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JA7

THE IMPORTANCE AND INCLUSION OF THE MENTALLY DISTRESSED

Mental health problems are surprisingly common. At any one time, one in every six adults is experiencing mental distress of some kind. Depending on its nature and severity, it can affect a person's worldview, mood, thought processes, perception of reality, emotions, and the ability to translate wishes and intentions into actions.

In this article, we will be looking at the range of types of mental distress which occur, some of the issues relating to diagnosis and treatment, and the importance of the pastoral support for sufferers which churches and individual Christians can be encouraged to provide.

1 Defining mental distress

Categorising mental illnesses is notoriously difficult and not always helpful to sufferers. The symptoms and experiences of those affected do not fit into precise diagnostic compartments. However, the main kinds and causes can be summarised in general terms, and this is helpful in determining the kind of care and pastoral support needed by the sufferer.

Broadly there are three types of mental disorder:

1.1 Reactive or Exogenous disorders

These tend to be caused by external pressure or stress, such as bereavement or other significant loss, unrealised expectations, overwork, burnout or trauma. The problem arises from circumstances and the individual's response to them, rather than from any organic deficiency. Experiences under this heading include reactive depression, anxiety, panic attacks, obsessive-compulsive disorder, phobias, and hysterical neurosis. Some of the above are familiar, but three of these conditions may need a little further explanation:

(a) Reactive depression is brought on by an individual's struggle or inability to respond to challenging circumstances in life. The struggle leads to a prolonged low mood, characterised by feelings of hopelessness, worthlessness, tiredness and loss of motivation.

(b) Obsessive-compulsive disorder involves disturbing thoughts forcing themselves into a person's consciousness, causing the performance, in response, of a particular ritual, such as repeatedly washing hands, to neutralise the anxiety which the obsessive thoughts create.

(c) Hysterical neurosis is an exaggerated behaviour pattern in which physical and psychological symptoms appear which have no organic or other physical basis.

1.2 Endogenous disorders

Sometimes also described as psychoses, these disorders are believed to be caused by malfunctions of the brain, and can be temporary, intermittent or lifelong. The typical sufferer is likely to have a greatly distorted view of the world in one or more respects. Conditions in this category include manic depression, bipolar disorder, schizophrenia, epilepsy, post-natal depression, seasonal affective disorder, eating disorders, self-harming, delusions, hallucinations and dementia. Although symptoms can vary greatly in nature and degree, this type of disorder is generally severe, and sufferers have little or no understanding of their condition while experiencing an episode. Specialist medical help, periods in hospital and regular support are likely to be needed.

(a) Manic depression and bipolar disorder are mood disorders affecting about one in every hundred adults. During manic episodes the sufferer tends to be hyperactive, uninhibited, reckless, full of grandiose schemes and scattered ideas. At the other extreme of the condition, they experience long periods of dark depression. It is this swinging from one extreme to another that gives rise to the term *bipolar.* Some sufferers do not experience both extremes, and if this is so, the condition is described as *unipolar.*

(b) Schizophrenia, which also affects about one in a hundred adults, is one of the most debilitating and frequently misunderstood of all mental illnesses. The sufferer may hear voices and see or smell things which other people cannot detect. Experience of the unreal, along with the associated, often negative, delusions, is the key feature of schizophrenia. The sufferer is likely to become confused, fearful or withdrawn, and his or her ability to perform everyday tasks and activities will be severely impaired.

(c) Dementia is neither a disease nor an illness, but rather a syndrome (a group of symptoms). It generally appears in old age, as a result of changes within the brain. It takes several different forms, the most common being SDAT – senile dementia of the Alzheimer's type – and vascular dementia, associated with small, initially undiagnosed, strokes.

(d) Eating disorders are of two main types – anorexia nervosa, where the person deliberately and drastically reduces his or her food intake, and bulimia nervosa, in which phases of binge eating are followed by self-induced vomiting. The first is virtually, and the second completely, unknown in developing countries, which suggests that there are cultural and social dimensions to these conditions. Some clinicians believe it is symptomatic of a form of severe depression.

(e) Self-harming seems to be a way of dealing with inner pain. More common among women than men, it is believed to be a way of controlling emotional distress by providing a temporary

distraction. It may also be an attempt at self-protection – harming oneself before others do. Help involves trying to encourage the person to find more appropriate ways of dealing with inner psychological pain.

(f) Post-natal depression can be extremely serious and ought not to be confused with the 'baby-blues.' It appears to be associated with the hormonal changes experienced after childbirth and before the resumption of the menstrual cycle.

1.3 Personality disorders

This is a controversial area of medicine, but the term tends to be used to describe conditions in which the sufferer has failed to develop the self-awareness necessary to interact with others in an acceptable way.

However, there is no agreement regarding what constitutes definite symptoms of personality disorders. Such a disorder may be diagnosed when several areas of someone's personality are causing them or others problems in everyday life, but at what point a trait becomes 'abnormal' is hard to determine. What is 'normal' behaviour is usually a matter of opinion and is widely different from culture to culture.

Personality disorders are also sometimes referred to as character disorders – the product of nature, nurture or life experience. The person has developed a habitual, lifelong way of acting or behaving which causes difficulty in relating to others and fitting into society. It is extremely difficult to discern when such a condition is mental illness, rather than merely an unusual personality type.

2 Diagnosis and treatment issues

One of the concerns which Christians will have about diagnosis and treatment is the present tendency to regard all forms of mental distress as neurological disorders. This may be valid for some conditions – particularly those which appear to have a genetic or biochemical cause. However, the depressive type of condition is much more common, and it is not clear that a solely mechanistic or neurobiological approach to their treatment is justified. Not only are there biochemical reasons for questioning an over-reliance on treatments which attempt to restore neurotransmitter levels, but there are also anthropological reasons, which evangelical Christians will immediately see as linked with the biblical view of man.

Depressive illnesses are deep-seated emotional disturbances. If, as some say, man is merely an animal, then a problem in the brain can be fixed by a mechanistic solution. However if, as the Bible teaches, man is a unique being, a complex of the material and the immaterial, made in the image of God, then such an approach is too reductionist. It cannot be right to reduce man's thought realm and emotions to mere brain activity. Man is fundamentally a 'living soul' and so mental distress will affect, and be affected by, the condition of the soul. If this is not recognised, then any treatment will, at best, be poorly targeted.

As Professor John Swinton* has said: 'There is a sense of spiritual crisis in depression that will not necessarily be alleviated by psychotherapy or pharmacology, particularly if the true nature of the crisis goes unnoticed.'

The recent successes of the so-called 'talking therapies' – especially Cognitive Behaviour Therapy – is a strong indicator that the biblical model of man is more accurate. Good pastoral counselling, which has always focused on listening, identifying, admonishing (counselling to bring about change) and encouraging, will make a vital contribution to helping those with depressive illnesses.

However, while CBT does share the Christian worldview to the extent of recognising the importance of governing thoughts and feelings, and that we are more than a product of our past and the addictive power of wrong choices, it does not accept the biblical view of man (made in the image of God, spoiled by the fall, needing a restored relationship with God and having an immortal soul). It emphasises a reliance on the inner resources of the individual, and tends to seek an outcome marked by self-reliance and personal self-esteem.

Pharmacological helps should not be rejected out of hand. In many cases of depression antidepressants can be an effective treatment, especially when linked to a talking therapy. The modern antidepressants are not addictive. They can be taken with confidence, especially when their prescription and monitoring is by a sympathetic clinician. It is important to remember that they may take two weeks or more to become fully effective, can initially make the patient feel worse, need monitoring to determine the most effective dosage and should never be stopped abruptly.

In all cases of mental distress, it is important that the sufferer is encouraged to seek medical attention and professional advice. Sometimes a simple blood test can expose an underlying medical condition.

3 Pastoral care and support

In spite of all the helpful steps which our contemporary society has taken towards equality, those with mental health problems still face a greater risk than healthy people of being marginalised, rejected or otherwise disadvantaged. They need to know that God loves them beyond all measure. They have been created in God's image for loving fellowship, and can experience this.

People with mental health problems struggle with psychological difficulties which are frequently destructive and incapacitating, and with a social experience which can be degrading, excluding and dehumanising. They find themselves represented by negative media images and defined by powerful stigmatising terms. At the most basic level, for instance, they suffer the indignity of being described as 'schizophrenics' or 'depressives,' rather than more generally and tenderly as 'sufferers from schizophrenia (or depression).' In these circumstances, effective care for people with an enduring mental health problem is not an optional ministry for a church, but a fundamental mark of its identity and its faithfulness to the call to be like Jesus. The pastoral

leaders of local churches must be at the forefront of making this a reality, both by their own involvement, and by the priority they give to ensuring that the church is organised to provide maximum support.

The personal involvement of pastors does not mean that only they can engage in this ministry. Appropriately-gifted mature believers, preferably equipped by some relevant training, are also of great value. They need an overarching understanding of the great themes of Scripture, and to be convinced of the Bible's ability to speak into all kinds of life circumstances. Their lives should be those that set a reassuring example. The best helpers will be those who are familiar with their own weaknesses and can sympathise with others, 'down to earth;' practically constructive; and can be trusted.

Research has shown that simply sitting with oppressed people can be a deeply therapeutic act. It shows sufferers that they are neither forgotten nor rejected. Willingness to understand a sufferer's problems is evidence of acceptance and sensitive concern. Having empathy – entering into the person's distress – is thoroughly biblical. The Bible speaks about 'weeping with those who weep' (Romans 12:15), 'carrying one another's burdens' (Galatians 6:2) and 'encouraging one another' (1 Thessalonians 4:18). The availability of this kind of pastoral help is a necessary step towards the recovery of a distressed soul.

Why are the schizophrenia recovery rates in the Third World so much higher than those in Western capitalist economies? The answer is thought to be a culture of social cohesion – the ability of 'family' to offer a closer, less stressful and more accepting environment. Third World culture also gives priority to people over tasks. There people sit with someone else just to be with them, without having to have answers or to justify the time they have given.

The local church can provide two kinds of vital support for those with mental distress – a general support network and the more specialist pastoral skills.

The church is a fellowship of the friends of Jesus, and at its best that quality of friendship bestows worth and dignity upon the individual, irrespective of condition and circumstance.

Those with a special ministry need to be available, to develop good listening skills, to be approachable and sympathetic, and to have a solid grasp of the Scriptures. They must be willing, in a non-judgemental and non-superior way, to 'admonish' with biblical truth. There must also be a commitment to pray for the distressed person (1 Samuel 12:23, 1 Thessalonians 1:2, 2 Corinthians 11:28-29).

The rest of the church can provide the vital friendship which the sufferer will need. Friendship must take centre stage in the church's care of people with mental health problems. People are created for loving relationships with God and with one another.

Sometimes Christians shrink from loving commitment to those who struggle with mental health difficulties because they think there is something that they have to do. The task of a Christ-like friend is not *to do* but *to be* – to be someone who is available and accepting. The church is a fellowship of the friends of Jesus, and at its best that quality of friendship bestows worth and dignity upon the individual, irrespective of condition and circumstance. A person with schizophrenia, for instance, would long for this. Such friendship enables people with mental health problems to experience care with compassion and Christ-like humanity.

Gerald Tanner

*John Swinton is Chair in Divinity and Religious Studies and Professor in Practical Theology and Pastoral Care at the University of Aberdeen

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The Old Bank House, 17 Malpas Road, Newport, South Wales. NP20 5PA
Telephone: 01633 893925
Email: office@affinity.org.uk
Website: www.affinity.org.uk

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gospel churches in partnership