Part III

Helping The Weak

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12 Integrated Care of the Mentally Ill

How can we best help someone who is going through a psychiatric crisis? Is there an integrated view of the treatment of individual suffering with mental illness which offers help without resigning itself to their condition, and awakens hope without churning out empty platitudes? Furthermore, can any basis for a comprehensive overview of the practical pastoral care of the mentally ill be derived from the Bible?

Multidimensional Perspective

In the course of this book one thing has become clear: Psychiatric disorders are not to be understood with the use of simple models. Our knowledge of the causes and treatment is, like so many things, »in part«. The Bible points us in the right direction, but doesn't contain answers to every question of detail in psychiatry, just as it does not tell us how to perform an appendicectomy.

The complicated interactions can only be described for the most part by models which are incapable of giving us a complete picture. The contour lines on a map can never convey the experience of a traveller on seeing the Matterhorn. In the same way the most detailed knowledge about the nature of psychiatric illnesses, even together with the most fascinating theories about the best way of giving care cannot convey the personal struggle experienced by the counsellor who takes on the care of a mentally ill person. For this reason I do not intend to go into details about the great

schools of psychiatric thought which have developed in the course of the years.

They have all described aspects of human existence, but all too often they get stuck at one level or other. While some emphasise working through childhood experiences, others restrict themselves to pharmacotherapy. One will put the patient's own experience at the centre, others plead for a systemic change in the family as the basis for healing. Similar developments can be seen in the field of pastoral care. Here we find a broad spectrum stretching from rules for behaviour based on biblical texts at one end, to inner healing through spiritually induced experiences at the other.

Anyone who views a person solely in one dimension, whether at the physical level (*disposition*), in social relationships (*environment*) or at the level of thought and behaviour (*reaction*) will leave out important aspects. Indeed, I doubt if that approach will really be of any help at all. Our goal, in our search for understanding, must therefore be to develop a multidimensional perspective, which keeps the most diverse points of view under-consideration, and makes an effort to see the human being as a whole.

The Goal of Pastoral Care

What is the proper goal for the pastoral care of the mentally ill? Often people give the spontaneous answer: »To make them well again!« In fact, many individuals who go through mental illness do have a good chance of being completely restored. However, others suffer throughout their lives from the limitations imposed by psychiatric illness.

They are not best served by one sided catchphrases such as »wholeness« and »full healing«. For them, *the goal has to be redefined*. Help for those who are psychiatrically weak doesn't consist in re-establishing the situation as it was before the illness, or in adapting to the ideals of our competitive society. It is advisable not to just direct one's gaze in a onesided way to the symptoms or course of the illness and try to remove them. It is precicely such a goal that cannot be achieved in patients with severe thought disorders (e.g. depressive withdrawal, compulsive rituals or paranoid delusions).

The therapeutic goal of effective long term care must be directed towards *coping with the existence in this world* with all its limitations. This approach, combining compassion and reality, is Christian at the deepest

level and goes far beyond treating sick individuals in a resigned way because »they can't be helped«.

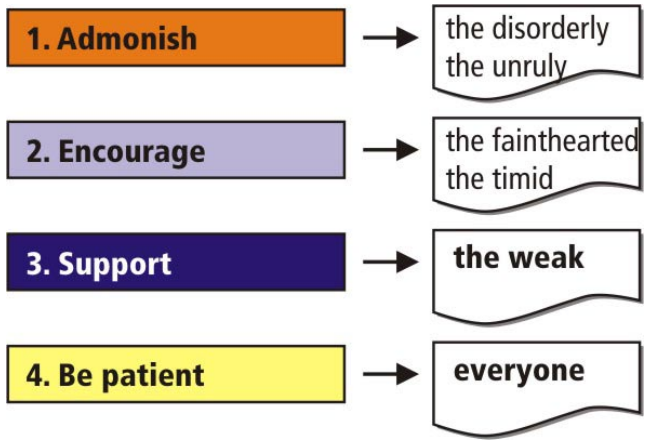
biblical Pastoral Care is Practical

In the first chapter I defined pastoral care briefly as »help to cope with life based on a foundation of biblical principles«. This implies that pastoral care and counselling go far beyond a mundane concept involving discussions of matters of faith. Pastoral counselling, as I find it in the Bible, does not, in the first instance, try to explain the *causes* of events, but helps us to understand their *purpose*, and to direct our life to achieving a new goal. For this reason, it is with concern that I observe tendencies in the field of pastoral counselling which attempt to establish supposed causes of a disorder, and in the process neglect compassionate empathy with the patient's suffering.

The Bible reflects a whole spectrum of helpful approaches which can assist a sick person, and a mentally ill person in particular, in coping with life. Paul admonishes the early Christians to develop a wide ranging programme of pastoral care (1 Thessalonians 5,14):

- admonish the idle
- encourage the fainthearted
- help the weak
- be patient with everyone.

Figure 12.1: A biblical model of differential counselling strategies



What do these four statements imply for contact with the mentally ill?

First: The carer should be in a position to correctly distinguish between different situations (*differential diagnosis*). He should be able to distinguish between » the idle, the fainthearted and the weak«.

a) »Idle« individuals are those who, all things considered, are capable of coping with life, but are living in behavioural patterns which the Bible calls »sinful« and which are detrimental to their own wellbeing and the wellbeing of their families.They need to be warned and pointed in the right direction.

b) The »faint-hearted« as I understand then, are individuals who are going through a crisis caused by difficult life situations and inner anxieties and conflicts. They often suffer from feelings of rejection and low self esteem, inhibitions and anxieties, which cast a shadow over their spiritual life as well.

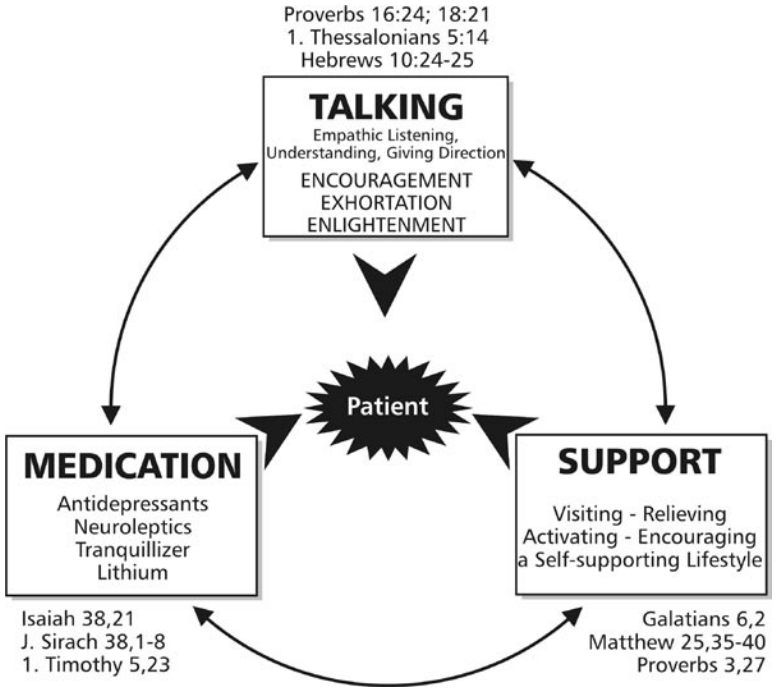
c) The »weak« are persons whose existence is clearly restricted as a result of physical and psychological handicaps. With the best will in the world they are no longer able to carry a full load, whether in everyday life, or in their Christian duties. Nevertheless, they are of no less value in God's eyes. They need a special measure of compassionate acceptance in the community.

Secondly: Different problems should be treated in different ways (*differential therapy*). All too often truths which are certainly helpful in moderate cases are applied without question to individuals who are suffering from severe mental illness, for whom these principles are no longer valid. Depressed individuals are so often unjustly treated by people who take their exaggerated guilt feelings at face value, making them confess and repent, even though they have already desperately pleaded for forgiveness many times for each and every tiny little sin.

Evangelical pastoral counsellors in particular, are in danger of emphasising only the admonishing, correcting kind of pastoral care. But when you are dealing with individuals who are suffering from a mental illness, it is more appropriate to draw attention to the *comforting* words of the Holy Scripture and be prepared help the weak person in the practical concerns of everyday life.

Thirdly: Wounds of the soul take time to heal. With good reason Paul admonishes the Christians in Thessalonica »Have patience with everyone!« *Patience is not passive, but active.* It doesn't signify resigned submission to the adversities of life, but an active approach which opens itself to the needs of others, living in a sharing community. Human patience and long suffering in this sense is thus not a quality of character, but rather an act, indeed the first act of love.

Figure 12.2: A comprehensive model of helping



In the diagram above I have tried to present a simple model of the comprehensive help needed by those who are »mentally ill.« In the centre stands the patient with his inner conflicts and external problems. Depending on the nature of his basic problem he will need one or more avenues of help. These I have summed up in three groups:

1. Helpful Talking
2. Practical Support
3. Medication

The different approaches have a mutually supportive effect and provide help only when they are interacting with one another. Administering medication requires that the helper should work closely with the doctor. But the opposite also applies. The physician is dependent on the help of carers who can encourage, support and carry the patient in between appointments.

Encouragement through helpful talk

»Kind words are like honey sweet to the taste and good for your health«. Thus the Bible describes the beneficial effect of counselling. It is full of advice about the therapeutic value of healing words. »What you say can mean life or death,« writes Solomon, »you will be rewarded by how you speak.« However, helpful talk begins even before the first word passes the lips of the helper. It starts with our *inner attitude* towards the suffering person. Jesus is our great example here. What love he had for those who came to him for help! »When he saw the crowds,« we are told, »he had compassion on them because they were harassed and helpless, like sheep without a shepherd.« His compassion was not just religious charity, but the most inward sympathy towards the suffering people.

Even though he knew everything that was in an individual's heart, he did not meet them as the judging God but as the merciful Saviour. Jesus knew how to distinguish between the strong and the weak. He could use strong words to correct the pharisees, with their arrogant dogmatism, but he met the weak with compassion and love.

This *attitude of compassion* towards the weak which I have described in this book is the most important prerequisite for comforting and supportive conversation with mentally ill individuals. In addition, a further condition is needed: *a willingness to listen*. Listening means paying attention to the other person without beginning to think over what you are going to say when they have finished, while they are still talking.

James warns his readers: »Everyone should be quick to listen, slow to speak, and slow to become angry«. What starts as silent attention can move into active listening during the course of an interview. By this I mean asking gentle clarifying questions, which encourage the counsellee to open his heart.

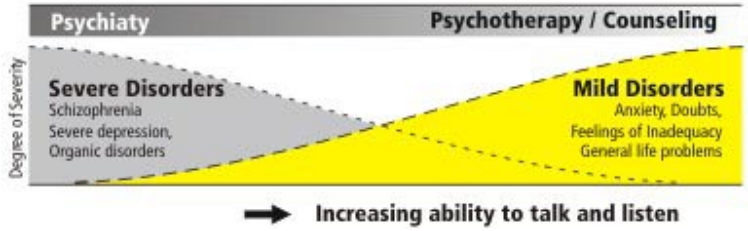
In this connection it is always advisable to resist the inward compulsion to be too quick to give explanations and advice. A great deal of empathetic skill and patience is needed to strike the right note. Psychiatrically

weaker individual are often enormously sensitive. For this reason the pastoral counsellor must take careful note of the personality and situation of the person he is dealing with. We should continually ask ourselves »Which words could reach the heart of this person?« and »How can I help this person to grow inwardly and cope better with life?«

Finally, the pastoral counsellor needs to know his limitations. When you are talking to mentally ill individual you cannot always set the same goals as in conversation with an individual who is receptive to a normal degree. The more severe the suffering and more acute the situation, the more restricted the patient's conversational ability will be. This connection is represented diagrammatically in Figure 12.3.

As became clear when I was describing the various illnesses, patients in severe depression and acute schizophrenic crises are scarcely receptive to their environment. It would be illusory to try to share biblical truths with them in an orderly way at this time of inner confusion and doubt. What is needed at this point is *common sense* without unworldly dogmatism, a practical and resolute approach which does not shrink from cooperation with the doctor, nor from the use of medication.

Figure 12.3: Severity of illness and the ability to follow conversation.



Of course, pastoral care isn't dependent on the spoken word alone. The Christian, more than anyone, knows that his own efforts can do nothing unless God himself is at work in the patient. Jesus undergirded his words and his actions with his prayers. In intercession the pastoral counsellor enters a new level of effectiveness, even when he can do nothing for the patient outwardly.

Praying with the patient: This often helps more than any number of words and quotations from the Bible. A lady with a severe depression recounted to me how she had been to see her pastor and shared her difficul-

ties with him. She could scarcely take in the things he said, but then he anointed her with oil and prayed over her together with one of the elders of the church. This act of loving attention and blessing did her an immeasurable amount of good, and gave her new courage to go on living.

In this connection many pastoral counsellors would point us in the direction of deliverance from occult powers, regarding this as of special importance with individuals suffering rom mental illness. They refer to the gospels where Jesus drove demons out of individuals with odd behaviour resembling schizophrenia or epilepy.

However, experience shows that it is very difficult to transfer these situations and apply them to someone with an endogenous psychosis. For this reason the *utmost restraint is advised* in too quickly assuming a demonic cause for psychiatric disorders. Many patients with minor disorders have been greatly helped by deliverance ministry from a pastoral counsellor, but with many others it has had exactly the opposite effect. Instead of experiencing inner freedom, their psychiatric problems detriorated. Instead of concentrating their attention on God's ability to support them and help them through, they slipped into an anxious fixation on the demonic powers.

Dr. Lechler, a well known Christian psychiatrist once wrote: »I have lost count of the cases in which I have observed the unhealthy effect on a mentally ill person of falsely labelling them as demonised. It is a great injustice for someone who is suffering emotionally and spiritually in this way to be told that he or she is in the Devil's power, Anyone who makes such an accusation without any knowledge of the sick soul, or of varieties of demonic influence, is at best acting presumptuously, and most certainly with cruelty.« A very helpful book on this topic was published by Dr. David Powlison (cf. literature reference at the end of this chapter).

Practical Help

Integrated help for the mentally ill has to go beyond kind words. Psychotherapy should not be limited to a nice dialogue, and Pastoral Counselling should not exhaust itself in conversation. When Jesus described the great judgement at the end of time, he didn't ask those he was judging about their words, but about their deeds. To the righteous he said: »What you did to the least of these my brothers you did to me!« Love shown in actions can give the weak person the courage to face the everyday routine and to take the risk of stepping back into life. I would like to divide this

practical help into three categories. Basically these are no different for someone with a psychiatric disorder than for someone with a broken leg.

1. Support
2. Activation
3. Rehabilitation

1. Support: You don't expect a person with a broken leg to start walking around straight away. He is given a plaster which supports the broken bone and holds it still to assist the healing process. It is the same with a mentally ill person, who feels overwhelmed by every bit of stress and sinks deeper into suffering. Support then, means relieving the sick person of stresses, taking responsibilities from her shoulders and giving a practical hand. A depressive woman for instance could be helped with the housework, or you could look after her children for her. These »simple« duties cannot be taken on either by the doctor, or other caring professionals. They have to rely on the help of the relatives and friends of their patients.

2. Activation: Once the ice of a depression begins gradually to melt, or the fire storm of a schizophrenic episode begins to abate, new seeds of life hesitantly start to grow again. At that point you need to get to know the sources of strength, the »resources« which a patient has. By this we mean the healthy parts of his personality, his interests and abilities, and also the opportunities for accommodation and work which will make it easier for the individual to return to normal life. These resources will be summed up in the framework of the treatment plan and should also be taken note of by those who care outside the hospital.

Perhaps an interview with an employer is called for, or someone knows a family in the country who are prepared to take the sick person in to stay with them. In any case it is good if someone can take over the coordination of these efforts and plans and carry them through in consultation with the afflicted person and his relatives. It is necessary to activate the sick person, without overstretching him. Demanding too much of a patient all at once can lead to great inner tension which may further unsettle his sensitive balance and trigger a relapse.

3. Rehabilitation: In psychiatry this term denotes re-integration and re-adaptation of a patient into business and private life after an illness. Unfortunately in only a proportion of mentally ill individuals does rehabilitation mean complete restoration of the situation before the crisis. Often

it is a question of helping the patient to live the most fulfilled life possible within the limitations of his disability. This task is nowadays recognised by social psychiatry, which has counselling centres in all major cities. In cooperation with the welfare associations many arrangements have been made in recent years, especially residential homes and sheltered workshops, which pave the way to reintegration of psychiatrically handicapped individuals back into society.

On a Christian basis, there are quite a few therapeutic facilities whichare supporting mentally handicapped patients on their way back into a more self-reliant life. In Britain, information on similar activities can be obtained from CARE (Christian Action, Research and Education).

Don't forget the family

In the midst of efforts to help the patient, the relatives are often forgotten. The psychiatrist only sees a sick person during the appointment, but parents, brothers, sisters and the partner have to live with their sick relative 24 hours a day. They suffer enormously as a result of the altered behaviour of their loved one which they find difficult to understand. Frequently they feel very much alone with feelings of rejection, guilt and helplessness.

For the relatives, the onset of schizophrenia is like entering a totally alien world in which they are left without a map. It therefore must be a duty for the hospital staff, G.P.s and the pastoral counsellor as well, to take seriously the suffering endured by the relatives and to give them advice to help them in their difficult task.

In recent years the importance of the relatives in the treatment of psychiatric patients has been increasingly recognised. They can meet in special groups for relatives to learn about the sickness and talk about their experiences and feelings. Actually, the relatives often know more about the practical problems than do the physicians.

The way in which the relatives relate to their sick loved one (»expressed emotions«) can contribute a great deal towards reducing tension and preventing relapses. When they are supported and encouraged they find it easier to meet the sick person with the sympathy that is needed, and to stand by him even in the midst of an acute apisode.

Help from Medication

Among lay persons, by far the most controversial question is the use of drugs in connection with mental illnesses. All too often the long term use of psychopharmacy is seen by well-meaning helpers as equivalent to addiction and »chemical dependence«, and involving the suppression or alteration of the personality. As a result, many sick individuals are caused to feel insecure and to leave off their medication. This frequently leads to a worsening of their situation.

I think of a young woman who had already been in hospital several times with episodes of schizophrenia. With regular medication she had made encouraging progress. She learned a trade, passed her driving test, found herself somewhere to live and began to work. She attended a Christian youth group and played an active part in her church. For several years now, she had not required a further stay in hospital. She had a few minor bouts which had been controlled through supportive counselling sessions and adjustment of the dose of her medication.

But then she tried to »live by faith« and gave up her medication. For a month everything went well. Then she became noticeably insecure, sensitive and driven. She lost her job, became confused and in the end had to be admitted to hospital again. The radiant Christian woman whom I had come to know during the counselling sessions presented a picture of misery. She had hoped to be »free« without medication, but now she was again being ruled by her confused thoughts and was surrendered defenceless to her delusive fears.

Situations like this make me sad and often cause me to feel very dismayed, because the people who advise against medication are not usually around to find the patient a new job, pay for any damage they cause or care for them until they have found their way back out of their relapse.

I would like to give one more reminder that psychopharmacy has made possible an increasing openness in psychiatry, and that many psychiatric conditions have now lost their terror as a result of it. Three groups of drugs are available in the treatment of psychiatric illness:

1. *Neuroleptic drugs* are the medication of choice in the treatment of psychoses.
2. *Antidepressants* have proved their value in the treatment of depressive conditions.

3. *Tranquillisers* (or benzodiazepines) have a calming, relaxing, and anxiety-reducing effect. Some of them (which are called hypnotics) induce sleep.

More detail concerning these drugs and their effects can be found in the descriptions of individual conditions in this book, and also in text books on psychopharmacology as well as in the internet. While some substances only need to be taken as a temporary measure in order to counter the effects of an illness episode, others, particularly the neuroleptics, have often to be administered over a period of years in order to prevent a relapse in individuals suffering from schizophrenia.

A Supplement to Pastoral Care

Nowadays medication stands alongside counselling and practical help as the third pillar of an integrated approach to treatment. Medication can be valuable as a supplement to pastoral care. Often it is the medication in fact which improves the patient's situation to the extent that pastoral help becomes possible.

Understanding the biochemistry of the brain, which God created, enables us to understand many phenomena in psychiatry. I see no distinction between lifelong injection of insulin and the prolonged administration of drugs in the treatment of a psychosis. Whereas diabetes is caused by a disorder of the metabolism of the pancreas, in the other case, administration of other drugs leads to an improvement in the metabolism of the brain.

Nevertheless, the difficulties involved in psychopharmacy should not be played down. Many aspects of the way that drugs work remain unclear. Many conditions have so far not responded to medication. All drugs are not equally effective or indeed necessary. And unfortunately there are always patients who suffer as a result of disturbing side effects.

Finally, the danger of dependency, especially from sleeping tablets and tranquillisers, should not be played down. Nevertheless, *a pastoral counsellor should not under any circumstances advise a client to set aside his medication, without consulting with the doctor.* With the background of his training and experience, the doctor is the only one who can estimate when medication is advisable, or when a change in the medication is possible.

Preventive Care

Treatment is good, but prevention is better! This statement is valid to a special degree regarding psychiatric problems. So to conclude this chapter we will ask in which ways Christian denominations and local churches can help in the prevention of psychiatric disorders. The potential of a live christian fellowship is often undervalued. Many ministers, preachers and church workers are never aware of the important contribution made by their work and their preaching towards the prevention of sicknesses of the soul. In an academic article two professors of psychology (Bufford und Johnston 1982) demonstrated the significance of the Christian church in the framework of psycho-social endeavours. In this context they distinguished three forms of prevention.

1. *Primary Prevention.* This meets needs and offers help in such a way as to prevent the development of psychiatric disorders. Various psychological studies have indicated that two factors contribute to this:
   a) Awareness of meaning and purpose in life and
   b) Social contact and viable family relationships which come alongside to give a person support through the difficult circumstances of life. Both needs can be met in an ideal way through live Christianity.

2. *Secondary Prevention* encompasses the early recognition and treatment of developing psychiatric problems. This reduces the severity and duration of the disorder and eventually makes hospitalisation unnecessary. At this stage a church member may well consult a doctor and perhaps even require medication. But this will be undergirded by sympathetic care on the part of friends and helpers in the church.

3. *Tertiary Prevention* takes place after a nervous breakdown or after a stay in hospital and helps the sick person to find their way back into everyday life. Impartial, non-judgemental acceptance by the the house-group and the congregation is of great significance at this point, allowing the person to experience love and acceptance in spite of their past rejection and their present limitations.

I can think of no better basis for integrated treatment and prevention of psychiatric disorders than the power and motivation which spring from Christian faith. If Christians are willing to let themselves be trained in this

field, if they learn to view their suffering fellow human beings with eyes of compassion and active love, they can make an invaluable contribution to the integrated treatment of psychiatric illness.

References Chapter 12: Integrative Care

Bible quotations:

1 Thessalonians 5:14
Proverbs 16:24
Proverbs 18:20-21
Matthew 9:36
Matthew 12:7
James 1:19
Matthew 25:34-35

Recommended books on basic psychotherapeutic skills and Christian counselling.

Egan G.: The skilled helper. A Problem-Management and Opportunity-Development Approach to Helping. Brooks / Cole.

Mark R. McMinn: Psychology, Theology, and Spirituality in Christian Counseling (AACC Library). Tyndale.

Collins C.: Christian Counselling. A Comprehensive Guide. Nelson.

Benner D.G.: Care of Souls. Revisioning Christian Nurture and Counsel. Baker Books.

Helpful literature concerning the question of »occult bondage«

Powlison D.A.: Power Encounters: Reclaiming Spiritual Warfare. Baker Books.