Towards a Christian Perspective on Mental Illness

By Brad Hambrick, Pastor Counseling at The Summit Church

This is a difficult subject to address, because of its complexity and highly personal nature. Everyone is affected by mental illness; either personally or someone they love. People you care about have experienced depression, ADD, addiction, bipolar, or other mental health struggle. For you the phrase "mental illness" may be a safe haven of explanation, a label that carries stigma, or a mystery that is hard to understand.

This is why mental illness is a subject that must be discussed in the church; otherwise, *our silence hurts people by leaving them to struggle in isolation*. How does the mind relate to the body? How do our emotions relate to our faith? These are important questions that everyone grapples with and are essential to holistic discipleship.

This is merely an attempt at "a" Christian perspective; not "the" Christian perspective. I believe there are others who, based upon personal experience, professional expertise, or doctrinal background, can and hopefully will add to this discussion. My desire is to start a conversation rather than speak the final word.

This presentation is a "perspective on" more than a "response to" mental illness. Christians have a response to sin, injustice, and other moral matters that we oppose and seek to eliminate. Christians have a perspective on politics, calamities, and other experiences in which we want to influence or offer care. My goal is to influence conversations about mental illness in the church and, thereby, equip us to be more skilled at caring for one another.

For the moment, I will defer an attempt at defining mental illness. At this point, it is enough to say that it is a term on which even the experts disagree; that this is a large part of what makes this conversation difficult. When the central term in any discussion lacks a clear definition, the rest of the conversation will always be challenging.

Let me state one important assumption before we begin; an assumption that I anticipate most readers want to know in order to determine whose "team" I am on or what my "agenda" is in writing:

> I am assuming there are a relatively equal number of people who avoid getting help (i.e., counseling or medication) because of the stigma of mental illness as there are people who use the labels of mental illness as a crutch to avoid taking responsibility for important choices in their life.

Whether the two groups divide into a neat 50-50 split in the culture at-large or in your specific circle of relationships, I believe it is generally agreed that there are a large number of people in both camps. Too often, discussions like this one are intended only to change the perspective of one side of the issue. This, I believe, biases those presentations.

My attempt is to be balanced by acknowledging both sides. This will make some parts of the presentation more tedious as we examine questions from both sides. One-sided presentations have the advantage of being simpler and clearer. But, in this case, the result of being one-sided would make the presentation simplistic.

How to Read this Article

It is important for you to know that this resource is intended to take you on a journey more than give you an answer. We will be trying answer the question, "How would I arrive at an accurate understanding of my struggle?" more than satisfying the expectation, "You're going to tell me what the Bible says about each mental illness struggle."

In order to use this resource effectively, it will require using it to catalyze conversations with other people. You will gain questions and categories to help you interact with friends, counselors, pastors, and doctors in your pursuit and maintenance of mental health. To take the journey outlined in this resource you'll need the perspective, support, encouragement, and expertise these people can provide.

Finally, take your time as you read. This journey covers complex terrain. But there are three markers I would suggest as the key touch points for this journey. My goals for the reader are: (1) to be able to understand the Venn diagram on page seven, so (2)

you can wisely assess question three about medication, in order to (3) equip the church to be more effective a living out the answer to question four. The rest of the article is important information to accomplish these objectives.

A Starting Point – Good Questions

When engaging a difficult and highly personal subject, it is better to start with good questions than a list of answers. The better our questions are, the more responsibly we will utilize the answers of which we are confidant, the more humbly we will approach areas of uncertainty, and the more we will honor one another in the process of learning.

As I've read, counseled, and thought about the subject of mental illness, here are some of the questions that have emerged. Feel free to skim these questions. It would be easy to become overwhelmed and get bogged down.

The purpose of these questions is to expand our thinking about mental illness. We all bring a "theory of mental illness" to this discussion. This theory, whether we can articulate it or not, shapes the questions we ask. Exposing ourselves to important questions from other perspectives is the first step in becoming more holistic in our approach.

- Is mental illness a flaw in character or chemistry? Is this the best way to frame the question? What do we lose when we fall into the trap of either-or thinking?

- Why do we think of genetic influences as if they negate the role of the will or personal choice? Substance abuse can have a clear genetic predisposition, but every addiction program – even those most committed to a disease model – appeal to the will as a key component to sobriety.

- In the modern psychological proverb, "The *genes* load the gun, and the *environment* pulls the trigger," where is the *person*? How do we best understand the interplay of predisposition (genetics), influences (environment), and the individual making choices (person)?

- What percent of those who struggle with "normal sorrow" are labeled as clinically depressed? What percentage of those who think their sorrow is normal are actually clinically depressed? How do we communicate effectively when the same word – depression – has both a clinical and popular usage?[1]

  > "There is concern that the way we make the diagnosis will apply the label of depressed to many who actually have emotional struggles but no disease (p. 13)." Charles Hodges, M.D. in *Good Mood Bad Mood*

- Would we want to eradicate all anxiety and depression if we were medically capable of doing so? What would we lose, that was good about life and relationships, if these unpleasant emotions were eradicated from human experience? Would that be heaven-on-earth or have unintended consequences that are greater than our current dilemma?

- Can we have a "weak" brain—one given to problematic emotions or difficulty discerning reality—and a "strong" soul—one with a deep and genuine love for God? If we say "yes" to this question in areas like intelligence (e.g., low IQ and strong faith), would there be any reason to say "no" about those things described as mental illness?

  > "Most of the man's psychological makeup is probably due to his body: when his body dies all that will fall off him, and the real central man, the thing that chose, that made the best or the worst of this raw material, will stand naked. All sorts of nice things we thought our own, but which were really due to a good digestion, will fall off some of us; all sorts of nasty things which were due to complexes or bad health will fall off others. We shall then, for the first time, see every one as he really was. There will be surprises (p. 91-92)." C.S. Lewis in *Mere Christianity*

- When do labels serve well (i.e., offering a sense of hope by breaking the sense of isolation and shame that comes with believing "my struggle is completely unique") and when do they serve poorly (i.e., diminishing hope by creating a sense

[1] This question is developed further at http://www.bradhambrick.com/the-role-of-language-in-the-stigma-of-mental-illness/.

of determinism and stigma)? How free should a counselor be to choose whether to use or not to use labels based upon these potential benefits and detriments for a given individual?

- What is happening when we "think" and "feel"? Are these experiences merely random neurological fireworks, the soul talking to itself using the physical organ of the brain like an internal telephone, or something else?

> "It is as if the heart always leaves its footprints in the brain… The Bible predicts that what goes on in the heart is represented physically. But the Bible would clarify that such differences do not prove that the brain caused the thoughts and actions. It may very well be the opposite. Brain changes may be caused by these behaviors (p. 48)." Ed Welch in *Blame It on the Brain?*

- Is mental illness a physical event with spiritual side effects or a spiritual event with physical side effects; do choices-emotions trigger biology or biology trigger choices-emotions?

- How do we best assess when the relief of medication would decrease the motivation to change versus when that same relief would increase the possibility of change? Pain can both motivate and overwhelm; is this simply about personal thresholds or should mental anguish be evaluated by a different set of criteria?

- Are our emotions more than the alarm system of the soul (moral) and the chemicals of our brain (biological)? Do these two categories tell us everything we need to know about emotions? Are these categories complimentary or competitive with one another?

- Can we have a collective disease? Is mental illness always personal or can it be cultural? Cultural changes necessarily add to or detract from the kind of stresses that influence mental illness. How should we understand this influence and when might an "epidemic" require a collective solution as much as personal choices?

- Why are we, culturally, more open about almost everything in our lives than we were a generation ago except mental illness? Why does this stigma / prejudice maintain its socially-accepted status when most others have been rejected?

> "The mentally ill are one group of handicapped people against whom it still seems to be socially acceptable to hold prejudice (p. 36)." Kathryn Greene-McCreight in *Darkness Is My Only Companion*

- Are we trying to medically create an idyllic sanguine personality? Is "normal" becoming too emotionally narrow? If not in the medical establishment, then are societal norms pushing people in this direction and the service-oriented medical profession trying to accommodate its well-intended, but misguided clientele?

> "The consumer model to which medicine seems to be uncritically adopting pursuance is providing what the patient wants—that is, customer satisfaction in matters of health—is the measure of success (p. 26)." Joel Shuman and Brian Volck, M.D. in *Reclaiming the Body: Christians and the Faithful Use of Modern Medicine*

- Does the alleviation of symptoms with medication always mean we are curing a disease? We medically treat the symptoms of many diseases and non-diseases to provide relief. This is good. Why have we allowed the debate over the disease model for mental illness to polarize the conversation about the roles of medication can play in mental health?

- How should we understand the effects of the Fall on the mind and brain? We know our bodies age and die. We know all of our organs are susceptible to disease and deterioration. We have "norms" for the frequency, duration, onset, and prognosis of these effects of the Fall; what are the equivalent expectations for the mind and brain?

> "As the brain is the most complex organ in our body, it is liable to be the most affected of all our organs by the Fall and the divine curse on our bodies (p. 64)." David Murray in *Christians Get Depressed Too*

- How do we understand the tension between "already" and "not yet" with regards to the health, development, and preservation of the mind? How much should we expect to be able to remedy the effects of the Fall upon the mind prior to the ultimate redemption that will occur when Christ returns (Revelation 21:4)?

- How much should we expect conversion and normal sanctification (spiritual maturity) to impact mental illness? Outside of medical interventions, most secular treatments for mental illness focus on healthy-thinking, healthy-choices, and healthy-relationships; so how much should Christians expect sound-doctrine, righteous-living, and biblical-community to impact their struggle with mental illness?

Don't allow these questions to overwhelm you. All of these questions existed before you read them. Speaking them didn't create them. Actually, an appropriate response to this list would be the generation of more questions. Take a moment to write down the additional questions you have.

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What do we gain from asking good questions? Humility. Humility may be more vital for this conversation than most other conversations we have. Why? Because the neurological, genetic, and medical research that have prompted many of these questions is still in its infancy. What we "know" in these areas will likely seem as outdated as a VHS tape 10 years from now.

> "It is very likely that in the future, with increased research into depression and also increased understanding of the Bible's teaching, much of the current confident certainty, which presently masquerades as biblical or medical expertise, will also look ridiculous, cruel, and even horrifying (p. 12)." David Murray in *Christians Get Depressed Too*

But if the Bible is timeless, do research developments in these areas matter? Yes. Not because new scientific discoveries will change what the Bible means, but those discoveries will likely change our application of the Bible. Did the discovery of epileptic seizures change the truthfulness of the Bible? No. But it did help Christians understand that these were not demonic events. It is likely, if God should tarry, that many similar discoveries will emerge in the area of mental illness.

What Is Mental Illness?

We can't put this question off any longer. What are we talking about anyway? What is mental illness? As close as we can get to an accepted definition would be the one given in the Diagnostic and Statistical Manual: 5th Edition (DSM-V) by the American Psychiatric Association (APA):

> "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."

But the accuracy and benefits of this definition are debated, even amongst various groups within secular psychology and psychiatry. That is why it is easy to find nuances of and alternatives to this definition. After the examples below, I will highlight the modifications each organization or author made to the DSM-V definition.

> "A mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning." National Alliance on Mental Illness[2]
>
> - Notice the narrowed declaration that mental illness is a medical condition.
>
> "Mental illness refers to a wide range of mental health conditions — disorders that affect your mood, thinking and behavior… Many people have mental health concerns from time to time. But a mental health concern becomes a mental illness when ongoing signs and symptoms cause frequent stress and affect your ability to function." The Mayo Clinic[3]

[2] http://www.nami.org/Template.cfm?Section=By_Illness

- Notice the desire to differentiate normal emotional struggles from those that are clinically significant.

"A disorder of the brain resulting in the disruption of a person's thoughts, feelings, moods, and ability to relate to others that is severe enough to require psychological or psychiatric intervention (p. 43-44)." Matthew Stanford in *Grace for the Afflicted: A Clinical and Biblical Perspective on Mental Illness*

- Notice the desire to locate the problem only in the physical organ of the brain (also in next definition).

"A group of brain disorders that cause severe disturbances in thinking, feeling, and relating, often resulting in an inability to cope with the ordinary demands of life (p. 17)." Marcia Lund in *When Your Family Is Living With Mental Illness*

"A mental illness can be defined as a health condition that changes a person's thinking, feelings, or behavior (or all three) and that causes the person distress and difficulty in functioning. As with many diseases, mental illness is severe in some cases and mild in others. Not all brain diseases are categorized as mental illnesses. Disorders such as epilepsy, Parkinson's disease, and multiple sclerosis are brain disorders, but they are considered neurological diseases rather than mental illnesses. Interestingly, the lines between mental illnesses and these other brain or neurological disorders is blurring somewhat. As scientists continue to investigate the brains of people who have mental illnesses, they are learning that mental illness is associated with changes in the brain's structure, chemistry, and function and that mental illness does indeed have a biological basis. This ongoing research is, in some ways, causing scientists to minimize the distinctions between mental illnesses and these other brain disorders." National Institute on Mental Health[4]

- Notice the care taken to differentiate that there are brain problems that are not mental illness; the mind is not considered co-terminus with the brain, but an acknowledgement that the mind and brain are so interwoven that it is often difficult to distinguish where the cause for a given struggle may be.

Where do these definitions agree? There is one main point of agreement.

In order to qualify as a mental illness the life-struggle must "impair life functioning." This reveals that the struggles known as mental illness exist on a spectrum; almost everyone will struggle with these challenges to some degree. However, there comes a point on the spectrum where life is impaired to a degree that it seems wise to classify this struggle differently.

Mental illness means that a common struggle has crossed a threshold and become "clinically significant." The term is an assessment that outside help is needed; that (a) the passing of time and (b) continuing in the same life pattern will not result in the desired relief from these struggles.

This means, whatever mental illness is, it usually has more in common with sun sensitivity (a common experience that can be severe enough for some people to require specialized intervention) than it does to Chrohn's disease (an uncommon experience that is only known by a small percentage of the population).

In this sense, what is unique to the person who experiences mental illness is not the experience itself, but the intensity and/or duration of the experience. What is shared in common by these definitions helps us forego an "us-them mentality" that fuels much of the stigmatization of mental illness.

Where do these definitions differ? We will consider two key points of difference.

First, some definitions seem very concerned to identify the location of mental illness in the physical organ of the brain. Other definitions seem less concerned with defining one single location for the struggle. The latter seems wise:

- Many instances of depression are rooted in the glandular system more than the brain.
- Often, with a brain-only focus, attention is exclusively given to brain chemistry to the neglect of neural pathways; which are not treated with psychotropic medications and have more to do with habituation.
- The role genetics plays in some forms of mental illness can be lost by an exclusive brain focus.

[3] http://www.mayoclinic.com/health/mental-illness/DS01104

[4] http://science.education.nih.gov/supplements/nih5/mental/guide/info-mental-a.htm

- A brain-only focus can reduce our "humanity," and inadvertently our value, to the strength of our frontal lobe – the aspect of human neural anatomy that is most distinct from other creatures.
- A brain-only focus can distract us from the beneficial influence of exercise, sleep, and other healthy practices; which not only improve brain chemistry, but also improve our quality of mental-emotional-social life through other body systems.

Yes, we want to continue to grow in our understanding of the brain's role in our emotions. But we must realize there is a modern temptation to reduce people to their brains, which parallels the historic temptation of the church to reduce people to their souls. Whenever we allow one facet of our humanity to trump all others, we become blind to other important factors. We become excellent in the things we do well, but dangerous because of the things we fail to consider or give their full weight.

Second, some definitions seem content with the broader term "syndrome" while others want to use the more narrow term "disease." Consider the difference in these two definitions.

1. Syndrome: "a group of signs and symptoms that occur together and characterize a particular abnormality or condition."[5]
2. Disease: "an impairment of the normal state of the living animal or plant body or one of its parts that interrupts or modifies the performance of the vital functions, is typically manifested by distinguishing signs and symptoms, and is a response to environmental factors (as malnutrition, industrial hazards, or climate), to specific infective agents (as worms, bacteria, or viruses), to inherent defects of the organism (as genetic anomalies), or to combinations of these factors."[6]

Disease implies a known and verifiable cause. *Syndrome* is merely a group of recognizable symptoms. With the multitude of factors that can result in depression, anxiety, inattention, addiction, and other experiences commonly called mental illness, it is seems wiser to call mental illness a syndrome rather than a disease.

Is this an attempt to somehow caution people against the use of medication?

No. It is merely an attempt to adjust people's initial expectations of medication; from curing a problem to relieving symptoms until the cause of their struggle can be identified. The present reality is that our prescriptive science (those things we can modify with medication and other biological-influencing treatments) is ahead of our diagnostic science (our ability to verify and measure the things we are modifying).

This expectation-management is important for several reasons. First, understanding a syndrome as a disease can give a false hope for medication; for those who are in an emotionally-fragile state this can be a dangerous thing to do. Second, with a syndrome a medication can be utilized while recognizing that the cause has not yet been found; "symptom alleviation" is a good thing for a syndrome because it reduces suffering while leaving room for continued efforts to identify the cause.[7]

So, after this discussion, how are we defining "mental illness" in this presentation?

> Mental illness is a life struggle, which is common to all people to some degree, that significantly (degree of impact) and persistently (duration of influence) impairs an individual's mental-social-emotional ability to function. With the exception of responses to trauma, this impairment is beyond a normal response to their life circumstances. The strengths and weaknesses associated with particular personality qualities and aptitudes are not mental illness.
>
> Mental illness may have its cause in the physical body (i.e., brain chemistry, habituated neural pathways, genetics, glandular system, viral or bacterial infection, etc…), environmental causes (i.e., trauma, poor socialization, abusive-neglectful home life, etc…), personal choices (i.e., the consequences of sinful or foolish decisions on a spectrum from isolated bad choices with significant emotional-relational implication to addiction), or a combination of these causes.
>
> The primary declaration made by the term mental illness is outside help is needed because the passing of time is unlikely to produce the desired decrease of symptoms. Based on this definition of mental illness any number of soul-body

[5] http://www.merriam-webster.com/medical/syndrome

[6] http://www.merriam-webster.com/medical/disease

[7] Later in this presentation we will propose a process for assessing the wise use of medication.

physician-counselors may be relevant and effective in assisting the process of change. A mental illness may be a true disease, a syndrome, or a consequence of life choices / circumstances.

This definition seeks to protect the distinction between "normal day-to-day emotional struggles" and "mental illness," and, thereby, protect against over-diagnosis and prescription. At the same time, this definition seeks to acknowledge that the symptoms of mental illness are commonly experienced by every person; recognizing that the symptoms of mental illness are not the mental-emotional equivalent of a sixth sense or third arm. This protects against stigmatizing those who struggle with mental illness like emotional mutants in a therapeutic X-Men movie.

The bullet points below clarify key points in this definition.

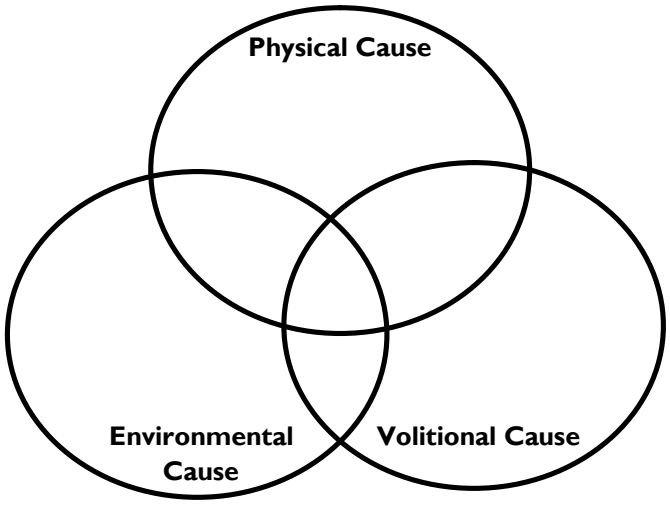
- Common to all people – emotional regulation, reality testing, and social awareness are struggles all people face
- Degree of impact – in order to qualify as a mental illness a struggle must impair someone's ability to function
- Duration of influence – in order to qualify as mental illness a struggle must last longer than is normal for its trigger
- Outside personality trait and aptitudes – the advantages or disadvantages of particular personality types or aptitudes should not be confused with mental illness
- No one universal cause – our cognitive-emotional systems and struggles are too complex to reduce to a single cause
- Multiple relevant helpers – the term mental illness should not result in an exclusive or restricted domain of helping relationships; effective care for complex problems will cover the spectrum of formal to informal care

An Assessment Exercise

To help you assess how you currently think about mental illness, let me invite you to participate in an exercise. Take the list of struggles commonly known as mental illnesses and place them in the appropriate place on the Venn diagram below. Use the overlapping segments of the circles to indicate where you believe there are multiple causal factors involved.

If any of these terms are new or confusing to you, ignore them and practice with the one's you already know. This is not the time to expand your therapeutic vocabulary.

Alzheimer's Disease
Anorexia and Bulimia
Anti-Social Personality Disorder
Anxiety
Asperger's Disorder
Attention Deficit Disorder
Bipolar Disorder
Compulsive Gambling
Depression
Dyslexia
Hallucinations
Narcissism
Obsessive-Compulsive Disorder
Paranoia
Post-Traumatic Stress Disorder
Post-Partum Depression
Pyromania
Schizophrenia
Seasonal Affective Disorder
Social Anxiety Disorder
Sleep Disorders
Substance Abuse / Addiction



> "Christians don't understand how physical, psychological, and spiritual realms interrelate because Satan muddies the boundaries. Many of our troubles are caused because we think a problem is spiritual when it is physical or we think a problem is physical when it is emotional or spiritual (p. 207-208)." D. Martyn Lloyd-Jones in *The Christian Warfare*

As you seek to identify the primary or initial cause of each struggle, many of them naturally find their place.

- Post-traumatic stress is clearly caused by the environmental influences.
- Substance abuse and addiction begin with choices by the individual that become life-dominating.
- Post-partum depression is obviously rooted in physical changes and stresses related to pregnancy and child birth.

However, others seem to almost always overlap in their origin.

- Anti-Social Personality Disorder involves many personal choices but also correlates strongly with a harsh upbringing.
- Attention Deficit Disorder has strong influences from both biology (brain) and environment (parenting and stimulation related to technological entertainment).
- Obsessive Compulsive Disorder appears to be rooted in both brain physiology and personal choices-beliefs-values.

We begin to see that other struggles may be caused by any one or all three of these areas.

- Depression-related struggles can have their origin in any or all of these circles.
- Anxiety-related struggles can have their origin in any or all of these circles.
- Sleep disorders can have their origin in any of these circles.

To complicate things further, the same individual can have multiple struggles (i.e., post-traumatic stress, a learning disability, and substance abuse), each of which have different origins but which feed into one another. How to prioritize multiple diagnoses goes beyond the scope of this presentation. But it reminds us that people are never as neat as whatever categories we devise to understand them.

If it is this complicated, should the church (or any group of non-professional people) take an always-refer position that limits meaningful conversation about this subject? No, that would be unhelpful, unloving, and impossible. Why?

1. We all have a theory of mental illness whether it is a good-accurate one or not.
2. We struggle. This is not an us-them subject. We will all face these types of struggles at some point.
3. Our everyday conversations pass along some culture and "common sense" about mental illness.
4. For better or worse, people take what they learn in the church and apply it to their mental illness.
5. Simplistic hope (hope that is simpler than reality permits) is actually a false hope and the church, of all institutions, wants to be leery of offering false hope (Jeremiah 8:11).

If the church ignores this conversation, several negative consequences will be strengthened.

1. The stigma related to mental illness will be reinforced.
2. An excellent we all should have in the church – authentic and healthy relationships – will be negated.
3. The discussion of mental illness will continue to grow more professional and secular.
4. People will live as if God has little concern about their emotions, at least the unpleasant ones.
5. We will miss an important opportunity to disciple people on how to engage with sin and suffering in this world.

So now the question becomes, "How does the church, or a particular Christian, engage the subject of mental illness; their own and others? What do we do with what we've learned so far?"

Getting Practical

Theory is needed. We must have a good framework and categories for understanding complex issues. Hopefully, we have done a good job of laying that foundation. But theory is not enough. Theory must be applied to be helpful. In the remainder of this presentation we will turn our attention to four practical questions as a way to unpack implications of what we've discussed.

1. How would you identify if a struggle has primarily biological, environmental, or volitional causes?
2. What are the different spiritual ramifications for struggles rooted in biology, environment, or personal choice?
3. What is a good process for deciding when and how to use psychotropic medications as a tool for mental health?
4. How should the church be involved in caring for one another with mental health struggles?

Question 1:
Biology, Environment, or Volition

Let's begin by remembering that not everything that can be diagnosed or makes us stand out as unique is a problem.

- An "ideal graduate student" has mild OCD qualities – great attention to detail and drive for certainty.
- Many police officers say if they lost the hyper-vigilance of PTSD (persistent tendency to look for what is wrong), they would be less effective at their job.
- Mild mania – expansive thinking and energy for big goals – can be a very adaptive quality and is found in many great leaders; those who struggle with bipolar frequently have highly successful siblings or close family members.

So, as we look for the cause of particular struggles, we do not need to be exclusively problem-oriented. This is always an important caution for problem-oriented professions like counseling.

Additionally, because our weaknesses are often just exaggerated strengths, we can often feel shame where it is not needed and want to eliminate qualities God would prefer to see us refine.

- Without the ability to be anxious we would have a hard time anticipating the needs of others.
- Without depression our capacity to empathize with the struggles of others would be non-existent.
- Also, consider again the strengths in the examples of OCD, PTSD, and mild mania described above.

But whether we are looking for strengths or weaknesses, illness or health, it is still helpful to be able to distinguish between the biological, environmental, and volitional source of a trait. The first step in this process it to let go of our pre-set assumptions. Ed Welch's critique of medical explanation is true for spiritual and environmental explanations as well. Whenever we "know" where the "real answer" is found, it will make other questions seems silly.

> "The problem with immediately opting for a medical explanation is that, once the decision is made, every other perspective seems superficial or irrelevant (p. 30)." Ed Welch in *Depression, A Stubborn Darkness*

After you're open to the possibility of each causal explanation, begin with these questions (the order is intentional). Use these questions to guide conversations with your trusted friends, counselor, pastor, or doctor.

- When did this struggle begin?
- What events or changes occurred just before and after the struggle began (for children and teens include changes in their physical-emotional-social developmental stages)?
- Have I experienced this struggle before? If so, when and what did I learn?
- What are the most common / obvious / simplest explanations of this struggle?
- What potential causes can I most easily eliminate by simple life changes (i.e., getting more sleep) or tests (i.e., going to the doctor for a broad spectrum blood exam)?
- Who should I pursue to come alongside me in this assessment process?

To provide guidance as you answer these questions, consider the following characteristics indicative of struggles rooted in each of the three causative areas. Remember that often a particular struggle may have its cause rooted in more than one area.

Indicators of Volitional Causes

- Natural consequence of a sinful (immoral) or foolish (unwise) choice.
- Result of over commitment in order to please people or achieve goals on an unrealistic time table.

- Lack of clear life systems (e.g., budget, schedule, etc…) to allow you to make informed, cohesive decisions.
- Conflict between life goals (e.g., healthy marriage) and temporal choices (e.g., continuing unhealthy dating relationship).
- Destructive choices (e.g., inadequate sleep, substance abuse, etc…) which have a cumulative negative effect.
- Struggles over which greater self-control or concerns for others would legitimately reduce its impact.
- Expecting a level of satisfaction or meaning from activities or relationships which on God can provide.

What are other possible indicators of volitional causes for mental-emotional-relational struggles?

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Indicators of Environmental Causes

- Onset of the struggle near a traumatic event or major life transition.
- A family history that models unhealthy ways of handling relevant emotions or relationships.
- The presence of an unhealthy or unsafe dynamic in your environment or relationships.
- Bullying and rejection, especially when based upon characteristics over which an individual has no control.
- Physical or emotional stress can be an environmental trigger for struggles to which someone is genetically predisposed.

What are other possible indicators of environmental causes for mental-emotional-relational struggles?

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Indicators of Biological Causes

- A family history can reveal where an individual is predisposed to particular struggles.
- A side effect of many diseases, medications, or major surgeries can be changes in one's emotions.
- Aptitudes and attractiveness impacts mental health via the pportunities and acceptance these qualities provide.
- Onset of a struggle after the age of 40 with little to no history of the particular struggle.
- A significant change in an individual's personality with no circumstantial explanations.
- Chemical imbalances and neural pathways in the brain both cause and respond to emotions and choices.
- General health factors (i.e., stamina, weight, strength, diet, etc…) impact mental health and neural functioning.

What are other possible indicators of biological causes for mental-emotional-relational struggles?

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To help us understand this first subject a bit further, let's briefly consider four questions.

First, what did you learn from this exercise?

Chances are you discovered that most of life's struggles can be attributed to factors in all three arenas. That is to be expected – as people, our lives do not sub-divide neatly. People are a dynamic unity of body, soul, mind, will, spirit, social context, and environmental influences. This means "cause" will rarely be as easy to identify as we would like.

Second, what are we looking for when we assess causation or contributive causes?

We want to know the place or places where we can catch the most traction in the process of change. The purpose of discussing causation is not to debate theories, but to identify how we can be most effective in our efforts to change. There are always many good and healthy things we could do which would positively impact our struggle, but we want to know which is most likely to provide the most benefit for the longest tenure because it is addressing the core of the problem.

Third, if cause can be unclear or overlapping, does that hinder our ability to make progress?

Yes and no. Consider an example pertaining to the brain but outside the field of mental illness – migraine headaches. Scientists and doctors do not know the changes or damage that happens at the cellular level which cause migraine headaches.

No one doubts that migraines are a biological problem with strong environmental influences. It also means doctors are alleviating symptoms more than working towards a cure until greater scientific advances can be made.[8] Progress (i.e., pain relief through medicine and strategic decisions like avoiding allergens) can be made even if enough information does not exist to eliminate the problem. Even when the cause is unclear for a mental illness, similar forms of progress can be made.

Fourth, does identifying the cause always lead to a solution?

While identifying cause is a wise first step, no, it does not guarantee a solution; at least not to the degree that we often would like.

Often identifying the cause will point us in the direction to see near total redemption (alleviation of the struggle and opportunity to be used of God to bless others with what we learned in the experience). We use the information we derive from understanding causation to identity the most relevant truths, medications, insights, and life practices. We then experience and are able to more fully appreciate the health we longed for in our time of struggle.

Other times, struggles may still persist or return, even when we implement the truths, medicines, insights, and life practices that lessen their impact. For instance, events related to one's post-traumatic stress may still produce an elevated sense of unrest even after those events are processed in a healthy way.

Does this mean we should just give up because what we want is not guaranteed in full? No, but it does mean that we need to understand the nature of redemption and how it relates to our various struggles better. That is the subject of the next question.

Question 2:
Spiritual Ramifications for Each Type of Cause

Now we are faced with questions like:

- What does God require and the gospel offer in the change process for biological, environmental, and volition struggles?
- How moral are struggles commonly called mental illness?
- How much (i.e., percentages of the problem) can we change when our struggle is rooted in each of these areas?
- What type of change (e.g., eliminate struggle, change perspective, redeemed only in heaven, etc…) is possible?
- How much should becoming a Christian or living out Christian teaching impact mental illness?
- Is mental illness divine punishment, outside God's control / concern?
- Is it a sign of weak faith or idolatry (e.g., replacing God) to seek help for these struggles from secular sources?

If we seek to answer these questions with a one-size-fits-all answer we will help some people but hurt many others. This is where I believe my beginning assumption – that there are as many people who need to de-stigmatize mental illness as there are who need to de-gospelize psychology and medication – is most important. That is why as we seek to answer these questions, we need to locate the individual in at least two ways:

1. What kind of struggle is an individual facing (i.e., sin-based, suffering-based, or identity-based)?
2. What beliefs does this person hold about how faith, medicine, therapy, friends, or their choices should be able to fix it?

[8] Again, we usually we use a term like "syndrome" to describe those phenomena that we do not understand.

Let's engage the first question by asking, "What are the three types of struggle an individual can face?" From a biblical perspective, I believe it is most helpful to delineate three types of struggle.[9]

1. Sin Struggles – challenges we face because of our immoral choices or mis-prioritized allegiances.
2. Suffering Struggles – challenges we face because of living in a world marred by sin that is inhabited by other sinners.
3. Identity Struggles – challenges we face because we define ourselves by the wrong things or lack a sense of identity.

These do not directly correlate with the previous categories of biology, environment, and volition.

- Substance abuse (volition cause) is the result of personal, sinful choices, often is a self-medicating reaction to suffering, and has a strong tendency to become an identity – "Hello, my name is [blank] and I'm an alcoholic."
- Struggles of same sex attraction (often biological cause) are often an unwanted form of suffering, always a struggle of personal identity, and acting on these desires is biblically prohibited.
- Post-traumatic stress (environmental cause) is a reaction to intense suffering, often results in many sinful-destructive choices, and carries a stigma that can alter one's identity.

Let's take a look at each of the potential causes of mental illness and consider how the gospel speaks to each. This is where we will engage a counselee's expectations of self, others, and God in the change process.

Volitional: When we are discussing various diagnoses it is easy to forget that there is always an active-choosing person. Even when there is clearly an "it" to discuss (a literal, physical disease), "it" still needs a host and the choices of this person will have a great impact on the intensity, duration, social impact, and possible elimination of the struggle.

In terms of counseling (a conversation between two people aimed at improving life), this person-making-choices and person-giving-meaning-to-experiences is the focal point of interaction. Environment cannot always be changed. Medications cannot eliminate symptoms. But there are always lifestyle choices and personal beliefs that can be changed which will have a significant impact on one's mental health.

What are the gospel-implications for *volitional causes or influences* on mental illness?

- Each individual must bear the responsibility for any choice he/she made (Ezek. 18:19-20).
- There is forgiveness available for the guilt and shame associated with any destructive choice (Rom. 3:1-39).
- There is an identity available as a "child of God" that is stronger than the shame of any choice (Eph. 5:1-2).
- God empowers every Christian to be able to make healthy, righteous choices in any circumstance (Deut. 30:15-20).
- We are never tempted beyond what we are able to resist by the grace of God (I Cor. 10:13).

Environmental: Every struggle has a context and is influenced by its context. For example, Attention Deficit Disorder is influenced by many environmental factors: (a) modern education model of extended, lecture-based classes, (b) increased exposure to high-stimulatory technology, (c) growing parenting culture that de-emphasizes discipline, (d) diets filled with more sugar and caffeine, etc…[10]

Certain environments allow for optimal development, especially during the childhood and adolescent years when key changes in cognitive, social, and emotional formation are occurring. If an individual's environment is unhealthy during these seasons, the challenge of responding to life in a healthy way, or valuing what "healthy" would entail, is made much more difficult.

There are not only developmental influences of environment, but also stress influences. At any age the presence of real or perceived threats in one's surroundings will trigger a series of physiological responses in the body and brain. "The stress response" has numerous, well-documented adverse influences upon an individual's physical and mental health.

[9] I am borrowing these categories from Michael Emlet, M.Div., M.D. in *CrossTalk: Where Life & Scripture Meet* (particularly chapter 5) New Growth Press (2009).

[10] I am not trying to say that ADD is purely caused by environmental influences. I am using environmental examples because that is the subject of this section.

Many more examples could be given about environmental influences on mental health, but these serve the purpose of illustrating the point well enough for us to appreciate the gospel-implications for *environmental causes or influences* on mental illness.

- Scripture recognizes the validity of our environment's influence upon our choices and emotions (various Bible narratives and psalms have too many references to significant environmental influences to list).
- God calls His people to be salt and light in environments in need of redemption (Matt. 5:13-16).
- God also allows, even commands at times, individuals to remove themselves from toxic environments (Matt. 7:6).
- God warns us against automatically interpreting unpleasant circumstances as punishment (Matt. 5:44-45).
- God promises to be with us in the midst of hard circumstances (Heb. 13:5-6).
- God knows and can sympathize with us whatever our circumstances (Heb. 4:14-16).
- God calls his church to be His body to care for individuals who are in difficult circumstances (Rom. 12:9-13).

Biological: Everything that we think, do, and feel registers a biological expression in our body and brain. Whether this biological expression is the cause or result of our choice, thought, or emotions can often be difficult to discern – the modern version of the common question, "Which came first, the chicken or the egg; the emotion or its neurological expression?" Unfortunately, people tend to be much more confidant of their emotion-neurology answers than they are of their chicken-egg answer.

There is no one answer to this question. There are times when it's clear that biology triggers emotions – steroids and other drugs can change biology in a way that changes our emotions. There are times when it's clear that emotions trigger biological changes – trust and affection necessarily result in neurological changes. And often it is simply unclear.

But the biology of emotion also begs the question of habituation. The pattern of our lives trains the neural-pathways of our brains. This is both choice and biology. We can condition ourselves to have strong emotional responses to particular events or triggers (i.e., anxiety, anger, despair, etc...). In these cases, a struggle for mental health is aided by a recognition that our biology is contributing to the "momentum" of our emotions and choices.

Again, many more examples could be given, but we've illustrated enough to ask; what are the gospel-implications for *biological causes or influences* on mental illness?

- Scripture recognizes the validity of our biology's influence upon our choices and emotions (Matt. 26:40-43).
- We are not morally responsible for our biological challenges unless we created them through habituation.[11]
- Seeking physical aid for biologically-based struggles honors God and is wise (I Tim. 5:23).
- Scripture places high value on taking care of our bodies because of how much they influence our souls (Exod. 20:8).
- Our biologically-based struggles may not find their full redemption in this life (Rom. 8:22).
- Our biologically-based struggles will increase as we age and our bodies weaken (Ecclesiastes 3:19-20).
- God warns us against interpreting un-health as punishment (John 9:3).

This discussion of how the gospel guides us in the care of the body leads us to our next question about making a wise decision about the possible use of medication as one means of pursuing mental health.

Question 3:
Deciding About Medications

Let's begin this discussion by placing the question in the correct category – whether an individual chooses to use psychotropic medication in their struggle with mental illness is a wisdom decision, not a moral decision. If someone is thinking, "Would it be bad for me to consider medication? Is it a sign of weak faith? Am I taking a short-cut in my walk with God?" then they are asking

[11] Christians may disagree about how much responsibility we bear for choices that have taken an addictive quality through habituation – is it a sin when an alcoholic drinks in order to stave off the symptoms of withdrawal? Regardless of the answer one gives to this question, the earlier portions of this article allow for an agreed conclusion – continued drinking is destructive and a strong appeal to the will must be made in the pursuit of sobriety.

important questions (the potential use of medication) but they are placing them in the wrong category (morality instead of wisdom).[12]

Better questions would be:

- How do I determine if medication would be a good fit for me and my struggle?
- What types of relief should I expect medication to provide and what responsibilities would I still bear?
- How would I determine if the relief I'm receiving warrants the side effects I may experience?
- How do I determine the initial duration of time I should be on medication?

In order to answer these kinds of questions, I would recommend a six step process. This process will, in most cases, take six months or more to complete. But it often takes many months for doctors and patients to arrive at the most effective medication option, so this process does not elongate the normal duration of finding satisfactory medical treatment.

Having an intentional process is much more effective than making reactionary choices when the emotional pain (getting on medication) or unpleasant side effects (getting off medication) push you to "just want to do something different." With a process in place, it is much more likely that what is done will provide the necessary information to make important decisions about the continuation or cessation of medication.

Preface: This six step process assumes that the individual considering medication is not a threat to themselves, a threat to others, and is capable of fulfilling basic life responsibilities related to their personal care, family, school, and work. If this is not the case, then a more prompt medical intervention or residential care would be warranted.

If you are unsure how well you or a friend is functioning, then begin with a medical consultation or counseling relationship. If you would like more time with your doctor than a diagnostic and prescription visit, then ask the receptionist if you can schedule an extended time with your physician for consultation on your symptoms and options.

Step One – Assess Life and Struggle: Most struggles known as mental illness do not have a body-fluid test (i.e., blood, saliva, or urine) to verify their presence. We do not know a "normal range" for neurotransmitters like we do for cholesterol. The activity of the brain is too dynamic to make this kind of simple number test easy to obtain. Gaining neurological fluid samples would be highly intrusive and more traumatic than the information would be beneficial. Brain scans are not currently cost effective for this kind of medical screening and cannot yet give us the neurotransmitter differentiation we would need.

For these reasons, the diagnosis for whether a mental illness has a biological cause is currently a diagnosis-by-elimination in most cases. However, an important part of this initial assessment should be a visit to your primary care physician. In this visit you should:

- Clearly describe the struggles / symptoms that you are experiencing.
- Describe when each struggle / symptom began.
- Describe the current severity of each struggle / symptom and how it developed.

As you prepare for this medical visit, it would be important to also consider:

- What important life events, transitions, or stressors occurred around the time your struggle began?
- What is the level of life-interference you are experiencing as a result of your struggle?
- What lifestyle of relational changes would significantly impact the struggle that you're facing?

Step Two – Make Needed Non-Medical Changes: Medication will never make us healthier than our current choices allow. Our lifestyle is the "ceiling" for our mental health; we will never be sustainable happier than our beliefs and choices allow. Medication can correct some biological causes and diminish the impact of environmental causes to our struggles. But medication cannot raise our "mental health potential" above what our lifestyle allows.

[12] For more on understanding the choice about psychotropic medications as a wisdom issue, I would recommend the lecture "Understanding Psychiatric Treatments" by Michael Emlet, MD at the 2011 CCEF conference on "Psychiatric Disorders" which can be found at http://www.ccef.org/understanding-psychiatric-treatments.

Too often we want medication to make-over our unhealthy life choices in the same way we expect a multi-vitamin to transform our unhealthy diet. We assume that the first step towards feeling better is receiving a diagnosis and prescription. This may be the case, and there is no shame if it is, but it need not be our guiding assumption.

Look at the lifestyle, beliefs, and relational changes that your assessment in step one would require. If there are choices that you could make to reduce the intensity of your struggle, are you willing to make them? Undoubtedly these changes will be hard, or you would have already done so. But they are essential if you want to use medication wisely.

As you identify these changes, assess the areas of sleep, diet, and exercise. Sleep is vital to the replenishing of the brain. Diet is the beginning of brain chemistry – our body can only create neurotransmitters from the nutrition we provide it. Exercise, particularly cardiovascular, has many benefits for countering the biological stress response (a primary contributor to poor mental health). Your first "prescription" should be eight hours of sleep, a balanced diet high in antioxidants, and cardiovascular exercise for at least thirty minutes three days a week.[13]

A key indicator of whether we are using psychotropic medication wisely is whether we are (a) using medication as a tool to assist us in making needed lifestyle and relational changes, or (b) using medication as an alternative to having to make these changes. "Option A" is wise. "Option B" results in over-medication or feeling like "medication didn't work either" as we continually try to compensate medically for our volitional neglect of our mental health.

Step Three – Determine the Non-Medicated Base-Line for Your Mood and Life Functioning: This is an important, and often neglected, step. Any medication is going to have side effects. The most frequent reason people stop taking psychotropic medications, other than cost, is because of their side effects.

If we are not careful, we will merely want to feel better than we do "now." Initially "now" will be how we feel without medication. Later "now" will be how we feel with medication's side effects. In order to avoid this unending cycle, we need to have a baseline of how we feel when we live optimally off of medication.

One of the reasons postulated for why placebos often have as beneficial an effect as psychotropic medication is the absence of side effects. Those who take a placebo get all the benefits of hope (doing something they expect to improve their life) without any unpleasant side effects. Getting the baseline measurement of how life goes when you simply practice "good mental hygiene" is an important way to account for this effect.

> "As I practice medicine these days, my first question when a patient comes with a new problem is not what new disease he has. Now I wonder what side effects he is having and which drug is causing it (p. 191)." Charles Hodges, M.D. in *Good Mood Bad Mood*

There is another often over-looked benefit of step three. Frequently people get serious about living more healthily at the same time life has gotten hard enough to begin taking medication. This introduces two interventions (medication and new life practices), maybe three or four (often people also begin counseling or being more open with friends who offer care and support), at the same time. It becomes very difficult to discern which intervention accounts for their improvements.

Writing out your answers to these questions will help you discern if you need to move on to step four and make the needed assessment in step five.

- What were the struggles that initially made me think I might benefit from medication?
- How intense were these struggles and how did they manifest themselves?
- What changes did I make in my lifestyle and relationships to alleviate these struggles?
- How effective was I at being able to make the needed changes?
- How much relief did the lifestyle and relational changes provide for my struggles?
- How do I anticipate medication would assist me in being more effective at these changes?

[13] Additional guidance on this kind of "life hygiene" can be found at www.bradhambrick.com/burnout.

Step Four – Begin a Medication Trial: If your struggles persist to a degree that is impairing your day-to-day functioning, then you should seek out a physician or psychiatrist for advisement about medical options. As you have this conversation, consider asking your physician the following questions:

- What are the different medication options available for the struggle I'm facing?
- What does each medication do that impacts this struggle?
- What are the most common side effects for each medication?
- How long does it take this medication before it is in full effect?
- If I chose to come off this medication, what is the process for doing so?
- What have been the most common affirmations and complaints of other patients on this medication?

These questions should help you work with your doctor to determine which medication would be best for you. Remember, you have a voice in this process and should seek to be an informed consumer with your medical treatment; in the same way you would for any other product or service you purchase.

In this consultation you also want to decide upon the initial period of time for which you will remain on the medication (unless you experience a significant side effect from the medication). In determining this length of time, you would want to consider:

- Your physician or psychiatrist will make recommendations based upon additional factors not considered in this article
- A minimum of at least twice the length of time it takes the medication to reach its full effect
- Significant life stressors that would predictably arise during this trial period (e.g., planning a wedding)
- How long it would take to make and solidify changes that were difficult to make without medication (see step three)

Once you determine this set period of time, your goal is to continue implementing the changes you began in step three while monitoring (a) the level of progress in your area of struggle and (b) any side effects from the medication.

Step Five – Assess Level of Progress Against the Medication Side Effects: Near the end of the trial period, you want to return to the life assessment questions you answered at the end of step three. Compare how you are able to enjoy and engage life at this point with your answers then. The questions you want to ask are:

- What benefits have you seen while you were on medication?
- What side effects have you experienced?
- Is there reason to believe your continued improvement is contingent upon your continued use of medication?
- Are the side effects of medication worth the benefit it provides?

The more specific you were in your answers at the end of step three, the easier it will be to evaluate your experience at the end of step five. At this point, try to be neither pro-medication nor anti-medication. Your goal is to live as full and enjoyable a life as possible. It is neither better nor worse if medication is or is not part of that optimal life.

Step Six – Determine Whether to Remain on Medication: At this point in the process there are several options available to you; this is more than a yes-no decision. But any option should be decided in consultation with your prescribing physician or psychiatrist. You can decide to:

- Remain on medication because the effects are beneficial and the side effects are minimal or worth it.
- Opt to stage off of your medication because the benefits were minimal or the side effects worse than the benefits.
- Stage off medication to see if the progress you made can be maintained without medication; knowing you are free to resume the medication if not without any sense of failure.
- Opt to try a different medication for another set period of time based on what you learned from the initial experience.

Regardless of what you choose, by following this process you can have the assurance that you are making an informed decision about what is the best choice for you.

THE SUMMIT CHURCH

Question 4:
How Should the Church Be Involved?

Facing mental illness is not an easy process. Regardless of how informed we are, this process is not easy. Trying to walk this difficult journey by yourself only makes it harder.

Often, in the arena of mental illness, what the church has to offer is not superior answers – if the problem is biological or environmental, the church should provide very similar advice as our secular friends in the mental health field.

- For the person who struggles with depression due to a hypoactive thyroid, hormone tests, consistently taking Synthroid, and monitoring hormone levels are the correct steps whether he/she is a Christian or not.
    - Christians believe that additional hope can be provided for the discouragement the frequently coincides. We do not believe people are merely bodies and simply correcting hormone levels is complete care.
    - But the latter steps of caring for the embodied-soul do not change the initial steps of caring for the body.
- For the spouse in a physically abusive marriage, taking steps to ensure safety, preparing to face the likely manipulative response, and explaining what would be required of them throughout the legal process of pressing charges (if warranted) are the correct steps whether he/she is a Christian or not. Christians believe in the sanctity of marriage, but this does not mean caring for the institution of marriage more than the individuals in that marriage, and does not mean we interfere with the due process when a crime has been committed.
    - Christians recognize that families in this situation need a high level of emotional support and accountability: husband, wife, and children. The legal process can make us safe, but cannot make us people who honor one another or help us process the grief-transition if those we love are not safe to live with.
    - The latter steps of possible marital restoration do not change the initial steps of ensuring safety and preparing someone to face the challenges to a major legal-relational transition.[14]

While the initial guidance the church provides would, in many cases, be the same, the church should always provide a superior context of living out those answers–a sphere of relationships where everyone acknowledges we are broken people in need of redemption, thereby, negating the stigma that makes overcoming these struggles so painfully isolating. Counseling is never merely principles and suggestions; it is also a context that facilitates a journey.

That is the ideal; a stigma-free, redemptive community. But the question remains, "How do we produce more of that reality in our churches?" Unfortunately, as Amy Simpson says in her book *Troubled Minds*, mental illness is often the "no-casserole illness (p. 37)" in Christian circles; a form of suffering from which the church, uncharacteristically, moves away from suffering people instead of towards them.

> "Friendship is very important for those with poor mental health, but it is very hard to be a true friend to someone in such a condition (p. 33)." Kathryn Greene-McCreight in *Darkness Is My Only Companion*

One of the reasons we move away instead of towards people is confusion and uncertainty about what we should do. When we don't have good answers, it is often easier to just avoid the people who generate the questions. That is why the previous parts of this presentation are essential to answering this last question. It is unlikely the church will offer the unique care of a redemptive community if its people are uninformed about and intimidated by mental illness. As we seek to offer answers to this final questions, let's review what our goals for this presentation were.

> My goals for the reader are: (1) to be able to understand the Venn diagram on page seven, so (2) you can wisely assess question three about medication, in order to (3) equip the church to be more effective a living out the answer to question four. The rest of the article is important information to accomplish these objectives.

Hopefully, at this point, you understand enough to make the recommendations below seem more feasible and can see their benefits more clearly. A particular individual or church does not have to be able to do everything in order to do some very significant things powerfully well.

[14] These examples are not meant to outline counseling protocols for hypothyroidism and domestic violence. Instead they are merely meant to be illustrative of the point that a Christian perspective on mental illness does not result in a radically difference counseling process for life struggles, especially those rooted in biological or environmental causes.

Consider the example of someone in need of knee surgery. There is a surgeon who repairs the ligament; a physical therapist who helps the individual regain a full range of motion; family and friends who care for day-to-day needs and provide encouragement; and a physician who oversees the pain medicine management. A similar set of roles can exist in the struggle with mental illness.

This metaphor is not meant to imply that the church only plays the "friends and family" role. A given church, pastor, or friend may be well-equipped to provide various levels of intensive soul care. But it is their responsibility to know the limits of their ability to help and be willing to invite other members on the care team with needed, supplemental expertise.

With that in mind, let's consider many things that the church – as a corporate entity or through its personal relationships – is uniquely equipped to do. Many of these functions have little-to-no secular alternative; ongoing gatherings of adults for mutual encouragement and instruction are rare in our culture.

The church, corporately or through individuals, can…

- … teach a balanced view of mental illness as a part of an ongoing education process. A church has many venues through which this education can occur. Mental health does not need to be the "focal point of the church" in order for the church to effectively disciple people in the care of their interconnected mind, soul, and body.
    - *Sermon Illustrations* – speaking of depression, anxiety, trauma, addiction, and other struggles in an informed, unstigmatized way will go a long way towards giving people the emotional freedom to talk about their struggle with friends and seek the help they need.
    - *Testimonies* – someone sharing their story has a powerful influence on any group's culture. As someone tells their story of wrestling with mental illness they should (a) speak of how personal faith, a community of care, wise care of their body, and counseling played a role in their recovery;[15] and (b) clarify that this is their personal story and not necessarily the map of how God guides every person with a similar struggle in their pursuit of hope and wholeness.[16]
    - *Follow Up Blogs* – A blog that follows up on a sermon or testimony can be a great way to connect people who still prefer to remain anonymous with helpful resources. The ultimate goal is to create an open community of care, but the process may involve facilitating many smaller steps in that direction.[17]
    - *Adult Education Classes or Conferences* – There are a growing number of excellent Christian books on various types of mental illness. These classes or events can simultaneously comfort and equip. Having classes like this communicates that your church is a "safe place" for these conversations and that these topics are a relevant part of living a God-honoring life.
    - *Support Groups* – While a class or event is educational (over-viewing a subject), a support group is therapeutic (taking someone on a journey). While support groups can create cliques within a church, they can also provide a context for a greater transparency as a next step towards more general authenticity. When starting these groups, a church would want to think through how to prevent a support group from becoming someone's long-term community and, thereby, inadvertently reinforcing their struggle as their identity.
    - As you can see in the examples above, a church is a unique context for allowing people to become progressively known, instructed, and loved. Where else in our culture could each of these levels of education and connection be provided within a context of ongoing community?

[15] If the public testimony only speaks of God's role in their pursuit of mental health, the implied message is "only God is needed for mental health." In this type of testimony, it is more important than usual for the individual to give credit to each source of assistance God used to play a role in their journey to peace of mind and life.

[16] Testimonies can often inadvertently imply that "how God worked in my life is how God will work in your life" or "my experience of depression is the same as you experience of depression because they share the same label" unless the person giving their testimony debunks this common misconception.

[17] Here is a sample for a blog post after a sermon on depression - http://www.bradhambrick.com/depression-belief-behavior-andor-body-brain/.

- … befriend those who are struggling with mental illness with multiple people so no one person carries the full weight of responsibility. We often fail to realize that no professional qualifications are required to be a friend.

  > "When churches have antibiotic-like expectations for mental health treatment, they communicate, 'go get treated, then you can come back and you can be a growing Christian with us' (p. 114)." Amy Simpson in *Troubled Minds*

- … have a relationship that includes but transcends the struggle with mental illness. In a purely professional setting, a struggle with mental illness is *why* an individual is known and cared for. This adds to the stigma and results in a mindset that says I have to be "all better" to be known authentically. With a professional counselor or recovery group if you get better, you "graduate" from having people who know and care for you.

- … help people sort their struggles into categories of sin, suffering, and identity which can be caused by biology, environment, or choice. Emotional unrest and embarrassment make it difficult to sort out how to best categorize struggles. One of the main goals for this presentation is to equip people for these conversations. *The more these conversations can be had effectively in natural relationships the earlier people will receive care, the longer they will stick with their care, and less ashamed they will be to embrace the care God wants for them.*

- … attend a counseling session with your friend, take notes, gain an understanding of their struggle, and serve as an echo of key truths or practices recommended by the counselor. This would require the permission of your friend and the cooperation of the counselor. But many counselors are willing to cooperate with this kind of counseling-advocate model, and it can greatly enhance both the short-term and long-term effectiveness of counseling.

This list is not exhaustive. Instead, it is meant to be the beginning of a brainstorming exercise. But there is a danger in thinking through what "the church" could do; our personal initiative gets lost in the corporate possibilities. For instance, we think "the church ought to mentor under privileged students," but we don't take the step of volunteering at the nearest school.

As you brainstorm possibilities, I would encourage you not to begin with programs your church could run or staff position that could be filled. Instead, begin with, "What conversations could I have about this material with someone I care about?" It may be following up on something they shared with you or you seeking their help in sorting through a struggle you've not talked about.

Make a few notes while this material is fresh on your mind.

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_____
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Conclusion

Undoubtedly, this has been a large quantity of information to assimilate. Chances are there were portions you disagreed with and more questions may have been generated than answered. But that's okay, as I said in the beginning, my goal was not to write "the last word" on mental illness. Instead my goal was to begin or extend an important conversation for the church.

Here would be some of the key take-aways I would want you to have from this material.

- We hurt people when we make complex questions simpler than they actually are.
- We also hurt people when we, individuals or churches, are silent on important areas of life.
- An important part of caring for one another well, even when medical care is needed, is the humility to listen well.
- It is possible to have a strong faith and a weakened brain-body that make life consistently hard.
- Christians who say faith-only, doctors who say medication-only, and counselors who say therapy-only are equally wrong about and equally hurtful to those who struggle with mental illness.

- The struggles known as mental illness cannot be reduced to a universal cause; even the same struggle (e.g., depression) can have different causes among different people with a highly similar experience.
- With mental illness we must not be more educated about the diagnosis than we are about the person.
- The gospel speaks to our struggles of sin, suffering, and identity in unique ways, but God is not opposed to us also seeking care from non-pastoral sources of care for these struggles.
- The gospel speaks to our struggles caused by biology, environment, and volition in unique ways, but God is not opposed to us also seeking care from non-pastoral sources of care for these struggles.
- The church is uniquely positioned to address the subject of mental illness.

I hope this reflection has encouraged you.

If you personally struggle with mental illness, I hope you have gained the ability to identify "what's next" in your journey and how God wants to walk with you on that journey.

If you are a family member or friend seeking care well for a loved-one, I hope you have gained a sense for your indispensable role and guidance for how you can wisely represent God's heart for your friend in the decisions and challenges ahead.

If you are a Christian mental health professional, I hope you have gained a greater appreciation for the intersection of your faith-practice, and identified ways the Bible and a community of faith can be involved in the care of mental illness.

In spite of whatever biases or near-sightedness exist in this material (which I know will be revealed with time), I hope that God will use this material to increase the willingness and effectiveness of his people in caring for one another.