was part of the Learning Organization course, in a comprehensive assessment of TWC. While each of the areas assessed was important, together the context supported my DMin leadership studies and was the setting in which I implemented the research study, which in turn represented, for me, partial fulfilment of God's calling on my life and of Tyndale's mission.

Dance 2 - My Philosophy of Christian Leadership

From the balcony, I envisioned my philosophy of Christian leadership as a couple dance, God and me. Learning this dance was a process involving a combination of parts of a tango, (a ballroom dance which includes specific

postures, rhythms and abrupt pauses), a paso doble (a ballroom dance which is fast-paced and follows a specific marching pattern) and then a slow waltz (where a couple moves rhythmically and in sync around the dance floor). The tango and paso doble represent the wrestling and closeness, back and forth, marching sometimes to God's beat and sometimes to mine, at first with a strong resistance and then giving in, as I worked my way through my philosophy of Christian leadership. Then in my surrender, we got to the waltzing stage as together, with God as the lead, we progressed along the path on the dancefloor that God had chosen to servant leadership.

Although most of my "dances with God" had been waltzes, from a balcony view, I saw that this dance was a new experience for me. The process involved an introspection of all areas of my life, from as far back as I could recall to where I saw myself going, the people who influenced me, what I learned then and continued to use in ministry. These filled some important gaps in my understanding of myself. One main discovery was the extent to which my family of origin impacted my leadership philosophy. For example, my parents as church/community leaders directly impacted me in the way they served in the community in a seamless church/life interface, and how they embraced and provided for persons in our community who were experiencing mental illness. I saw how that was reflected in my own life as I was involved with prison ministry, feeding persons who lived on the streets, being in leadership positions throughout my life, and in supporting persons with mental health issues.

My philosophy of Christian leadership, which is servant leadership supported by adaptive and collaborative leadership was born out of three realizations. The first was a new understanding of Jesus in his multi-faceted roles of servant, prophet, priest and king, and how I can represent Him in those ways. The second was recalling my understanding of who people are, made in God's image and deeply loved by him. The third was understanding servanthood as doing what God called me to do, including serving in the areas of ministry and mental health and multiplying that work by training ministry leaders to do so within their contexts, which spurred my research project.

Dance 3 - The Action Research Project

On the dancefloor, I envisioned the research project as a group dance, with a leader instructing and guiding as part of the group, and with each dancer doing their part, using their unique dance styles to make it the best it could be. The dance of the project was organized, with dancers taking leading and supporting roles in their segments, while following the rules of the dance. Although some dancers had more prominent parts because of their skills or availability, they were not more important than the others. The leader took responsibility to ensure the safety of the dancers, was accountable to those in authority and provided feedback to the group. Of necessity, success depended on a collaborative process, and there was always room for improvement.

From the balcony view, the group dance represented the action research project, which was an iterative process with each participant contributing, and with me as the research leader and participant observer. It included the nine ministry leaders from eight ministries in the Greater Toronto Area (GTA) and one north of the GTA as the research participants. Prior to the research, the participants already had an interest in mental health issues, and some were referring their members for therapy. They attended the research training sessions and contributed by sharing about their ministries and themselves, and then applied the information from the training to their contexts to identify the issues and successes within their own contexts, with opportunity to learn more. The research training program helped participants to understand how to make supportive referrals to psychotherapy. This was done by providing them information about mental health and mental illness, why and when they should refer their members to psychotherapy, how they would be involved in the referral process, what the process would be like for the members they referred, some of the ethical and legal considerations in psychotherapy, and how they could support their members who were in therapy.

Balcony View of the 3 Dances

While I have presented the three components of the portfolio as three distinct dances, in real time they were happening simultaneously, which each impacting and being impacted by the other. A balcony view was needed to see the

interplay. For example, Dance 1 (the context) was always changing, therefore, for any repeat or application of Dance 3 (research) to be effective, it would need to consider the changes in Dance 1. Another example is that many parts of Dance 2 (philosophy) could be applied to Dances 1 (context) and 3 (research) as needed, when representing the different roles of Jesus as servant, prophet, priest or king. That said, the essential principle of seeing God's image in everyone and recognizing God's love for all, are always applicable to Dances 1 and 3. Dance 3 (the research project) created more confidence in Dance 2 (my philosophy of servant leadership) and vice versa. For example, the research project provided the opportunity to apply components of my philosophy and in turn, the philosophy strengthened my belief in the importance of the research.

In providing this metaphor, I bore in mind that each new visit to the balcony or dance floor may produce different views of the same scene. In the words of Heifetz and Linksy "The process must be iterative, not static. The challenge is to move back and forth between the dance floor and the balcony, making interventions, observing their impact in real time, and then returning to the action. The goal is to come as close as you can to being in both places simultaneously" (Heifetz and Linsky 2017, 53). This DMin program has provided a life-transforming journey and momentum towards achieving this movement.

APPENDICES

Appendix 1: Invitation and Information Letter

Regarding Research at Tyndale Wellness Centre by Wilma Nevers, Doctor of Ministry (DMin) Student at Tyndale University on:

Training Ministry Leaders Towards Appropriate Psychotherapy Referrals to Tyndale Wellness Centre

I am inviting you to participate in a research study on "Training Ministry Leaders Towards Appropriate Psychotherapy Referrals to Tyndale Wellness Centre", because you are a leader in Christian ministry in the Greater Toronto Area who has expressed interest in this topic. To help you decide if this research is of interest to you, please take at least 3 days to review this information before giving your consent to participate. Always feel free to contact me by email or telephone to provide you with more information. (See contact information below.)

Tyndale Wellness Centre (TWC) is a department of Tyndale University, and it seeks to promote the wellbeing of the Tyndale and extended communities. The current primary foci include psychotherapy services to students and members of the public (mainly within the GTA, but throughout Canada), professional development training within the field of psychotherapy and research. The TWC team includes Registered Psychotherapists and Interns all trained in Spiritually Integrated Psychotherapy, Social Workers, Psychiatrists and Administrative staff. Psychotherapy is offered in 6 languages (Arabic, Cantonese, English, French, Korean and Mandarin) at competitive prices and within accessible service hours Mondays to Fridays 8:00am to 9:30pm and Saturdays 8:00am to 7:30pm (EST) with services currently available online or by telephone.

You will be one of 10 – 12 Christian ministry leaders from the GTA who I will ask to provide information on their experiences of referring their members for therapy, their understanding of the scope and impacts of mental illness among their members, their understanding and experience of psychotherapy and to provide input into what are the most important areas of training they would need to better facilitate appropriate referrals of their members for therapy.

This research is part of the requirements for completion of my study in the Doctor of Ministry program at Tyndale University and my hope is that this focused study will help ministry leaders know more about mental health/illnesses and help them make appropriate referrals to psychotherapy.

Name of Research Study: "Training Ministry Leaders Towards Appropriate Psychotherapy Referrals to Tyndale Wellness Centre."

Principal Investigator: Wilma Nevers (Email: ; Phone number: I am also the Director for Tyndale Wellness Centre. This is a single site study, conducted through Tyndale University and there are no sponsors or grant agencies associated with the research.

Research Supervision: The research supervisor is Dr. Narry Santos, Doctor of Ministry Department, Tyndale University. Email: nsantos@tydndale.ca Tel: 416-226-6620 Ext. 2227. DMin Track Coordinator is Dr. Michael Krause, DMin. Email: mkruase@tyndale.ca Tel: (416) 226-6620 Ext. 2239. Program Director is Dr. Mark Chapman, PhD. Email: mchapman@tyndale.ca Tel: (416) 226-6620 Ext. 2208

Purpose: The purpose of this research study is to collect information on what ministry leaders already know and to provide information on what they need to make appropriate referrals for psychotherapy, so that more Christians or other persons served by Christians will access mental health services.

Research Approval: This research study has been reviewed and received ethics approval through the Research Ethics Board, Tyndale University. If you have questions about your rights as a participant, please contact reb@tyndale.ca

Data Collection: Data collection will take place between July 2022 and October 2022.

Procedures: The research study will be conducted in English. I will ask you to provide consent to participate and complete a questionnaire and/or interview to provide me with information and guidelines for the training. During the training, your feedback will help to determine the remainder of the focus of the training. After training you will be asked to complete the same questionnaire you completed at the beginning, to compare your responses. See more details below.

Vulnerable Sectors Reference Checks – because persons with mental illnesses may be considered to be vulnerable, it is recommended that each participant has a recent (within 1-2 years) positive vulnerable sectors reference check from their local Police. If needed, I will provide you with more information on how to get this done.

Questionnaire will be sent to you by email, (see below). Please complete the participant information/demographics form at the top of the questionnaire as well as the other questions.
Interviews will be done by Zoom, telephone or in person if safe to do so, to answer any questions you have about the questionnaire and the research in general.

Training will be total of 8-10 hours over a few sessions to be agreed upon by the participants. Please begin to think about which day of the week, time of the day and the number of hours per session that will work for you. The current plan is that it will be done online by Zoom. If it is safe to do so, and all participants agree, part of the training will be done at Tyndale University campus. A supervisor or Assistant Director of TWC will assist with the training.

Referral: I will encourage you to refer your members to TWC for psychotherapy during the research period, as a way of practicing the information you are learning. However, you have the freedom to choose to refer to a therapist outside of TWC. I may not be able to provide some of the details needed for a referral outside of TWC.

Debriefing Session: The last training session, will give you opportunity to debrief on the research process and provide any additional recommendations you may have. Once data collection is completed and findings are established, I will email you a debriefing document to reveal the findings of the research and provide some resources for referring your members.

Confidentiality: The privacy, security, and confidentiality of your questionnaire / interview responses will always be protected. To help in that process, I will assign you a unique Participant ID which will be used to refer to any of your information included in the study. I will be the only one with access to your responses. Your data will be electronically stored, and password protected.

Exceptions to Confidentiality: There are some circumstances where your information will not be completely confidential. e.g., if child abuse, suicide, homicide is suspected or reported.

Emotional: While completing the questionnaire/interview or during training, you may be triggered/have strong negative reaction which cause you to be upset. See information below about resources to help you.

Privacy: While I will do everything to protect your privacy, in the unlikely event that there is a privacy breach, the answers you have provided may identify you. Additionally, the researcher cannot guarantee that other research participants who are with you in group settings will maintain your confidentiality, although I strongly encourage everyone to do so.

Benefits and Compensation: There is no financial compensation for participating in this research study. However, the benefits include new learning or increased awareness of mental illnesses and how to respond to your members. You may also be able to share your insights with other ministry leaders and members. Findings

from the research may be used for training other ministry leaders and increase the care of ministry members in the GTA. In addition, ministry members you refer to psychotherapy during the research period, will qualify for reduced fees if they have financial challenges. The number of referrals that can be accommodated will be determined by the availability of therapists/interns.

Conflict of Interest: To avoid conflict of interest, I will not be involved in the placement, psychotherapy or supervision of the cases for members you refer for therapy during the research period.

Voluntary Participation: Your participation is voluntary and at any time you may choose to withdraw from the research, refuse to attend a training, refuse to provide answers to any questions or participate in any further area of the research. You will not be able to withdraw, correct or delete the data you provided that has already been integrated into the research work. Your withdrawal will not affect any benefits you or your members have received or qualified for, up to the point of withdrawal.

Use of Research Results: Findings from this research will be used for completion of my studies in the Doctor of Ministry program and shared in public presentations both online and in person. Tyndale University archives all students' research work. A copy of the findings will be made available to Tyndale Wellness Centre and to you upon your request. No personal identifying information will be included in the findings, reports, publications or presentations arising from this study**.** If you wish to appear and be identified at any presentation, you will provide a written consent prior to the identification.

Additional Information: If you have questions about the study, please contact me (Wilma Nevers) at : or

Thank you for taking the time to complete this document.

PLEASE EMAIL COMPLETED DOCUMENT TO ME AT:

Appendix 2: Research Participants' Consents

1. Consent to Participate

I _____ have read and understand the information provided about the research study and freely consent to participate in the study "Training Ministry Leaders Towards Appropriate Psychotherapy Referrals to Tyndale Wellness Centre".
I understand that I am not waiving any legal rights by participating in this project.
Completing and returning this consent, is proof of my free consent to participate.
I will keep a copy of this consent.

_____ _____
Research Participant Name Date

2. Consent to Quote Participant's Responses

I _____, give my consent for the researcher to quote my personal responses in the publication of this research study "Training Ministry Leaders Towards Appropriate Psychotherapy Referrals to Tyndale Wellness Centre" on the condition that I will not be identifiable.
Completing and returning this consent, is proof of my free consent to quote my responses.
I will keep a copy of this consent.

_____ _____
Research Participant Name Date

3. Consent for Re-use of Study Data

I, _____, freely give consent for the researcher to re-use the data collected from me during this study in future research or training projects. I understand that this may extend to sharing my study data with other researchers involved in other studies. Any data that is reused will not be able to identify me as a participant. This consent does not include permission for the sale or re-use of my study data for non-research or for commercial purposes.

Completing and returning this consent, is proof of my free consent for re-use of study data. I will keep a copy of this consent.

_____ _____
Research Participant Name Date

Appendix 3: Questionnaire (including Demographics)

Notes

- The information you provide below will be seen only by me, the researcher. You will not be identified in the findings in the research.
- Approximate time to complete questionnaire: _10 to 20__ minutes.
- This questionnaire will be used at start of the research and after the last training session.
- For clarification of any of the questions, please contact me at the information below.
- If completing this questionnaire causes you to feel overwhelmed or significantly triggered, please discontinue the process, contact Tyndale Wellness Centre or other resources for support, using the information provided at the end of this document
- Your Participant ID will be assigned when you complete and return this document. To help protect your identity, your ID will be used to refer to your information for this research.
- Click on box to check or uncheck it.

Participant's Information

Participant's ID: _____ (to be assigned upon return of this document)

Date completed this questionnaire: _____

Participant's Ministry/organization: _____

Ministry position / role: _____

First (dominant) language: _____ **Number of years in ministry**: ____

Which of the following best describe(s) you? (Click on boxes to check all that apply)

☐Aboriginal ☐Arabic ☐Black ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean
☐ Latin American ☐ Mixed ☐ Not sure ☐ South Asian ☐ White ☐ Other

What are the groups of the persons you serve directly? (Check all that apply)
☐ Infants ☐ Children ☐ Youth ☐ Young adults ☐ Adults ☐ Seniors

Which of the following best describe(s) the persons you serve? (Check all that apply)

☐ Aboriginal ☐ Arabic ☐ Black ☐ Chinese ☐ Filipino ☐ Indigenous ☐ Japanese ☐ Korean ☐ Latin American ☐ Mixed ☐ Not sure ☐ South Asian ☐ White ☐ Other _____ ☐ High Income ☐ Middle income ☐ Low Income ☐ Unknown ☐ Immigrants ☐ Canadians ☐ Refugees

INSTRUCTION: Use the scale below to show the extent to which you agree with the information expressed in each statement.

1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree

_____1. I understand what mental health is
_____2. I know many signs of mental illness
_____3. I have/had personal experience with mental illness
_____4. There is/has been mental illness in family
_____5. I know at least one member of my ministry who has/had mental illness
_____6. I am comfortable talking with my members about mental health/mental illness
_____7. I know how to care for myself when supporting members who have mental illness
_____8. Some ministry members are comfortable to talk about mental illness
_____9. Some ministry members are uncomfortable to talk about mental illness
_____10. Mental illness is a demonic issue
_____11. Mental illness is a private issue, not to be shared with anyone
_____12. The solution for mental illness is deliverance ministry
_____13. Psychotherapy and faith are not compatible
_____14. Psychotherapy and faith can work together
_____15. I have used psychotherapy and found it helpful
_____16. I know others who used psychotherapy and found it helpful
_____17. I would never use psychotherapy
_____18. I encourage my members to use psychotherapy
_____19. I would not refer my members to psychotherapy
_____20. My members want to use psychotherapy
_____ 21. My members do not want to use psychotherapy
_____22. Psychotherapy can help persons who have relationship issues
_____23. My ministry members trust me to refer them to psychotherapy if needed
_____24. I know when to refer to psychotherapy
_____25. I know the difference between counselling and psychotherapy

_____26. When I refer my members, I need to know what is happening in the sessions
_____27. I understand what confidentiality in psychotherapy means
_____28. I understand exceptions to confidentiality
_____29. I understand duty to report (that is, having to report to authorities when certain vulnerable persons e.g., children are at risk or being abused)
_____30. I understand informed consent
_____ 31. I understand clients' rights in psychotherapy
_____ 32. I understand clients' responsibility in psychotherapy
_____ 33. I know the risks of psychotherapy
_____ 34. I know the benefits of psychotherapy
_____ 35. I have a good idea of the current cost of psychotherapy
_____ 36. I understand that clients may access psychotherapy on-line
_____37. I know of the Tyndale Wellness Centre
_____38. I know how to refer members to Tyndale Wellness Centre
_____39. I have referred members to Tyndale Wellness Centre
_____40. I would like to know more about referring members to Tyndale Wellness Centre

If you need clarification or have concerns about any questions in this questionnaire, please contact me (Wilma Nevers) at

Thank you.

Please use this contact information if you are feeling overwhelmed or significantly triggered.

Tyndale Wellness Centre
3377 Bayview Avenue, Toronto, Ontario M2M 3S4
416.226.6620 x 2123 Email: counselling@tyndale.ca
If you are in crisis, please call 911 or go to the nearest hospital emergency room.
Some additional crisis support services are:

Suicide and Crisis Hotline: 1-800-448-3000
Crisis Services Canada: 1-833-456-4566
Mental Health Crisis Line: 1-888-893-8333
Distress Centres of Greater Toronto: 416-408-HELP (4357)
Kid's Help Phone: 1-800-668-6868 Text: 686868

Appendix 4: Information Re Training

Dear Participant:
Thank you for agreeing to participate in this action research on "Training Ministry Leaders Towards Appropriate Psychotherapy Referrals to Tyndale Wellness Centre" and completing the first questionnaire. There are _____ participants in the research.

Based on participants responses from questionnaire and interviews, and my knowledge in this field, the first training topic will be on _____.
Please let me know your preferences for training by choosing from the table below. The ones chosen by most of the participants will be selected.
Total suggested training is 8-10 hours during August and October 2022. Sessions are expected to be via Zoom. If participants prefer in person training and it is safe to do so, part of the training will be held at Tyndale University campus.

Please check your selection for preferred day, starting time, duration 2 or 2.5 hours, in the table below.
Total suggested training is 8-10 hours during August and October 2022. Sessions are expected to be via Zoom. If participants prefer in person training and it is safe to do so, part of the training will be held at Tyndale University campus.

DAY					
Monday	Tuesday	Wednesday	Thursday	**Comments**	
START TIME					
Starting 11am	Starting 12 noon	Starting 5pm	Starting 5:30pm	Starting 6pm	**Comments**
DURATION					
2 hours / session	2.5 hours / session	4 or 5 hours per session			
(4 - 5 sessions)	(4 sessions)	(2-3 sessions)			

Appendix 5: Interview Guiding Questions

Participant ID: _____ Date of Interview: _____

Contact: ☐ Zoom ☐ Teams ☐ WhatsApp ☐ Phone ☐ Email

Are you freely participating in this research? If no, please explain.

Review of research process, permission to record on Zoom, signed consent meaning, withdrawing, power differential, collaborative nature of the research, referrals on members during the research.

What are the questions for which you need clarification?

If you have further concerns, please email me (Wilma Nevers) at
Thank you.

Appendix 6: Research Training Program – Topics, Materials Used

Training Day/Number of Participants	**Training Topics and Outline**	**Primary Resources Used**
Day One (September 19, 2022) All nine participants attended	Mental Health/Illness (Definitions, Examples, Prevalence, Common symptoms of mental illness, The role of faith leaders in the mental health care of their members) Self-care (Anxiety, Stress, Burn out, Boundaries, Accountability, Areas of wellbeing) Feedback on training Based on today's training, what do you need to make a referral to TWC for psychotherapy Plan for next Session	*Mental Health: A Guide for Faith Leaders* (American Psychiatric Association 2018), *Quick Reference on Mental Health for Faith Leaders* (American Psychiatric Association 2018) and *MHFA Basic* (Mental Health First Aid Canada 2021) Presentation prepared by researcher Mental Health: *A Guide for Faith Leaders* (American Psychiatric Association 2018)
Day Two (September 26, 2022) Seven participants attended (TWC-08 and TWC-04 were absent)	Supporting members with mental illness (Protective factors e.g., legal and ethical issues, ministry workers, duty to report; Sanctuary Mental Health Course; Community resources) Barriers to psychotherapy (Stigma, Racism, Poverty) Feedback on training Based on today's training, what do you need to make a referral to TWC for psychotherapy Plan for next Session	Ontario Association of Children's Aid Societies (2021) *Sanctuary Course* (Sanctuary Mental Health Society 2022) *Overcoming Stigma* (Gretchen Grappone 2017), *Addressing Stigma* (Canadian Mental Health Association 2022), *Mental Health Program-Supporting Black Youth* (CAMH 2022)

Training Day/Number of Participants	**Training Topics and Outline**	**Primary Resources Used**
Day Three (October 3, 2022) Seven participants attended (TWC-09 and TWC-10 were absent)	Understanding psychotherapy (Important definitions and key terms, Who can practice psychotherapy in Ontario, Spiritually Integrated Psychotherapy at TWC) Making appropriate referrals to TWC (Issues to consider, Processes) Feedback on training Based on today's training, what do you need to make a referral to TWC for psychotherapy Plan for next Session	*CRPO* (College of Registered Psychotherapists of Ontario 2021) *Disclosure Information, Informed Consent, Other resources* (TWC 2022)

Appendix 7: Permission from American Psychiatric Association

AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

December 22, 2021

Wilma Nevers
Director, Tyndale Wellness Centre
Tyndale University
3377 Bayview Avenue
Toronto, Ontario M2M 3S4

Re: Permission Request to use APA materials for training

Dear Wilma,
I am responding to your request to reproduce the content listed below as part of your ongoing training sessions and research:

Mental Health: A Guide for Faith Leaders (full text)

Gratis permission is granted under the following conditions:

- Material must be reproduced without modification
- Permission is nonexclusive and limited to classroom/training sessions
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Sincerely,

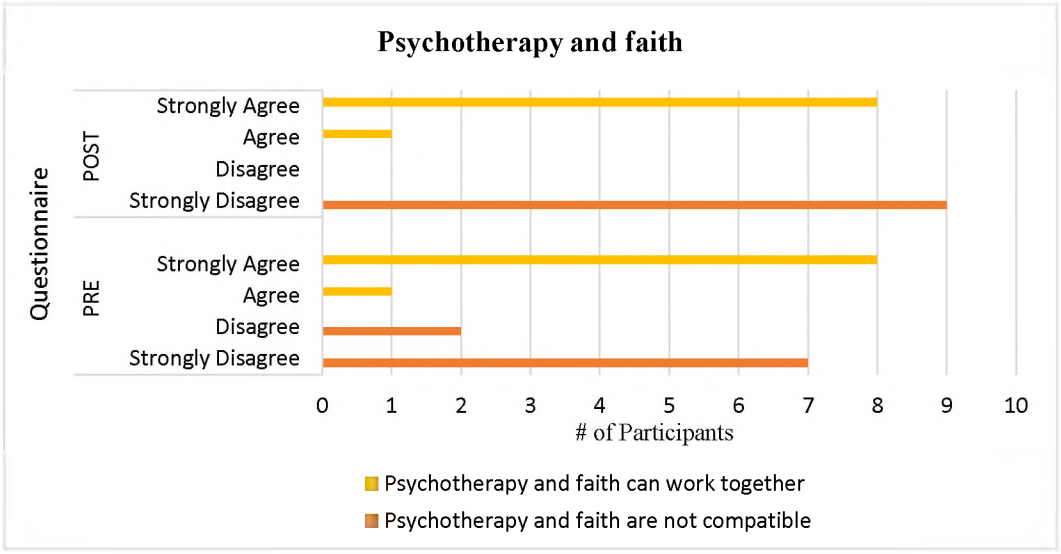
Puja Telikicherla
Licensing & Subsidiary Rights Manager

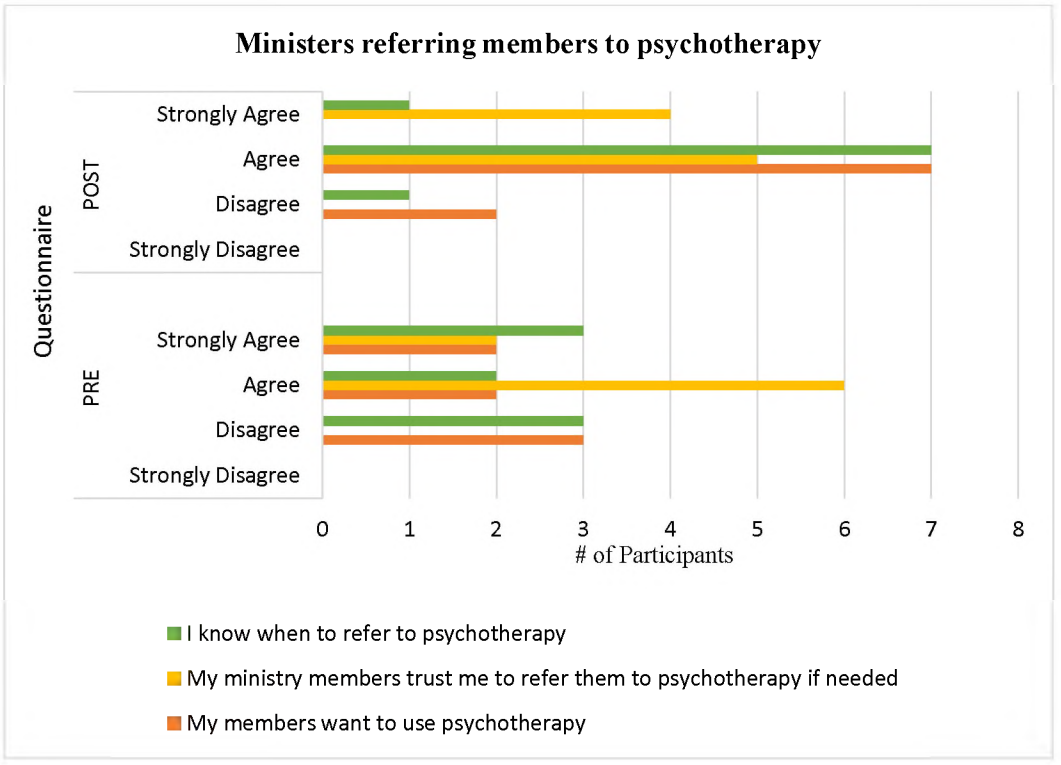
Appendix 8: Comparative Pre/post-questionnaire Data with Number of Participants and the Rating Scale

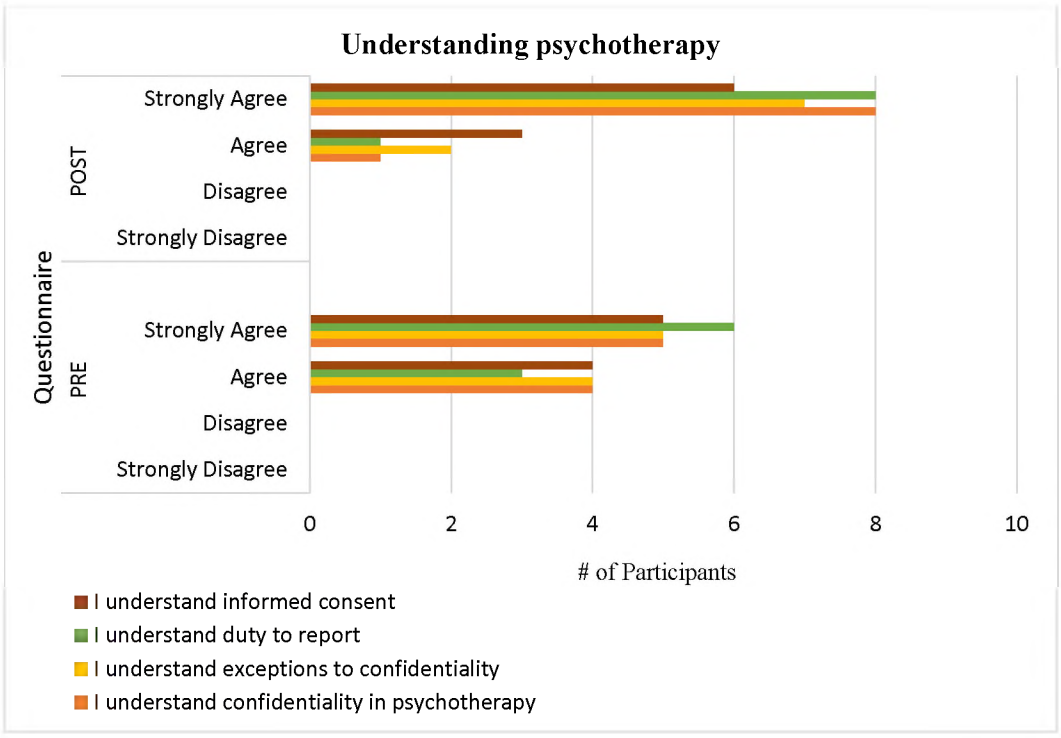
	Rating: 1= Strongly Disagree. 2= Disagree. 3= Agree. 4= Strongly Agree	*1*	*2*	*3*	*4*	*1*	*2*	*3*	*4*
	QUESTIONS	**No. of Participants Pre-questionnaire**				**No. of Participants Post-questionnaire**			
1	I understand what mental health is	**0**	**0**	**5**	**4**	**0**	**0**	**3**	**6**
2	I know many signs of mental illness	**0**	**0**	**7**	**2**	**0**	**0**	**7**	**2**
3	I have/had personal experience with mental illness	**1**	**2**	**4**	**2**	**1**	**4**	**3**	**1**
4	There is/has been mental illness in family/close friends	**0**	**1**	**5**	**3**	**0**	**1**	**4**	**4**
5	I know at least one member of my ministry who has/had mental illness	**0**	**0**	**3**	**6**	**0**	**0**	**1**	**8**
6	I am comfortable talking with my members about mental health/mental illness	**0**	**0**	**4**	**5**	**0**	**0**	**3**	**6**
7	I know how to care for myself when supporting members who have mental illness	**0**	**2**	**5**	**2**	**0**	**0**	**6**	**3**
8	Some members are comfortable to talk about mental health/mental illness	**0**	**1**	**6**	**2**	**0**	**2**	**5**	**2**
9	Some members feel ashamed/uncomfortable/hesitant to talk about mental illness	**0**	**2**	**4**	**3**	**0**	**0**	**5**	**4**
10	Mental illness is a spiritual / demonic issue	**3**	**4**	**1**	**0**	**3**	**4**	**2**	**0**
11	Mental illness is a private issue, not to be shared with anyone	**6**	**2**	**0**	**0**	**6**	**3**	**0**	**0**
12	The solution for mental illness is deliverance ministry	**5**	**4**	**0**	**0**	**4**	**5**	**0**	**0**
13	Psychotherapy and faith are not compatible	**7**	**2**	**0**	**0**	**9**	**0**	**0**	**0**
14	Psychotherapy and faith can work together	**0**	**0**	**1**	**8**	**0**	**0**	**1**	**8**
15	I have used psychotherapy and found it helpful	**0**	**2**	**5**	**2**	**0**	**3**	**2**	**4**
16	I know others who used psychotherapy and found it helpful	**0**	**2**	**4**	**3**	**0**	**0**	**5**	**4**
17	I would never use psychotherapy	**8**	**1**	**0**	**0**	**8**	**1**	**0**	**0**
18	I encourage my members to use psychotherapy	**0**	**1**	**4**	**3**	**1**	**1**	**6**	**1**
19	I would not refer my members to psychotherapy	**5**	**4**	**0**	**0**	**8**	**1**	**0**	**0**
20	My members want to use psychotherapy	**0**	**3**	**2**	**2**	**0**	**2**	**7**	**0**
21	My members do not want to use psychotherapy	**1**	**3**	**2**	**1**	**3**	**3**	**3**	**0**
22	Psychotherapy can help persons who have relationship issues	**0**	**0**	**6**	**2**	**0**	**0**	**4**	**5**
23	My ministry members trust me to refer them to psychotherapy if needed	**0**	**0**	**6**	**2**	**0**	**0**	**5**	**4**
24	I know when to refer to psychotherapy	**0**	**3**	**2**	**3**	**0**	**1**	**7**	**1**

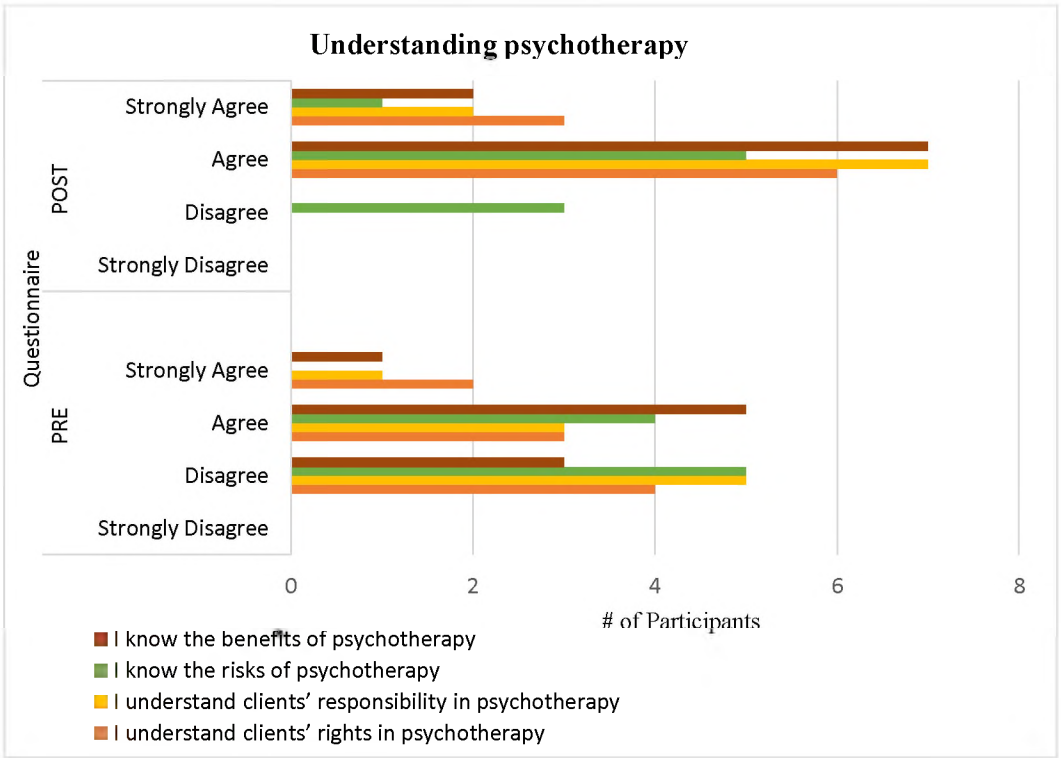
	Rating: 1= Strongly Disagree. 2= Disagree. 3= Agree. 4= Strongly Agree	*1*	*2*	*3*	*4*		*1*	*2*	*3*	*4*
	QUESTIONS	**No. of Participants Pre-questionnaire**					**No. of Participants Post-questionnaire**			
25	I know the difference between counselling and psychotherapy	**1**	**3**	**4**	**1**		**0**	**1**	**6**	**2**
26	When I refer my members, I need to know what is happening in the sessions	**4**	**3**	**2**	**0**		**6**	**3**	**0**	**0**
27	I understand what confidentiality in psychotherapy means	**0**	**0**	**4**	**5**		**0**	**0**	**1**	**8**
28	I understand exceptions to confidentiality	**0**	**0**	**4**	**5**		**0**	**0**	**2**	**7**
29	I understand duty to report (that is, having to report to authorities when certain vulnerable persons e.g., children are at risk or being abused)	**0**	**0**	**3**	**6**		**0**	**0**	**1**	**8**
30	I understand informed consent	**0**	**0**	**4**	**5**		**0**	**0**	**3**	**6**
31	I understand clients' rights in psychotherapy	**0**	**4**	**3**	**2**		**0**	**0**	**6**	**3**
32	I understand clients' responsibility in psychotherapy	**0**	**5**	**3**	**1**		**0**	**0**	**7**	**2**
33	I know the risks of psychotherapy	**0**	**5**	**4**	**0**		**0**	**3**	**5**	**1**
34	I know the benefits of psychotherapy	**0**	**3**	**5**	**1**		**0**	**0**	**7**	**2**
35	I have a good idea of the current cost of psychotherapy	**1**	**4**	**3**	**1**		**1**	**1**	**5**	**2**
36	I understand that clients may access psychotherapy on-line	**0**	**3**	**4**	**2**		**0**	**0**	**5**	**4**
37	I know of the Tyndale Wellness Centre	**1**	**3**	**3**	**2**		**0**	**0**	**5**	**4**
38	I know how to refer members to Tyndale Wellness Centre	**1**	**4**	**1**	**3**		**0**	**0**	**5**	**4**
39	I have referred members to Tyndale Wellness Centre	**2**	**3**	**1**	**3**		**2**	**3**	**1**	**3**
40	I would like to know more about referring members to Tyndale Wellness Centre	**0**	**1**	**6**	**2**		**1**	**2**	**4**	**2**

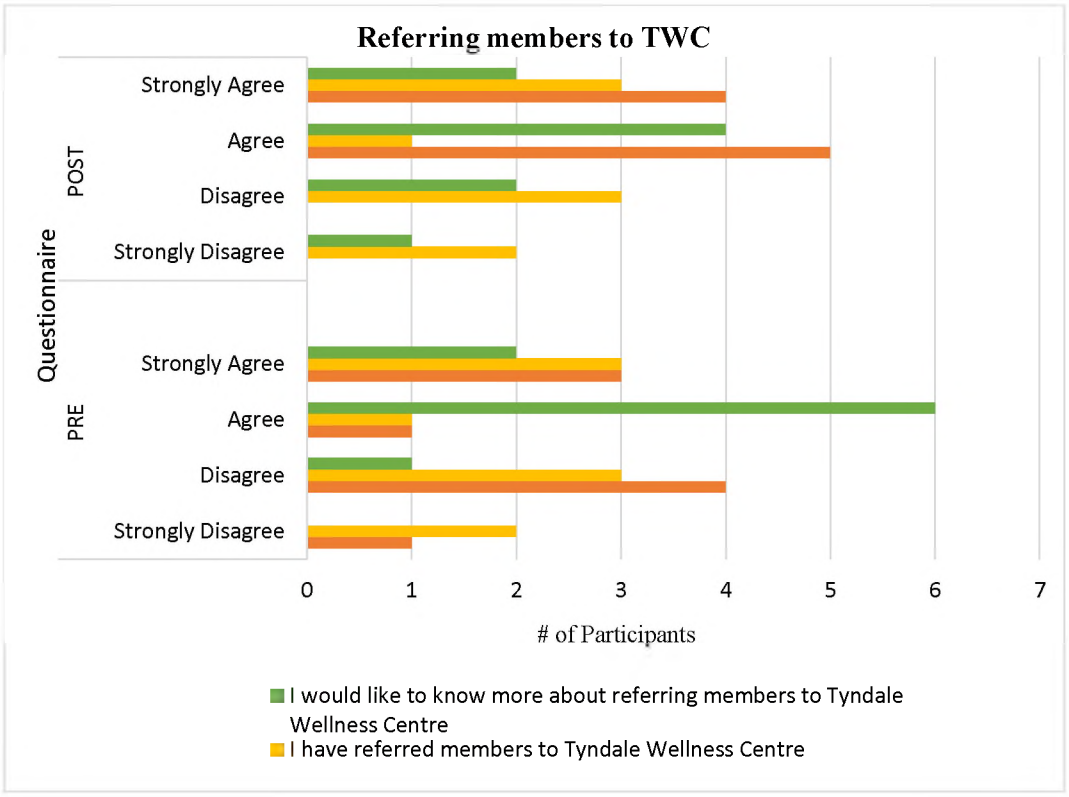
Appendix 9: Bar Charts Showing Pre/Post-Questionnaire Changes in Selected Areas

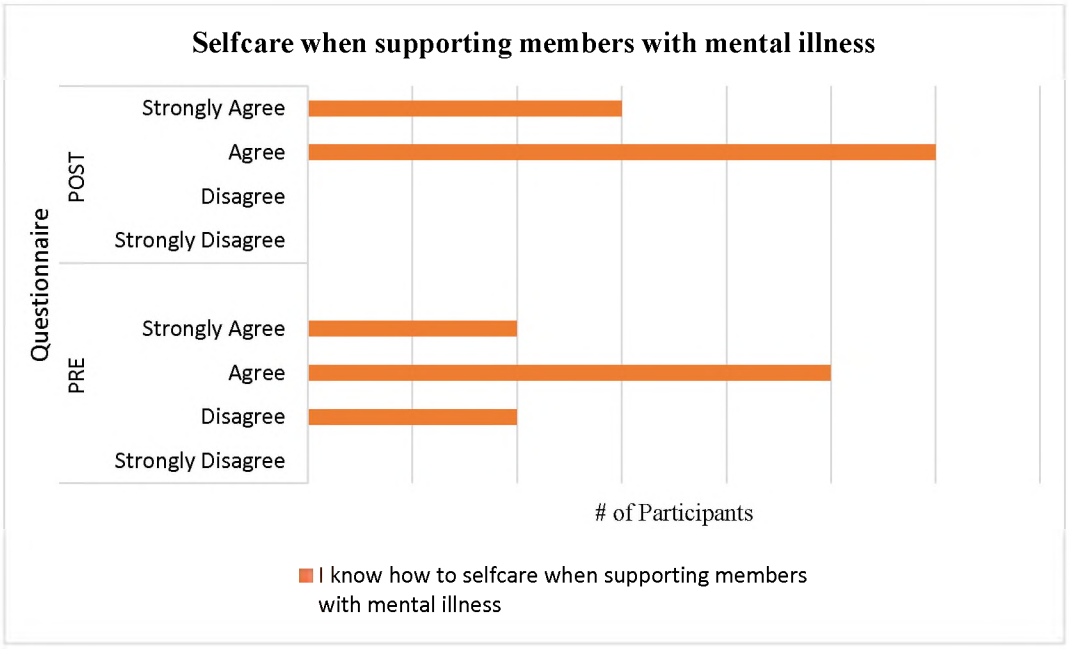


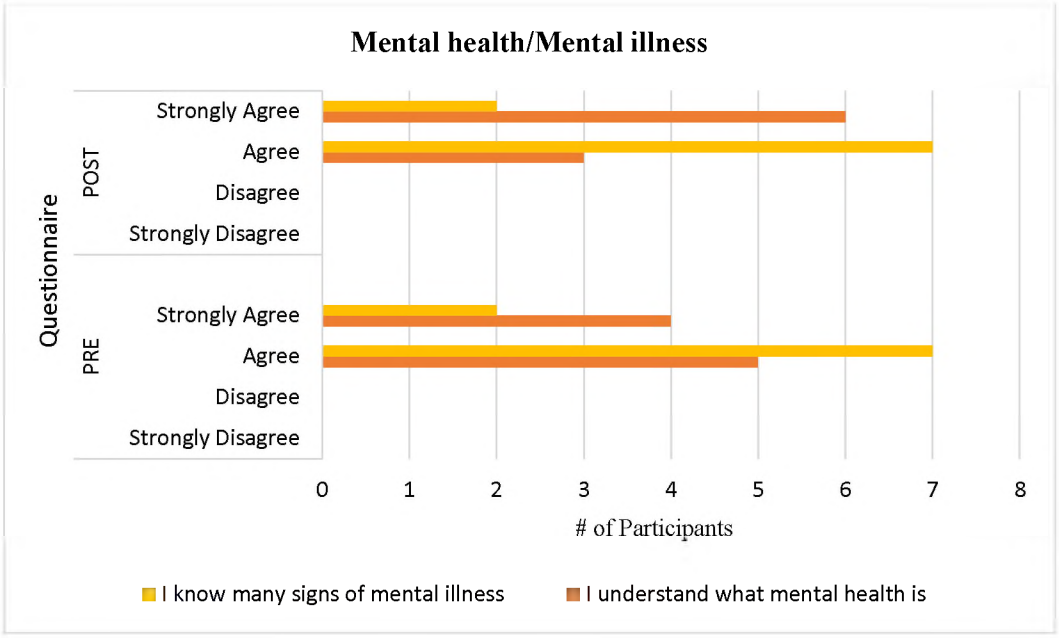


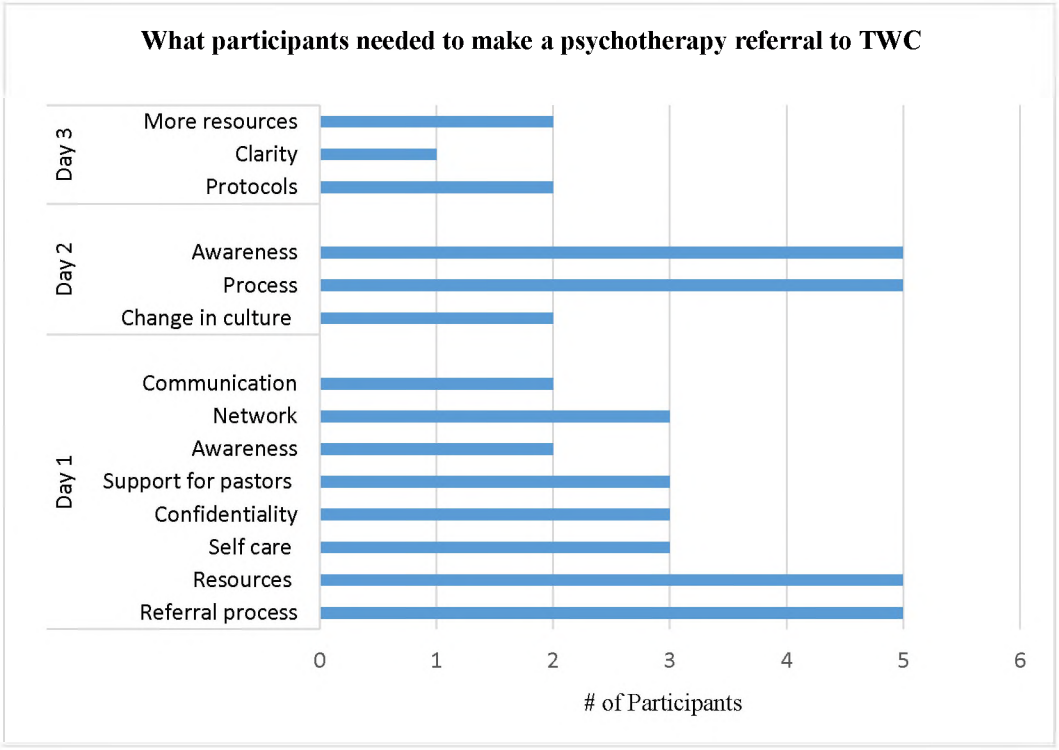

Understanding psychotherapy
Questionnaire
POST
PRE
Strongly Agree
Agree
Disagree
Strongly Disagree
0
2
4
6
8
10
# of Participants
I understand informed consent
I understand duty to report
I understand exceptions to confidentiality
I understand confidentiality in psychotherapy


Understanding psychotherapy
Questionnaire
POST
PRE
Strongly Agree
Agree
Disagree
Strongly Disagree
0
2
4
6
8
# of Participants
I know the benefits of psychotherapy
I know the risks of psychotherapy
I understand clients' responsibility in psychotherapy
I understand clients' rights in psychotherapy


Referring members to TWC
Questionnaire
POST
PRE
Strongly Agree
Agree
Disagree
Strongly Disagree
Strongly Agree
Agree
Disagree
Strongly Disagree
0
1
2
3
4
5
6
7
# of Participants
I would like to know more about referring members to Tyndale Wellness Centre
I have referred members to Tyndale Wellness Centre


Selfcare when supporting members with mental illness
Questionnaire
POST
PRE
Strongly Agree
Agree
Disagree
Strongly Disagree
Strongly Agree
Agree
Disagree
Strongly Disagree
# of Participants
I know how to selfcare when supporting members with mental illness


Mental health/Mental illness
Questionnaire
POST
PRE
Strongly Agree
Agree
Disagree
Strongly Disagree
Strongly Agree
Agree
Disagree
Strongly Disagree
0
1
2
3
4
5
6
7
8
# of Participants
I know many signs of mental illness
I understand what mental health is


What participants needed to make a psychotherapy referral to TWC
Day 3
Day 2
Day 1
More resources
Clarity
Protocols
Awareness
Process
Change in culture
Communication
Network
Awareness
Support for pastors
Confidentiality
Self care
Resources
Referral process
0
1
2
3
4
5
6
# of Participants

Appendix 10: Research Phases and Timetable (June 2022 – November 2022)

Phase	Who	What	When	How	Status
Phase 1 Preparation		Action Research Proposal	Oct 2021-Feb 2022	Completing related assignments	Completed
	Manager (Provost)	Updated provost on plans for research and got written consent	Dec 2021	Email	Completed
	TWC Super-visor Team	Provided information on Research, got views on needs of ministry leaders, potential training topics, value of research, potential conflict of interest	Nov /Dec 2021	Conversation in supervision meetings	Completed
	Researcher	Got approval from APA for use of material for training	Dec 2021	Email thread	Completed
	Ministry leaders in GTA	Began preliminary conversations about the research to gauge interest in participation and document results.	Dec 2021-Feb 2022	Individual telephone/email/in person conversations	Completed
	Researcher	Preparation of tentative topics for training	Dec 2021 - June 2022	Used information from ministry leaders, supervisors, and resources on mental health and faith leaders	Completed
	Researcher	Tentative training schedule	Dec 2021-June 2022	Used availability of researcher	Completed
Phase 2 Recruiting Participants	Researcher	Invitation with information, consent, questionnaire for the research to potential participants	June 2022	Emailed potential participants and followed up with telephone calls to answer questions that arose.	Completed
	Researcher	Prepared preliminary / tentative training modules	June - July 2022	Finalize presenter /literature for topics and prepare tentative outline	Completed
	Partici-pants		July	Complete and return questionnaires	Completed

Phase	Who	What	When	How	Status
Phase 3 Preliminary Data Analysis & Training revision	Researcher	Analyzed responses to pre-questionnaire and interviews to provide feedback for training	July 2022	Used spreadsheet of questions & answers from prequestionnaires, used Statistical analysis of questionnaire – frequency, mode	Completed
	Researcher	Feedback to participants on initial training based on prequestionnaire responses	July 2022	Email to participants giving preliminary feedback on pre-questionnaire / survey information and requesting choice to days & times for training.	Completed
	Partici-pants	Chose times/dates for training sessions	Aug 2022	Chose days and times for training sessions and start date	Completed
	Researcher	Arrangement for Interviews/conversation	Aug 2022	Emailed participants requesting a conversation to clarify the details of the research and answer questions/ concerns	Completed
	Researcher	Interviewed Participants	Aug 2022	Zoom / email conversation with each participant – clarifying the research details, consent signed, process, power differential, collaborative nature of the project, finalize training dates and times, agreement to record Zoom sessions	Completed

Phase	Who	What	When	How	Status
	Researcher	Post-questionnaire	Oct 2022	Emails post-questionnaire to participants	Completed
	Partici-pants	Post-questionnaire completion	Oct 2022	Participants completed and emailed post-questionnaire	Completed
	Researcher	Analyzed during training sessions	Sep - Oct 2022	Used first cycle coding during training sessions to highlight important, repeated, behavioural information	Completed
	Researcher	Analyzed training sessions, to notes and observations and post-questionnaire	Oct - Nov 2022	Using Excel spreadsheet to code training sessions, researcher's notes and observations, and post-questionnaire Statistical analysis – frequency and mode	Completed
	Researcher	Thank you letter and next steps note	Oct 2022	Emailed thank-you and plan to be informed of the outcome and next steps	Completed
Phase 4 Final Analysis & Evaluations	Researcher	Evaluation and Outcomes	Oct - Nov 2022		Completed

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