

# SERVING

those with

# MENTAL ILLNESS

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# LATEST RESEARCH

# 1

## What Does it All Mean?

*Dr. Ed Stetzer*

*New data from LifeWay Research discovers ministry opportunities among the acute mentally ill and their families. ([Full study by LifeWay Research](#))*

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According to the National Institute of Mental Health (NIMH), every year one out of every 20 people in America suffers from serious mental illness.

Not a run of the mill case of the blues or the normal day-to-day anxieties of life, but a mental illness—like serious depression or bipolar disorder—that disrupts their lives.

In some cases, like Matthew Warren, the son of my friends Rick and Kay Warren, the pain and suffering is too much to bear, and their lives are cut short through the tragedy of suicide.

The pain of mental illness is real.

## BREAKING THE STIGMA

As a pastor, I've seen it in the lives of my church members and in the lives of family and friends. Chances are you have, too. You may have even prayed for someone affected by mental illness or talked with them about their struggles.

And we know Jesus came to comfort us in all our afflictions.

But in the church, it seems we just don't talk much about mental illness.

So people suffer in silence. They feel abandoned by God at times and blame their illness on some kind of spiritual failing. Worst of all they suffer alone, without the comfort that other believers can offer them.

It's time for that to change. The time has come for the church to recognize and admit acute mental illness exists within the body of Christ and to minister accordingly.

For that reason, LifeWay Research recently partnered with Focus on the Family and the family of a man who endured schizophrenia to conduct this "Study of Acute Mental Illness and Christian Faith."

We found that acute mental illness is common in the church, just as it is common in the rest of society. We also found churches want to help those affected by mental illness.

But pastors need more guidance and preparation for dealing with mental-health crises. They often don't have a plan to help families affected by mental illness, or to provide ongoing spiritual care to church members who have mental illness.

Most troubling, though people in faith communities are generally seen as more psychologically healthy, the stigma of mental illness

is disproportionately present in the church. In other words, there is often a greater shame in the church than outside the church—and the church is called to be a place of grace, not a place of shame.

But our research also found when people suffer from mental illness, they often turn to pastors for help. Actually, pastors and the police are often the first responders in mental-health crises.

Those crises give the church the opportunity to be the church—to demonstrate the love of God to families and fellow believers in their time of need.

And if the church understands acute mental illness as one example of weakness that can happen, those crises can help every one of us to better understand our own weaknesses.

## SOME METHODOLOGY

This study's parameters defined acute mental illness as moderate depression, severe depression, bipolar disorder or schizophrenia. Using telephone and online surveys over the spring and summer of 2014 among Protestant adults, responders included pastors, people with acute mental illness and their family members. We used the best methods available to reach three quantitative audiences.

Further, the study used LifeWay's ProTheo theological research service to deal exegetically with sensitive issues including spiritual commitments and growth among those with acute mental illness.

Perhaps one reason the church throughout the ages has been notably silent on mental illness issues goes beyond a lack of understanding to a lack of faith. What hope can the church offer?

We also interviewed 15 Christian clinical experts on mental illness about how mental illness affects their patients and how churches can better minister to those struggling with mental illness.

## PASTORAL EXPERIENCE

Most pastors say they know people who have been diagnosed with mental illness, including clinical depression (74%) and bipolar disorder (76%). Fewer than half of pastors know someone with schizophrenia. And more than one in five pastors say they've personally struggled with mental illness.

Still, there are challenges. Almost one in four pastors say they are reluctant to get involved with people with acute mental illness because of the challenges involved—and there are challenges.

The study also found most of those who suffer from mental illness still believe they can thrive spiritually, as do their families.

Still, one in five people with acute mental illness say no, they can't grow or thrive spiritually. So while there are some for whom the diagnosis is particularly difficult, most think spiritual growth and mental illness are not incompatible.

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6 in 10 pastors have counseled someone who was *eventually diagnosed* with an acute mental illness.

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Yet, believers will likely struggle if their mental illness is not stable. So pastors have to walk a fine line of challenging people to grow while giving them grace during their struggles.

As one of the experts interviewed by LifeWay put it, people can't give themselves away to Christ if they don't know who they are. Someone who isn't stable in their illness may not be able to grow or show much progress in their Christian life.

## SIN, SPIRITUAL STRUGGLE, WEAKNESS AND MENTAL ILLNESS

We must understand the difference between spiritual struggle, weakness and mental illness. Sometimes the difficulty someone experiences causes us to assume sin is the problem. In some cases, it's simply a spiritual struggle. In others, it is a weakness. Scripture reminds us in Hebrews 4:15 that Jesus is able to sympathize with our weaknesses. We can and must help people deal with sin in their lives, to grow through their spiritual struggles, to comfort and encourage them through their weaknesses and to address mental illnesses.

Sometimes it is a mental illness—and we can't break out even after a period of dealing with the other issues with the Word, in the power of the Spirit and in the Christian community.

But all of these—sin, spiritual struggle, weakness and mental illness—are places for grace to shine. We can and must help people deal with sin in their lives, to grow through their spiritual struggles, to comfort and encourage through their weaknesses and to address mental illnesses.

## PASTORS THEMSELVES

One factor that complicates the discussion is that nearly 25% of pastors admitted in the survey they struggle with some form of mental illness. Who's talking about that difficult reality and ministering to them?

Pastors with acute mental illness don't find their condition easy to discuss. Our churches need healthy leaders—physically, mentally, and spiritually. One positive outcome from this study would be for churches to create a healthy environment for even their pastor to

be transparent with such issues. When we're not talking about how God helps in weakness, we're withholding some of His glory.

How can the church thrive when hiding its light under a bushel?

## FAMILY'S PERSPECTIVE

There may be only one person in a family with an acute mental illness, but the entire family shares in the experience on both good days and bad. Those caregivers deserve much affirmation and encouragement. Likewise, their perspective is important in this issue.

God designed the family to be the safest place for any of us. For those with acute mental illness, God's design is particularly meaningful and important. People with mental illness need their family, and the family needs the church!

Seventy-five percent of family members say the church has been supportive, while 53% of people with acute mental illness agree. That's an interesting and important difference and tells us we are making progress, but there is still work to do.

## BREAKING THE STIGMA THROUGH OPENNESS AND CONVERSATION

What appears to be missing in most church responses is an open forum for discussion and intervention that could help remove the stigma associated with acute mental illness.

For example—and let this sink in—two-thirds of family members and six in 10 affected by mental illness want their churches to have an open discussion about mental illness. They want to feel that their struggles are normal and God loves them in the midst of their illness.

Churches talk openly about cancer, diabetes, heart attacks and other health conditions—they should do the same for mental illness, in order to reduce the sense of stigma.

Thankfully, we found few people are leaving churches because of a bad reaction to their diagnosis. We found only about 10% of individuals with acute mental illness “have changed churches based on church response to their mental illness.”

## CHURCHES PROVIDE SUPPORT?

Perhaps one of the study's most encouraging outcomes is agreement—with pastors rated highest—that the church has responsibility “to provide resources and support.” A disconnect occurs when asked how churches render that support.

Sixty-eight percent of pastors say their church provides help by maintaining referral lists for other local mental-health professionals. Yet, only 28% of family members agree that is happening. That's an important distinction.

That's another downside of the stigma of mental illness. If no one talks about it, those in need won't know the church has resources to help them.

Perhaps one reason pastors are reluctant to bring mental illness to the forefront is their own insecurity or lack of knowledge. There has been a de-emphasis on pastoral preparation for these kinds of issues in the past few years, particularly in evangelical schools that are more focused on preaching or theology alone.

As mentioned earlier, pastors and police are often the first responders in mental health crises—yet, police often receive more training than pastors to de-escalate some of these crises. Seminaries need to reconsider their treatment of topics like family counseling.

Meanwhile, let's not forget we don't have to be experts to care.

However reluctant pastors might be, individuals and family members of the mentally ill are anxious to recognize the elephant

in the room and remove the taboo status. If a church is going to be transformational in society, it has to address needs.

## ACTION STEPS FOR CHURCHES AND PASTORS

The main action step is simply to be proactive, which can happen several ways.

- *Start with the Gospel and stay with the Gospel. At no point do you say, “Well, I am turning this over to someone else.” The fact is, the Scriptures are sufficient, the Christian community is necessary and the Gospel matters—at every moment. Working with others does not mean turning over the mentally ill to the secular establishment. These are our friends, family members and church community—and the Gospel, the Scriptures, the indwelling of the Spirit, and the Christian community are essential to those struggling with mental illness and the families that love them.*
- *Learn about mental illness. The majority of pastors do not have formal training related to mental illness intervention, but they apparently recognize the need. The good news is that 66% of pastors have read books on counseling. The learning should neither begin nor end with the pastor. This information should permeate the church.*
- *Talk about acute mental illness. Accept the reality that this condition exists within the church and deserves attention, love and grace.*
- *We are not engaging and loving our community if we are not addressing prevalent societal needs including mental illness. Clearly, this would be a cultural shift in the church as well as a ministry shift.*
- *Furthermore, don’t talk about it assuming that the world of secular psychology/psychiatry is all we need. The fact is, much of the worldview of such movements is different than the Christian worldview. Thus, we approach these issues with the attitude that “all truth is God’s truth,” but not unaware the Bible is our ultimate standard as evangelical Christians.*
- *As such, rely on some of the trusted resources in this book to help you discern.*
- *Create a network of referrals. Referring congregants to professionals outside the church is sometimes uncomfortable for pastors as trust issues emerge. Within your community, pastors need to know who is licensed and able to assist. In most communities, start with Christian professional psychotherapists. Focus on the Family maintains a list of these service providers (check local listings here: [FocusOnTheFamily.com/FindACounselor](http://FocusOnTheFamily.com/FindACounselor)). Then refer to psychiatrists and others who can consider medical issues as well.*
- *Start a recovery ministry. Either start or partner with other community churches to sponsor a recovery ministry for those struggling beyond normal spiritual struggles. Likewise, this structure could become the local support group for caregivers. Respondents want open forums whereby education and support can address the stigma of mental illness.*
- *Create better training for pastors. Seminary education is packed with theological courses, most of which an aspiring pastor will need. But the deficit of counseling education creates a hardship for the pastor.*

Pastors need to realize the Word of God is sufficient to give the kind of spiritual guidance and discernment believers need. Our call is not away from biblical authority. But there are some real mental illnesses with physiological components. Pastors need to know to whom they can refer congregants in the counseling and medical fields. The survey indicates pastors favor medication and therapy when those resources are available for the acute mentally ill.

## THE CHURCH AND MENTAL ILLNESS

After this article, you will see some highlights of the research. Perhaps you might use them in your church and ministry to encourage greater engagement of the issues. Either way, let them challenge you about the church's engagement in this important issue.

It is past time for the church to recognize and admit acute mental illness exists within the body of Christ and to minister accordingly.

Our research found people who suffer from mental illness often turn to pastors for help, but pastors need more guidance and preparation for dealing with mental-health crises. They often don't have a plan to help individuals or families affected by mental illness, and miss opportunities to be the church.

The entire family of a person with mental illness shares in the experience, and those caregivers deserve affirmation and encouragement. Family members want their churches to provide resources and support and to have an open discussion about mental illness.

If we are to "Carry one another's burdens; in this way you will fulfill the law of Christ" (Gal. 6:2), that includes those who struggle with mental illness and their families.

## PASTORS' EXPERIENCE WITH ACUTE MENTAL ILLNESS

Most pastors indicate they personally know people who have been diagnosed with clinical depression and bipolar disorder. However, for most it has only been a handful of people they know in each situation. Almost half know someone with schizophrenia.

The number of individuals with these illnesses that pastors say they know is relatively small given their frequent contact with family, friends and church members. Yet six in 10 pastors have counseled someone who was eventually diagnosed with an acute mental illness. Lower percentages of pastors have taken courses in counseling or care for the mentally ill. The most frequently used learning resources for pastors have been reading books on counseling (66%) and personal experience with friends or family members (60%).

Less than one in four pastors is reluctant to get involved with people with acute mental illness. More than one in five pastors have personally struggled with mental illness of some kind.

- 74% of pastors indicate they personally know one or more people who have been diagnosed with clinical depression.
- 76% of pastors indicate they personally know one or more people who have been diagnosed with bipolar disorder.
- 50% of pastors indicate they don't personally know anyone who has been diagnosed with schizophrenia.

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Family members most want churches to *talk openly about mental illness* to remove the stigma.

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- 59% of pastors have counseled one or more people who were eventually diagnosed with an acute mental illness.
- 41% of pastors strongly disagree that they are reluctant to get involved with those with acute mental illness because previous experiences strained time and resources.
- 66% of pastors have read several books on counseling people with acute mental illness.

Since many pastors provide counseling and all pastors shepherd a flock that functions as a social network, they may see and hear symptoms of acute mental illness. While 80% of pastors feel somewhat equipped to identify when a medical professional may be required to help someone with an acute illness, less than half of those feel completely prepared.

- 38% of pastors strongly agree they feel equipped to identify a person dealing with acute mental illness that may require a referral to a medical professional.
- 23% of pastors indicate they have personally struggled with mental illness of some kind.

## HOW WELL CHURCHES ARE CARING FOR THOSE WITH ACUTE MENTAL ILLNESS

The majority of individuals with acute mental illness and family members describe the local church as supportive. Among individuals who have attended church regularly as an adult, the perceptions of support are higher (67% vs. 53%). However, the response of people in church to the individual caused 18% to break ties with a church and 5% to fail to find a church to attend.

- 10% of individuals with acute mental illness have changed churches based on church response to their mental illness.

- 17% of family members in a household of someone with acute mental illness say their family member's mental illness impacted which church their family chose to attend.
- 53% of individuals with acute mental illness say their church has been supportive.
- 75% of family members in a household of someone with acute mental illness say their church has been supportive.
- 39% of individuals with acute mental illness agree their local church has specifically helped them think through and live out their faith in the context of their mental illness.

## THE CHURCH'S ROLE IN CARING FOR ACUTE MENTAL ILLNESS

Strong majorities of pastors, family members and those with acute mental illness agree that local churches have a responsibility to provide resources and support for individuals with mental illness and their families. Overall, family members and individuals who have attended church regularly as an adult indicate churches have been supportive.

In terms of resources, individuals and families want churches to connect them to local resources, create openness about the topic by discussing it, and to make people aware and educate them on mental illness. There are some key disconnects. Two-thirds of pastors indicate they maintain lists to connect people to local mental health resources, but only a quarter of families are aware their pastor has a list of resources. Family members most want churches to talk openly about mental illness to remove the stigma. Yet, 49% of pastors rarely or never speak to their church in sermons about acute mental illness.

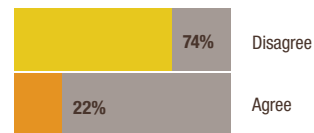


- 56% of pastors, 46% of family members in a household of someone with acute mental illness, and 39% of individuals with acute mental illness strongly agree that local churches have a responsibility to provide resources and support to individuals with mental illness and their families.
- 69% of individuals with acute mental illness indicate churches should help families find local resources for support.
- 68% of pastors but only 28% of family members in a household of someone with acute mental illness indicate their church provides care for the mentally ill or their families by maintaining lists of experts to refer people to.
- 65% of family members in a household of someone with acute mental illness believe local churches should do more in talking about mental illness openly so that the topic is not so taboo.
- 49% of pastors rarely or never speak to their church in sermons or large group messages about acute mental illness.
- 70% of individuals with acute mental illness would prefer to have a relationship with people in a local church through individuals who get to know them as a friend.

## HELPING WITH MENTAL ILLNESS

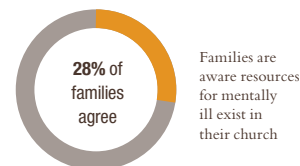
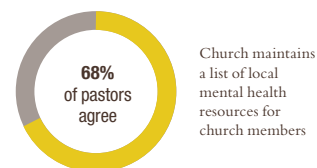
### AMONG PASTORS:

I am reluctant to get involved with those with acute mental illness because it takes too much time and resources.



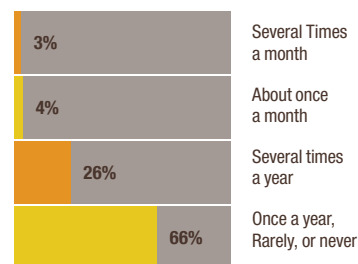
Notes: 4% Don't know.

Mental health resources need to be communicated and made available.



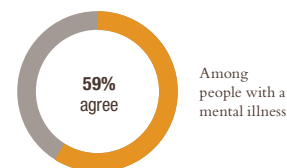
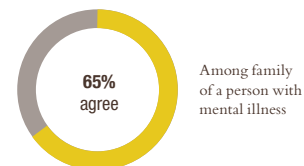
## TALKING ABOUT MENTAL ILLNESS

How often pastors speak to the church in sermons or large group messages about mental illness.



Notes: 1% Don't know. Numbers do not total 100% due to rounding

Want their church to talk openly about mental illness, so the topic will not be a taboo.



## How to Identify Potential Signs of Mental Illness in Your Congregation

*Dr. Jared Pingleton*

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Currently it is estimated that nearly 20 percent of adults in the U.S. suffer from mental illness in any given year,<sup>1</sup> and that between 14 percent and 20 percent of young people have experienced a mental, emotional or behavioral disorder. Of the 10 leading causes of disability identified in the United States and in other developed countries, four are brain and behavior disorders: major depression, bipolar disorder, schizophrenia and obsessive-compulsive disorder. The economic impact of serious mental illnesses in America amounts to over \$193 million in lost wages per year.<sup>2</sup> They also create significant, but difficult to calculate, associated “soft” costs and losses such as hospitalizations, increases in suicide, heightened stress on families and loved ones, and many misdiagnosed and/or untreated disorders.

Most major mental illnesses have a fairly gradual onset and rarely appear “out of the blue.” Generally, family members and friends will recognize that something about the individual is unusual, odd, or “not quite right” about their thinking, speech, behavior or social interactions. This can be well before the diagnosable indicators of severe mental illness are fully manifested.

Being informed about early warning signs and developing symptoms can lead to appropriate intervention and treatment which often can help to greatly reduce the severity and stress of an illness to both the individual and their loved ones. Consequently, early intervention can delay or even prevent the onset of a chronic course for a number of disorders. As with many medical conditions, early detection and treatment can not only minister to the person’s suffering more effectively, but many times the pain and subsequent course of treatment can be reduced accordingly. Being educated about and alert to key early warning symptoms may even prevent more severe distress and dysfunction.

Here are some common signs and symptoms which are potentially indicative of mental illness:

- *Recent social withdrawal and loss of interest in relationships with others.*
- *Intensified conflict and difficulty relating normally with others.*
- *Unusual reduction in functioning at work, school, church and/or community activities.*
- *Problems with concentration, memory, confusion and cognitive processing.*
- *Loss of initiative or desire to participate in normal and/or pleasurable activities.*

- *Marked changes in sleep and/or appetite.*
- *Rapid or dramatic shift in emotions or “mood swings.”*
- *Deterioration in personal hygiene.*
- *Excessive and/or unexplained fears, suspicions, worries and anxieties.*
- *Numerous vague or ambiguous physical ailments and complaints.*
- *Intense and prolonged feelings of sadness, nervousness, irritability or anger.*
- *Progressive inability to cope with everyday stress and strain.*
- *Heightened sensitivity to sensory stimuli such as sights, sounds, smells or touch.*
- *Uncharacteristic, bizarre or peculiar behavior, thoughts and/or beliefs.*
- *Vague or specific mentions of hopelessness, apathy, despair and/or suicidality.*

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Each person’s situation must be *carefully assessed* and their treatment *individualized*.

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Please know that these symptoms in and of themselves cannot clearly or conclusively predict mental illness. In fact, symptoms of mental illness may be the result of a medical condition (for example, hypothyroidism may result in symptoms of depression). A person

showing signs of mental illness should be screened by a physician to determine if there are any underlying medical issues. Barring any medical causes, persons exhibiting even a few of these are likely to be experiencing significant psychological problems which may be impairing or interfering with their ability to love and work well, and thus are candidates to be screened by a mental health professional. Supportively and compassionately encouraging persons who are displaying several of these symptoms to seek help may prove difficult but it is essential.

One thing that should be considered is the role of pharmacologic assistance in the treatment of certain mental or emotional problems. There is a stigma attached to the use of medication to treat mental illnesses including depression, anxiety disorders and even more serious issues. Fortunately, that stigma has diminished somewhat in recent years, but it is still alive and well in many places, including the church. As followers of Christ we may feel that our problems should go away if we simply have more faith or trust in God. While faith and trust may be at the root of many of our difficulties, there are some issues that aren't caused by deficiencies in our relationship with God. We live in a fallen world where things go wrong with our physical bodies, including our brains. For many whose disordered behaviors or thoughts are caused by chemical imbalances in the brain, the right medication can allow these individuals to regain balance along with the capacity to deal with personal issues and problematic beliefs and ways of thinking. You can do your parishioners an invaluable service by supporting them in their appropriate use of medication.

Spiritual tools, resources and disciplines have been proven helpful in reducing the symptom severity and relapse rate. They can activate and speed up the recovery process, as well as render distress and suffering easier for the person to endure. Providing hope,

health and healing to the hurting in an informed and capable manner is a valuable and specialized form of ministry no less important than any other way in which you serve your congregation.

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Abundant research has demonstrated that *strong spiritual supports and beliefs are instrumental* not only in preventing some mental and emotional difficulties in the first place, but are *highly effective* in their treatment and recovery.

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1. *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*, US Department of Health and Human Services, December 2013.
2. *American Journal of Psychiatry*, 166(6), 2008.

# How to Make an Effective Referral to a Christian Counselor

*Dr. Jared Pingleton*

Life is relational. We were designed by the Creator in relationship, through relationship and for relationship. Without the reality and reciprocity of relationships, life itself could not continue.

But like life, relationships are rarely simple or easy. Sometimes life throws difficult things our way. For all of us, there is often hurt and heartache. Distance and disappointment. Crisis and conflict. The results of life's trials, temptations and tragedies can leave us filled with pain, doubt, resentment and unforgiveness. We wonder why God permits our suffering, sadness and sorrow. We may feel hurt, alone, confused, hopeless and scared to reach out for help.

As ministry leaders, we are not immune to or exempt from these “growth opportunities.” First, whether addressing these issues personally, or on behalf of members of our flock professionally, the quintessential question becomes: “Who can I turn to for help?” This is a crucial concern which must be considered carefully. Several factors are important in prayerfully selecting a person from whom we seek guidance and assistance for ourselves, or our family members or for parishioners when their problems transcend the scope of our expertise or training.

Among other things, we wonder if the therapist will be safe, trustworthy and respectful of my (or my congregant's) issues. Will they treat these concerns with care and confidentiality? Will they be nonjudgmental, accepting and sensitive? Can I trust them as

a supportive ally to my ministry or will they be an undermining adversary? And most importantly, are they doctrinally orthodox and do they know what they're doing—i.e., will they lead a client astray or to the path of life?

Consequently, I strongly recommend you make a concerted effort to develop a close and healthy working relationship with a reputable Christian counselor(s) in your area so that you can make referrals with confidence and assurance. Here are some key “fruit” to look for in selecting a good referral for Christian counseling:

- *Does the therapist possess and manifest a personal and growing relationship with Jesus Christ?*
- *Does the therapist possess and demonstrate a genuine love and concern for people who are hurting?*
- *Does the therapist base their work on a biblical worldview and value system?*
- *Does the therapist express a desire to be seen by you as a trusted colleague in ministry, and are they open to consulting with you on the client's behalf provided the appropriate release forms are signed to maintain a healthy confidentiality boundary?*
- *Does the therapist have the appropriate professional training, credentials, experience and state licensure as a certified mental health professional? There are several types of professional credentials reflecting various levels of training, ranging from masters-level professional counselors, marriage and family therapists, and social workers to doctoral-level psychologists and psychiatrists.*

That last point is one that you may have to help your parishioner or his/her family explore, as many find the mental health care field confusing. For instance, many people are unaware of the differences between psychologists (individuals with doctoral-level education who specialize in counseling and psychotherapy) and psychiatrists (medical doctors with special training in the treatment, including pharmacologic treatment, of mental disorders). Your aid in understanding the various forms of professional assistance available can be valuable and encouraging at a time when people often feel highly vulnerable.

Secondly, once we have established a strong collegial working alliance with a good, solid therapist, often the tricky part becomes how to successfully hand off our church member to them. Many times your sheep may feel abandoned or rejected by thinking you don't care for them or don't want to help them yourself.

In this scenario, it is essential to emphasize to the person/family that the best way you can care for them is to recommend someone else—a trained specialist in their particular area of need—who can help them better than you can. Make the referral clear; explain why you believe it to be in their best interests, and make sure to follow up with them later to see if they contacted the clinician and how the process is going. A good referral is crucial to good counseling.

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Many times, it is also important to *reduce the shame and stigma many in the church still have* regarding counseling or psychotherapy and mental illness.

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That applies to the appropriate use of antidepressants and other medications, too. Our culture is still in some respects confused and/or ignorant about the nature and dynamics of emotional, mental and relational dysfunction, and in other ways humiliates those who suffer with these (e.g., media/sitcom depictions and labels of “crazy,” “wacko,” “nutcase,” or “funny farms,” “psycho wards,” etc., to disparage persons with such pain).

Your role is both instrumental and invaluable in helping to sensitively and compassionately normalize the incidence and universality of typical human struggles. Most resistance to receiving help is based on fear, pride, shame or some combination thereof. Keep in mind that nearly 44 million<sup>1</sup> U.S. adults suffer from a diagnosable mental illness each year ... that's about one of every five people! Address it. Communicate about it with your congregation. Don't over-spiritualize it. There is much ministry to do.

Keep shepherding! Set and maintain healthy boundaries with them regarding their treatment by asking them in general ways

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It is very important to *stay alongside persons* whom you refer for help, not only to offer them ongoing quality pastoral care, prayer and support, but to *ensure that they do not feel discarded or forgotten.*

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how the counseling process is going. It may be helpful to ask their permission to consult with their clinician and have them sign the requisite release of information form to do so. Many

clinicians find that working together with a referring pastor makes each's respective role easier and more productive. Feedback about medication compliance, social interaction-functioning, supportive structures and other pastoral observations can be vital information to a clinician to better help your sheep.

If you do not live in an area that has mental health professionals who meet all the above criteria, or have any related questions or concerns, please give our Counseling Department a call at 1-855-771-HELP (4357). A member of our highly trained and experienced team of licensed mental health clinicians and pastoral counselors will be happy to consult with you or your parishioners to offer helpful resources and/or referrals through Focus on the Family's Christian Counselor Network ([FocusOnTheFamily.com/FindACounselor](https://www.FocusOnTheFamily.com/FindACounselor)).

# PRACTICAL ENGAGEMENT

# 3

## Approaching Mental Illness in Your Congregation

*The following section details steps church leaders can take when approaching the sensitive topic of mental illness with a member of their congregation. Listed below are the most common situations in which a pastor may encounter an individual experiencing mental illness.*

- A PASTORAL OBSERVATION**  
Pastor observes concerning behavior in a church member
- B INDIVIDUAL SELF-DISCLOSURE**  
Church member confides in pastor
- C CONGREGATIONAL CONCERN**  
Group within your congregation expresses concern for a fellow member

1. [samhsa.gov/data/NSDUH/2k12MH\\_FindingsandDetTables/2K12MHF/NSDUHmlhf2012.htm#fig2](https://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmlhf2012.htm#fig2)

## A PASTORAL OBSERVATION

### 1. Pray for wisdom on how to approach the issue.

#### QUESTIONS: Personal vs. group intervention? Does this situation need professional assistance?

- If you don't feel confident in approaching by yourself, **seek help** from elders and/or deacons.
- If you plan to approach the individual/family in a group setting, **ensure** that privacy, dignity and respect are foundational.
- If you feel the situation needs professional guidance, please **call** Focus on the Family for a counseling consult.

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#### PITFALL TO AVOID

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Be sensitive to the fact that your *well-intended reaching out* can, and often will, be misperceived as criticism, judgment and rejection.

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### 2. Determine resources needed to meet the need of the family/individual.

#### QUESTION: Where do you find quality resources?

- **Reference:** page 63 of this booklet.
- Call Focus on the Family for a consultation with a counselor.

### 3. Commit to ongoing shepherding.

- **See:** Ongoing care article on page 22 of this booklet.
- It's important that after resources are determined and possible counseling referrals are made, you continue to **regularly meet** with and personally serve the individual/family. Continuing to **pastor families** as they work through these challenges is part of your call as a minister of the gospel.

## INDIVIDUAL SELF-DISCLOSURE



### 1. Have a **compassionate and empathetic response** to the family/individual that has confided in you.

- If an imminent risk of suicide or harm to others is expressed, call 911.

### 2. **Pray** for discernment on how to meet the need.

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#### PITFALL TO AVOID

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Be aware of the shame and stigma some people feel about mental illness. Biblically normalize human struggles and differences. *Christ died for everyone.* The Bible never whitewashes or hides our brokenness. *All are Imago Dei* and are of equal worth and value at the foot of the cross.

### 3. Commit to helping find resources and provide/

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#### PITFALL TO AVOID

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Don't forget that *mental illness is a legitimate medical issue* involving the brain. It is not unlike medical issues involving other parts of the body such as diabetes, immune disorders or heart conditions. Take care to *avoid encouraging people to simply have more faith* in order to be "cured."

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**enlist support** from others in the congregation and/or community concerning your church.

- **See:** "How to Make an Effective Referral to a Christian Counselor" article on [page 22](#) of this booklet.

### 4. **Evaluate** how your church can make a bigger ministry contribution to that family/individual.

- *Financial assistance*—provide **consistent respite care** for families.

**EXAMPLE:** meals, regular/frequent childcare, counseling/medical, basic living needs

- *Tailor **programming** during church service to help the individual, give the family reprieve, and encourage others to serve in a diverse and needed manner.*

**EXAMPLE:** Tailor classes or care to meet the needs of the family or individual

- ***Dedicate** a volunteer or a team of volunteers to serve consistently alongside a family to ensure familiarity, structure and continuity of care.*
- ***Seek out** community resources and connect them to your church or the families in your church.*
- ***Work in partnership** to support the individual or family in need.*

**EXAMPLE:** transportation, daily living logistics and care

### 5. Evaluate Commit to **ongoing shepherding.**

- **Reference:** [A, Step 3](#)

## C CONGREGATIONAL CONCERN

1. **Validate** those who are concerned, lovingly reminding people that mental illness is a real and medical concern, not simply an issue of one's attitude.

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### PITFALL TO AVOID

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When evaluating what is needed to care for the individual/family, ask what they need before you offer suggestions. *Be ready to listen and serve.* Don't approach a situation if you can't or don't intend to *serve* in a meaningful way. Failure to follow through with care and ongoing shepherding can be extremely hurtful to those who are reaching out and result in further discouragement and isolation.

2. **Challenge and inspire** those who are concerned to exemplify Christ-like behavior and attitudes toward the family/individual and anyone else involved.

- *Cut out all gossip and encourage compassion and empathy.*
- *Admit to frustrations and/or challenges that might lay ahead, but do so in a way that is respectful and in a loving manner.*
- *Remember that we are to edify each other in Christ, as we are all made in His image and likeness.*

3. **Pray** for wisdom on how to approach the issue.

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### PITFALL TO AVOID

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It's normal to feel overwhelmed and ill-equipped to effectively meet the ministry needs of severe and/or chronic mental illness. *Pray* for provision. *Enlist* help from others. *Utilize* resources. *Give* yourself grace.

- **Reference:** *A, Step 1-3*

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### PITFALL TO AVOID

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Don't forget that *mental illness is a legitimate medical issue* involving the brain. It is not unlike medical issues involving other parts of the body such as diabetes, immune disorders or heart conditions. Take care to *avoid encouraging people to simply have more faith* in order to be "cured."

## Depression

*Dr. Donald Graber*

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Life has its discouraging moments, and everyone feels down and sad at times. We are imperfect people living in an imperfect world where we experience disappointments, setbacks, illnesses and losses. Difficulties in a relationship, losing a job, moving away from family and friends—all of these can evoke feelings of great sadness, and this is common and normal. Similarly, the grief that's experienced with a profound loss—say, the death of a loved one—brings feelings of sorrow and distress that are natural. Depression, however, is a different sort of emotional and mental challenge. It is a serious condition that can be incapacitating, devastating and even deadly for those who suffer from it.

Usually, depression affects the whole person. When patients ask me if their depression is physical, psychological or spiritual, my answer is “yes.” Physically, or biologically, depression typically affects energy levels, appetite, sleep, sex drive and other aspects of our physical health. In the same way that depression can affect our

bodies, physical illnesses can affect our moods and emotions. It's important that certain medical conditions be ruled out before a diagnosis of depression is made.

Psychologically, depression can affect concentration, confidence and interest in the activities of daily life or things which once gave pleasure. At its worst, depression can make a person feel so helpless and hopeless that they may be tempted to take their own life.

Spiritually, depression can cause a person to feel that God is distant or unconcerned. Sometimes it can give rise to doubts and guilt that one might not feel apart from depression.

In the U.S., nearly 8 percent of adults and teens report current feelings of depression, and about 16 percent of people will experience depression in their lifetime. Because depression is so widespread, it has been referred to by some as “the common cold of mental illness.”

Depression's costs to society are enormous. It's estimated that depression is the primary diagnosis for nearly 8 million visits to health care providers, including physician offices and emergency rooms. For those cases of depression that result in a hospital admission, the average stay is longer than six days. The economic cost of depression is figured to be around \$83 billion per year, including lost workplace productivity and treatment costs.

While the societal costs of depression are significant, let's talk about the toll it can take on the individual, which can be enormous.

## WHAT IS DEPRESSION?

When people talk about clinical depression (sometimes referred to as major depression or major depressive disorder), they are typically referring to one of a variety of serious, disabling mood disorders.

According to the American Psychiatric Association's DSM-5 (the Diagnostic and Statistical Manual of Mental Disorders), for a diagnosis of clinical depression to be made, a person must have at least five of the following symptoms for at least two weeks, and depressed mood or loss of interest or pleasure must be among the symptoms:

- *Depressed mood most of the day, nearly every day.*
- *Markedly diminished interest or pleasure in all or almost all activities.*
- *Significant weight loss when not dieting, or weight gain, or significant decrease or increase in appetite.*
- *Changes in sleep habits, either insomnia or hypersomnia (sleeping more than normal).*
- *Psychomotor agitation (e.g., restlessness or fidgeting) or retardation (sluggishness).*
- *Lack of energy or fatigue.*
- *Feelings of worthlessness or excessive or inappropriate guilt.*
- *Difficulty thinking, concentrating or making decisions.*
- *Recurrent thoughts of death or suicide.*

Additionally, the symptoms must cause significant distress and impairment in social or occupational functioning, and must not be due to the physiological effects of a substance (such as medications, drugs or alcohol) or a medical condition.

## WHAT CAUSES DEPRESSION?

In layman's terms, depression results from a deficiency or imbalance in various neurotransmitters, the chemical messengers in the

brain. Serotonin, norepinephrine and dopamine are just three such chemicals. One of the most compelling lines of evidence for the idea that depression stems from neurotransmitter imbalance or deficiency is that antidepressants, which are known to increase the availability of certain neurotransmitters, offer relief from depression for many sufferers. There are many reasons why one might become deficient in neurotransmitters, including genetics, certain drugs, and various physical diseases such as hypothyroidism or stroke. A physician should work to identify and rule out any possible medical conditions that could account for symptoms of depression.

That's not to say that we know all there is to know about the causes of depression. For example, we don't know for sure why stress or trauma triggers depression in some individuals and not in others, or why depression occurs in some individuals with no apparent trigger at all. And while we know that medications can relieve depression in some people, scientists cannot say with exact certainty how these medications work. In fact, the cause of depression in certain individuals is often unknown, as is true for many illnesses. Nevertheless, depression can be treated.

Depression seems to have a genetic component, and some types of depression tend to run in families. It can occur, however, in some people who have no family history of the disorder.

### WHAT HELP IS AVAILABLE FOR PEOPLE WITH DEPRESSION?

Most people who receive help for depression see improvements in their mood and their lives. The two main forms of treatment for depression include antidepressant medication and psychotherapy.

A medical approach to dealing with depression may involve a primary care doctor (typically a family physician or internal

medicine specialist) who may run tests to determine whether symptoms are the result of physical problems (for example, hypothyroidism, anemia or even stroke). If no underlying physical illness or condition is found, the doctor may recommend an antidepressant. Most antidepressants are designed to help regulate certain neurotransmitters in the brain, including serotonin and norepinephrine. The primary care professional may refer to a psychiatrist for cases that do not resolve with relatively simple medical care. A psychiatrist is a medical doctor who is specially trained to treat mental disorders. Be aware that a particular antidepressant may work effectively in one person but not the next, so a doctor may have to adjust medication to find the medication (and the dosage) that is best. And as these medications typically take weeks to exert their effects, understand that the process can take some time.

While antidepressants are the primary biological treatment of depression, they are not effective in all patients. In cases of depression that are unresponsive to antidepressants, therapies such as transcranial magnetic stimulation or electroconvulsive therapy may be recommended.

Psychological treatments include many kinds of psychotherapies such as cognitive-behavioral, interpersonal, and psychodynamic therapies. Mental health professionals such as psychologists or counselors can be key to treatment. Therapists employ a number of approaches that can assist individuals with depression, helping them to recognize and deal with psychological, interpersonal or behavioral factors that might be contributing to the depression. For some people with depression, learning new ways to think about a problem, approach a troubled relationship or take charge of personal behaviors can provide substantial relief. False beliefs and self-defeating ideas can be changed.

Focus on the Family may be able to help you locate a licensed Christian counselor in your area. For more information, call Focus' Counseling Department at 1-855-771-HELP (4357) Monday through Friday between 6:00 a.m. and 8:00 p.m. Mountain Time.

While medication and therapy are important means of dealing with depression, don't underestimate the value of healthy lifestyle changes. Many people find that symptoms of depression are relieved or lessened with regular physical activity, and proper nutrition is always helpful. Getting enough sleep (somewhere around seven to eight hours each night) can be difficult for people whose depression leads to sleep disturbances, but many find that dealing with existing sleep disorders helps with mood and cognitive problems associated with depression. Likewise, regular contact with friends and family can bolster social support. Finding new ways to reduce or deal effectively with stress helps, too.

Finally, one ought not to forget the spiritual dimension of those who are suffering from depression. Spiritually, I emphasize grace and unconditional love and acceptance. A person's understanding of grace and His acceptability are not rooted in performance—that is, measuring up to any set of rules, codes of conduct, personal or parental expectations and the like. Most people suffering from clinical depression really don't get this. We get into trouble as soon as we add anything to grace as a condition for God's acceptance and love. An intimate relationship with God grounded in His grace alone is very freeing psychologically and spiritually. We become less critical of ourselves and others, and more loving in our relationships. Yes, God wants to change us to become more like Himself, but genuine change comes from His Spirit at work in our hearts, not from external threats of punishment or the fear that He won't accept or love us if we “miss the mark.”

There is no question in my mind that God does not want us to be anxious or depressed (Philippians 4:6-7; Colossians 3:15). He wants us to be at peace with Him and others. And God often uses medications and people to impact our health. Christian medicine and psychiatry should utilize any available and necessary medical, psychological and spiritual resources to alleviate anxiety and depression, restore relationship with God and others, and promote recovery of health to body, mind and spirit. God wants to do good things in our lives, and He wants to do good things in others' lives through us. But the primary basis of it all is our relationship with God. Let all the rest grow out of this relationship.

### **WHY MIGHT SOMEONE NOT SEEK HELP FOR DEPRESSION?**

Many people with depression never get the help that's available. Some avoid getting help because they fear that dealing with depression will be perceived as weakness, or that reaching out for help will send the same signal. Many Christians don't get help because they believe that depression is a sign of spiritual failure, or they fear the stigma in their faith community that's associated with depression (see below). Others neglect help because they simply do not realize that what they are experiencing is not normal, and that help is available for them.

### **HOW CAN I HELP SOMEONE WHO MAY BE DEPRESSED?**

Depression is a very lonely illness, and people with depression tend to avoid other people and isolate themselves. If this is the case with your congregant, you'll need to take the initiative in seeking her out and talking with her about what you're seeing in her life and why you are concerned for her.

Share any encouragement you can. Let her know that depression is very common and that it's treatable. While depression can be an

enduring condition, in my more than 40 years of experience as a psychiatrist I have never seen an incidence of depression last forever. Let the individual know that depression doesn't last forever, and that it is likely to resolve more quickly if treated.

Someone with severe depression may find themselves incapacitated by the disorder. Offers of practical assistance—preparing meals, providing transportation (including to appointments), and assisting her in finding professional help for her depression—can be an incredible blessing.

On a very serious note, if your congregant expresses any intention of suicide, she should not be left alone. Do whatever is necessary for her safety. This may include taking her to an emergency room.

### **WHY AM I EXPERIENCING DEPRESSION WHEN I AM A CHRISTIAN?**

Christians are not immune to depression, and the epidemic of depression seems to be as great inside the church as outside. One great tragedy in some Christian circles is the notion that depression is primarily a spiritual issue, and is reflective mainly of one's level of faith and trust in God.

Can depression affect a person's spiritual life? Of course. Can unresolved spiritual problems contribute to symptoms of depression? Yes. But to say to the person dealing with depression that he should rid himself of depression by simply praying more or having greater trust in God is like telling the man with a broken arm that he should have greater faith and his arm will be well. We wouldn't scold a person for having a broken bone or send him away with a platitude. Why would we do that to a brother or sister in Christ who's suffering the torments of depression? Why do so many in the church look askance at the use of antidepressants (or psychotherapy, for that matter) as a sign of weak faith when

they wouldn't dismiss a diabetic taking insulin as a person who obviously lacks trust in God?

If someone is dealing with depression and they feel that the use of medications is somehow sinful or evidence of a lack of faith, urge them to reconsider. For some people, the use of antidepressants is a lifeline, allowing them to function normally and helping them to reconnect with others and with God in ways that might not otherwise be possible. The same can be said for the use of professional counseling and psychotherapy.

In my years as a psychiatrist I have seen marriages decimated and families wrenched apart by depression. But it doesn't always have to be that way. If someone is suffering from depression, encourage him or her to get the help that's needed.

## Anxiety Disorders

*Dr. Donald Graber*

We've all felt worried or anxious at one point or another. Taking a test in school, interviewing for a job, undergoing a tax audit, facing an unexpected health crisis—these are the types of situations that many people find stressful and which might provoke intense feelings of unease.

As a psychiatrist, I've brought to many people's attention the fact that many of the troubles we worry over never do actually come about. Furthermore, when we take the time to realistically consider and work through "worst-case scenarios" we can enjoy a measure of clear-headedness and calm when considering potential problems. So while worry and anxiety are unpleasant, these feelings can be quite useful if they prompt us to plan and take action. For example, considering the situations above, if worry causes us to study harder, prepare for the job interview, keep our tax records and financial paperwork in order, or attend to the needs of our physical body, these anxious feelings will have served a good purpose.

We all worry to some extent from time to time, but most people move through life without being debilitated by the fear of life's difficulties and unknowns. Some of us, though, find our lives disrupted by fear and anxiety.

### ANXIETY AS A MENTAL HEALTH CONCERN

God gave us the capacity for fear to protect us. Fear not only motivates us to avoid hazardous situations, but it helps to prepare our bodies to fight or flee when we are in danger. Unfortunately, our brains and bodies can act as if we're facing an imminent threat even when we're not, and feelings of fear can explode

into uncontrollable dread and panic. These feelings can arise suddenly even in the absence of any discernible trigger. One can experience worry or fears about future uncertainties that are so overpowering that normal everyday functioning is impaired. These are just a few of the signs of a class of illnesses known collectively as *anxiety disorders*.

As is common with other mental health issues, people with anxiety disorders can feel very alone, like they are dealing with something that no one else is facing. The fact is, anxiety disorders are not uncommon. It's estimated that each year about 18 percent of adults in the U.S. deal with an anxiety disorder. If a parishioner is struggling with an anxiety disorder, they are *not* alone. Let's take a look at some of these disorders.

### *Generalized Anxiety Disorder (GAD)*

People who suffer from this disorder experience excessive anxiety or worry about the things of everyday life in a way that causes distress or significant impairment in normal daily functioning. For a diagnosis of GAD to be made, feelings of anxiety must occur most days for six months. GAD sufferers may have feelings of restlessness or edginess, become easily fatigued, have difficulty concentrating or experience their mind going blank and experience irritability, muscle tension or sleep disturbances.

Treatments for GAD include psychotherapy such as cognitive behavior therapy to address patterns of thinking that lead to anxiety. Certain medications may also be of help.

### *Panic Disorder*

The hallmark of this disorder is sudden, terrifying and often unexpected panic attacks. There are a number of symptoms that may accompany these attacks: an elevated heart rate or a pounding heartbeat, sweating, trembling or shaking, the feeling of being short



of breath or being unable to breathe, a sensation of choking, chest pain or discomfort, nausea or abdominal distress, dizziness, light-headedness, or feeling faint, feelings that one is not experiencing reality or is detached from oneself, fear of losing control or going insane, a sense of doom or imminent death, numbness or tingling sensations, and chills or hot flushes. A person having a panic attack may believe they are having a heart attack. The intensity of these panic attacks can be so great that people may live in constant fear of the next attack.

Psychotherapy can be helpful in the treatment of panic disorder, as can the use of certain medications. Many people respond best with a combination of psychotherapy and medication.

### ***Agoraphobia***

This disorder is characterized by a dread associated with certain places, usually public ones. Places that provoke discomfort often are vastly open or crowded spaces, and sufferers may fear being unable to escape. They may feel helpless or embarrassed at the thought of having feelings of anxiety in public places. Consequently, some with agoraphobia may refuse to leave their home, or leave it only with feelings of great distress.

Agoraphobia can be treated with psychotherapy or medication, or a combination of the two.

### ***Social Anxiety Disorder***

While a lot of people find novel social situations (like going to a party where they don't know anyone, or going on a blind date) to be a bit awkward or stressful, people with social anxiety disorder—sometimes called social phobia—have an intense, excessive, persistent fear of being judged or scrutinized by others or being humiliated in social situations. Individuals with social anxiety

disorder might seemingly get through a social event okay, but the anxiety felt before and during the situation can be excruciating, and the individual may worry for hours afterward about how they were perceived. The anxiety can be such that it can even provoke a panic attack when social situations approach or are contemplated. The diagnostic criteria include avoidance of social situations, along with distress that interferes with a normal routine or normal functioning at work or school. For adults, this persists for at least six months.

Certain medications may be helpful in the treatment of social anxiety disorder, as can psychotherapy.

### ***Specific Phobias***

Specific phobias are marked by a persistent, powerful, irrational fear of something. The object of fear may be something that most other people would encounter with some sense of discomfort (like snakes) but the fear may also focus on apparently harmless things (clowns, kittens). Sometimes even just thinking about the object of the phobia can bring on intense anxiety, and encountering the feared object or situation can provoke a panic attack. Many phobias can interfere drastically with the individual's ability to function. A person with a phobia against flying, for example, might turn down job offers or choose career paths based on the fear that air travel might be involved.

Effective treatment of specific phobias involves psychotherapy. One particular form of therapy that can be useful is called desensitization. In desensitization therapy, the patient is asked to experience or think about the object of the phobia while at the same time the patient employs relaxation techniques. By confronting anxiety-provoking thoughts while relaxing, the patient finds that specific thoughts or experiences do not have to be linked to fear and anxiety.

Another form of therapy called eye movement desensitization and reprocessing (EMDR) has been gaining popularity in recent years. EMDR involves the patient visually tracking the hand movements of the therapist while the therapist prompts the patient to think about the object of the phobia. While a number of individuals have claimed success with this mode of therapy, research into EMDR is ongoing.

The list of anxiety disorders above is not exhaustive, and DSM-5, the latest version of the manual used by mental health professionals to diagnose mental health conditions, mentions several other conditions that fall within the classification of anxiety disorder.

In previous years the category of anxiety disorders had included two other conditions—obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). While both of these are characterized in part by feelings of anxiousness and discomfort, DSM-5 distinguishes OCD and PTSD from anxiety disorders. I describe them below for those who may be used to the older classification.

### ***Obsessive-Compulsive Disorder (OCD)***

Almost everyone has left their home only to wonder later if they've turned off the stove or locked the door. A person dealing with OCD, however, may have troubling thoughts (obsessions) like these that are persistent, recurrent and distressing. The obsessions that an OCD-sufferer may struggle with are varied. Some individuals are preoccupied with symmetrical or ordered arrangement of objects and may feel troubled if objects are disarranged. Others may obsess over fears of committing a repugnant act of violence against a loved one. The fear of performing acts or harboring thoughts that are prohibited by one's religious beliefs is a common obsession. Many Bible-believing Christians with OCD experience incredible emotional suffering over concerns that they might have committed "the unpardonable sin" (Matthew 12:31; Mark 3:28-29; Luke 12:10).

Often, people with OCD will engage in ritual or repetitive behaviors (compulsions) in an attempt to reduce the anxiety produced by their obsessions. For instance, a person might have an obsession with germs, and his compulsion might manifest as repetitive hand washing. The fear that an oven might have been left on might lead a person to check the oven to make sure it's turned off—not once or twice, but many times. Common compulsions also include counting things or placing items in a precise order. These compulsions are not only distressing, but they take so much time and energy that they interfere with the course of normal life.

Certain antidepressant medications have proven helpful in treating some individuals with OCD. Additionally, psychotherapy designed to desensitize sufferers to situations that prompt anxiety or compulsive behavior can be helpful.

### ***Post-Traumatic Stress Disorder (PTSD)***

This particular disorder has gained greater attention over the past decade as servicemen and women return from deployment having faced horrible and traumatizing circumstances. It is also being recognized more frequently as a common psychological result of violent crime, sexual assault, domestic abuse and even motor vehicle accidents.

PTSD can occur when a person is involved in or witnesses a life-threatening event or one that causes or threatens serious personal harm to oneself or others. Intense distress may be caused by things that remind the person about the event (such as loud noises or being surprised by another person). They may experience distressing memories of the event, a sense that the incident is somehow being replayed (such as flashbacks), or have disturbing dreams about the event. They may avoid any conversation about the trauma or make special efforts to avoid activities or places that remind them of the trauma. Conversely, a person with PTSD may be unable to recall

significant aspects of the trauma. They may become detached from others and find it difficult to show affection. They may find that they no longer enjoy things or activities that were once of interest.

Individuals who suffer from PTSD may also experience difficulty falling or staying asleep, or have difficulty concentrating. They may become hypervigilant or be easily startled. They may become irritable or prone to angry outbursts. Symptoms of PTSD are distressful to the point of impairing normal functions, including causing significant social or occupational difficulties.

Several medications have been useful in treating PTSD, and certain types of psychotherapy, including desensitization therapy and EMDR, may also be helpful.

### WHAT CAUSES ANXIETY DISORDERS?

Our understanding of the roots of anxiety disorders is very incomplete. Anxiety disorders constitute a class of mental health issues, and the underlying causes for each one may vary.

It is not clear, for example, why a specific phobia might afflict one person but not another. It's likely that genetic and environmental factors combine to make some people more susceptible to certain anxiety disorders, and research is currently being done to increase our knowledge.

### WHY MIGHT SOMEONE NOT SEEK HELP FOR AN ANXIETY DISORDER?

Some people with anxiety disorders never get the help that's available. They may simply be unaware that something can be done about their anxiety, or they may avoid getting help because they fear that dealing with anxiety or reaching out for help will be perceived as weakness. Sometimes Christians don't get help because they believe anxiety is a sign of spiritual failure, or they fear the

stigma in their faith community that's associated with an anxiety disorder (see below).

### WHAT CAN I DO TO HELP SOMEONE WITH AN ANXIETY DISORDER?

Anxiety disorders cause tremendous suffering to those who are afflicted, but they can also devastate a patient's family and loved ones. Too often, the stress and pain of an anxiety disorder shatters families and destroys relationships. If you believe that a parishioner is dealing with an anxiety disorder, encourage them to get help. Often, a person with anxiety will seek the help he or she needs if only someone will encourage them in that direction.

### WHAT HELP IS AVAILABLE FOR PEOPLE WITH ANXIETY DISORDERS?

Left untreated, anxiety disorders can be disabling. The good news is that there are helpful treatments for these disorders, and most people who undergo treatment see real improvements.

Individuals who believe they may have an anxiety disorder should seek a thorough examination by a physician to examine the possibility that symptoms are the result of a separate medical condition. In fact, DSM-5 lists "Anxiety Disorder Due to Another Medical Condition" as a distinct diagnosis. Medical conditions that may produce anxiety include hyperthyroidism, hypoglycemia, cardiac arrhythmia and vitamin B12 deficiency, among others. A physician can help identify and treat medical conditions that may produce anxiety. He or she may also be able to determine whether the anxiety being experienced is the result of medications or other substances (a condition known as "Substance/Medication-induced Anxiety Disorder").

If it appears that anxiety is not the result of an underlying medical condition or any medication, another type of anxiety disorder may

be diagnosed. A primary care doctor such as a family physician or an internal medicine specialist may prescribe medications to relieve anxiety, and may also recommend psychotherapy. A primary care professional might refer to a psychiatrist for cases that don't respond to relatively simple medical care. A psychiatrist is a medical doctor who is specially trained to treat mental disorders.

Medications cannot “cure” anxiety disorders but they may relieve a person's symptoms enough to allow them to function and respond to psychotherapy. Antidepressants including selective serotonin reuptake inhibitors (SSRIs) have been found to be effective in treating panic disorder and social anxiety disorder. They may also be effective for OCD and PTSD. GAD may be treated with certain serotonin-norepinephrine reuptake inhibitors. An older class of anti-anxiety drugs known as benzodiazepines may be used in the treatment of GAD, social anxiety disorder and panic disorder, but these drugs are typically reserved for use as adjunct therapies.

A drug that is effective in treating an anxiety disorder in one patient may not be effective in someone else. Some drugs take several weeks to exert their full effects, and patients may not experience improvements for some time. It may take a patient and his or her doctor weeks or even months to find the right medication at the dosage that works best.

Sometimes people will begin to feel better after being on medication for a while, and they may stop taking medication because they feel they no longer need it. Unfortunately, symptoms can return after a person stops taking their prescription. Abruptly quitting certain medications can result in negative side effects. Individuals who wish to discontinue their medication should do so in consultation with, and under the supervision of, a physician.

In addition to medication, psychotherapy can be an effective treatment for anxiety disorders. Psychotherapy involves talking

with a qualified professional who can help patients learn how to deal with their anxiety. One form of psychotherapy that is particularly helpful in treating anxiety disorders is cognitive-behavioral therapy (CBT). With CBT, individuals examine how their thoughts and behaviors contribute to anxiety. They then learn new ways to think about their experiences and circumstances and how to recognize and alter dysfunctional thought or behavior patterns. CBT may be useful in the treatment of GAD, panic disorder, specific phobias and social anxiety disorder, as well as OCD and PTSD. Another form of therapy—desensitization—is mentioned above.

Many individuals experience best treatment results when medications are combined with psychotherapy.

Focus on the Family may be able to help you locate a licensed Christian counselor or mental health professional in your area. For more information, call Focus' Counseling Department at 1-855-771-HELP (4357) Monday through Friday between 6:00 a.m. and 8:00 p.m. Mountain Time.

## WHY AM I EXPERIENCING AN ANXIETY DISORDER IF I AM A CHRISTIAN?

Christians are not immune to anxiety disorders. One tragic notion that persists in some Christian circles is the idea that problems like anxiety are primarily, if not completely, spiritual in nature. Many Christians sincerely believe that a person should not experience anxiety disorders if he or she just has enough faith and trust in God. That is simply not true.

Well-meaning Christians may quote Scripture passages such as, “There is no fear in love, but perfect love casts out fear ... whoever fears has not been perfected in love” (1 John 4:18, ESV). This verse reminds us that God is greater than anything we will face

in this world, and it assures us of the confidence we can enjoy when we stand before God someday. But it was not written as a pronouncement on anxiety disorders. Anxiety disorders can affect a person's spiritual life, and spiritual issues may be interwoven with a person's anxiety, but to say that the person with an anxiety disorder should simply trust God more is like telling the woman with a broken bone that she should just have greater faith, and she will be well. We wouldn't scold or throw out-of-context Bible verses at a person with a broken bone. Why would we do that to a fellow believer who's suffering the torments of an anxiety disorder?

In a similar vein, some Christians disparage the use of medications in treating anxiety disorders or other mental health problems. But we wouldn't dismiss a diabetic who takes insulin as someone who obviously lacks trust in God. In the same way, we ought not to look at those who take medication for anxiety as somehow deficient in their faith.

If someone is dealing with an anxiety disorder, and they feel that the use of medications is somehow sinful or evidence of a lack of faith, urge them to reconsider. For some people, the use of medications is a lifeline, allowing them to function normally and helping them to reconnect with others and with God in ways that might not otherwise be possible.

### A FEW WORDS ON ANXIETY AND SUBSTANCE ABUSE ...

Some people with anxiety disorders use alcohol or drugs to medicate themselves and relieve feelings of distress. Unfortunately, illicit drugs and alcohol are no more helpful for treating anxiety disorders than they would be for treating pneumonia.

Alcohol and drugs can mask the symptoms of anxiety disorders, making diagnosis and treatment more difficult. In some people, they can worsen or actually cause anxiety. Additionally, using

drugs or alcohol to deal with anxiety increases risks for drug addiction or alcoholism. If someone uses drugs or alcohol to cope with an anxiety disorder, counsel them to speak to a qualified mental health professional. Substance abuse has only downsides, never an upside.

### CONCLUSION

Anxiety disorders are much more than simple jitters or nervousness; the feelings of fear and anxiety that accompany them can be debilitating. The good news is that help is available and these conditions can be managed with the proper combination of medical and psychological care and spiritual support. While not discussed in detail above, this last element is extremely important, as anxiety disorders can challenge the notion that God is a loving Father who is trustworthy and cares for us and is in control of all things. If someone is dealing with an anxiety disorder, encourage them to consider the benefits of Christian counseling, pastoral care and the support of a strong faith community. Combined with other forms of care, these can help people struggling with anxiety to live a vibrant and effective life for Christ.

## Bipolar Disorder

Dr. Donald Graber

*“When I was high, I was high as the sky,  
but when I was low, I was low as a snake’s belly.”*

*The above quote is from a woman diagnosed and treated for bipolar disorder in her 80s. It illustrates the oscillation of mood between mania and depression that can be all encompassing and disruptive of normal daily activities for the individual affected by bipolar disorder, as well as their family and loved ones.*

Bipolar disorder, a relatively common mental illness affecting millions of Americans, is sometimes known as “manic depressive illness.” Both names are descriptive of a single condition: “bipolar” refers to the two opposite poles of the mood swings, known as the highs and lows, and “manic–depressive” refers to these same exaggerated highs and lows.

As a psychiatrist, I find that when discussing bipolar disorder, or mental illness in general, it is especially important for patients and their loved ones to know there is hope and good news, because such diagnoses sound overwhelming and terrifying. It is tempting for individuals and their loved ones learning of a diagnosis of bipolar disorder to resent or deny its presence because, in part, of the stigma of mental illness.

A myth that has persisted is the belief that this disorder is the result of difficult personal circumstances or a series of poor or wrong choices, when, in fact, it ultimately results from imbalanced neurotransmitters (chemical messengers in the brain) that are

beyond the control of the individual. Our society has not placed a negative stigma on people for taking medication for other imbalances such as a thyroid disorder, heart disease or diabetes. But sometimes, when it comes to mental illness, there is the presumption of weakness, irresponsibility, lack of faith or some other character flaw.

As if that weren’t enough to contend with, there is an extra measure of shame and guilt heaped on the individual affected by mental illness, and often their loved ones. Sadly, it is not uncommon for these individuals to hear untruthful advice and condemnation in words such as, “If you would pray more,” or “If only you trusted God completely ...” Such misinformation has resulted in unnecessary suffering, lack of treatment and sometimes fatal outcomes.

### CHARACTERISTICS OF BIPOLAR DISORDER

Mood swings are a defining characteristic of bipolar disorder. It is normal for everyone to have fluctuations in mood, but those associated with bipolar disorder are distinguished by their extreme, severe and sometimes dramatic nature, as well as their potential dire consequences. These pronounced transformations in mood, which are cyclical (recurrent) in nature and go well beyond the normal range of “ups and downs” most people face, result from a disruption in brain function.

The extreme mood swings associated with bipolar disorder are challenging in their own right, and they can affect one’s perception of God, self and others, and therefore have a negative effect on relationships. The manic cycle of bipolar disorder consists of a period of elevated, euphoric, and sometimes irritable mood lasting a week or more.

It is characterized by some or all of the following:

- *Increased energy*
- *A decreased need for sleep*
- *Increased confidence, sometimes to the point of grandiose delusions*
- *Racing thoughts*
- *Rapid speech*
- *Impulsive sexual behavior*
- *Reckless behavior such as speeding, erratic driving and overspending*

Lesser degrees of mania (called hypomania) can cause people to be talkative, engaging, outgoing, exhibit increased productivity and creativity, and be quite enjoyable.

By contrast, the depression cycle usually follows a manic episode. It is a period of depressed mood lasting weeks, months or even years and is characterized by:

- *Lowered confidence and self-esteem*
- *Decreased energy*
- *Lack of motivation*
- *Diminished interest or pleasure in most or all activities*
- *Disruption of normal sleep patterns which may involve excessive sleep*

- *Significant changes in appetite*
- *Decreased sex drive*
- *Difficulty concentrating and making decisions*
- *Sadness and tearfulness*
- *Social withdrawal*
- *Irritability and anger*
- *A sense of hopelessness*
- *Sometimes suicidal thoughts or behavior*

The most typical age of onset of bipolar disorder in my experience has been the late teen years or early 20s, often around the last year or two of high school or the early college years. However, it can develop in children, as well as adults at any age. Development of bipolar disorder in older age sometimes occurs in the absence of a family history. In these cases, I would suggest a thorough evaluation with a psychiatrist and a particularly careful search for a medical cause of the mood swings, because there are other conditions that can mimic bipolar disorder in the older population.

## CAUSES

The cause of bipolar disorder is uncertain, and most scientists believe it results from many factors rather than a single cause. These factors include genetics, environment and certain medical conditions. There does appear to be a genetic propensity because the disorder tends to run in families. But it is also known that it is not purely genetic because in studies with identical twins there are instances when one is affected by bipolar disorder but the other is not. This suggests the coexistence of many factors, such

as multiple genes in addition to environmental conditions, to produce the illness. Further, brain imaging studies have been able to identify differences between individuals with bipolar disorder and individuals without the disorder. Such studies may eventually be beneficial in determining the underlying causes and aid in the development of medications specifically targeted to the areas of the brain affected.

### COEXISTING CONDITIONS

There are several conditions which often occur in conjunction with bipolar disorder, especially alcohol or drug abuse and attention deficit hyperactivity disorder (ADHD). In fact, because alcohol abuse is often, but not always, associated with bipolar disorder, when individuals who have been diagnosed with bipolar disorder deny a family history of alcoholism it causes me to question a bipolar diagnosis. In the presence of bipolar disorder, the incidence of coexisting ADHD may be as high as 20–30 percent.

When bipolar disorder does coexist with ADHD, it is important that the mood swings be controlled before the hyperactivity, restlessness and impulsivity of ADHD can be addressed. The medical treatment for ADHD is a class of drugs called stimulants. If stimulants are given in the presence of unrecognized bipolar disorder, the mood swings are likely to worsen. The fact that some symptoms of bipolar disorder and ADHD overlap, such as restlessness and distractibility, does not negate the reality of both conditions nor their simultaneous presence. However, once mood swings are stabilized, ADHD symptoms can be safely and effectively managed. Ideally, the simultaneous treatment of bipolar disorder, ADHD and substance abuse, if present, should be concurrent, since to leave any of them untreated sabotages the successful management of all the others.

### TREATMENT

The importance of finding a well-trained and experienced physician in the diagnosis and treatment of bipolar disorder cannot be overstated. Sometimes it is difficult to differentiate symptoms and correctly diagnose bipolar disorder. A thorough evaluation, most often in conjunction with medication, combined with other treatments such as Christian counseling and close follow-up are paramount.

The optimal treatment of bipolar disorder often includes a motivated client that recognizes their condition, an experienced and competent physician, medications, educational and motivational therapy, support of family, friends and church, and a spiritual awakening. I frequently tell patients, “You have a condition that you can learn to control. If you do not, it will likely control you.” Bipolar disorder is a condition that can be successfully managed, and those affected can expect to live relatively normal lives with appropriate care and the right combination of treatment modalities.

From a medication perspective, the foundation of treatment is the use of prescription mood-stabilizing drugs. In more severe cases, another class of medications called antipsychotics may be utilized when there is a loss of contact with reality such as delusions or hallucinations. It is important to understand that these drugs are not without some side effects. Typically, the benefit of medication use outweighs the risk of side effects because a significant percentage of untreated bipolar individuals will commit suicide. The current recommendation is that mood stabilizers should probably be continued so long as they are effective and well-tolerated, and all medications should be monitored at regularly scheduled intervals with a doctor.

Another class of medications in the treatment of bipolar disorder is antidepressants. Their role in treatment and the appropriate time to



initiate them warrants careful consideration. I prefer to use them after mood stabilizers are at the appropriate therapeutic levels, and then only as long as is necessary to relieve severe depression, at which point they are often discontinued with medical supervision. My concern is that antidepressants sometimes have a destabilizing effect, especially when used alone or over long periods of time in the treatment of bipolar disorder.

In summary, it is important to note that bipolar disorder is usually a recurrent condition which most often requires lifelong treatment and management. Optimal treatment includes a combination of medical, psychological and spiritual care and support. It is necessary for most people with bipolar disorder to take prescription drugs to control their symptoms, and we now have many medications available to help these individuals lead relatively normal productive and meaningful lives. Another tier in management should include Christian counseling to address behaviors, thoughts, emotions and spiritual well-being for the one affected by bipolar disorder and, in many cases, their family and loved ones as well. Finally, prayer partners, Christian fellowship and a strong, safe support system consisting of family and friends can assist in successful management of bipolar disorder. This is a condition that certainly warrants all the biological, psychological, social and spiritual resources at our disposal. Bipolar disorder can definitely be successfully treated and managed.

# RECOMMENDED RESOURCES

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## MINISTRY HELP:

### *Focus on the Family*

**Pastoral Care Line:** 844-4PASTOR (472-7867)

**Counseling Line:** 855-771-HELP (771-4357)

**Family Help Center:** 800-A-FAMILY (232-6459)

**Focus on the Family's Christian Counselor Network**

## BOOKS:

[Troubled Minds](#) by Amy Simpson

[Grace for the Afflicted](#) by Matthew Stanford

[Christian Mindful Manners: How the Church Must Act  
Concerning Mental Illness](#) by Marvis Williams

[Leading a Special Needs Ministry](#) by Amy Fenton

[A Trusted Friend: When It Matters Most](#) by Timothy Clinton  
and Pat Springle

[Counseling the Hard Cases: True Stories Illustrating the Sufficiency  
of God's Resources in Scripture](#) by Stuart Scott and Editor  
Heath Lambert

*We are here  
to help you serve those  
with mental illness.*

<b>COUNSELING LINE</b>	<b>855-771-HELP (771-4357)</b>
<b>PASTORAL CARE LINE</b>	<b>844-4PASTOR (472-7867)</b>
<b>MINISTRY CONSULT</b>	
<b>FAMILY HELP CENTER</b>	<b>800-A-FAMILY (232-6459)</b>



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