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Climbing Out of the Pit:  
Christian Responses to Mental Illness and Suggestions for Change

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## **Abstract**

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By Julianna Kate Jones

In our society, the diagnosis, treatment, and discussion of mental illness remains largely taboo. In recent months, as incidences of mass violence dominate the news and public discussion, some attention has turned to whether those struggling with mental health issues are receiving adequate focus, care, and treatment. This paper seeks both to understand why mental illness has long been so stigmatized and to suggest a means for change, highlighting specifically a potential role for the Christian Church in enacting this change. The paper begins by examining, through both historical and scriptural study, pre- and early Christian responses to mental illness in order to gain an understanding of where we come from and where we are. After discussing historical and current responses to mental illness, I will discuss the chasm that exists between psychiatry, psychology, and religion and spirituality. After examining these tensions, I will discuss the importance of overcoming them, and weaving clinical mental health care and religious and spiritual care back together in order to provide those suffering with a holistic plan and multiple resources for overcoming their struggles. Afterwards, I will discuss the specific role that religious leaders and communities are in a position to play in order to achieve this goal. My suggestions for the Church include using the pulpit responsibly and utilizing our theological and religious education to equip religious leaders with the skills necessary to act as first-responders and resources for congregants grappling with mental and emotional issues. Ultimately, it is my hope that Christian leaders and members of congregations will be inspired to speak openly about mental health issues without prejudice or fear, and to become actively involved in the mental health care of their community members.

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Introduction

<sup>1</sup>O LORD, God of my salvation, when, at night, I cry out in your presence,

<sup>2</sup>let my prayer come before you; incline your ear to my cry.

<sup>3</sup>For my soul is full of troubles, and my life draws near to Sheol.

<sup>4</sup>I am counted among those who go down to the Pit; I am like those who have no help,

<sup>5</sup>like those forsaken among the dead, like the slain that lie in the grave, like those whom you remember no more, for they are cut off from your hand.

<sup>6</sup>You have put me in the depths of the Pit, in the regions dark and deep.

<sup>7</sup>Your wrath lies heavy upon me, and you overwhelm me with all your waves. Selah

<sup>8</sup>You have caused my companions to shun me; you have made me a thing of horror to them. I am shut in so that I cannot escape;

<sup>9</sup>my eye grows dim through sorrow. Every day I call on you, O LORD; I spread out my hands to you.

<sup>10</sup>Do you work wonders for the dead? Do the shades rise up to praise you? Selah

<sup>11</sup>Is your steadfast love declared in the grave, or your faithfulness in Abaddon?

<sup>12</sup>Are your wonders known in the darkness, or your saving help in the land of forgetfulness?

<sup>13</sup>But I, O LORD, cry out to you; in the morning my prayer comes before you.

<sup>14</sup>O LORD, why do you cast me off? Why do you hide your face from me?

<sup>15</sup>Wretched and close to death from my youth up, I suffer your terrors; I am desperate.

<sup>16</sup>Your wrath has swept over me; your dread assaults destroy me.

<sup>17</sup>They surround me like a flood all day long; from all sides they close in on me.

<sup>18</sup>You have caused friend and neighbor to shun me; my companions are in darkness.



The words of Psalm 88, authored millennia ago, speak to the mental anguish and feelings of suffering that were and are a commonality among men and women across societies and cultures. The editors of the translation from which I take this psalm have given it the title “[A] Prayer for Help in Despondency.”<sup>1</sup> Despondency, defined as a state of dejection or hopelessness, has, as one of its synonyms, depression. Rather than discuss here the clinical definition of depression, we can simply look to the words of the Psalm itself. The third verse reads, “For my soul is full of troubles, and my life draws near to Sheol.” We know, from reading these words, that the author is overwhelmed by what he refers to as “troubles,” so much so, that he believes he is close to the Pit, or Hell. Reading on, we see that the author feels completely forsaken and abandoned by the God to whom he prays, and, indeed, feels as though he is being subjected to God’s wrath and sense of vengeance. Despite feeling as though he is being punished, however, the author continues to pray to the Lord, but, in the end, states, “You have caused friend and neighbor to shun me; my companions are in darkness”(Psalm 88:18). Another way of wording this verse, as expressed by Kathryn Greene-McCreight in her own memoir of mental health struggles, is “[the] darkness is my only companion.”<sup>2</sup> This feeling, of having only darkness and being utterly consumed by it, is familiar to people suffering from any number of mental illnesses, from depression and anxiety to schizophrenia and mania. However, even those of us who have never experienced symptoms severe enough to necessitate a diagnosis have lived through periods, no matter how brief, when life seemed hopeless and full of darkness. That this description of hopelessness, along with other poems and prayers of lament, were included in the

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<sup>1</sup> Harold W. (ed) Attridge, *The Harper Collins Study Bible*. (Harper San Francisco, 2006), 803.

<sup>2</sup> Kathryn Greene-McCreight, *Darkness Is My Only Companion: A Christian Response to Mental Illness* (Grand Rapids, MI: Brazos Press, 2006).

Psalms, is indicative of how common the experience is to humanity. And yet, the stigma associated with experiences of sadness and darkness throughout biblical history and into the present would lead us to believe that depression and other mental health difficulties are rare and suspect. Now, more than ever, however, it has become necessary to acknowledge the truth.

In the last year, instances of mass violence have been dominating media and public forums. While some discussion participants, whether private citizens or government officials, focus on the issue of access to weapons, others are drawing attention to issues of mental illness and mental health care across the country and in our communities. In the confusing aftermath of both Aurora, Colorado and Newtown, Connecticut, questions arose about the mental health history of each of the perpetrators, including how two people who, by many accounts, were in need of mental health care long before their acts of astounding violence, were able to “fall through the cracks.” Unfortunately, though millions of Americans suffer from mental illness each year, it seems little focus is paid to their suffering until tragedy forces our hand and attention. This essay seeks to offer both an explanation and a remedy for this unfortunate trend in our society.

The history of our response to mental illness and issues of mental health care is long and complex. Mental health issues, of course, pre-date the existence of Christianity, but Christian interpretation of these issues has had a significant and lasting impact on the way the mentally ill have been treated in the centuries since the crucifixion of Christ. Both pre- and early Christian interpretations and responses to mental and emotional illness will be discussed in this work in order to establish a foundation for understanding how our modern society regards and reacts

to mental health issues. In order to enact change, it is necessary to understand where we come from and where we are.

After discussing historical and current responses to mental illness, I will discuss the chasm that exists between psychiatry, psychology, and religion and spirituality. This is also a complex issue, with tensions and indignation present on both sides. After examining these tensions, I will discuss the importance of overcoming them, and weaving clinical mental health care and religious and spiritual care back together in order to provide those suffering with a holistic plan and multiple resources for overcoming their struggles. Afterwards, I will discuss the specific role that religious leaders and communities are in a position to play in order to achieve this goal. My suggestions for the church include using the pulpit responsibly and utilizing our theological and religious education to equip religious leaders with the skills necessary to act as first-responders and resources for congregants grappling with mental and emotional issues. Ultimately, it is my hope that Christian leaders and members of congregations will be inspired to speak openly about mental health issues without prejudice or fear, and to become actively involved in the mental health care of their communities.

## **The Bible and Mental Illness**

### **An Overview of Key Characters and Passages**

To begin an examination of how Christianity has responded and *should* respond to mental illness and mental health care, we must first look to the text on which we base our faith. In the *Handbook of Religion and Mental Health*, Samuel B. Thielman states, “One has to look no further than the Bible to appreciate the multifaceted nature of the relationship between

spirituality and mental health.”<sup>3</sup> To thoroughly comprehend this relationship, we must examine the Bible for passages, characters, and stories that can aid in understanding the origins of the close ties between faith and mental illness. Throughout Scripture, there are many characters, speeches, and behaviors that, when looked at with a modern, critical eye, resemble what we could now associate with symptoms of mental illness. While there are outright references to mental disturbances throughout the Bible, a second look should also be given to the puzzling nature of many of the stories that serve as tenets of our faith.

Beginning with the Old Testament, our first example comes early in the pages of Genesis. After God’s creation and rest, we witness Eve falling victim to the suggestions of an animal, eating a piece of forbidden fruit at the behest of a snake:

[The Serpent] said to the woman, “Did God say, ‘You shall not eat from any tree in the garden?’” The woman said to the serpent, “We may eat of the fruit of the trees in the garden; but God said, ‘You shall not eat of the fruit of the tree that is in the middle of the garden, nor shall you touch it, or you shall die.’” But the serpent said to the woman, “You will not die; for God knows that when you eat of it your eyes will be opened, and you will be like God, knowing good and evil.” So when the woman saw that the tree was good for food...she took of its fruit and ate (Gen. 3:1 – 6).

Unable to discount the words of the animal (or the voice) speaking to her, Eve makes a decision to disregard a command that, previous to her encounter with the snake, she had no trouble abiding. Jewish and Christian lore associates the serpent with whom we have come to know as Satan, but if we do not blame evil, and look at Eve’s actions with a religiously impartial eye, we are forced to consider if the serpent, manipulations and all, could be merely a product of Eve’s

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<sup>3</sup> Harold G. Koenig, ed., *Handbook of Religion and Mental Health* (San Diego: Academic Press, 1998), 4.

own mind. After all, we do not witness Adam interacting with the snake, or even acknowledging its presence.

In the next generation, Adam and Eve's son Cain defies our standards of behavior by taking the life of his brother Abel in a fit of jealousy and anger over his perception of the Lord's better treatment and reception of Abel. The text reads, "So Cain was very angry, and his countenance fell. The Lord said to Cain, 'Why are you angry, and why has your countenance fallen?'"(Gen. 4:5 – 6). God then goes on to assure Cain that, unless he allows himself to sin, he too will be given ultimate favor. However, "Cain said to his brother Abel, 'Let us go out to the field.' And when they were in the field, Cain rose up against his brother Abel and killed him"(Gen 4:8). After, when God asks Cain about his brother's whereabouts, Cain is defiant, saying, "I do not know; Am I my brother's keeper?"(Gen. 4:9 – 10). Each of us have, at some point, experienced anger, resentment, and perhaps even violent thoughts. Was there then, perhaps, something amiss in Cain's mind, that he was unable to control his temper or his urge to hurt his brother?

A few generations later, Abraham nearly robs his son Isaac of his life, at the request of a voice he attributes to God, a voice that only he can hear. Abraham was used to conversations with God, a God who promised Abraham a people and a nation of his own. And so, without hesitation, whenever God would call Abraham's name, Abraham would respond "Here I am." In Genesis 22, Abraham hears God's voice say to him "Take your son, your only son Isaac, whom you love, and go to the land of Moriah, and offer him there as a burnt offering on one of the mountains that I will show you"(Gen. 22:2). This voice offers Abraham no explanation for its request, nor the explicit destination of the journey on which it is sending Abraham. Nonetheless,

“Abraham rose early in the morning, saddled his donkey, and took two of his young men with him, and his son Isaac; he cut the wood for the burnt offering, and set out and went to the place in the distance that God had shown him”(Gen. 22:3). When Abraham arrives at the place that the voice of God directed him to, he takes his son Isaac alone, and binds him to an altar. Then

Abraham reached out his hand and took the knife to kill his son. But the angel of the Lord called to him from heaven, and said, “Abraham! Abraham!” And he said, “Here I am.” He said, “Do not lay your hand on the boy or do anything to him; for now I know that you fear God, since you have not withheld your son, your only son, from me”(Gen 22:10 – 12).

But for a reappearance of the voice that spoke to Abraham, and a change in plans, Isaac would have been slaughtered. Søren Kierkegaard was fascinated by this particular tale, and in his *Fear and Trembling*, he delves deeper into it. Kierkegaard imagines the inner thoughts of Abraham, and, when it comes time for the sacrifice, pictures this interaction:

Abraham climbed the mountain in Moriah, but Isaac did not understand him. Then he turned away from Isaac for a moment, but when Isaac saw his face a second time it was changed, his gaze was wild, his mien one of horror. He caught Isaac by the chest, threw him to the ground and said: “Foolish boy, do you believe I am your father? I am an idolater. Do you believe this is God’s command? No, it is my own desire.”<sup>4</sup>

In Kierkegaard’s imagination, Abraham behaves this way in order to maintain Isaac’s belief in God. After the incident is over, Kierkegaard acknowledges the darkness in Abraham’s mind, writing, “From that day on, Abraham became old, he could not forget that God had demanded this of him. Isaac thrived as before; but Abraham’s eye was darkened, he saw joy no more.”<sup>5</sup>

Kierkegaard also states, “It was a tranquil evening when Abraham rode out alone, and he rode to the mountain in Moriah; he threw himself on his face, he begged God to forgive his sin at having

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<sup>4</sup> Søren Kierkegaard and Alastair Hannay, *Fear and Trembling: Dialectical Lyric by Johannes De Silentio* (London: Penguin Books, 2003), 45.

<sup>5</sup> *Ibid.*, 46.

been willing to sacrifice Isaac.”<sup>6</sup> It is clear that, in Kierkegaard’s view, Abraham was disturbed by his actions; what we do not know, is whether it was a mental disturbance that led to his actions.

Continuing the exploration of the earliest biblical characters, we may next turn to Moses.

Moses is entranced by a voice he hears from a bush consumed with fire. The text reads,

Moses was keeping the flock of his father-in-law Jethro, the priest of Midian; he led his flock beyond the wilderness, and came to Horeb, the mountain of God. There the angel of the Lord appeared to him in a flame of fire out of a bush; he looked, and the bush was blazing, yet it was not consumed... When the Lord saw that he had turned aside to see, God called to him out of the bush, “Moses, Moses!” And he said, “Here I am”(Ex. 3:1 – 4).

Moses then forms a relationship with this voice, which he identifies as God, and follows God’s voice, through the desert, and throughout his life. Although the voice is largely benevolent, helping Moses and Moses’ people to achieve freedom, at other times it is unforgiving, locking an elderly Moses out of the promised land. Before Moses’ death in Deuteronomy, we read, “The Lord said to him, ‘This is the land of which I swore to Abraham... I have let you see it with your eyes, but you shall not cross over there’”(Deut. 43:4). What would it mean for a man or woman today to follow the directions of a disembodied voice throughout their life?

Continuing the exploration of characters that hear and follow the voice of God, we may turn to the prophets. We regard Joshua and Samuel as prophets, men who were chosen by God to share God’s message with humankind. Samuel is even more special in the authority that he claims to name a king for Israel. In his 1962 book *The Prophets*, Abraham Heschel discusses the relationship between prophecy and psychosis. Heschel argues, in his chapter, that all of the prophets experienced a level of psychosis or mental illness. He begins his argument by referencing Plato, writing, “According to Plato, ‘no man, when in his wits, attains prophetic truth

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<sup>6</sup> Ibid., 46 - 47.

and inspiration; but when he receives the inspired word, either his intelligence is enthralled in sleep, or he is demented by some distemper or possession.”<sup>7</sup> Plato views prophecy as either a dream or something that is achieved only by the presence of a disorder or an instance of possession. Heschel additionally quotes Socrates, writing,

There is a madness which is a divine gift; *the greatest of blessings have come to us in madness*. For prophecy is a madness... And as the act of the prophet is more perfect and venerable... by so much the more, as the ancients testify, *is madness superior to reflection, for reflection is only human, but madness springs from the gods*.<sup>8</sup>

Here, Socrates directly links prophecy with a kind of insanity. However, he believes that madness comes from a divine source.

Continuing his exploration of the prophets, Heschel acknowledges that, with the development of psychology as a discipline, connections between mental illness and religion were questioned. He writes, “scholars have insisted that prophecy was due to a morbid condition, resulting from perturbations of the growth of the psyche, or from derangement from the nervous system.”<sup>9</sup> To support this statement, Heschel quotes T.J. Meek’s *Hebrew Origins*, writing, “There is a close relationship between prophecy and insanity. The kind of temperament that lends itself to psychic experience, to automations, may result in genius or it may become psychopathic and lead to melancholy and outright insanity.”<sup>10</sup> Heschel then turns to *nabi* (נָבִיא), the Hebrew word for prophet, to further explore this relationship.

The etymology of the word “*nabi*” and certain manners of the prophets’ behavior have been cited in support of this theory. It was suggested that *nabi* denoted a man who poured out his utterances loudly and madly with deep breaths, that the original meaning of the stem was “madness,” “insanity.” *Nabi* meant, therefore,

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<sup>7</sup> Abraham Joshua Heschel. *The Prophets*. (New York: Perennial, 2001), 500.

<sup>8</sup> *Ibid.*, 501.

<sup>9</sup> *Ibid.*, 505.

<sup>10</sup> *Ibid.*, 505.



originally, one who is carried away by a supernatural power. Thus, “insanity was sacred to the Israelites, the insane man being believed to be possessed by a supernatural power.”<sup>11</sup>

Heschel’s exploration of the *Nabi'im* leads him to the belief that the Israelites looked to the prophets with a sense that there was something off-balance about them, but believed that any sense of madness was a gift that came from God. Jewish reverence for the prophets is clear, in their reliance upon them for delivering the word of God and providing a king for Israel. Saul, one of the kings selected by the prophet Samuel, exhibits strange behavior throughout his life.

As king, Saul frequently disappoints Samuel by making poor decisions, and, eventually, it is said that “the spirit of the Lord departed from Saul, and an evil spirit from the Lord tormented him”(1 Sam 16:14). The text continues,

And Saul’s servants said to him, “See now, an evil spirit from God is tormenting you. Let our lord now command the servants who attend you to look for someone who is skillful in playing the lyre and when the evil spirit from God is upon you, he will play it, and you will feel better” (1 Sam 16:15 – 16).

It is David that is chosen for this task, and “whenever the evil spirit from God came upon Saul, David took the lyre and played it with his hand, and Saul would be relieved and feel better, and the evil spirit would depart from him”(1 Sam. 16:23). As scholarly interests in the twentieth century turned to the relationship between psychology and spirituality, some special attention was given to Saul and this “evil spirit.” One of the earliest articles on the subject, written by H.C. Ackerman in 1920, states that “The malady of Saul...was obviously a case of nervous disorder; for the scriptural writer who describes the affliction of the king in terms of ‘spirit’ dealt in reality with a condition of nervous exhaustion.”<sup>12</sup> Ackerman also argues that “sick souls are in [biblical]

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<sup>11</sup> Ibid., 505.

<sup>12</sup> H.C. Ackerman, “Saul: A Psychotherapeutic Analysis,” *Anglican Theological Review* 3, no. 2 (October 1, 1920): 114-24, 114.

terms cases of spirit possession.”<sup>13</sup> It should be noted that Ackerman’s goal in his study of Saul was to highlight the “logical affiliations between spiritual and scientific ministry to the suffering,”<sup>14</sup> an enlightened goal, indeed, and one that will be turned to in later pages. Despite the early date of this article, there is a wide gap in time between studies that take on this subject.

In addition to his bouts of nervousness, Saul later becomes jealous and frustrated by the love and worship with which his people come to view David. In their 2012 article “King Saul’s Mysterious Malady,” Williams and le Roux write that Saul was “very pre-occupied with David’s increasing fame which severely depressed him...He eventually became *mentally unstable* and suspected everyone of plotting against him.”<sup>15</sup> Williams and le Roux go on to write, “It is suggested by some scholars that Saul suffered from ‘depression’ or ‘heaviness of heart’ as a result of post-traumatic stress disorder (PTSD) and many other reasons.”<sup>16</sup> On the subject of the “frenzy” Saul exhibits in 1 Sam. 19:24, they write, “Others describe Saul’s behavior as it manifests in 1 Samuel 19:23, 24 as epileptic-like fits, exacerbated [by his enemies].”<sup>17</sup> While what we now identify as epilepsy and its symptoms are the focus of many biblical and post-biblical accounts of spiritual sickness or possession, I am more interested in the idea that Saul suffered from depression or even post-traumatic stress disorder. Post-traumatic stress disorder (PTSD)

occur[s] after a distressing or catastrophic event. Common examples include involvement in war, accidents...assault (including physical or sexual assault, mugging or robbery, or family violence), or witnessing a significant event...A

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<sup>13</sup> Ibid., 114.

<sup>14</sup> Ibid., 114.

<sup>15</sup> Gillian P. Williams and Magdel Le Roux, "King Saul's Mysterious Malady," *HTS* 68, no. 1 (2012): 1, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

<sup>16</sup> Ibid., 2.

<sup>17</sup> Ibid., 2

person is [likely] to develop post-traumatic stress if the response to an event includes fear, helplessness, or horror. A major symptom is re-experiencing the trauma. This can include recurrent dreams, flashbacks, intrusive memories, or unrest in situations that bring back memories of the original trauma... Persistent symptoms of increased arousal also can occur, such as constant watchfulness, irritability, jumpiness, being easily startled, outbursts of rage, or insomnia.<sup>18</sup>

With this definition in mind, we can further understand the reasons Williams and le Roux have for believing that Saul might have been afflicted by this syndrome. Citing Allan Young's 1988 exploration of PTSD in relationship to war within the Bible, Williams and le Roux write, "events which cause severe trauma are usually those acts which are contrary to good or sound morals... Examples of this would be the slaughter of innocent women and children in a combat situation, which Saul was commanded by God to carry out (1 Sam. 11:6 – 11)."<sup>19</sup> Another example of trauma witnessed by Saul is the brutal murder of King Agag of the Amalekites (1 Sam. 15:33). Was the "evil spirit" tormenting Saul his inescapable memories? We also see that Saul was prone to irritability and depression, exemplified by his attempt to spear David (1 Sam. 18:10 – 12). As David's popularity grows, so does Saul's "watchfulness" and paranoia. Did Saul suffer from insomnia, another key symptom of post-traumatic stress syndrome? The text tells us that David played his lyre by Saul's side in the late hours of the night and the early hours of morning. Williams and le Roux write,

the king's apparent depression with characteristic insomnia, feelings of worthlessness (1 Sam. 18:28 – 29), indecisive behavior (his dependence on Samuel) and paranoia complex, indicate that his condition eventually developed into psychosis as a result of his troubled relationship with David.<sup>20</sup>

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<sup>18</sup> Kitchener, Betty, A. F. Jorm, and Claire Kelly. *Mental Health First Aid USA*. Annapolis, MD.: Anne Arundel County Mental Health Agency, 2009, 42.

<sup>19</sup> Gillian P. Williams and Magdel Le Roux, "King Saul's Mysterious Malady," *HTS* 68, no. 1 (2012): 2, accessed March 7, 2013, ATLA Religion Database with ATLASerials..

<sup>20</sup> *Ibid.*, 2.

Given all of the possible triggers for mental difficulties and the symptoms Saul exhibits throughout the text, it is clear that he is a deeply troubled character.

Continuing to move through the Old Testament, we come upon the unfortunate story of Job, who, among other afflictions, can also be seen as a victim of mental health struggles. In the midst of his suffering, he names it, and bitterly speaks the following:

I loathe my life; I will give free utterance to my complaint; I will speak in the bitterness of my soul. I will say to God, Do not condemn me; let me know why you contend against me. Does it seem good to you to oppress, to despise the work of your hands and favor the schemes of the wicked? (Job 10:1 – 3).

We know from Job's story that he has lost everything; his children and his livestock, as well as his entire livelihood. This is at the hands of Satan, part of a challenge to God over Job's seeming unending faith and loyalty. Job's peers, however, blame his losses on him, and Job becomes angry, as exhibited in the verses above. As things worsen, and Job finds no reprieve, he becomes depressed and despondent, and prays for relief. He declares, "My spirit is broken, my days are extinct, the grave is ready for me"(Job 17:1). *His* depression, however, is relieved when God restores Job's former existence at the end of the story. Others are, of course, not as fortunate.

Moving into the New Testament, and the life of Jesus, we can find many examples of his behaviors that would be suspect if exhibited by a modern man or woman. Included in all three Synoptic Gospels is the story of Jesus' sojourn in the wilderness, which occurs after his baptism by John in the Jordan River. In Matthew 4:1 – 11, it is written, "Then Jesus was led up by the Spirit into the wilderness to be tempted by the devil... The tempter came and said to him, 'If you are the Son of God, command these stones to become loaves of bread.'" When Jesus refuses, "the devil took him to the holy city and placed him on the pinnacle of the temple, saying to him 'If you are the Son of God, throw yourself down'"(Matt. 4:1; 3; 5 – 6). The devil also

attempts to convince Jesus to worship him. This text is paralleled briefly by Mark 1:12 – 13, and in greater depth by Luke 4:1 – 13. This story is important to the psychological interpretation of Jesus examined by, among others, Albert Schweitzer, and will be discussed below.

### **The Limitations of a Psychological Evaluation of the Bible**

After completing a cursory overview of some of the biblical characters and events that have undertones (or outright references) to mental and emotional struggles, as well as a survey of some of the psychological theories about them, it is important to identify the limitations of attempting a psychological evaluation of the Bible. Abraham Heschel and Albert Schweitzer are just two critics of this endeavor. In the same work discussed above, Abraham Heschel discusses the history of the psychological exploration of the words and deeds of the prophets. Heschel states that the question was “brought within the realm of scientific inquiry by psychiatrists in the second half of the nineteenth century.”<sup>21</sup> He explains the nature of the problem, writing,

In the visionary experiences of the prophets, in their unmannerly appearance and sensational behavior, scholars sought to discover features of an abnormal mentality. The secret of prophetic experience was felt to lie in their tendency to ecstatic possession, in mental derangement.<sup>22</sup>

As an example of this, Heschel cites the prophet Hosea and the conclusions that were made about him based on his behavior, such as marrying a promiscuous woman. Heschel also looks to Hosea to analyze points where the prophet is referred to as a “madman.” He cites Hosea 9:7, which reads, “The days of punishment have come, The days of recompense have come; Israel shall know it. The prophet is a fool, The man of the spirit is mad.”<sup>23</sup> Despite scriptural use of the

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<sup>21</sup> Abraham Joshua Heschel. *The Prophets*. (New York: Perennial, 2001), 501.

<sup>22</sup> *Ibid.*, 506.

<sup>23</sup> *Ibid.*, 513.

words “mad” and “madness,” Heschel is still weary of attempting to psychoanalyze prophecy and prophetic behavior.

In his discussion of the psychoanalysis of prophecy, Heschel makes it clear that attempting to do so comes with problems. He writes,

The scientific hazards involved in the attempt to expose, on the basis of literary remains, the subconscious life of a person who lived thousands of years ago are so stupendous as to make the undertaking foolhardy...one would have to take into account...the tremendous distance and dissimilarity in relation to words, in historic perspective, in intensity of emotion, and in spiritual sensitivity. A reliable diagnosis...remains beyond our scope. The prophet cannot be brought to the laboratory for tests and interviews, nor do we possess the subtlety required for asking the right questions about experiences totally beyond our range of perception.<sup>24</sup>

Not only can we not bring the prophet [or any other biblical character] into our “laboratory,” but it is somewhat anachronistic to attempt to ascribe a modern diagnosis to an ancient behavior. On this subject, Heschel writes,

Neurosis and psychosis are concepts we form in terms of cultural patterns of our particular society. What is considered strange and abnormal according to the manners and conventions of...the twentieth [and twenty-first] centur[ies] may be considered entirely proper and normal [elsewhere].<sup>25</sup>

Additionally, Heschel argues, even if we were able to accurately diagnose the prophets, it does not satisfactorily answer the question of “whether these symptoms were the results or the cause of the experience.” Heschel asks this question because, he argues, the messages that they were prophesying were

ages ahead of human thinking...What we think is due to mental disorder may have been due to higher spiritual order. Whatever departs from the normal is not necessarily pathological. From the fact that the prophet exhibits features which

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<sup>24</sup> Ibid., 516.

<sup>25</sup> Ibid., 516.

differentiate him from the average we must not deduce any conclusions about his total personality.<sup>26</sup>

While Heschel devotes his attention to discouraging the psychoanalysis of the prophets, Albert Schweitzer devotes his time to debunking attempts at psychologically evaluating Jesus.

In his forward to Albert Schweitzer's *The Psychiatric Study of Jesus: Exposition and Criticism*, Winfred Overholser discusses the birth of scientific inquiry and advances, the shift in attitude that led to the demand for evidence as part of the scientific process, and the transition that led to aspects of that process being applied to the study of history. He argues that the Bible became a part of this historical study, and writes, "late in the seventeenth century (1670) there came about the beginnings of the 'higher criticism,' with the appearance of Spinoza's *Tractatus Theologico-Politicus*."<sup>27</sup> Overholser continues by acknowledging that some of this criticism was a "hostile" attempt to debunk established religious belief, but states that the majority of it was what he refers to as "healthily skeptical," arguing that there was "a genuine seeking for historic truth and for a study of motives...some consideration [was therefore] given to the possibility that the beliefs of Jesus might be explained as those of a mentally abnormal person, perhaps even of one clearly deranged."<sup>28</sup> As Overholser mentions in his forward, in the beginning decades of the twentieth century, three medical doctors devoted their energy to a psychiatric interpretation or evaluation of Jesus. These included German Dr. Georg Lomer, writing under the pseudonym of George de Loosten, a Frenchman named Charles Binet-Sanglé, and an American, Dr. William Hirsch.<sup>29</sup> It is the assertions of these three authors that Albert Schweitzer seeks to argue against

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<sup>26</sup> Ibid., 517.

<sup>27</sup> Albert Schweitzer and Charles Rhind Joy, *The Psychiatric Study of Jesus: Exposition and Criticism ; Tr. and Introd* (Boston: Beacon Press [1958, 1948), 11.

<sup>28</sup> Ibid., 11.

<sup>29</sup> Ibid., 12.

in what would become his thesis for his medical degree in 1913. Overholser concludes his foreword by asserting two important points about psychoanalysis and psychiatric diagnosis. His first argument is that, in order to make an accurate diagnosis, we must have a solid, detailed case history. Overholser argues that, in the case of Jesus,

We have virtually none. The first Gospels were probably written forty or more years after the death of Jesus; as such, their accuracy as to detail, at least as a psychiatric document, must be questioned. Furthermore, we know nothing except by tradition of any but the last three years of Jesus' life.<sup>30</sup>

As a result of “missing” much of the details of Jesus' life, we know next to nothing about his childhood, his relationship with Mary, Joseph, and his siblings, or his relationship with the people in his community prior to the beginning of his ministry. While we are fortunate in that we are able to have some understanding of the religious, social, economic, and political environment that Jesus would have been facing during his lifetime, we do not have the ability to know precisely how each of these factors impacted Jesus, which is an essential aspect of understanding a person's mental health. Or, as Overholser states, “we know very little of the manner in which they played upon him and molded his feelings and reactions...[and] in the second place, we cannot study any patient in a vacuum...everyone is conditioned by his environment.”<sup>31</sup>

Overholser makes this point in order to construct the crux of his, and, indeed, Schweitzer's argument, which is that “To form a judgment about any person on the sole basis of his acts is contrary to all psychiatric practice...If this is true for the present age, how much more restraint must be exercised when we are dealing with people from a very distant” time.<sup>32</sup> Nonetheless,

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<sup>30</sup> Ibid., 14.

<sup>31</sup> Ibid., 14.

<sup>32</sup> Ibid., 33.



multiple authors, including those mentioned above, have tackled the task of diagnosing Jesus, and it is their conclusions that Albert Schweitzer finds problematic.

George de Loosten, the first author whose work is taken apart by Schweitzer, believed that Jesus was delusional, having “intensive religious tendencies...and [a] one-sided preoccupation with the writings of the Old Testament. Jesus was moved to express his ideas by the appearance of John the Baptist” and eventually “Jesus finally arrived at the point of relating to himself all the Scriptural promises.”<sup>33</sup> De Loosten also makes note of times at which Jesus’ mood appears to be unstable, especially the moments at which Jesus appears to be depressed, like in Gethsemane. Besides depression, de Loosten argues that Jesus often found himself in “a highly nervous, excitable state,” such as in the moments before his arrest. He also believes that Jesus suffers from hallucinations, mentioning specifically Jesus’ baptism by John. De Loosten is unclear about how often Jesus must have had these hallucinations, but believes that Jesus “depends upon them even for his decisions and that similar visions...occurred later.”<sup>34</sup> De Loosten also posits that Jesus suffered from “voices which seemed to him to come out of his own body. Jesus placed an exalted value upon the supernatural spirit allegedly residing within him [which] determined what he should do and leave undone, and he obeyed.”<sup>35</sup> The second author examined by Schweitzer that delved into the psychology of Jesus is William Hirsch.

Based on his research and interpretation of Jesus, Hirsch came up with a diagnosis of paranoia, and he traces the “development of the delusion” all the way back to Jesus’ childhood, when he was merely a boy that was, perhaps, gifted and talented intellectually. Jesus spends his time focusing almost solely on reading scripture which, in Hirsch’s view, contributes to the

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<sup>33</sup> Ibid., 37.

<sup>34</sup> Ibid., 39.

<sup>35</sup> Ibid., 39.

growth and development of the mental illness. By the time we join Jesus as an adult, Hirsch argues, his paranoia is full-blown. Chief among the evidence for Hirsch's theory is Jesus' forty days in the wilderness. Schweitzer discusses this foray into the wilderness, writing,

These forty days lie between two sharply differentiated sections of his life. The delusions which up to that time were isolated and unrelated to each other henceforth merged into a great systematic structure of delusions; doubtless Jesus at that time repeated conversations with God...Such a development of his illness, a transition from the latent to the active stage of paranoia, is quite characteristic of this psychosis.<sup>36</sup>

In addition to Jesus' time spent alone in the wilderness, Hirsch finds further evidence of Jesus' paranoia in the biographical details that Jesus offers about himself, specifically his claim to be a descendent of David. This claim "relates to the well-known tendency of youthful paranoiacs to substitute for their real descent a highly-colored fanciful one."<sup>37</sup> Taking Hirsch's diagnosis of psychosis and paranoia a step further is Charles Binet-Sanglé.

Through his own research, Binet-Sanglé determines that Jesus is a victim of "religious paranoia," which ultimately results in a total change in his personality. In his study of Jesus, Binet-Sanglé finds evidence for no less than seven hallucinations, some visual, and some auditory, including the aforementioned baptismal hallucination at the Jordan River, and those experienced during Jesus' solitude in the wilderness. Speaking about Jesus' hallucinations, Schweitzer summarizes Binet-Sanglé, writing,

The content of the hallucinations always refers to religious objects, particularly to the devil. They may be separated into the fearsome and the comforting...The comforting ones are visual: at the baptism the dove appears, in the wilderness the angel of God appears, in Gethsemane Jesus is strengthened by an angel according to the text in Luke.<sup>38</sup>

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<sup>36</sup> Ibid., 41.

<sup>37</sup> Ibid., 41.

<sup>38</sup> Ibid., 44.

Regardless of this argument, and despite the time he dedicates to dissecting their theories, Schweitzer is ultimately critical of de Loosten, Hirsch, and Binet-Sanglé for not considering or studying the historical life of Jesus in their attempts to understand his psychopathology.<sup>39</sup>

In his attempt to debunk the theories of de Loosten, Hirsch, and Binet-Sanglé, Schweitzer reiterates that there are great “difficulties which confront every effort at a diagnosis,” and, given the nature and age of the material on Jesus with which we have to work, “if...diagnostic conclusions are deduced from this kind of material, they must be...for the most part of a very hypothetical kind,” due, in part, to the nature of biblical interpretation.<sup>40</sup> Schweitzer also ultimately argues that it is difficult, if not impossible, to ascribe a modern psychological diagnosis to a figure in antiquity, because, as argued above, we are “too little acquainted with the contemporary thought of the time to be able to do justice to it.”<sup>41</sup> Additionally, he writes, identifying “hypothetical symptoms,” even among those that can be considered historical or fact, such as Jesus’ view of himself, and the hallucination he experiences at the baptism, “fall far short of proving the existence of a mental illness.”<sup>42</sup>

Having considered possible outcomes of psychological evaluations of biblical characters as well as the negative aspects and limitations of these evaluations and diagnoses, it is important to question whether such an endeavor is helpful in attempts to improve and broaden the Christian response to the mentally ill. The goal of these evaluations is not to debunk faith or diminish the religious value of the text, but to bring the discussion of mental illness to the forefront using stories that are universally accessible to Christians. By questioning whether the behavior of some

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<sup>39</sup> Ibid., 44-55.

<sup>40</sup> Ibid., 54-55.

<sup>41</sup> Ibid., 75.

<sup>42</sup> Ibid., 75.

biblical characters, even that of Jesus, constitutes mental and emotional disturbances or illness, we are potentially allowing ourselves to acknowledge the normalcy of these issues, perhaps making it possible for people who are struggling themselves with these issues to feel welcome and able to relay their experiences with their religious leaders and fellow community members, thereby starting an important dialogue. Having considered the interpretation and evaluation of the Bible, we can turn next to a discussion of pre- and early Christian responses to mental illness.

### **Pre- and Early Christian Responses to Mental Illness**

To achieve a complete picture of early Christian responses to mental illness and mental health itself, we must first examine thought which predates Christianity. In the *Handbook of Religion and Mental Health*, edited by Harold G. Koenig, Samuel B. Thielman writes, “Early Christian thought was deeply influenced by Plato and Platonism, and Plato wrote at times about the relationship of the soul to mental health.”<sup>43</sup> Thielman noted that Plato believed that

Mental disorders were multifactorial in origin; when individuals with flaws of temperament lived under bad forms of government, were offered inadequate education, and had inadequate upbringing, imbalance of the soul occurred. For Plato balance of the mind and body was essential to mental health.<sup>44</sup>

Plato discusses what he refers to as mania in his work, the *Phaedrus*, writing that there “are two kinds of mania, one involving a mental strain that arises from a bodily cause or origin, the other divine or inspired... This latter kind, he says, is now called ‘divination,’ but in earlier times was called ‘madness;’ that is, the Greeks now call it ‘prophetic inspiration.’”<sup>45</sup> These thoughts are

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<sup>43</sup> Harold G. Koenig, ed., *Handbook of Religion and Mental Health* (San Diego: Academic Press, 1998), 4.

<sup>44</sup> *Ibid.*, 5.

<sup>45</sup> Robert M. Grant, "Views of Mental Illness Among Greeks, Romans, and Christians," in *The New Testament and Early Christian Literature in Greco-Roman Context: Studies in Honor of David E. Aune*, ed. John Fotopoulos (Leiden: Brill, 2003), 373.

further explored in a chapter by Robert M. Grant in the volume entitled *The New Testament and Early Christian Literature in Greco-Roman Context*.

In his chapter, Grant details the various views of mental illness among Greeks, Romans, and early Christians in an attempt to highlight their ways of thinking, as well as how they reflected each other or differed. Many are aware of the scholarly and medical contributions of Hippocrates. His fourth century B.C.E. treatise, *On the Sacred Disease*, confronts ideas about epilepsy, a misunderstood illness of the mind that many physicians attributed to mysterious and mystical forces, so much so that it was referred to as a “sacred disease.” Hippocrates wrote,

Those who first attributed a sacred character to this malady were like the magicians, charlatans, and quacks of our own day, men who claim great piety and superior knowledge. Being at a loss, and having no treatment that would help, they concealed and sheltered themselves behind superstition and called this illness sacred, so that their own utter ignorance may not be manifest.”<sup>46</sup>

Grant dissects this treatise, stating, “It is clearly intended to differentiate medicine from magic, though not necessarily from conventional religion.”<sup>47</sup> Additional improvements in medicine came from the physician Asclepiades, who arrived in Rome in the first century B.C.E.

Asclepiades was “pioneer in the humane treatment of mental disorders, [who] had insane persons freed from confinement in the dark and treated them by using occupational therapy, music, soporifics (especially wine), and exercise.”<sup>48</sup> Another Roman, the poet Lucretius, discusses mental illness in his work *Natura Rerum*. He believed, according to Grant, that the mind is subject to afflictions and disease in the same way as the body. Grant quotes Lucretius, writing, “we see that the mind like a sick body can be healed and changed by medicine.”<sup>49</sup> Despite the

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<sup>46</sup> Ibid., 370.

<sup>47</sup> Ibid., 370.

<sup>48</sup> Ibid., 371.

<sup>49</sup> Ibid., 371.

growing influence of medicine, Grant references Aretaeus, a Greek physician, to express the fact that the ancients often “associated madness with a kind of prophetic power.”<sup>50</sup> Aretaeus recorded his theories about melancholy and love, which he believed to be the cure for sadness. He also wrote about mania, including religious mania, stating, “Some cut their members in a pious fantasy, as if propitiating particular gods... This madness is of divine origin.”<sup>51</sup> Another physician, Soranus, in his *Chronic Diseases*, discusses helpful versus wrongful treatments of mental afflictions. He recommended “measures... similar to those employed in epilepsy.” His suggestions included a light, warm atmosphere with few people to avoid “the danger of exciting and aggravating [the] madness,” as well as soft bedclothes and bindings if necessary.<sup>52</sup> Soranus’ idea of poor treatment included dark rooms, starvation, bleeding, and alcohol.<sup>53</sup> Other scholars, such as the astrologer and astronomer Ptolemy, believed that psychic ailments like epilepsy and insanity were incurable, because they were the result of the cosmos. It is clear, from this survey of some philosophers and physicians, that opinions on mental afflictions and their cure were many and diverse. Having taken this under consideration, we can turn next to spiritual beliefs surrounding mental illness in the time period immediately preceding and during the development of Christianity.

In antiquity, the god most associated with matters of illness and healing was Asclepius, to whom many shrines and temples were devoted. These shrines “existed from at least the fifth century BCE and Asclepian temples existed throughout ancient Greece and Rome.”<sup>54</sup> The sick

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<sup>50</sup> Ibid., 374.

<sup>51</sup> Ibid., 380.

<sup>52</sup> Ibid., 375 – 376.

<sup>53</sup> Ibid., 376.

<sup>54</sup> Samuel B. Thielman, "Reflections on the Role of Religion in the History of Psychiatry," in *Handbook of Religion and Mental Health*, by Harold G. Koenig (San Diego: Academic Press, 1998), 6.

and afflicted would visit the temple, “bringing offerings in the form of small images of the affected part.”<sup>55</sup> Patients slept inside the temple and received dreams from Asclepius that provided healing advice. As payment for healing, patients offered money and inscriptions. One shrine, at Epidaurus in the Peloponnese, contains inscriptions dated to the fourth century B.C.E., describing “healings [that] took place not only for physical ailments but also for psychosomatic disorders. Few cases concern mental illness, however.”<sup>56</sup> The cult of Asclepius continued well into the early years of Christianity, even as Hippocratic medicine developed.

In the first chapter of the *Handbook of Religion and Mental Health*, Samuel B. Thielman notes that

Healing of all kinds in the ancient world generally seems to have taken place in a context that was religious. Though much has been made of the contrast between the naturalistic medicine and religious interpretations of disease, religious and medical views of disease in the ancient world were not mutually exclusive.<sup>57</sup>

Despite, this, Hippocrates did not approve of supernatural (here, meaning pagan) interpretations of illness, whether they be physical or mental. Because of this resistance to paganism, Hippocratic medicine appealed to Christians and “led to the acceptance of a natural origin of diseases of the body and mind by most early Christian writers.”<sup>58</sup> However, for these early Christian writers, identifying, interpreting, and prescribing solutions for mental disorders was difficult, because they “lacked a precise vocabulary for describing various mental disorders and mood states.”<sup>59</sup> Even as they accepted Hippocratic ideas about there being a natural cause to

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<sup>55</sup> Ibid., 6.

<sup>56</sup> Robert M. Grant, "Views of Mental Illness Among Greeks, Romans, and Christians," in *The New Testament and Early Christian Literature in Greco-Roman Context: Studies in Honor of David E. Aune*, ed. John Fotopoulos (Leiden: Brill, 2003), 386.

<sup>57</sup> Samuel B. Thielman, "Reflections on the Role of Religion in the History of Psychiatry," in *Handbook of Religion and Mental Health*, by Harold G. Koenig (San Diego: Academic Press, 1998), 6.

<sup>58</sup> Ibid., 6.

<sup>59</sup> Ibid., 6.

mental illnesses, early Christianity still perceived supernatural influences at work when it came to mental and emotional struggles. Indeed, sometimes these Christians placed greater weight on a supernatural cause, even if a natural cause was relatively obvious.<sup>60</sup> This historical fact leads us to the study of demons and exorcism.

Among the church fathers, Origen (ca. 185 – 254) was one of the most influential in crafting the demonological beliefs of the early church. In his *De Principiis*, Origen observed that “demons could completely take over the mind of an individual...He used the terms possession and insanity interchangeably and referred to Christ as having been a healer of the insane, although the New Testament records no instance of Christ healing anyone with mania.”<sup>61</sup>

Exorcism as a cure for “insanity” was, by the first century C.E., highly regarded and utilized by Hellenistic Jews, who traced the origins of the rite all the way back to King Solomon. Solomon, they believed, had been granted by God the “knowledge of the art used against demons for the benefit and healing of men, and he composed incantations by which illnesses are relieved, and left forms of exorcisms with which those possessed by demons drive them out so that they never return.”<sup>62</sup> By the time of the New Testament, mental illness, possession, and exorcism were fully intertwined.

Looking at the New Testament, we can see that the Synoptic Gospels, in particular, contain examples of what were viewed by Greco-Roman society as mental illness. Grant cites Matthew 4:24 with its list of various patients and afflictions, “including ‘the demonized, the moon-struck, and paralytics.’” Reading on, we see that

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<sup>60</sup> Ibid., 8.

<sup>61</sup> Ibid., 8.

<sup>62</sup> Robert M. Grant, "Views of Mental Illness Among Greeks, Romans, and Christians," in *The New Testament and Early Christian Literature in Greco-Roman Context: Studies in Honor of David E. Aune*, ed. John Fotopoulos (Leiden: Brill, 2003), 388.



Matthew 12:43 – 45 [and parallel] Luke 11:24 – 26 tell how an unclean spirit, once driven out, will seek first refreshment in waterless places and then return with seven others more wicked than itself. It should be noted that, though an unclean spirit is mentioned in Zechariah 13:2 and in rabbinic literature, the term appears nowhere else in the Old Testament, nor have we seen it in the medical writers [above].<sup>63</sup>

In his own gospel, Luke, believed to have been a physician himself, describes victims of such unclean spirits, like the boy in Luke 9:39 who is seized and convulses. In Luke 13:11 – 13, Jesus heals a woman with a “spirit of weakness.” In Acts, Luke notes that “People brought ‘the sick and those afflicted with unclean spirits’ to the earliest Christians of Jerusalem, ‘and they were all healed’ (Acts 5:16).”<sup>64</sup> Grant highlights that, despite these mentions, it is the Gospel of Mark that contains the most references to and strongest emphasis on “unclean spirits” and the importance of driving them out of the bodies they inhabit.<sup>65</sup> The cure for these afflictions is, in the New Testament, Jesus. In Mark 2:17 (and parallels Matt. 9:12 and Luke 5:31), Jesus tells the Pharisees, “Those who are well have no need of a physician, but those who are sick; I have come to call not the righteous but the sinners.” In stating this, Jesus is defining his work as being comparable to a medical doctor. Indeed, Ignatius of Antioch refers to Jesus as a “‘physician fleshly and spiritual’ possibly meaning ‘physician of body and soul.’”<sup>66</sup> Exorcism and other religious rites were not, however, the only biblical mental health remedies.

In their aforementioned article on Saul, Williams and le Roux identify possible mental health remedies during biblical times. Regarding Saul specifically, they write that, despite the number of medical doctors that would have been available by this time, a physician is not called for Saul, and “no mention is made of herbalists or herbal medications. The reason for this was

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<sup>63</sup> Ibid., 391.

<sup>64</sup> Ibid., 391.

<sup>65</sup> Ibid., 391.

<sup>66</sup> Ibid., 389.

that prophets [here, Samuel]...were spiritual leaders not healers and regarded illnesses as coming from God – healing also would come only from God” through prayer and other forms of worship.<sup>67</sup> Furthermore, there is no medicine listed in the Old Testament that would combat what we now call depression. There are only suggestions for coping, or, as Williams and le Roux refer to them, “indirect avoidance techniques.”<sup>68</sup> These include suggestions in Deuteronomy to look for the positive and laugh frequently (Deut. 26:11; Deut. 28:47) and the recommendation to count one’s blessings, found in Psalm 2:11. Despite the lack of any specific mention, however, there were remedies available during this time period, including frankincense, which was thought to ward off evil spirits; pomegranate rind, which was believed to be useful in repelling demons that caused illness and disease; and laurel or sweet bay seed, which was used to relieve seizures, as it was believed that the leaves and fruit had narcotic properties.<sup>69</sup> On the subject of medicine and antidotes for mental afflictions, *The Dictionary of Pastoral Care and Counseling* notes that, “As medicine began to emerge as an art distinct from religion in Classical Greece, mental illness was increasingly attributed to natural causes...[this] movement in medicine exercised considerable influence during the Greco-Roman era.”<sup>70</sup> However, even with these early advances in care and medicine, superstitious notions about mental disorders impacted their treatment well into the Middle Ages.

*The Dictionary of Pastoral Care and Counseling* notes that, despite the creation (in some European countries) of homes for the care of the “insane,” the fifteenth century work *Malleus*

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<sup>67</sup> Gillian P. Williams and Magdel Le Roux, "King Saul's Mysterious Malady," *HTS* 68, no. 1 (2012): 4, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

<sup>68</sup> *Ibid.*, 4.

<sup>69</sup> *Ibid.*, 4.

<sup>70</sup> Rodney J. Hunter, "Mental Health and Illness," in *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon Press, 1990), 711.

*Maleficarum (The Witch's Hammer)* “linked witchcraft and mental illness. Within two centuries, this unfortunate confluence resulted in the torture and execution of perhaps two hundred thousand demented persons in France and Germany.”<sup>71</sup> After this period of massacre came a reprieve in the form of the scientific revolution in the seventeenth century and the social and intellectual growth that occurred in the eighteenth century during the Enlightenment period. These revolutions impacted popular thinking about mental illness and “madness.” *De Praestigiis Daemonum*, published in 1563 by Johannes Weir, is given credit as one of the first works of the era to argue that those believed to be possessed or witches were, in fact, suffering from a mental condition.<sup>72</sup> With this change, the supernatural aspects of medicine, particularly in the area of mental disorders, were chipped away and replaced with scientific ideas. Those suffering from mental illness eventually became wards of the state and placed in the care of physicians who regarded their patients in “increasingly humane and optimistic” ways. Indeed, new hospitals for the mentally ill were built in Europe and the United States through the 1800s.<sup>73</sup> On a religious level, though many spiritual and faith healers still cited the devil and demonic causes for mental disturbances, the changes among physicians and hospitals resulted in some people being less likely to see mental and emotional struggles as a punishment from God.<sup>74</sup> Additionally, as a result of the Enlightenment, psychiatry was developed as a discipline.

By the early twentieth century, psychiatry was established as its own specialty of medicine, and Sigmund Freud’s ideas and concepts about the influence of the subconscious and

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<sup>71</sup> Ibid., 711.

<sup>72</sup> Samuel B. Thielman, "Reflections on the Role of Religion in the History of Psychiatry," in *Handbook of Religion and Mental Health*, by Harold G. Koenig (San Diego: Academic Press, 1998), 10.

<sup>73</sup> Rodney J. Hunter, "Mental Health and Illness," in *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon Press, 1990), 711.

<sup>74</sup> Samuel B. Thielman, "Reflections on the Role of Religion in the History of Psychiatry," in *Handbook of Religion and Mental Health*, by Harold G. Koenig (San Diego: Academic Press, 1998), 10.

the use of psychoanalysis to treat poor behavior and mood disturbances were gaining popularity. Moving through the century, World Wars I and II led to the discussion of the effects of extreme stress, including war, economic depression, and other socio-environmental factors on the mental health of not only individuals, but the population at large. In the 1950s, antidepressant medications and phenothiazines (antipsychotic drugs) allowed for the treatment of patients previously thought of as being beyond help. As a result, the stage was set for two major developments: “(a) the controversial movement...to deinstitutionalize the nation’s chronically mentally ill, and (b) new advances in research regarding the neurological, genetic, and biochemical factors that influence mental health and illness.”<sup>75</sup> These advancements and changes bring us to a discussion of the current beliefs and attitudes surrounding mental illness in our society.

### **The Current State of Mental Illness**

The English Standard Version (ESV) of the Bible translates Ecclesiastes 7:7a as “Surely oppression drives the wise into madness.” This verse is a perfect starting point for beginning a discussion of the current “state” of mental illness in our society. In today’s society and culture, very few forms of sickness or disease evoke the kind of visceral response that mental illness does. We feel sympathy for those incapacitated by cancer or heart failure. Even illnesses that once were entirely misunderstood and feared, like HIV/AIDS, are today largely accepted by wider society. People struggling with mental illness or addiction, however, are often regarded with fear and suspicion. Is he unstable? Will she hurt me? Is he a criminal? The stigma associated with mental illness can cause people who are “well” to avoid those who are not, and

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<sup>75</sup> Rodney J. Hunter, "Mental Health and Illness," in *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon Press, 1990), 710 - 711.

the mentally ill often find themselves isolated, not only by their symptoms and struggles, but by their very community. Quoting actress Margot Kidder, who had a very public “breakdown” in the 1990s, Kathleen Greider writes, “Mental illness is the last taboo, the one that scares everyone to death.”<sup>76</sup>

In his introduction to *Ministry with Persons with Mental Illness and Their Families*, Robert H. Albers touches on the history of various illnesses to understand how mental illness was viewed in biblical times, and how it is viewed today. Albers makes a connection between mental illness and leprosy, which is mentioned extensively in biblical texts and other writings from that era. He writes, “Those who are mentally ill might be considered as the ‘modern-day lepers’ who suffer from a socially ‘unsanctioned illness’ and who continue to be misunderstood and mistreated by society and religion alike as a consequence.”<sup>77</sup> He continues, “Individuals [with leprosy] were confined to colonies on the geographical fringe of society. Similarly, people suffering from mental illness were also for centuries sequestered away...remanded to institutions...that prohibited them from interacting with the mainstream of society.”<sup>78</sup> When lepers went outside their boundaries, they were forced to announce that they were “unclean” as they went along, perpetuating the stigma against them and diminishing themselves; they were no longer people, but things to be avoided. The biblical Holiness Code (specifically Leviticus 13, 14

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<sup>76</sup> Kathleen J. Greider, *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-Suffering* (Kelowna, BC.: Pilgrim Press, The, 2007), 81.

<sup>77</sup> Robert H. Albers et al., *Ministry with Persons with Mental Illness and Their Families* (Minneapolis: Fortress Press, 2012), 2.

<sup>78</sup> *Ibid.*, 2.

and 2 Kings 5:1 – 27) dictated societal protocol for dealing with the lepers.<sup>79</sup> Albers relates this to our modern treatment of the mentally ill, writing, “Even though their malady is neither infectious nor contagious, they are often treated as though coming into even remote contact with them will somehow contaminate or sully the character of other people.”<sup>80</sup> To begin to appreciate why this is, it is important to articulate, as clearly as possible, what we mean, exactly, by “mental illness.”

Defined for providers of pastoral care in the *Dictionary of Pastoral Care and Counseling*,

Mental illness refers to a variety of enduring or recurrent disturbances in patterns of an individual’s thinking, mood or behavior that are typically associated with painful distress and/or impairment of social, occupational or leisure functioning. Severity of symptoms may range from mild annoyance to extreme discomfort, from little or no violation of conventional norms to floridly deviant behaviors, and from minor distortions of reality to significant impairment.<sup>81</sup>

From this definition, one can see that the term “mental illness” is one that encapsulates a wide spectrum of disorders, signs, and symptoms. Similarly, “mental health,” is not a simple term that merely indicates a lack of symptoms. It includes having “positive self-acceptance,” “balance and purposiveness in behavior,” “ability to engage in productive work and fulfilling love,” and “commitment to a source of devotion beyond oneself,” among other criteria. Additionally, for the purpose of addressing illness, mental health also refers to “rehabilitation of the mentally ill, prevention of mental and emotional disorders, and efforts to promote socio-environmental

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<sup>79</sup> Ibid., 2 – 3.

<sup>80</sup> Ibid., p. 3

<sup>81</sup> Rodney J. Hunter, "Mental Health and Illness," in *Dictionary of Pastoral Care and Counseling* (Nashville: Abingdon Press, 1990), 711.

conditions in which individuals can function according to their highest mental and physical potentials.”<sup>82</sup> In order to avoid perpetuating the idea that mental health and mental illness are on opposite poles, rather than two points of a continuum on which everyone falls, it is important to note that “Everyone experiences transient thought disturbances, periods of depression, unexplained fears, and outbursts of unjustifiable behavior; it is when these ‘symptoms’ persist and interfere with one’s daily living” that one is diagnosed with a mental illness.<sup>83</sup>

Returning to the idea that mental illness is a taboo, it is also clear that the *discussion* of mental illness is largely taboo, as well. Ivor Moody writes, “What people perceive as different, difficult to comprehend and appearing outside the norm, they often simply isolate and ignore.”<sup>84</sup> The incidence, however, of mental illness is high; according to the World Health Organization (WHO), an estimated 450 million people globally exhibit psychiatric and/or neurological problems at any given time, and approximately 873,000 people die by suicide each year.<sup>85</sup> Examining statistics merely within the scope of the United States, we know that one in four adults, or nearly 60 million Americans, experiences symptoms of a mental health disorder each year. One in seventeen adult Americans lives with a chronic, serious mental illness, like schizophrenia, depression, or bipolar disorder. Additional research even suggests that, “at some point in their lives, half of the U.S. population will meet the criteria for a psychiatric condition.”<sup>86</sup> Though it is therefore extremely likely that each of us has been touched in some manner by the difficulties and pain associated with it, psychiatric disorders remain an extremely

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<sup>82</sup> Ibid., 711.

<sup>83</sup> Ibid., 711.

<sup>84</sup> Ivor Moody, "Assessing Chaplaincy's Contribution to the Care of Mental Disease on Campus," *Modern Believing* 50, no. 4 (2009): 32, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

<sup>85</sup> Kathleen J. Greider, *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-Suffering* (Kelowna, BC.: Pilgrim Press, The, 2007), 15.

<sup>86</sup> Ibid., 15.

misunderstood form of illness. People who suffer from psychological or emotional issues and addictions are often looked down upon, and thrust to the outskirts of our society.

Over the past several decades, the way in which the mentally ill receive treatment in this country has changed entirely. Previous to the late 1950s and 1960s, as mentioned above, the majority of the mentally ill found themselves in state-run institutions. Though these institutions were often found to be extremely poor in terms of living conditions and their treatment of patients, the mentally ill at least had consistent and long-term access to doctors, therapy, and medications. As inhumane conditions came to light, however, the government began shutting down these facilities and what is known as the “deinstitutionalization movement” began. New legislation dictated that, as these facilities were closed, local governments and communities should and would pick up the role of caring for the mentally ill on an independent basis, through such things as community-run facilities and outreach. However, this plan largely did not come to fruition, and, as decades passed, it became clear that the mentally ill were not receiving proper treatment and were, indeed, falling through the cracks of our society.<sup>87</sup> Kathleen Greider writes,

Mental health treatment is in its infancy, the system of resources is not sufficient to meet needs, and care is offered only to a limited extent through most insurance policies... for too many, their search for help in the mental health system is thwarted, and the search itself becomes something they survive or, after too many lost rounds, something to which they succumb.<sup>88</sup>

As a result of the lack of resources, homeless and prison populations have become inundated with people suffering from psychological and emotional disorders. This problem persists today. In the state of Georgia, for example, it is claimed that one in six inmates have been diagnosed

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<sup>87</sup> Richard Erikson, "Serving the Needs of Persons with Chronic Mental Illness: A Neglected Ministry," *Journal of Pastoral Care* 44, no. 2 (1990): 153 – 162, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

<sup>88</sup> Kathleen J. Greider, *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-Suffering* (Kelowna, BC.: Pilgrim Press, The, 2007), 63 – 66.



with some form of mental illness, and are serving time for crimes committed in the confusion of psychosis and other symptoms.<sup>89</sup> Once in the prison system, the large number of inmates requiring consistent mental health care is taxing already limited resources. In terms of homelessness, “according to the Substance Abuse and Mental Health Services Administration, 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness.”<sup>90</sup> Given these kinds of statistics, it is clear that there is a disconnect between the once-stated goal of communities caring for their mentally ill members, and the reality that has developed.

In a collection of stories of mental illness and emotional suffering she calls *Much Madness is Divinest Sense: Wisdom in Memoirs of Soul-Suffering*, Kathleen Greider presents personal accounts of what it is to struggle with mental illness in a society that is weary and frightened of that struggle. The title of the book is a nod to a poem by Emily Dickinson, whom we know, from historical accounts, suffered from a mental illness that resulted in her spending much of her life as a recluse. Devoting a few pages to interpreting the poem that helped inspire her, Greider determines that, not only is Dickinson writing about personal experiences of “madness,” but she is also referencing societal experiences of mental illness. Greider believes that Dickinson is arguing that “the sickness of society sometimes causes or complicates the sickness of persons.”<sup>91</sup> Indeed, this idea is supported by the various memoirs included in Greider’s collection; the autobiographical accounts she studies confront “madness” in multiple

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<sup>89</sup> "Georgia Mental Health Consumer Network, Inc.," Georgia Mental Health Consumer Network, Inc., accessed December 19, 2012, <http://www.gmhc.org/>.

<sup>90</sup>"Mental Illness and Homelessness," National Coalition for the Homeless, accessed October 19, 2012, [http://www.nationalhomeless.org/factsheets/Mental\\_Illness.html](http://www.nationalhomeless.org/factsheets/Mental_Illness.html).

<sup>91</sup> Kathleen J. Greider, *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-Suffering* (Kelowna, BC.: Pilgrim Press, The, 2007), 3.

forms: “emotional suffering that stops short of illness, as well as serious psychiatric disorders, both of which can be caused and complicated by the sometimes sick quality of human society.”<sup>92</sup>

Throughout her volume, Greider refers to mental illness and emotional struggles as “soul-suffering,” writing

Soul-suffering is a sobering, even alarming, experience, no matter if we have a psychiatric disorder, encounter psychospiritual turmoil in others, or are typically healthy people swamped occasionally by our own depths. When ‘madness’ surfaces, everyone is captive to fear, stereotypes, and stigma.<sup>93</sup>

Greider further argues that labels like “mentally ill,” “insane,” and “psychotic,” allow the larger population to write off the people that we are labeling and “excuse ourselves from their world...[to] keep them from disrupting” ours.<sup>94</sup> This stigma and rejection often has the effect of worsening the mental illness itself. Indeed, Greider calls stigma “life-threatening,” because sufferers who are already weighed down by their psychic turmoil are pushed to the brink by the lack of resources and sympathy available to them. Stewart Govig argues that our society is “infected with ‘mentalism,’” a prejudice he compares to racism, sexism, and classism due to the damage it is capable of inflicting.<sup>95</sup> Ultimately, it is the position of Greider and others that, despite the prevalence in the twentieth and twenty-first centuries of various liberation movements, the “liberation of people who are emotionally different is barely visible on the horizon.”<sup>96</sup> She continues,

Activists argue that the destigmatization of mental illness – or, we can add, any emotional experience outside the status quo – will require much more aggressive

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<sup>92</sup> Ibid., 5.

<sup>93</sup> Ibid., 16.

<sup>94</sup> Ibid., 70 – 71.

<sup>95</sup> Ibid., 81.

<sup>96</sup> Ibid., 82.

and wide-ranging efforts than change of language – efforts like successful treatment, advocacy, and legislation.<sup>97</sup>

Combating stigma and improving the treatment of the mentally ill is a monumental task, and, ultimately, one in which I believe religion and the Church have a significant role to play. First, however, it is important to tackle the issue of the chasm between the disciplines of psychology and psychiatry and religion and spirituality.

### **Weaving Mental Health Care, Religion, and Spirituality Back Together**

With the development of psychology came a chasm between the discipline, religion, and spirituality. This chasm has also impacted mental health care. In *Spirituality and Religion in Recovery from Mental Illness*, Roger D. Fallot writes,

There is a long history of mutual skepticism, if not antagonism...between science and religion. As mental health practice became increasingly allied with natural science and rationalis[m]...in the early twentieth century, many psychiatrists and psychologists wrote dismissively of spiritual or religious experience.<sup>98</sup>

Fallot offers, as an example, Freud's argument that religious ritual is parallel to obsessive-compulsive behaviors and his idea that religion in general is merely illusion, or perhaps even *delusion*. This rejection, however, is not merely one-sided. As Fallot notes, some religious leaders and clergy have denied the validity and value of "secular" mental health services and resources. Believing science to be antagonistic to religious faith, these leaders have instructed members of their congregations and communities to rely entirely on religious resources, like

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<sup>97</sup> Ibid., 48.

<sup>98</sup> Roger D. Fallot, *Spirituality and Religion in Recovery from Mental Illness* (San Francisco: Jossey-Bass Publishers, 1998), 3.

prayer, when suffering from mental and emotional disorders.<sup>99</sup> Despite the seemingly wide range of differences between secular and spiritual mental health care, Fallot argues that there have been, in recent decades, attempts at overcoming this “mutual rejection.” Members of both the secular, scientific world and the religious and spiritual world have begun collaborating to create new “models for theory, practice, and professional organization...[and] constructive relations, both mutually supportive and mutually critical...[have] become evident in the literature of both disciplines.”<sup>100</sup> Indeed, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) is a testament to psychiatry’s increased receptiveness to the importance and legitimacy of religion in the lives of mental health care seekers. The manual includes religious and spiritual problems and difficulties as “potentially appropriate foci of clinical attention.”<sup>101</sup> This is appropriate, given the importance given to religion and spirituality in our society; and yet, “little has been written about the place of religion and spirituality in the lives of people with severe mental illness.”<sup>102</sup> Fallot argues that this is partially a result of the somewhat ambiguous nature of the terms “religion,” “faith,” and “spirituality.” Fallot writes,

Definitions of *spirituality* and *religion* in both the clinical and research literatures have often been confusing and ambiguous. Attempts to refine these concepts for research purposes are ongoing. For some authors, religion is the more encompassing of the two constructs...[seeing religion] as “the search for significance in ways related to the sacred,” whereas spirituality refers to religion’s most central function – the “search for the sacred.”<sup>103</sup>

Both religion and spirituality, however, involve “a sense of ultimate meaning, purpose, and values; a relationship with a transcendent being or higher power; or a sense of the sacred or

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<sup>99</sup> Ibid., 3.

<sup>100</sup> Ibid., 4.

<sup>101</sup> Ibid., 4.

<sup>102</sup> Ibid., 4.

<sup>103</sup> Ibid., 4.

holy.”<sup>104</sup> We also know and understand that “religion” goes beyond the personal, encompassing the institutional. With every religion comes a defined doctrine and core set of beliefs, and involves rituals, means of prayer, and practices, as well as a congregation or some other community of like-minded believers.<sup>105</sup> Despite the sense of confusion among mental health care professionals and religious leaders about how best to compromise and work together, it is clear that religion and spirituality remain an important component of the average American’s life. Participation in religious communities is broad, and many people view faith as being an important part of their daily lives.<sup>106</sup> According to a 2011 poll constructed and distributed by Gallup, 92% of Americans report that they believe in God.<sup>107</sup> This is an overwhelming statistic, and may not even present a complete picture. Fallot argues that “Measures of religious commitment might yield even stronger findings if a less institutional and traditional set of criteria were adopted – for example, if people who identified themselves as spiritual but not religious were included as well.”<sup>108</sup> Given these findings, Fallot writes,

In this broader social and cultural context, the relative inattention to matters of religion and spirituality in mental health programming is striking indeed. And given the movement of the past two decades toward more inclusive, multidimensional (holistic) assessments and the similarly comprehensive and integrated service arrangements in community-based treatment, the lack of attention to spirituality in the lives of mental health service consumers is all the more noteworthy.<sup>109</sup>

Given this, it is important to examine why the lack of attention to issues of spirituality and the lack of integration in care exist. There are multiple factors to consider in order to understand the

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<sup>104</sup> Ibid., 4 – 5.

<sup>105</sup> Ibid., 5.

<sup>106</sup> Ibid., 5.

<sup>107</sup> Frank Newport, "More Than 9 in 10 Americans Continue to Believe in God," Gallup, June 3, 2011, accessed March 7, 2013, <http://www.gallup.com/poll/147887/americans-continue-believe-god.aspx>.

<sup>108</sup> Roger D. Fallot, *Spirituality and Religion in Recovery from Mental Illness* (San Francisco: Jossey-Bass Publishers, 1998), 5.

<sup>109</sup> Ibid., 5.

“theoretical, clinical, and personal convictions” that cause a minimization or altogether avoidance of religious issues in mental health care treatment.<sup>110</sup> In addition to the historical chasm between science and religion mentioned above, it is also necessary to mention that in “certain psychodynamic and cognitive-rational traditions...religion is closely tied...to irrational and distorted views of reality, or to automatically rigid and dogmatic patterns of thinking,” causing some mental health care providers to view religious faith and experiences to be evidence of dysfunction.<sup>111</sup> This is especially true when it comes to working with individuals who experience delusions and hallucinations. It is often difficult for clinicians to discern between “religious delusions and valid commitments.”<sup>112</sup> Despite all of this, there are equally convincing reasons to incorporate and respect the role of religion and spirituality in the treatment and care of the mentally ill.

Among the arguments for the integration of religion and spirituality and mental health care is the idea that, for many, religion and spirituality are critical in the crafting and articulation of identity and self-understanding. Fallot writes,

Even though data are relatively sparse on the fuller meanings of religious commitment among people with severe mental disorders, the data available indicate that this population does not differ markedly from the larger public...As is true for many other individuals, then, people with severe mental disorders may find in religion and spirituality deep sources of identity and meaning.<sup>113</sup>

Given this, the choice of mental health care professionals to neglect this aspect of a mentally ill person’s identity, may prove detrimental to the patient’s ultimate ability to improve.

Additionally, besides helping to clarify identity, religious commitment may also provide

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<sup>110</sup> Ibid., 6.

<sup>111</sup> Ibid., 6.

<sup>112</sup> Ibid., 6.

<sup>113</sup> Ibid., 9.

personal and social resources, including those that lead to increased self-esteem, a sense of personal empowerment, and a feeling of purpose.<sup>114</sup> As paradigms of recovery from mental and emotional illness have shifted, examining a full array of resources has become more common for individuals. In a 1995 study by Lindgren and Coursey, eighty percent of participants said that religion and spirituality were generally helpful to them, and seventy-four percent stated that religion helped them when they were ill. Lindgren and Coursey concluded that “religion and spirituality help with ‘strength for coping, social support, a sense of coherence, and the feeling of being a ‘whole person.’”<sup>115</sup> A third reason for weaving mental health care and religion back together is the growing awareness of the need for culturally sensitive and competent plans of care. It is believed that in many cultural and ethnic groups, religion and spirituality are “especially vital sources of meaning and structure as well as healing;” it is important, therefore, that care providers are understanding of the depth and breadth of these religious commitments, and are able to competently incorporate them into their plans of care.<sup>116</sup> Finally, there is an empirical imperative for integrating religion and mental health care. It is observed that “there exists a trend toward a slight but positive relationship between most measures of religion and most measures of mental health...religiousness is connected to lower rates of suicide, drug and alcohol use, and depression.”<sup>117</sup> This is a compelling reason for cooperation between religious institutions and mental health clinicians in the treatment of the mentally ill.

Above all, it seems that religion has a valuable role to play in preventing mental health care seekers from getting “lost” in the process of receiving a diagnosis, counseling, and drug

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<sup>114</sup> Ibid., 9.

<sup>115</sup> Ibid., 9.

<sup>116</sup> Ibid., 10.

<sup>117</sup> Ibid., 10.

therapies. On this note, Fallot argues, “In our incessant and necessary attempts to understand the mechanics of serious mental illness, we often lose touch with those who matter most – the persons trying to make sense of their lives and survive on a day-by-day basis.”<sup>118</sup> Kathleen Greider also discusses this point in *Much Madness is Divinest Sense*, stating that diagnoses and other aspects of psychiatric care

tend to limit our understanding of soul-suffering to psychiatric conceptualizations...[and] focus our attention exclusively on pathology, when...the distress secondary to the pathology and also the grace and resurrection that sufferers sometimes experience are as important.<sup>119</sup>

Additionally, Greider argues, the emphasis on diagnoses also ultimately serves to segregate us, creating an exaggerated sense of difference between “well” and “unwell,” “sane” and “insane.” This feeling of difference is wholly artificial, because “human religiosity and the search for spiritual wisdom are incessant in large measure because most human beings have known psychic anguish that remains impervious to science or other human remedies.”<sup>120</sup> This argument, however, is not meant to discourage or deter from the importance of receiving an accurate diagnosis, working with mental health clinicians, and using psychiatric medications as they are prescribed. All of these things are vital; it is believed, however, that

Psychology has far eclipsed religion...[as a] framework for human experience, and psychological explanations for soul-suffering have come to almost completely dominate religious ones...Psychologists are showing more interest in spirituality, but most mental health professionals lack expertise to address it.<sup>121</sup>

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<sup>118</sup> Ibid., 26.

<sup>119</sup> Kathleen J. Greider, *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-Suffering* (Kelowna, BC.: Pilgrim Press, The, 2007), 12.

<sup>120</sup> Ibid., 13.

<sup>121</sup> Ibid., 23.



Because of this, as well as the dominance of psychology, many people who suffer from mental and emotional distress assume that “psychological explanations are the only expert advice available, and they are left largely on their own to find appropriate help” in the religious and spiritual realm.<sup>122</sup> Additionally, “Because we operate under the collective delusion that science will find the solution for mental health problems, we fail to attend adequately to finding alternatives. Thus, proactive help for the most vulnerable is neglected and whole societies suffer the costs.”<sup>123</sup> Ultimately, it is the conclusion of many, including myself, that, given all of the ideas discussed above, spirituality, religion, and psychology are valuable, separately and ultimately together, in the effort to provide care and hope to those struggling with mental illness. To that end, the Church, including clergy, other religious leaders, and the congregants themselves have an important role to play.

### **The Role and Responsibility of the Church**

In churches and congregations there has been an unfortunate history of associating the symptoms of mental illness and addiction with weakness in spirit, faith, or even demonic possession. The sick are encouraged to “pray harder” in order to receive relief. Much of this is the result of interpretations of the many healing stories that are found in the gospels, where the faithful are rewarded with Jesus’ miracle touch. On the opposite end of the spectrum, many pastors are silent on the issue of mental illness altogether, and, from a preacher, silence can and *does* give the impression that the issue is not important, or, even worse, something to be fearful of and shun. When asked about their own church experiences, clients of one local mental illness and addiction recovery facility reported that they could not remember a time in which their

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<sup>122</sup> Ibid., 23.

<sup>123</sup> Ibid., 80.

pastor spoke about the realities of mental illness from the pulpit.<sup>124</sup> This, again, has the effect of silencing and even shaming those who are suffering either personally with mental illness and addiction or struggling as the loved one or caregiver of a person with mental illness. It perpetuates the long-standing idea of “otherness” that I believe Christianity is charged with working against. It is my argument that a key way in which the Church can be helpful in working with the mentally ill is through the use of religious and theological education to foster awareness of mental health issues and care. Additionally, through this education, religious leaders will be in a position to educate and inspire their congregations to involve themselves in the mental health care of their religious and extended communities.

To lay the groundwork for an initiative that uses theological education to foster a religious community that engages mental illness, one must first examine the theological foundations. I find the beginnings of such a foundation in Scripture itself. On the subject of Scripture, James Gustafson writes that he distinguishes two methods for drawing on the text: the first is as “the revelation of a morality that is authoritative for the judgments of Christians,” and the second as “a revelation of theological principles that are used to interpret what ‘God is doing,’ and thus, in turn, [giving] clues to what man as a moral agent is to do in particular historical circumstances.”<sup>125</sup> In other words, one can approach Scripture to ask “what should I do?” or “what is God doing?” While it is entirely possible and necessary to ask both, I am principally looking to Scripture as a way of seeking answers about what we, as people, should

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<sup>124</sup> In my second year of Contextual Education at Candler School of Theology, I worked as a pastoral counseling intern at a renowned local facility for the treatment of mental illness and addiction. As a result of my work there, I began to develop an interest in the responses of Christianity to the mentally ill, and interviewed several clients on their experiences of ministry and whether they could recall that ministry engaging the topic of mental illness.

<sup>125</sup> James M. Gustafson, “Ways of Using Scripture,” in *From Christ to the World: Introductory Readings in Christian Ethics*, by Wayne G. Boulton, Thomas D. Kennedy, and Allen Verhey (Grand Rapids, MI: W.B. Eerdmans, 1994), 21.

do. It is therefore theologically possible and necessary to use the Bible to engage the congregation in a discussion of mental illness. The story of the man with the withered hand is, to me, a clear directive from Jesus to aid those who are ill, especially if they are often overlooked and marginalized. Though Jesus heals the man of a physical ailment, it seems to be entirely comparable and applicable to the healing and treatment of mental illness.

The story of the man with the withered hand is found in each of the Synoptic Gospels (Matthew 12:9 – 14; Mark 3:1 – 6; and Luke 6:8 – 11); the most developed version appears in Matthew. The context of the story is central to understanding the message. In each Gospel, this pericope is a continuation of the controversy over Jesus' perceived violation of traditions and laws regarding the Sabbath. Having just angered the Pharisees in the story immediately preceding by allowing his disciples to pick grain on the Sabbath, Jesus enters the synagogue. Inside the synagogue, Jesus encounters a man who is described as having a "withered" hand. In both Mark and Luke's renditions of the story, the Pharisees stand back and observe Jesus' interactions with the man. They carefully watch to see if he will again violate the Sabbath by curing the man, in hopes of making another accusation against him. Jesus reaches out to the man with the withered hand and beckons him forward. In Luke's rendition, Jesus does this "Even though he knew what the [Pharisees] were thinking"(Luke 6:8). It is at this point, according to both Mark and Luke, that Jesus asks "Is it lawful to do good or to do harm on the Sabbath, to save a life or to kill?"(Mark 3:4 - 5; Luke 6:9 - 10). Jesus' question about whether it should be considered unlawful to do good on the Sabbath has a clear implication: should we not always help those who are in need, regardless of the time? This implication is made more

explicit in Matthew. In Matthew's account, Jesus' attempts at reaching the Pharisees with his belief that it is lawful to do good on the Sabbath go further: "He said to them, 'Suppose one of you has only one sheep and it falls into a pit on the Sabbath; will you not lay hold of it and lift it out?'"(Matt 12:11). Jesus then declares, "How much more valuable is a human being than a sheep!"(Matt 12:12). By asking such a poignant question, Jesus is challenging the Pharisees' notions about what is truly important. Would God want a law to be strictly followed, or would God want God's people to work to alleviate each others' suffering? Jesus is not denying the importance of observing the Sabbath as one of God's laws; he is simply trying to draw attention to the idea that there might be a higher law at play. Jesus is asking us to consider how we treat each other, and whether we have responsibility to the sick or an obligation to heal if we have the ability. He is asking us to consider the value of human life, as well as ways to respect that value.

Throughout the gospels, Jesus focuses on the physically ill who have been cast aside in disgust and brings them back from the margins of their society through healing and the acknowledgment of their plight. By Jesus' example, both his contemporary followers and his followers throughout history into current times have crafted their own healing ministry, focusing their energies on ways to ease the pain of those suffering from disease and physical ailment. The struggles of the mentally ill have long been bubbling underneath the surface, largely written off both by secular society and religious communities. In recent decades, however, the prevalence of mental illness and the plight of those suffering have become more transparent and difficult to ignore. This new transparency has led to many people questioning, given the long history of churches caring for the ill, if Christian churches and communities have a theological mandate to help the mentally ill. In order to determine an answer this question, one must begin by learning

what the realities of mental health patients look like, whether clergy and church communities have the ability to be of service, and whether doing so fits with Christian tradition.

Published in *The Journal of Pastoral Care*, “Serving the Needs of Persons with Chronic Mental Illness: A Neglected Ministry” seeks to demonstrate to clergy and lay church members alike that there is a special role that they may fill in the lives of those suffering with mental illness. The article’s authors begin by describing the deinstitutionalization movement that took place in the United States, beginning in the 1950s and peaking in the 1980s. As mentioned above, the number of patients residing in institutions diminished by several hundred thousand as people within the mental health profession and others began to view state-run institutions as places of “dehumanization.” Additionally, breakthroughs with psychotropic medications led professionals to believe institutionalization was no longer necessary for many patients. Finally, legislative efforts led to the establishment of more community-based treatment centers.<sup>126</sup> Deinstitutionalization had both positive and negative consequences for the country’s mental health patients. Negatively, the article states that “the number of persons with chronic mental illness has not decreased and the emptying of hospitals has not solved the problem.”<sup>127</sup> The article educates churches by describing those who are in need and what they look like:

They are often alienated, lack skills for functioning in the community, and are poorly served by the present system...[they are] people who abuse drugs and alcohol, attempt suicide, engage in socially disruptive behaviors, reject or make inappropriate use of mental health services, and who are wholly or partially financially dependent. We have not solved this major social problem by means of deinstitutionalization; in some ways we have only made it worse.<sup>128</sup>

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<sup>126</sup> Richard Erikson, "Serving the Needs of Persons with Chronic Mental Illness: A Neglected Ministry," *Journal of Pastoral Care* 44, no. 2 (1990): 154, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

<sup>127</sup> *Ibid.*, 154.

<sup>128</sup> *Ibid.*, 155.

Positively, the reduction in the number of institutions has made vacant a significant space that the article's authors believe can and should be filled by religious communities. They continue, stating,

The structures and supports formerly provided by the hospital have been replaced by community alternatives which are incomplete and delivered in a fragmented manner... It is precisely here that churches can be helpful... Underfunded community mental health centers and well-organized church efforts in combination can make significant inroads into these major social problems.<sup>129</sup>

Would churches be imposing themselves on the mentally ill? Or do the mentally ill value a religious presence in their treatment and healing?

In addition to the findings mentioned in the previous chapter, in her article "Utilizing Religious Schemas to Cope with Mental Illness" Nicole Taylor discusses the lack of abundant studies and scholarship focused on the relationship between mental illness and religiosity, as well as the relationship between mental illness treatment and religiosity. However, Taylor writes that "the available results overwhelmingly suggest the use and importance of religious coping among mentally ill persons."<sup>130</sup> Some of these results include a study done by Katherine Frantz that found 42.1% of mental health patients stating that religion helped them to cope with their various illnesses "considerably."<sup>131</sup> Another study by Sharon Young also concluded that "spirituality is an important part of the recovery process."<sup>132</sup> Given this, it is understandable that clergy have the potential to play an important role with mental health care seekers. Taylor argues that the role of religious leaders in matters of health has a large background:

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<sup>129</sup> Ibid., 155.

<sup>130</sup> Nicole M. Taylor, "Utilizing Religious Schemas to Cope with Mental Illness," *Journal of Religion and Health* 40, no. 3 (2001): 387.

<sup>131</sup> Ibid., 387.

<sup>132</sup> Ibid., 387.

Throughout history...the person responsible for a given community's religious rituals was often the same individual responsible for the community's mental health. [They often] had the additional role of counselor or therapist. This has not changed much today. In fact, 40% of the population seeking help with emotional problems first turned to a local religious leader before or instead of a psychologist. It has been, and continues to be, the role of ministers, rabbis, and priests to help members of their congregations through the difficult life transitions that cause psychological distress.<sup>133</sup>

Of course, religious leaders and churches are not always a positive resource. Many who struggle with mental illness have traumatic experiences with clergy and church communities due to the reinforcement of old ideas about illness being a punishment for sin or the notion that one can simply “pray away” their symptoms. Because of these traumas, there have been studies that explore this aspect of the relationship between religion and mental health, and 23% of these found that the relationship is negative in nature. However, Taylor reinforces the notion that, despite the actions of some people within religious communities, there is a place in the treatment of mental illness that should be filled by clergy and church communities.

Throughout their article, the authors of “A Neglected Ministry” make allusions to Scripture but largely appeal to Christian tradition in order to compel church communities to engage in and acknowledge the plight of the mentally ill. The article states that “The church has a long and honorable history of service to those with chronic physical diseases and disabilities.”<sup>134</sup> This tradition obviously has as its foundation the many gospel narratives that tell of Jesus' extensive healing ministry. Jesus reaches out to and heals those suffering from leprosy, paralysis, hemorrhages, and other physical ailments, and this established within his followers and Christian churches the importance of ministering to the ill. This tradition has a solid foundation;

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<sup>133</sup> Ibid., 384.

<sup>134</sup> Richard Erikson, "Serving the Needs of Persons with Chronic Mental Illness: A Neglected Ministry," *Journal of Pastoral Care* 44, no. 2 (1990): 162, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

but as Douglas Ottati discusses, traditions must also be open to new incarnations. This is what it means to “stand in a living tradition” by, Ottati states, “participat[ing] in a dynamic process of interpretation – one that moves between received heritage and the realities and challenges of the present world in order to express a continuing vital orientation or identity.”<sup>135</sup> The tradition of aiding and ministering to the physically ill is clear, but, using Ottati’s understanding of tradition, Christians must be pushed further. The authors of “A Neglected Ministry” do this by discussing the history of Christian service to the physically ill, adding,

Ministry to persons with chronic mental illness is in every significant way analogous to work with persons with chronic physical illnesses and the disabled. There is, then, no reason for the church to abrogate its ministry to these people within the congregation or in the broader community.<sup>136</sup>

This argument is a further reflection of Ottati’s position on tradition and the necessity of allowing it to be reshaped: “A contemporary interpretation must...engage the community’s experiences of the distinctive realities of the present, yet stand in a meaningful measure of continuity with the originals.”<sup>137</sup> The growing needs of the mentally ill population, both nationally and within smaller communities, cannot be denied by modern churches, and so they must be incorporated into the tradition of healing and caring for the ill. Taylor highlights the necessity of church clergy and communities looking honestly at the plight of the mentally ill by appealing to empirical data. She very precisely presents the results of studies that have been done, stating that many mental health patients themselves believe that religion is part

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<sup>135</sup> Douglas F. Ottati, "What It Means to Stand in a Living Tradition," in *From Christ to the World: Introductory Readings in Christian Ethics*, by Wayne G. Boulton, Thomas D. Kennedy, and Allen Verhey (Grand Rapids, MI: W.B. Eerdmans, 1994), 82.

<sup>136</sup> Richard Erikson, "Serving the Needs of Persons with Chronic Mental Illness: A Neglected Ministry," *Journal of Pastoral Care* 44, no. 2 (1990): 162, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

<sup>137</sup> Douglas F. Ottati, "What It Means to Stand in a Living Tradition," in *From Christ to the World: Introductory Readings in Christian Ethics*, by Wayne G. Boulton, Thomas D. Kennedy, and Allen Verhey (Grand Rapids, MI: W.B. Eerdmans, 1994), 82.



of their recovery. The empirical data she presents can and should therefore be used, as Gustafson discusses, to develop moral norms. The data forces the church to move from “the is to the ought”; it is clear that many mentally ill people use religiosity to think about and cope with their mental illness, and so clergy and church communities are left with questions about what they ought to do to engage these patients who wish to find healing and peace through religion.<sup>138</sup>

With the right information and motivation, the authors discussed above believe that churches can truly be a place of aid for the mentally ill. By taking up such an important role, churches would be filling a void in the lives and treatment of many mental health patients. For the authors of “A Neglected Ministry,” these churches would be working within the bounds of a tradition that mandates ministering to the sick within one’s own community. For Taylor, these churches would be engaging in moral actions based on strong empirical data that demonstrates that the mentally ill need and value religion and spirituality in their lives and treatment.

Another way in which religion and spirituality may have a positive impact on the mentally ill is through friendship. In his book *Resurrecting the Person: Friendship and the Care of Mental Health Problems*, John Swinton seeks to develop a model for how clergy and congregations can be helpful in the treatment and lives of those struggling with chronic mental health issues. Through his research, his own experiences, and his interpretation of the gospel, Swinton determines that friendship is one of the best resources that faith communities have to offer the mentally ill. True friendship, he argues, can help people overcome or become separated from their diagnoses; through friendship, a person can surpass the label of “a schizophrenic” and

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<sup>138</sup> James M. Gustafson, “The Relationship of Empirical Science to Moral Thought,” in *From Christ to the World: Introductory Readings in Christian Ethics*, by Wayne G. Boulton, Thomas D. Kennedy, and Allen Verhey (Grand Rapids, MI: W.B. Eerdmans, 1994), 168.

achieve a higher level of “personhood.” What’s more, Swinton’s ideas about the healing functionality of friendship are inspired entirely by Jesus’ own ministry. Swinton writes,

The model of friendship presented in the life and work of Christ offers real possibilities for therapeutic change. Committed friendship that reaches beyond culturally constructed barriers and false understandings and seeks to “resurrect the person” – who has become engulfed by their mental health problems – is a powerful form of relationship. It offers hope and new possibilities to people with...mental health problems.<sup>139</sup>

Swinton and other researchers argue that hope is one of the key reasons that friendship is so vital to the recovery and progress of those with mental health issues, stating that “the ability of the sufferer to develop some degree of *hope* is fundamental to the recovery process. The primary way in which hope is engendered within an individual is through personal relationships.”<sup>140</sup>

Swinton believes that Jesus’ own actions prove this argument. Swinton believes that Jesus’ friendships and relationships throughout his ministry were “personal, as opposed to instrumental,” meaning that he always aimed to help people regain their “dignity and personhood,” even in the face of society’s rejection.<sup>141</sup> To reframe this in terms of pastoral care, we can return to the existence and function of hope in ministry. Swinton believes that “hope and the inspiration and maintenance of hope” are an integral part of the “*church’s* ministry of mental health care.” He continues, “The Christian community, as a community of memory, resurrection, and hope” is in a unique and valuable position to make a large difference for those struggling with mental health crises and long-term mental health care needs.<sup>142</sup> Swinton believes this to also be true in terms of the therapeutic process. “Friendship,” Swinton argues,

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<sup>139</sup> Ibid., 138 – 139.

<sup>140</sup> Ibid., 139.

<sup>141</sup> Ibid., 142.

<sup>142</sup> Ibid., 141.

is catalytic. Unlike...counseling and psychotherapy, which set out specifically to do something, it is a form of a relationship that acts as a catalyst that enables health and rehumanization simply by being there...the Christlike friend is not to *do* anything for them, but rather to *be* someone for them – someone who understands and accepts them as persons; someone who is *with* them and *for* them in the way that God is also *with* and *for* them; someone who reveals the nature of God and the transforming power of the Spirit of Christ in a form that is tangible, accessible, and deeply powerful.<sup>143</sup>

Though Swinton believes that the resources for this kind of catalytic influence are inherent in congregations and faith communities, he also believes that it must be enabled and nurtured. He believes that, to be effective in friendship, the Church, as congregation and institution, must actively work to come together with the marginalized in order for each to “encounter the humanity of the other” and create the kind of “mental-health-in-community” that Swinton believes is possible. Swinton argues that part of this work can be accomplished through what he calls “community mental health chaplaincy.”<sup>144</sup> A chaplain, a person appointed or commissioned by a faith institution to provide pastoral care and counseling to a community, has a unique and varied function. A community mental health chaplain, as defined by Swinton, is someone who the church would select to work not only in psychiatric facilities and contexts, but in the community at large in order to “authentically embody the faith community’s desire to minister to those suffering from mental health problems, and to bridge the gap between hospital, community, and church.”<sup>145</sup> In Swinton’s model, the mental health chaplain would have three very specific functions: 1) to enable those with mental health problems to transition between hospital or facility and community and feel a sense of acceptance within the community, 2) to

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<sup>143</sup> Ibid., 143.

<sup>144</sup> Ibid., 146 – 147.

<sup>145</sup> Ibid., 148.

advocate for the mentally ill in a way that fosters a sense of empowerment, and 3) establishing relationships with mental health agencies working in the larger faith community.<sup>146</sup> Clearly, Swinton believes that, through a model of friendship, ministry and chaplaincy have an invaluable role to play in the treatment and reintegration of the mentally ill into faith and wider communities. With all of these ideas in mind, we can turn next to specific recommendations for religious leaders and communities.

### **Recommendations for Religious Leaders and Communities Using Theological Education to Inspire Community Involvement**

In his article, “Making Differences: A Table of Learning,” Lee S. Shulman creates what he calls a “taxonomy” of learning. He refers to it as a table, but later shows that it is actually cyclical in nature. The ultimate goal is to achieve a level of commitment that inspires further engagement in the community. He writes,

Learning begins with...engagement, which in turn leads to knowledge and understanding. Once someone understands, he or she becomes capable of... action. [This leads to exercising] judgment in the face of uncertainty and [creation]...in the presence of...unpredictability. Ultimately, the exercise of judgment makes possible the development of commitment. In commitment, we become capable of professing our understandings and our values, our faith and our love...making them integral to our identities. These commitments, in turn, make new engagements possible—and even necessary.<sup>147</sup>

Shulman continues his discussion of commitment by stating, “We also commit ourselves to larger groups, larger communities, larger congregations, and professions at large—and by doing so, we make a statement that we take the values and principles of that group seriously enough to

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<sup>146</sup> Ibid., 148 – 149.

<sup>147</sup> Lee S. Shulman, “Making Differences: A Table of Learning,” *Change* 34, no. 6 (November/December 2002): 3.

make them our own.”<sup>148</sup> Essentially, educating to create engaged people who are willing to not only identify their faith and values but commit to acting on them inspire the same level of engagement in other people. For the purposes of this theory, it is the hope that educating ministers to be engaged in the topic of mental illness will result in their being charged to act and require engagement and involvement in their congregations and communities.

Having considered both my question and Shulman’s argument, I view a specific goal of theological education to be engaging those struggling with the issues of mental illness and addiction (whether personally or as loved ones) through providing members of the congregation with the resources to understand mental illness, its symptoms and its treatments. Providing congregations with the tools to understand what mental illnesses really are and how they function is vital to beginning to chip away at the stereotypes and stigma surrounding mental and emotional needs. I also see the goal of theological education to be equipping religious leaders with the skills and ability to inspire their congregants to be activists for providing various kinds of mental health resources throughout their congregation and community. This includes allowing for church space to be utilized for mental health causes and encouraging individual, personal responsibility for participating in various conversations on the subject of mental illness. I believe that engaging the mentally ill begins with being brave enough to help normalize and legitimize these types of conversations about mental illness within congregations, and so the purpose and goal of this theory must begin, first and foremost, with encouraging and educating pastors to use the pulpit as a stage for the changing of minds and attitudes, as well as for inspiring helping behaviors and attitudes.

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<sup>148</sup> Ibid., 8.

The first step in using theological and religious education to engage mental illness in congregations and communities is to educate our church leaders and preachers. A foundational course in pastoral care is required for most seminary students, and this course works to address a wide range of issues and theories, including family systems, comforting people with terminal diseases, and marriage and family counseling. It also broaches the subject of mental illness. While this is a good start, the class incorporates too many subjects to address and educate about mental illness with the time and depth it deserves. A class that focuses solely on mental illness and the real-life situations that students, as members of the clergy, are guaranteed to face during their ministry should be required for graduation and ordination. One option for this (being used by some seminaries and religious institutions) is “Mental Health First Aid.” The program was created in order to help people become as versed in responding to mental health crises as they are in giving CPR or responding to someone who is choking. Many churches have begun utilizing the program. The program introduces participants to the various forms of mental illness that they might encounter in their communities and within their congregations, including depression, eating disorders, anxiety, bipolar disorder, and schizophrenia. The program is meant to address misinformation, fear, and stigma, and allow people to recognize basic symptoms and feel comfortable approaching the subject of mental and emotional distress in conversation.<sup>149</sup> By impressing upon future pastors the importance of recognizing and acknowledging mental illness from the pulpit and through church programs and outreach, these students will have the power to begin enacting change in the congregations and communities they lead. For many people in congregations, their pastor is their first resource in times of difficulty. Ministers therefore need to

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<sup>149</sup> Betty, A.F. Kitchener and Claire Kelly, *Mental Health First Aid USA* (Annapolis: Anne Arundel County Mental Health Agency, 2009).

know what to look for, how to be compassionate and understanding, and how to recommend a course of action to people who are struggling with psychological and emotional issues. As a component of this education, seminaries must encourage their preaching students to reconsider old ways of viewing some biblical stories, including the healing miracles within the gospels, in order to be inclusive to everyone, especially those who have not experienced healing through medicinal or spiritual means. Similarly to Shulman's argument, teaching seminary students to begin preaching and teaching with an eye and ear to the prevalence and realities of mental illness is essential to the goal of ministers incorporating care for the mentally ill into the fabric of their ministry. To this end, Tom Long argues that if

the preacher files the rough edges off these experiences and transforms them into stories with simple, happy, and purely victorious endings, an unrealistic triumphant picture of the gospel is conveyed, with little room for unfinished suffering and continuing struggle.<sup>150</sup>

Clearly, ministers and other members of the clergy have a vital role to play in the care of people in mental or emotional distress.

Much of the conversation surrounding health and the role of churches tries to convince us that the two have no place engaging one another. Attempts to counter this belief began decades ago. In her article, "Religious Education, A Factor in Mental Health," Rose Thomas writes, "Workers in the field of religious education and mental health share a vital interest in the development of better mental, physical, and emotional health of youth and adults." She continues by stating that "The upsurge of interest in religious education stamps it as a potent force through which man seeks better mental health."<sup>151</sup> Thomas discusses in her article "the Judeo-Christian

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<sup>150</sup> Thomas G. Long, *The Witness of Preaching*, 2nd ed. (Louisville, KY: Westminster John Knox Press, 2005), 199.

<sup>151</sup> Rose C. Thomas, "Religious Education, a Factor in Mental Health," *Religious Education* 53, no. 3 (1958): 307-10.

principle, ‘Love Thy Neighbor,’ or... ‘the worth and dignity of every individual.’”<sup>152</sup> She writes “the ‘fellowship of believers’ supplants the sense of isolation [that the mentally ill can have]...[and provides] a genuine sense of belonging – to God and to the company of ‘saints in the making’ – and with a social fellowship that is meaningful.”<sup>153</sup> Research has continued today to encourage the Church to engage in conversations and a helping relationship with the mentally ill. For example, in her article (the result of a conference presentation) entitled “Mental Health and the Churches: The Story of Lucrecia,” Brenda Conseuelo Ruiz uses the background of a woman named Lucrecia to highlight the ways in which churches and Christian communities can be supportive of people suffering from mental and emotional problems. The victim of multiple forms of abuse and trauma, Lucrecia found relief at a Christian counseling center where Ruiz states she was “listened to attentively, [allowed to] recover her self-esteem, [and shown how to] read the Bible from a liberating perspective.”<sup>154</sup> Ruiz writes that there “are around 450 million people worldwide [experiencing mental illness] at any given time...Churches have a significant role to play in ameliorating the suffering that is caused by crisis situations, which precipitate mental strain, breakdown and violence.” She goes on to quote the Rt. Reverend Christopher Herbert of the United Kingdom, who states that

The church has a responsibility to support people’s mental as well as their spiritual well-being. We know that up to one person in four experiences some kind of mental distress in their life. We need to ensure that churches are welcoming and accepting places for those people to go, however severe the mental health problems.<sup>155</sup>

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<sup>152</sup> Ibid., 307.

<sup>153</sup> Ibid., 309.

<sup>154</sup> Brenda Consuelo Ruiz, “Mental Health and the Churches: The Story of Lucrecia,” *International Review of Mission* 95, no. 376-377 (2006): 104-6.

<sup>155</sup> Ibid., 105



Ruiz concludes her article by suggesting ways in which churches can promote mental health, including “creating a welcoming environment for everyone so that a sense of belonging can be developed, raising mental health awareness and capacity building, [and] challenging the stigma of mental health problems.”<sup>156</sup> She is certainly not alone in her convictions.

In his article on the ministry and mental health (with an additional focus on campus chaplaincy), Ivor Moody writes that

[Clergy] have authority to minister to the mentally distressed...precisely *because* [they] sometimes ‘falls between professional demarcation lines.’ For that is where those suffering mental distress often are – frightened or incapable of seeking out the different kinds of professional advice available; caught in the interstices between where to go and who to see.<sup>157</sup>

This statement supports the experiences of many providers of pastoral care, who are often utilized as the “first stop” when congregants are in need of professional help. However, many ministers are not properly equipped to adequately respond to many forms of mental health challenges. Through Moody’s experiences of providing campus mental health resources through chaplaincy, he has detailed a program that can be used as a model for other campuses, congregations, and communities. He writes, “Chaplaincy’s interaction with those suffering mental ill health...can offer a type of support which challenges a therapeutic model of care that has long pervaded Western society; [by creating] a passive, attentive listening, comprehending stance...”<sup>158</sup> As part of this interaction and support, Moody argues for the creation and provision of “sacred space,” “hospitality,” “love,” and finally, “hope.”<sup>159</sup> Each of these goals and outcomes

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<sup>156</sup> Ibid., 105.

<sup>157</sup> Ivor Moody, "Assessing Chaplaincy's Contribution to the Care of Mental Disease on Campus," *Modern Believing* 50, no. 4 (2009): 31, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

<sup>158</sup> Ibid., 32.

<sup>159</sup> Ibid., 33-35.

can be realized through a congregation's active presence in not only their own mental health care, but through an active presence in the greater community.

While people like some acknowledge that clergy and church members may lack the professional expertise to engage in the technical aspects of treatment, it encourages church communities to be confident in the ways that they can help. These ways include supporting established mental health programs in their communities, places for which there is no shortage of need for people willing to volunteer their services. Churches are also encouraged to allow their buildings to be used for meetings of Alcoholics Anonymous, Narcotics Anonymous, and other support groups. The article also encourages church communities to make their voice known by supporting legislative efforts to protect agencies and programs that provide services to the mentally ill. Additionally, churches can themselves successfully provide the kind of communal continuity that mental health patients need to engage and improve, and “such availability offers concrete reassurance that nothing – including mental illness – can separate us from the love of God.”<sup>160</sup>

### **Conclusions**

Mental illness and mental health care are two topics that, in our society, are often difficult to broach. Fear, discomfort, and lack of knowledge lead to an avoidance of the issue, which has a significantly negative impact on the people struggling with mental and emotional difficulties. As shown in the first part of this work, the way we utilize the Bible and interpret some of its characters and stories is a starting point for understanding how mental illness has been viewed throughout history and into the present. While there are some differences in opinion on whether

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<sup>160</sup> Richard Erikson, "Serving the Needs of Persons with Chronic Mental Illness: A Neglected Ministry," *Journal of Pastoral Care* 44, no. 2 (1990): 161, accessed March 7, 2013, ATLA Religion Database with ATLASerials.

it is appropriate to attempt a psychological evaluation of biblical characters like the various prophets and even Jesus, as seen in the works of Abraham Heschel and Albert Schweitzer, discussing the potential presence of mental illness in our sacred text has the potential power to begin to normalize the discussion in our present religious communities and larger society. It is obvious that responses to mental illness have been varied throughout history. Even before the development of Christianity, there were members of other religions and belief systems that conceived of mental disorders and relief from them as coming from divine and other worldly sources, such as the god Asclepius or the cosmos. In the centuries immediately preceding Jesus' ministry and death, physicians like Hippocrates began to posit that mental and emotional interruptions were natural phenomena that could be treated in natural (medicinal) ways. Because these physicians rejected paganism (which is how they viewed the temples and rituals devoted to Asclepius), the idea of natural remedies was largely accepted by early Christian writers. Despite this, however, the long standing belief in demonic possession and the use of exorcism was perpetuated for many centuries after the death of Christ. Beginning in the seventeenth and eighteenth centuries, institutions were used to house and treat people who were deemed "insane." Fortunately, with the development of the scientific method, the Enlightenment, and the creation of psychology as a discipline came better treatment plans and a more positive outlook for people with mental disorders. Moving into the twentieth century, psychology and religion became segregated from one another, and many viewed the two as being contradictory. Because of this, there was in mental health care an absence of well-rounded, holistic plans for mental wellness. It is the belief of many, including myself, that clinicians and religious and spiritual care providers have an imperative to work together to provide mental health patients and

care seekers with multiple avenues for achieving relief and peace. Psychology, psychiatry, religion, and spirituality have much to learn and gain from one another. Part of the responsibility for this should be placed on religious leaders, ministers, and clergy. Through theological and religious education, religious leaders should be required to receive training in mental health care, as clergy and ministers are often utilized as first-responders in times of mental health crisis by their congregations and communities. Through this education, religious leaders can become encouraging of their congregations to engage in an honest dialogue about mental health struggles and provide opportunities for care in the congregation and in the community at large.

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