

Samuel Pfeifer M.D.

SUPPORTING THE WEAK

*Christian Counselling and
Contemporary Psychiatry*



*To my Father,
who awoke in me
an interest in psychiatry,
and a love for those
who are weak.*

Samuel Pfeifer

SUPPORTING THE WEAK

**Understanding mental illness
Integrating behavioral medicine with Christian care of souls.**

Translated by Michael Jobling
Originally published by
WORD PUBLISHING, Nelson Word Ltd, Milton Keynes, England
ISBN 0-85009-599-9

*In the
poor
weak
sick
perplexed
helpless
defenceless
the failures
the dejected
the doubting
and the doubted
the wreckers
and the wrecked
people others avoid
who don't look normal
who have lost the will to fight on*

... God arranges to meet us.

Anton Kner

Table of Contents

Introduction	7
---------------------------	----------

Part I: PSYCHIATRY IN FLUX

Chapter 1: Psychiatry under fire.....	15
--	-----------

Christians have problems, too – Illness or Problems? – Severe Psychiatric Disorders – Psychology and Psychotherapy - A substitute Religion? – Psychology, Psychotherapy or Psychiatry? – Criticism of psychiatry – Diagnosis: Merely Labelling? – Should psychiatric Hospitals be closed? – Repression of Morals and Religion? – Psychiatry and Pastoral Care: Conflicting or Complimentary?

Chapter 2: The image of human nature in psychotherapy	29
--	-----------

Models of the Psyche – The Analytic-Dynamic Model – Inner Healing – The Behavioural / Moralistic Model – The Humanistic Relationship Oriented Model – Self Actualisation: A Mirage – Challenge to Pastoral Care – Transpersonal Psychology – Mysticism and Magic as Therapy – Hold on to what is good.

Chapter 3: The miracle of the human brain	41
--	-----------

What do we know about the brain? – The Brain and Psychiatry – A map of the brain – The search for Personality – The world of Brain Cells – The Miracle of the Synapse – Valium, A synthetic Neurotransmitter – The Autonomic Nervous System – The Brain – A Computer? – Brain, Soul or Spirit?

Chapter 4: How mental illness develops	55
---	-----------

biblical Concepts and the Bio-Psycho-Social Model – Disposition: the Stuff We are made of – Temperament: Inherited or Acquired? – My Strength is made perfect in Weakness – Environment: Life's Burden – Childhood Influences – Living with Stress – Stress and Vulnerability – Reaction: The Power of Thoughts – Our "Belief System" – A New Way of Thinking.

Part II: SUFFERING SOULS

Chapter 5: Neurotic disorders an overview 73

Are we all neurotic? – Psychological Reactions in a Crisis – Exactly, what is neurosis? – The causes of “neuroses” – Disposition, Environment, Reaction – Diagnostic Features of Neurosis.

Chapter 6: Anxiety, compulsions, and hysteria..... 85

Anxiety as an Illness – Imprisoned by Fear – Help With Anxiety Syndromes – Obsessive Compulsive Disorder (OCD) – Therapy for OCD – The Histrionic Personality – Setting Boundaries – Does Faith Make You Neurotic? – Chances and Limitations of Pastoral Care – Empathic Compassion

Chapter 7: Depression – an overview 99

A Desperate Search for Help – How to Recognise a Depression – The Forms of Depression – Diagnostic Criteria for Depression and for Mania – Physical Symptoms of Depression – The Beck Depression Inventory – How Does Depression Develop? – Mild and Moderate Depression – Severe Endogenous Depression – The Course of Severe Depression – Delusions of Guilt and Sinfulness – Mania: From joy to derailment.

Chapter 8: Therapy and pastoral care of severe depression..... 123

Guidelines for Counselling the Depressed – Avoidable Mistakes – Practical help and encouragement – Pharmacotherapy: Help through medication – Personality Change through Antidepressants? – The problem of Suicide – Helping People at Risk from Suicidal Tendencies – Help for the Pastoral Counsellor.

Chapter 9: Schizophrenia: an Overview 139

Definitions and Statistics – Diagnostic Criteria for Schizophrenia (DSM-IV) – Forms and Cause of Schizophrenia – Hebephrenia or disorganized type – Catatonic schizophrenia – Paranoid schizophrenia – The Course of Schizophrenia – The Psychosis as a »Jamming Station« – How Does Schizophrenia Develop? – Schizophrenic Phenomena and their Explanations.

Chapter 10: Schizophrenia – therapy and pastoral care 155

Explaining Religious Delusions – Religious images used to explain schizophrenic experience – Delusive distortions of genuine religious faith – Unusual expressions of faith – Does Christianity make you psychotic? – Schizophrenia in the Literature on Pastoral Care – Schizophrenia and Sin – Schizophrenia and the Occult.

Chapter 11: Schizophrenia: Therapy and Pastoral Care 165

Three Pillars in the Treatment of Schizophrenia – Medication – Daily structure – Emotional climate – A Word about the Psychotherapy of Schizophrenia – Pastoral Care for the Schizophrenic Person – How to Respond to Acute Symptoms – Pastoral Care on the Return From Hospital – Questions of Meaning and Faith – Questions About The Illness – Compassion and Patience – Rehabilitation: Support or Burden?

Part III: HELPING THE WEAK

Chapter 12: Integrated care for the mentally ill 179

Multidimensional Perspective – The Goal of Pastoral Care – biblical Pastoral Care is Practical – A comprehensive model of helping – Encouragement through helpful talk – Support, Activation, Rehabilitation – Don't forget the family – Help from Medication – A Supplement to Pastoral Care – Preventive Care.

Chapter 13: Living with limitations. 195

Five Stages of Grief – Can Faith Give Support? – Faith Healing – The Limitations of Manageability – Weakness: God's power in earthen vessels – A fresh glimpse of hope – Supporting and being supported.

Introduction

This book developed from a series of seminars I used to hold on the topic of »Modern Psychiatry and Pastoral Care«. The interest these lectures aroused showed me that there are many people looking for answers regarding the tension between mental illness and spiritual values.

Psychiatric illness seems to be more problematic than ever before. The World Health Organization estimates that depressive disorders are one of the largest problems in world health, causing severe individual burden but also a high economic cost. What are the causes of this development? Professor Paul Kielholz, a senior researcher in this field, once wrote »This increase can be traced back to improved diagnosis and treatment of depressive conditions on the one hand, and on the other, its causes lie in the fragmentation and isolation individuals experience in our fast-paced consumer society.«

Hufeland, a German physician, made a similar observation. He writes: »Nervous illnesses were never so common as today, never so manifold.« However, the date of this note is somewhat surprising. He wrote this complaint in 1812! In fact extensive research has shown the risk of developing serious psychological disorder has not increased in recent years!

What has increased however, is the awareness of the problem. People talk much more openly about psychological illness nowadays. The opening up of psychiatry means that the average person is much more likely to be

confronted with mentally handicapped individuals. In our highly technical, prosperous society, it is much harder for them to find suitable employment and acceptance within a community than would have been the case years ago among a rural and agricultural population. The availability of therapy has also increased, together with a tendency to regard every deviation and emotional disturbance as psychological illness. Yesterday's »oppressed« are today's »depressives«.

At first sight pastoral care and psychiatry would seem to be mutually exclusive. Many people take a suspicious view of psychiatry as a science and as a »system«, and with good reason. Only recently Professor Hans Küng made an interesting and justified observation about »the repression of religiousness by psychology, psychiatry, and psychotherapy«. In talking to doctors, theologians and lay people, both Christian and agnostic, I have observed four basic approaches which are used to describe this tension:

1. *Psychiatry and religion have nothing to do with each other.* Psychiatric problems are to be solved with the help of psychotherapy and psychiatry. Questions about faith can be left to the church.

2. *Psychological illness is caused, or at any rate made worse, by religion.* People often bring into the argument at this point concepts such as »religious neurosis« and »religious mania«. In the process they often disregard the important distinction between the cause of a neurosis or mania, and its expression. The fact is that the more society is estranged from religion and the church, the less religious content is found in schizophrenia and depressive delusions. Nowadays, people don't rebel against God, they rebel against the demands of society. The basic problem is the same, only the vocabulary has changed.

3. *At the other extreme there are those who say (this time from a Christian viewpoint) that mental illness is a spiritual problem which can only be healed through faith.* Its causes lie for example in lack of holiness, demonic influence, or that a person has not fully grasped the meaning of the cross, and repented. This approach has adverse spiritual and psychological effects on people who are plagued with mental illness. Such exhortations put them under pressure. They feel that they are excluded from the community of faith. Such an attitude, unbiblical as it is, leads to increased inner tension, which can make a psychological illness worse, indeed.

All three views are one-sided, and unfair to the mentally ill. For this reason I would like to propose a fourth view as follows:

4. *Psychological disorders are part of our life on earth. The biblical concept of »weakness« can be applied to these conditions. The Christian community has an important responsibility to fulfill, both in helping to prevent mental disturbances, and in caring for the psychologically weak.* It is possible for Christians to work together with psychiatrists, and the cooperation can be of significant help, when both pastoral counselors and psychiatrists know their limitations, and treat one another with respect.

Naturally, many of the assertions made in this book are the outcome of experiences I made during my training to become a specialist in psychiatry and psychotherapy. I can still remember my first impression of a psychiatric clinic. As a young registrar, I remember well the peculiar feeling of inner tension when I entered, for the first time, a psychiatric admission ward for men. The large room looked like a strange mixture of a shelter for the homeless and a railway station waiting room (it has long since been renovated). The men whom I met there seemed strange, almost sinister. But the more I got to know them, the more I realised that behind their odd exterior, my patients were »people like you and me« – simply people in a crisis, who needed clinical treatment. Eugene Bleuler once wrote, poignantly, that the basic feature of psychosis was that schizophrenics hold on to their sanity. They do not lose it, it merely become hidden. In later years it became a fulfilling vocation for me to accompany suffering people along the road where they would rediscover the healthy part of themselves.

However, the foundations of my present vocation were laid long before my medical training. My father, who himself was active for many years as a chaplain in a large rehabilitation clinic, gave me an important stimulus in that direction. He awoke in me a love for psychologically weak people, and encouraged my interest in a medical and scientific approach of psychiatry. The Christianity, which I learned at home, was a liberating and enriching experience. For my parents, the Bible was the guide for living a fulfilled life, and prayer meant talking naturally with God. I too have personally experienced the supporting power of a living faith in Christ.

An additional help was a year of integrative studies in psychology and theology at Rosemead School of Psychology in California. Here I got to know professors who were academically, as well as biblically well grounded, so that they were well equipped to tackle pressing questions about the nature of man and the problems of humanity. They gave me the courage to take a closer look at psychology, psychotherapy and psychiatry, and to challenge the world view of these disciplines with critical questions from a

biblical perspective.

In my search for answers, I have found it painful to discover that most books about pastoral care only address themselves to minor problems, and give little help towards gaining a full understanding of schizophrenia and severe depression, of major neurotic syndromes or organic brain disorders. On the other hand, I have also found little advice in psychiatric literature about dealing with psychiatric patients for whom faith plays an important role. Religious experience has often been only described in its pathological manifestations without adequately underlining its positive aspects.

As professor Hans Küng writes: *»The person who has not understood religion will never understand those great spiritual resources which can act decisively for the good of the patient. He is poorer than those who prescribe treatment with a perception, which has been liberated and healed through religious experience.«*

New treatments in psychiatry have now made it possible for many individuals to live outside hospital, but they still have to contend with psychological disabilities, which make their life difficult. Not infrequently, pastoral workers and interested Christians come into contact with their suffering. Mentally suffering individuals are often attracted to the Christian message of redemption and forgiveness, of love and acceptance from God, and of Christian fellowship. Quite often they decide for Christ in the midst of their crisis.

Counseling with mentally suffering and weak persons raises many questions. If Christians want to effectively help people with psychiatric disorders, they need to gain a broader understanding of mental illnesses, how they affect people in general, and in particular how they affect a person's faith. They need to learn both the possibilities and the limitations of psychiatry and of pastoral care.

This book is intended for those whose search is not just for specialist medical knowledge, but who want to understand the problems of psychological weakness against the background of Christian faith. For this reason, I have intentionally used everyday language. It is a book for pastoral workers and interested lay people, as well as the relatives of the mentally ill.

For those who want to know more about modern psychiatry, I have included a list of recommended literature at the end of most chapters. Although some illnesses are described in great detail, this book is not intended to replace the physician's expertise.

I am well aware of the limitations of my undertaking. What is being described in the following chapters, is not a new truth, but a description

of old experiences set against the background of new discoveries in psychiatry. I write as a medical doctor not a theologian, but nevertheless I have tried to combine the discoveries of academic psychiatry with a biblical outlook. There are many areas, which I have only been able to touch on briefly, and final answers are often not possible, but in spite of this, I hope to provide the reader with a new understanding of psychologically weak people. As I describe these serious conditions, I hope also to provide a new insight into the Bible.

If a by product of this book is to stimulate increased dialogue between Christian pastoral counselors and physicians, between practical theology and clinical psychiatry, and if it gives pastoral counselors and lay helpers the courage to help the weak, it will have fulfilled its purpose.

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P.S. A Word about the Literature References

When this book was first published, it contained a voluminous section with scientific literature reference backing up the text. For the online edition, I have decided to cut back the references and to limit them to some seminal works which I deem valuable to the average reader. This decision has two reasons:

- a) readability is enhanced
- b) The internet has become a source of information which contains virtually all diagnostic criteria and a wealth of original data in the field.

References: Introduction

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PART I

The changing world of mental health

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Psychiatry in dispute

It is doubtful if any specialty of medicine raises more questions than psychiatry. Many people have difficulties about associating with people who are mentally ill. Someone wrote to me: »I have difficulty in meeting people like that. They are so strange . . . a bit frightening at times. And I'm not so sure about psychology and psychiatry. I don't believe there are any real 'experts', in any case, ordinary help from other people is what is needed more than anything else.« In the course of private conversations about psychiatry, I often encounter fear and defensive resistance, or criticism and prejudice.

Yet we are continually being confronted with psychiatric problems. Depression and psychosomatic disorders trouble modern people more than ever. Every second person has a near relative who has already required at least one period of treatment in a psychiatric hospital.

Christians have problems too

No doubt, Christians are not immune to psychiatric illness. This may be a surprising statement to some. Yet Christians are just as prone to weakness and temptation as anyone else. Again and again I hear people ask: »How can a Bible believing Christian make sense of the existence of mental illness?«

What causes:

- a thirty year old lady to be so afraid of the next day that she cannot cope without tranquillisers?
- a forty five year old man, who sustained a head injury in a road traffic accident to suffer with bursts of anger in which on one occa-

sion he smashed a television set to pieces?

- a forty year old married woman to fall into such a deep depression that she can no longer sleep properly and to develop deep doubts about her faith, which was formerly a great strength to her?
- a twenty two year old student to gradually come to feel that his fellow students are persecuting him, to start saying strange things, and to violently attack his father?

Do Christians really have any explanation for these conditions? Is it possible to develop biblical models which can help us understand such people, and at the same time: be true to reality? Or do you have to entrust yourself to a school of psychotherapy to understand mentally ill people? Is there a biblical view of human behaviour, which not only explains sin, but can also be applied to serious mental illness?

Illness or Problems?

If certain psychiatrists and their books are to be believed, practically everyone is psychologically disturbed and in need of treatment. All too often no distinction is made any longer between minor and major conditions. Many experts are warning that nowadays our understanding of »illness« has been stretched too far. We are well on the way to the »Therapeutic Society« which exists in America, where some people seem unable to exist without regular therapy. This pervasive psychologising of our society is questioned, not only in Christian circles, but also by other responsible authors who understand the limitations of psychology and its therapeutic methods.

Nevertheless, it is beyond dispute that the incidence of depressive conditions has increased markedly in recent years. Many people suffer as a result of emotional wounds in early childhood as well as traumatic experiences in later life.

The worries people had in earlier generations about issues of sheer survival have subsided. It is a distinctive feature of our affluent society that inner conflicts and psychosomatic complaints have become more central to its life, and anyone who doesn't feel content with their environment will feel themselves psychologically disturbed. We often forget, moreover, that internal tensions, anxieties, and emotional ups and downs are part of life and can come to the surface at times of disappointment or crisis. They do not necessarily indicate the presence of an illness (in any case, not one which merits specialist treatment).

Severe Psychiatric Disorders

The excessive use of psychiatric terminology in pop psychology conceals the reality that there *are* psychiatric illnesses which go beyond the everyday problems of life and call for special treatment by a medical, psychiatrist. This applies to the disorders in the list that follows, all of which in their restricted definitions are included among the psychiatric illnesses and affect between five and ten per cent of the population:

- Schizophrenia, and other psychoses
- Severe (endogenous) depression
- Organic brain disease (especially resulting from brain damage, or in old age)
- Severe anxiety disorders and personality disorders as well as somatoform disorders (the former »neuroses«).

The risk of becoming ill with schizophrenia once during your life stands at about one per cent, the risk of a severe depression at about ten per cent. About five per cent of the population suffers from disability as a result of a severe psychiatric illness. About fifteen per cent are affected by moderately severe disorder (neuroses, personality disorder and substance dependencies). A further twenty per cent undergo minor and temporary difficulties.

It is not always possible to draw a sharp distinction between minor and major conditions. The course of many psychiatric disorders follows a wave pattern. A ripple of personal unease can rise to the flood tide of a major breakdown under the influence of a storm of internal distress or external difficulty. A disorder may seem dramatic at a given moment, but that implies nothing about its long term development. The psychiatrist will often find impressive improvements taking place even after a severe breakdown.

In this book I want to give priority to the consideration of severe illness where the long term prognosis involves major suffering and obvious restrictions to everyday life. Talking it through is of only limited use in dealing with these conditions and not helpful at all in some phases of the illness, because the people affected are not fully receptive to encouragement. Pastoral counselling and psychotherapy both come to the limitations of their usefulness at this point. Any treatment which did not draw on the help of specialist psychiatric knowledge would be irresponsible in such situations.

This is not to say that the pastoral counselor can have no part to play in attending to people who are seriously ill in this way. But he or she needs more

information about the background of such illnesses, and needs to work alongside a doctor with psychiatric training.

Psychology and Psychotherapy – A Substitute Religion?

Many Christians take an extremely sceptical attitude towards everything to do with psychology and psychotherapy. I am myself well aware of the criticisms levelled at modern psychology. These are openly expressed by secular as well as Christian experts. Although psychological research has contributed to a better understanding of people, many of our contemporaries are in danger of raising psychology to the status of a substitute religion. A society that no longer wants to have absolute values makes itself increasingly dependent on »experts« to solve its problems.

By no means everything that goes by the magical title of »psychology« is actually helpful. A fundamental distinction has to be made between interesting ideas in psychotherapy, and evidence-based facts. Many of the assertions made by various schools of psychotherapy cannot be proven. In spite of this, psychotherapy can often be helpful and effective in minor disorders, not as a result of the theory on which it is based, but because the therapist treats his clients with warmth and genuine interest, and because the patient is prepared to change.

It is thus possible for Christians, as well as others, to gain help from therapy, if the therapist knows his limitations, and respects the nature (and beliefs) of the counselee. In spite of my critical questioning, I would want to clearly underline this fact. For many people, the psychotherapist is a (paid) friend in need, with whom they can discuss their difficulties; an expert, who can show them a new way to cope with life. Unfortunately, most psychotherapists can only be of limited help in dealing with the severe illnesses which are the subject matter of this book. Their ways of thinking, however fascinating they may appear, only touch the edges of medical psychiatry in the strict sense.

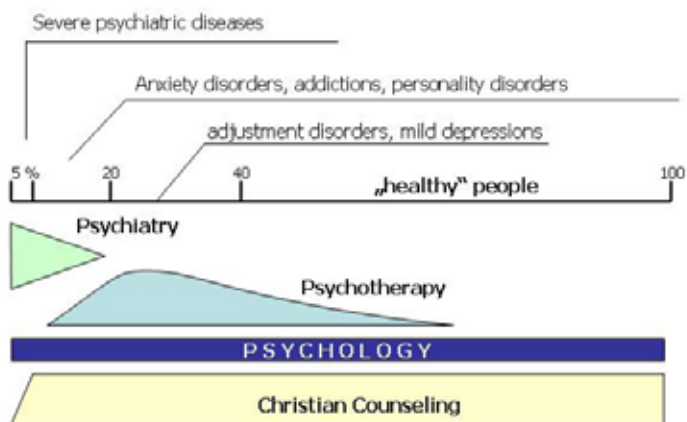
Psychology, Psychotherapy or Psychiatry?

In my experience, many people find it hard to understand the distinctions between psychology, psychotherapy and psychiatry. So before I tackle the problems raised so far, I need to explain the meaning of these terms. *Figure*

1.1 illustrates these different areas in a diagrammatic way.

PSYCHOLOGY describes the human »psyche« in general terms, whether it is healthy or sick. It concerns itself with an individual person's experience, thought and behaviour. The term »psyche« was used in the Bible long ago. In the New Testament alone it is used no less than 101 times and is translated into English as *soul*, *heart* and *life*. The word »logeia« also occurs in the Bible

Figure 1.1: Different areas of expertise: psychiatry, psychology, psychotherapy, and counselling



and means *compilation, gathered knowledge, teaching*. Psychology thus means »gathered knowledge or teaching about the Soul«. In connection with psychology during the last 100 years the most diverse models have been developed to describe the human being. None of these ideas can claim to have completely and correctly understood the nature of the human individual. All of them contain partial truths and point to glimpses of what we can observe in everyday life.

A psychologist normally completes four to eight years of studies at a university, and continues for another four years to get his psychotherapy training. Unfortunately, the title is not protected in all countries, so many people call themselves psychologists without these high qualifications.

PSYCHOTHERAPY is a general and comprehensive term for all tech-

niques of treatment which are intended to lead to the alleviation or healing of disturbances of the »psyche«. There are more than 200 schools, from Analysis to Primal scream – a veritable »psycho boom«! The training of psychotherapists is very varied. Many complete a basic course of studies in psychology and then undergo training, in one of several methods. However, there are others (particularly those who are humanistically orientated) who complete a course and then use the title »psychotherapist«.

PSYCHIATRY finally, is a branch of medical science concerned with the prevention, cause, and treatment of mental disorders. Modern psychiatry is increasingly making discoveries about biochemical processes in the brain, and has made great steps forward in the last five decades concerning the treatment of severe mental illness. A psychiatrist completes a full study medicine like every other physician. This is followed finally by at least six years of training in the psychiatric and neurological departments of a hospital, with for most psychiatrists a parallel training in one or more methods of psychotherapy. As can be seen from the training, the psychiatrist with his comprehensive medical and psychological training makes his main contribution with mental disease and severe psychological disorders, while psychotherapists, without the foundation of medical training still have a part to play in helping those with minor or more neurotic disorders.

Criticism of Psychiatry

Unfortunately, psychiatry does not have a good reputation. I can understand people posing critical questions about it. The crisis in psychology and psychotherapy has also cast a shadow of doubt over psychiatry as a medical discipline. The psychiatric hospital has been drawn into the general crossfire of criticism, as the place where severe mental disorders are, gathered together. Plenty of suitable points for attack present themselves, because all too often those of us involved in psychiatry are unable to provide complete healing. Disappointed hopes easily turn into vehement complaints against psychiatry. On top of this, it is not always possible, within the limitations of doctors' professional need to keep confidences, to explain to other people exactly why a patient needs hospitalisation.

Hospital staff of psychiatric units have similar difficulties. Not a few try to transfer their personal ideals of freedom and the pursuit of happiness to their severely ill patients. Disappointments are programmed into this scena-

rio. German psychotherapist Wolfgang Schmidbauer has aptly described the difficulties of the professional carer in his books, describing »helpless helpers« and »professional caring as marketing of neighbourly love«. They make it easier to understand many of the negative experiences encountered in psychiatry and psychotherapy (and incidentally in Christian pastoral counseling as well.) Nevertheless, psychiatric hospitals and their staff must try not to hide behind psychological jargon, and be open to criticism. Only in this way can they learn to care for their patients better.

Diagnosis: Merely Labelling?

The doubts people have about psychiatry are most strongly expressed in relation to the questions of diagnosis. A young doctor remarked recently: »If ten psychiatrists see the same patient they will come up with ten different diagnoses.« It is certainly true that over a period of time several different names can be given to the same set of symptoms. The diagnosis of »depression« can be applied to everything from a mild mood change resulting from a disappointment, to a severe depressive psychosis.

This makes accurate definition of symptoms all the more necessary. We need diagnosis, in order to give appropriate treatment. This diagnosis needs to be a consensus which helps us to evaluate the nature and level of severity of an illness, and from which we can draw inferences about its likely course.

In the case of milder depressions sympathetic counseling is all that is called for. But with more severe depressions medication is needed which in turn will vary according to the nature of the underlying illness.

So diagnosis is not just a question of putting labels on symptoms. It has to do with planning appropriate therapy. If the patient is to be helped, rather than merely suffering from the stigma of a diagnosis, the doctor must be concerned to:

- Use the clearest and most cautious principles possible in making a diagnosis.
- Share any diagnosis with sympathy and consideration.
- Generate more understanding of mental illness among the general public by open and comprehensive information.
- Offer hope in the midst of a mental breakdown, which will pave the way for a new beginning.

Should Psychiatric Hospitals be Closed?

Do we need psychiatric hospitals any more? Isn't it time we did away with the existing structures and looked for new ways of caring for the mentally ill? These questions are posed by both psychiatrists and concerned Christians, albeit from different motives.

The call for clinics to be closed down arose particularly in the 1970's in left wing psychiatric circles in Italy. The circumstances in the institutions there at that time were hair raising in fact, and bore no comparison to the situation in many other countries. That is why the anti-psychiatry lobby wanted to bring them to a radical end.

The whole system was purely an instrument of oppression against those whom society considered abnormal, and it needed to be overhauled. »Schizophrenia should be lived out like a simple cold«, asserted Dr Basaglia, a leading anti-psychiatrist of the time.

And so an enormous experiment took place. Many psychiatric hospitals in Italy were closed by law, and the patients sent home. The results were devastating. Most of the patients were overwhelmed by the sudden freedom. They no longer had anyone to care for them. Without treatment the tormenting delusions came back. Many became vagrants and beggars on Italy's streets. Others became such a burden on their relatives that over taxed parents were driven to suicide. Soon it was clear that the law was mistaken. The fatal disintegration of personality in long term patients was irreversible. Many patients suffered greater distress during the period of freedom than they had done in hospital. Today in Italy they are trying to find new ways of caring for severely ill psychiatric patients.

Humanitarian treatment of people with severe psychiatric illness requires that there should be places where they can find refuge, undergo medical assessment and therapy, and in many cases also be cared for over a long period of time. For all its deficiencies the hospital psychiatric unit is the place where properly trained personnel can fulfill these conditions.

Repression of Morals and Religion?

Christians who have had a bad experiences with psychiatric hospitals raise another set of questions. They criticise the moral and religious framework of the hospital and its staff. I have often been asked: »How can the hospital help

a person if it doesn't take his belief in God into consideration or if it allows behaviour (particularly of a sexual nature) which will cause him to undergo further severe stress at a later point in time?»

Like all institutions, psychiatric hospitals are not perfect, influenced by the behaviour of individual members of staff and restricted by all manner of pressures from circumstances. The value of a hospital should not be measured by the few particular cases where the patient experiences a lack of respect and care. It is certainly true that many people working in the field of psychiatry have no personal relationship with God, and meet expressions of religion without understanding, or at best with tolerance. Nevertheless, it should be remembered that many patients are admitted with disorders so severe that they can hardly be tackled as questions of faith alone. They are helped by simply being accepted with their troubles and receiving the appropriate medical treatment.

For many people, admission to a psychiatric hospital constitutes an enormous barrier. Nevertheless they are often really surprised by the loving attention they receive there, and the considerable benefit they gain from their stay.

During my career in different hospitals in Switzerland I have come to know many doctors, nurses and social workers who have shown great interest in the patients they have worked with, and great empathy towards them without violating their Christian convictions. We mustn't tar them with the same brush as more irresponsible therapists.

However, many pastoral workers are so disillusioned by individual experiences that they will take even severely ill patients out of hospitals in order to receive help elsewhere. Sadly, this often works to the disadvantage of the patient and his family. He will often be subjected to painful and unproductive efforts to help which only make the suffering worse, and may even drive him to suicide. In the end the only possibility remaining is to re-admit him to hospital. That constitutes the main danger of irresponsible handling on the part of Christian pastoral counselors. Their efforts will only be understood with difficulty by the hospital, and will lead to renewed prejudice against believing patients and carers.

Psychiatry and Pastoral Care: Conflicting or Complementary?

In view of all this, does the possibility of working together exist? Can we hope for a fruitful integration of modern psychiatry and Christian pastoral counseling? In order to arrive at a conclusion on this issue, I need to briefly

define what I mean by »pastoral counseling«.

Pastoral counseling helps people to cope successfully with life on the basis of biblical principles. It establishes the position of humanity from the viewpoint of the Bible and approaches everyday problems from this perspective.

The Bible makes use of various ideas which give definition to pastoral counseling. Of particular note is the word »paraklesis« or the verb »parakaleo«. In English this means encouragement, exhortation and comfort. Every Christian needs this, whether mentally stable or emotionally weak. The mentally stable Christian needs exhortation and encouragement to change his or her life. The emotionally weak needs encouragement and comfort in the midst of suffering.

The psychiatrist who is caring for believing people would be well advised to look for support from a pastoral counselor. Doctors, pastors and Christian counselors need to become increasingly aware that they are all confronted by the same human difficulties and problems. Criticism of psychiatry is not enough. Alternatives must be looked for which are biblically orientated as well as academically sound.

It only needs both sides to enter into dialogue for prejudices on both sides to be broken down, and greater insight to be gained into contemporary problems and issues in both psychiatry and pastoral counseling. With this in mind I will attempt, in the following chapters, to produce a short summary of the prevalent understanding of human nature among people involved in psychotherapy, and of the miracle of the human brain, which provides the basis of biological psychiatry.

References chapter 1

The following books contain material which is discussed in this chapter

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2

Understanding the human nature in psychotherapy

You probably know the oriental fable about the blind men who were asked to describe an elephant. Puzzled, they stood around the colossus. Their eyes gazed into emptiness, but they could touch the elephant with their hands. Each one tried to describe what he felt.

The first said: »An elephant is like a spear!« »No!« exclaimed another. »An elephant is like a snake!« »How can you make such a comparison?« said a third man. »An elephant is like a tree.« And so the argument went on. The fourth compared the elephant to a fan which wafted cool air towards him, the fifth detected a wall and, the last one talked about a rope. How could they describe the same animal in such different ways? Quite simply, one had felt the sharp tusks the next the flexible trunk. One had embraced a leg, the other felt an ear. Finally, the fifth had leaned against its stomach and the sixth had held its tail in his hands.

The common factor in their observations was that each had restricted his description to only one part of the body. The descriptions of human nature found in psychotherapy are often very similar.

Models of the Psyche

Most researchers and therapists describe what they have observed and established in their work with the people who come to them for advice, and even more than the blind men in the fable, they are forced to describe the complicated appearance of human nature with the help of pictures and

models. The image they choose depends on the perspective from which they are viewing human nature. All too often, (whether through short sightedness or fascination with a detail they have just noticed) they do not manage to stand far enough back for the picture of human nature they depict to be fully comprehensive.

I would like to outline four models which are instrumental in forming the predominant way that psychotherapists think about psychiatric problems. Medical scientific psychiatry builds additionally on an neurobiological / organic view of human nature which I will describe in Chapter 3. Here are the four models in summary:

1. The analytical / dynamic model.
2. The behavioural / moralistic model.
3. The humanistic / relationship-orientated model.
4. The mystic / occult model.

It is impossible to list all the methods of each model and describe its teaching in the finest detail. This presentation can thus only be in note form (and of necessity incomplete). A good overview with plenty of reference notes, can be found in the following books:

- Roger F. Hurding: *Roots and Shoots. A guide to Counselling and Psychotherapy.* (Hodder & Stoughton, London 1986)
- Stanton L. Jones & Richard E. Butman: *Modern Psychotherapies. A Comprehensive Christian Appraisal* (Intervarsity Press, Downers Grove, Ill, 1991).

I will look briefly at the root causes of problems proposed from each model, and then deal with the recommended solutions. In the process readers may be surprised to discover that Christian pastoral counsellors have borrowed from each of the models, often without realising it.

1. The Analytical Dynamic Model

By far the most well known form of psychotherapy today is psychoanalysis, or depth psychology. This was initiated at the turn of the century by Sigmund Freud. The Viennese neurologist started from the view that a person's reactions and behaviour patterns can all be explained in relation to early experiences and suppressed conflicts. The goal of the treatment is to bring these suppressed areas to consciousness.

Psychoanalysis in its original form requires up to four counselling sessions a week over a period of several years. Few people can afford that any longer. It is also no longer the rule that you have to lie on a couch for treatment by a psychoanalyst! Since Sigmund Freud, psychoanalysis has been further developed to a considerable degree through various schools. Although these all make use of the terms »dynamic« or »depth psychology«, and emphasise personal development and people's (often unconscious) motives, they are nevertheless quite distinct in their procedures and the assertions they make.

Treatment through analysis is for the most part appropriate in the case of milder disorders, because it demands a lot from the patient. In particular, the patient needs to be motivated enough to lay out his or her life story in long conversations to gain insight into the way things hang together, and to change. Psychodynamic therapy can be understood as a maturing process helping the patient regain his capabilities of working, loving and social interacting.

Analytical thinking has inspired many popular books. A particularly successful author is Alice Miller, whose bestseller bears the title »The Drama of the Gifted Child and the Search for True Self«. In this book, she endeavours to show how much parents hinder a person in his or her personal development. She sees discipline as patronising and manipulation, through which a child is prevented from expressing and living out his own needs. This leads to a deep anxiety, which must however be suppressed, so as not to lose the love of the parent. The aim of her therapy is to relive the hurts of childhood in the protected atmosphere of analytic therapy. As a result the patient will hopefully understand his own reactions, and no longer be helplessly abandoned to life as he was once to his parents.

Inner Healing

As with all psychotherapies, depth psychology depends on the therapists who practice it. Not all of them paint quite such a negative picture of parents as Alice Miller. I personally know many fine people who have an analytical orientation. They have two strengths which are especially important to me. They show empathy and take the patient seriously in his distress. And they have patience. Because they are aware that change needs time, they don't push for instant successes.

Nevertheless, I have questions. Let's stop for a moment and look at what

is being said in analytical therapy. It comes through in the short 'connecting words: because someone had painful experiences in childhood, and because they suppressed feelings, therefore they suffer from, for example anxiety or depression. If they become aware of these experiences then they will lose their difficulties. Similar assertions are increasingly found in Christian pastoral counselling. The catch words are »Inner Healing«, »Healing of the Memories«, or »Emotional Healing«.

Many of these books are very helpful and point to the fact that a person needs to cast off their childhood hurts with God's help. In contrast to pure analytical therapy, Christian faith offers the possibility of forgiveness, which goes much further than just making people aware of painful and suppressed memories. This approach really can bring a great deal of healing.

Nevertheless it is tragic when, for instance, a pastor suffering from terminal cancer is told that he can't be healed from his complaint because he hasn't yet released all the hurts of his life to God. I am thinking here especially of David Watson's experience described in his book »Fear No Evil«.

2. The Behavioural/Moralistic Model

In the fifties many psychotherapists became unhappy with analysis. For years they had tried to uncover the hidden complexities of their patients without seeing any change. B. F. Skinner was one of the first who introduced a radical change of direction. The preoccupation with childhood was meaningless. Wrong behaviour was learned and therefore could be removed by training. In the course of years techniques of behavioural therapy were developed which pointed out practical ways to avoid anxiety and depression. The main goal was to change thinking and behaviour in a particular situation.

In the field of pastoral counselling people had also noticed that thinking and behaviour were important if the client is to break free from problems and overcome them. The approach of Jay Adams is by far the best known, though one should be aware of its limitations. The exclusive emphasis on the obedience of faith and accountability may be helpful and healing for the »average sinner«. And here it is biblical. But it not only creates excessive demands on the Christian with severe mental illness, it also presents him with a moralising model of counselling which creates new problems for him. Nevertheless, the rediscovery of the importance of behaviour and

thought in pastoral counselling is very important.

The Bible says nothing about constant rummaging about in the past to understand human problems. It begins from the position that we are sinful and weak people who need God's help every day to overcome difficulties. Again and again the Christian is instructed to lay aside his old behaviour («the works of the flesh») and to put on «the new nature». Special importance is given in holy scripture to the thoughts. It is our thoughts which determine our behaviour, and in part our feelings as well. The christian has to learn to be controlled by what is »above« and to be permeated by God's word.

So there is room for a cognitive behavioural therapy with a Christian basis. In what way will this be different from secular approaches like those which have been popularised by Albert Ellis or Arnold Lazarus? In behavioural therapy the individual's efforts stand at the centre. *Self help, self control, personal security, personal liberation and self healing* are the catch phrases.

Christian pastoral counselling makes an appeal to accountability and personal effort. Faith without works is dead. But it points people outwards towards God and his standard for life. God's will should be the supporting pillar of inward change, not one's own abilities and interests alone.

3. The Humanistic Relationship-Orientated Model

For many people, behavioural therapy is too intellectual and one sided. What is the use of the best training, and simply changing your thinking, when no attention is given to feelings? This is where the third great movement in psychotherapy comes into play ... the humanistic school.

As the name suggests, humanistic psychotherapy puts the person at the centre. The needs of the client – as the patient is called – are the measure for the therapy. This approach became well known through the former theologian Carl Rogers. The basic problem of every person lies in the area of broken relationships – with themselves and others. All the client needs from the therapist is unconditional and sensitive concern. The client must feel that he or she is accepted with their whole personality. There is no need to gain insight into deep causes. Wrong patterns of behaviour are not being questioned. The therapist is to be supportive and »non-directive« without giving advice. Sin has no place in this concept. In every person »the power of good« is dormant, and this will enable them to reach selfrealisation.

In the consultation the therapist tries to create as comfortable an atmosphere as possible. The counsellor tries to put into new words what the client has first expressed in a tentative way. Emotions stay at the centre. They give direction to the consultation. If feelings can be experienced consciously, blockages are removed and the counsellee can gain entrance to his inner healing potential.

Once he has first experienced a warm relationship with his counsellor he can also build warm, fulfilling relationships with other people. In doing so, he should allow himself to be led entirely by his feelings, without looking back to restrictive moral codes imposed by either society or his faith. Humanistic group therapies also build on this philosophy. Here people find the security that they have missed elsewhere, the acceptance which is denied to them in the cold world outside. The group becomes a yard stick for their interactions and experiences. The group is their escape when life in the real world becomes too hard. In the group they find love when a marriage has broken apart.

Self Actualisation: A Mirage

Ever since the 1960's, the glistening promises of humanistic psychology have drawn in and moulded millions of people. They have shaken off the chains of personal accountability and allowed themselves to be guided by their feelings. In the quest for self-actualisation, they have burned their bridges to family, friends and marriage, partners, only to spin themselves more and more into the cocoon of their own self.

The Zurich psychiatrist, Professor Jörg Willi, complains: »The narcissistic rage is not satisfied even by the family in its needs for attention, tenderness, understanding and self-affirmation. It allows people to destroy the family in order to withdraw more and more into itself. Much is said nowadays about the destruction of the environment, but a much worse tragedy is the destruction of relationships through the ideology of unrestrained self fulfilment. Humanity is threatened today, not only by the destruction of the natural environment, but also by the destruction of humanity's most elementary social structures.«

While responsible psychologists and critical theologians have long since bemoaned the pile of shattered fragments left behind by humanistic thinking, this emphasis has made its way deep into ecclesiastical pastoral care. Even in many evangelical circles, the gospel of following Jesus has

been twisted into the message of self fulfilment.

Challenge to Pastoral Care

But do we have to discard the tendencies of humanist psychology quite so thoroughly? Is group therapy not more helpful than earlier forms of fellowship? Many people have found themselves really accepted for the first time as part of a group – much more than they had done with their pastoral counsellor or in their home Bible study. Are we right to ignore the human longing for security and development? Does the Bible not also speak about love, acceptance and personal growth? In my opinion, it is sometimes valid to make more of a distinction between the ideological content of a therapy, and the manner in which any particular therapist approaches a client. I personally know Christians who have trained themselves in counselling therapy without taking on board the whole ideology of self actualisation. I also know of many non-Christian therapists who have been a great deal of help to believers by their loving acceptance. I am thankful for their valuable work in attending to difficult and suffering people.

For all the doubts about its ideological basis, humanistic psychology gives an impetus to pastoral care in several ways. Love should always be an important aspect of counselling. Therein lies a challenge to the Christian pastor and to the churches. Anxiety in the face of behaviour that is hard to understand, along with an unbalanced search for sins or occult bondages, can often lead the counsellor to forget the most basic of biblical rules: listen first, then speak. The client must sense security, acceptance and compassion, because this enables him to open himself to whatever correction may be needed in his life. However, Christian faith is comprehensive. Love and personal fulfilment do not stand in isolation. God's love for mankind should deepen mankind's love for God. True love finds its expression, not in an egotistical living out of one's own feelings, but in accountability to one's neighbour.

The very fact that God wants to satisfy our deepest yearning for love enables us to set our own wishes in perspective. He can give a fulfilled life,

even though we may have to live within our psychological and physical limitations.

4. Transpersonal Psychology – Mysticism and Magic as Therapy

The psychology of self-actualisation has taken a further step in its development. Its founding fathers Rogers, Maslow, Pearls, to name but a few became increasingly aware that humanity's ultimate longings could not be satisfied solely from earthly or rational sources. They uncovered a new need of the human soul, which took them on to another goal: the need for spiritual experience. The way they opened up would have been inconceivable twenty years earlier, yet currently, in the wake of the *New Age* movement, their teaching has become a *Fourth Power* in psychology, alongside psychoanalysis, behavioural therapy and humanistic psychology.

»Magicians are among us again – the world of magic has been rediscovered«, wrote the German edition of »Psychology Today«: »Magic and mysticism, mythology and fairy tale, meditation and imagination, dream and fantasy, eastern and western religion, shamanism and rituals, parapsychology and occultism have become the business not only of cranky outsiders and drop outs, but to an increasing extent also of scientists.«

More and more people are disappointed by long winded monologues in the presence of their analyst, the tender words of the humanistic counsellor, and the behavioural therapists' list of goals. They are longing for an ultimate meaning to life, for sources of energy beyond the limits of their own existence.

Yet they are not looking for it in Christian faith. The new magic phrase is *transpersonal psychology*. This is supposed to be the bridge between natural science and religion. The method is scientific, but the goal is religious. The psychologist has to become a priest again – »a guide who leads his clients on to experience higher dimensions«.

Their goal is the transpersonal experience which fuses humanity, nature and the cosmos into a totality. It should lead to »new understandings of our cosmic origin«. More and more people hope in this way to gain more self confidence, and mastery over their existential fears. They see here the dawning of a new generation: not just a *New Age* for the world, but an awakening from torpidity for their own personality. Energetic massage of the body and soul has to provide them with cosmic power.

Hypnosis and meditation lead to enhanced consciousness and new »spiritual« experiences. With pendulum, and tarot cards, horoscope and crystal ball they try to get guidance for their life. Spiritualist mediums facilitate their contact with the spirit world, and experiences in »reincarnation therapy« help them to new understanding of their immediate conflicts.

For many Christians it will be difficult to find anything positive in transpersonal psychology. None of the four models is so clearly recognisable as a substitute religion. At best one can approve the fact that the movement has brought a spiritual dimension to psychotherapy and made the religious dimension in its widest sense a talking point in psychology. The content and the methods of transpersonal psychology are, however, diametrically opposed to Christian expressions of faith.

One could almost think that there would be no parallel in Christian terms to this model, so extreme is the separation of this content from Christian belief. And yet many pastoral counsellors stand in danger of tracing back psychological problems and crises of life too rapidly to »negative energies«, »powerful demons«, »occult bondages« or simply »spiritual blockades«, even though this vocabulary has no biblical basis. Theories of pastoral care like this are often nearer to occult mysticism than the testimony of the Bible

Many will reply that we should nevertheless take into account the spiritual aspects of psychiatric illness in our understanding. Since these questions are given great importance, particularly in the evangelical world, but also in catholic circles, I will try to tackle them in the context of a biblical and comprehensive overview, as I describe individual patterns of illness.

Hold on to what is good

We have now looked at four ways of viewing psychotherapy and its understanding of mental problems. Clearly, it is not possible to summarise and evaluate the life's work of many therapists in a few pages. However, I hope I have given a few pointers towards a better understanding of psychotherapeutic thought. In the process it has been an important concern to point out that:

- Every model gives expression to important truths
- An approach to psychotherapy is strongly dependant on the personal attitude of the therapist.

At the same time, however, it is clear that, if detached from biblical first

principles, psychotherapists are in danger of forming a substitute religion. As early as 1946 the Swiss theologian Edward Thurneysen wrote: »Pastoral care needs psychology as an auxiliary science which serves the investigation of people's inner nature and which can mediate this knowledge. In the process it has to critically set boundaries to guard against the incompatible philosophical presuppositions of psychology, which run parallel with but can encroach upon those which its own understanding of mankind gleans from the Holy Scriptures.« That's why it was necessary to raise critical questions from a Christian, as well as a psychiatric point of view. These questions may perhaps provide the impetus for a reappraisal of the assertions of psychotherapy and in turn help the reader to gain a comprehensive understanding of human nature. The Bible exhorts us to »test all things, and hold on to that which is good.« In the same spirit Lawrence Crabb, for example, in his book, *Effective biblical Counselling* has presented a synopsis of biblical principles and their corresponding psychological concepts.

Careful observation of human beings can provide important keys to their behaviour, and the causes of their disturbances. The Christian's duty, however, consists in testing the conclusions of psychology against the Bible, to filter out what is useful and to arrange this into a comprehensive overview of the faith. The noted philosopher Karl Jaspers once said: »Psychotherapy therapy needs a religious basis, but does not provide it from itself. Therefore it is important for the integrity of the therapist to take an open and approving stance towards true faith, and secondly that he resists what experience teaches to be an almost unavoidable tendency to allow psychotherapy to develop into an ideology.«

In the next chapter, I would like to set out a fifth way of thinking which is indispensable to an understanding of modern psychiatry. It is not built on depth psychology and philosophical reflection, but on medical and scientific research. It will lead us into the wonderful realm of God's creation and into new discoveries about the role of the brain in the understanding of psychiatric illness. Science so far knows only a little about the process of the unique labyrinth of the brain, but even the present information opens a new understanding of disorders which those who care for the psychiatrically ill have encountered, but which, until now, have been unexplainable.

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The miracle of the human brain

The human brain is the greatest wonder of creation. This little organ weighs only 1500 grams, but contains more nerve cells than there are people on the earth, more than 10,000 million a simply unimaginable number. Each nerve cell is joined to others by hundreds of little offshoots, and the exchange of information between them is brisker than the telephone exchange of a busy capital city. The number of »telephone connections« in one brain exceeds the number of stars in a galaxy. It would be more than 1,000,000,000,000! No computer or telephone exchange is in a position to store and exchange so much information in such a small space as that occupied by the human brain.

What do you know about your brain?

Most people talk casually about their »little grey cells« without ever taking account of what goes on inside them. While you are reading these words, your brain is carrying out a vast number of highly complex functions. You are turning the pages with the most delicate movement of your muscles. The muscles in your eyes are adjusting so that you can see with equally sharp clarity in changing light conditions. Your retina is picking out the letters on the paper and reducing them to tiny points which the optic nerve sends on in the form of an impulse code to the visual centre, where the words are reassembled into a new picture.

Of course the purely visual recognition of the words isn't enough. The

meaning of the words is fed in at the speech centre, so that the sentence can be compared with information already to hand. This reservoir is gigantic. It holds tens of thousands of words with every possible nuance of meaning. And there is more: Many words and sentences evoke feelings in us – both positive and negative. Often pictures which have impressed us come to the surface.

So a colossal amount of information is bound up with every word, which is recalled to consciousness in fractions of a second, each time it occurs. So the description of an apparently commonplace task performed by our brain leads into the miracle of information handling, memory consciousness and beyond into the riddle the brain always poses us. Even the well known brain researcher and Nobel prize winner John Eccles recognises: »We are always on the brink of understanding the mystery that we are«. The little that is known already is more than enough to fill whole libraries.

The Brain and Psychiatry

Knowledge about the processes inside the brain has opened up new ways to understand and treat psychiatric illness. Biological psychiatry has seen an enormous increase in popularity since the introduction of psychopharmacology fifty years ago, and the successes seem to support it. Drugs have changed psychiatry. In Switzerland it has been possible to remove more than 25% of the beds in psychiatric hospitals in the last forty years alone. In 1931, 155'000 people were treated in psychiatric hospitals in Germany, for an average of 300 days each. In 1983, only 85'000 for an average of 125 days, which is a reduction of more than 70% in the number of hospital days.

Many patients who would have needed permanent hospitalisation before 1950, can now live at home, thanks to medication. To get a better understanding of severe psychiatric illness, we have to apply ourselves to the miracle of the brain – a sheer impossibility in a book which aims to be understood by the average reader. For this reason I will often need to simplify things and use pictorial images for better understanding.

Modern brain research has eroded the sharp division between »organic« and »mental« illness. Earlier only brain damage and degeneration of the brain through ageing were recognised as »organic« disturbances, especially in the literature concerned with pastoral counselling, though also in psychoanalytical circles.

This view can be compared with an investigation of a defective telephone exchange in which the engineers pay attention only to the broken switches and corroded cables, whereas we know that the effectiveness of a telephone exchange depends on connections being properly made. These cannot be corrected simply by repairing the existing components. In the same way, we have now become aware that the important thing about the brain is not just the number of »grey cells«, but how they exchange information with one another.

A Map of the Brain

Where are the movements of the arms and legs steered from? Where is the memory situated? Which part of the brain processes the sounds of a thundering organ prelude, and which the colours of a summer meadow? Which area directs our speech? And which centre tells us we are experiencing hunger, thirst, or tiredness?

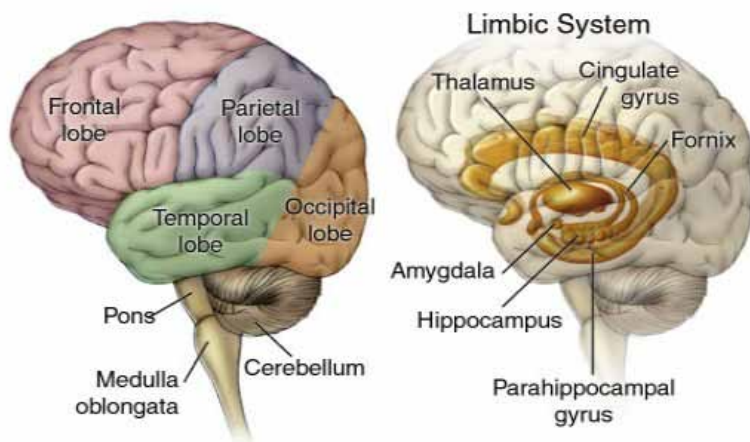
The answers to these questions stem from a mass of tragic experiences. They have been gained as a result of observing people who have suffered from brain damage in an accident, or as a result of a tumour. In them it became apparent, for instance, which functions were affected if someone was injured on the left temple. In this way, over the years, it was possible to build up a map of the brain. Figures 3.1 gives a rough overview, which are much more detailed in modern textbook (or on the internet). Nevertheless, even the most comprehensive presentations are something like a map of the world on which one looks in vain for the streets of a particular city.

The Search for Personality

When Trevor (not his real name) rejoined the youth group, after his severe motor cycle accident, everyone rejoiced with him. »What? Were you really unconscious for four weeks? No one would know to look at you now,« said his friends. Again and again he had to point to the scar on his forehead, but otherwise, there was nothing wrong with him. Yes, he could move everything, and he was as athletic as before, yet something was different. No one could quite say to begin with what it was.

The young man, who seemed so venturesome before, was now quieter and less cheerful. He did his work, but often walked off in the middle of it to eat a snack. If rebuked, he would react in an excessively injured way, and

Figure 3.1: The human brain



burst into tears. Yet five minutes later, he would embrace his boss, talking exuberantly. He behaved the same way in the youth group. Previously, faith had been very important to him, but now he often seemed indifferent. Towards girls, he was forward and obtrusive. If someone reprimanded him, he was sorry for his behaviour, but after a short time seemed to have forgotten everything once more.

Trevor has sustained an *injury to the frontal lobe*, which has connections to every part of the brain, and coordinates its functions. It seems a centre is situated here which controls thought, behaviour and feelings. The discovery of this fact at the beginning of the thirties gave many scientists the hope that they had at last found the location of the personality, indeed of the soul. Attempts were made to change people through brain surgery, but the results soon proved disappointing. Today, such operations are only carried out in rare cases of severe aggression or epilepsy, when all other methods have failed.

The World of Brain Cells

Since then the world of science has turned its attention to research on the functions of brain cells and neuronal networks. Each cell is a world on its own, as complex as a computer. In a multitude of tiny organs highly specialised biochemical substances are produced, which are of the highest importance for the correct functioning of the brain. They can store data, and can determine which impulses will be passed on to other cells.

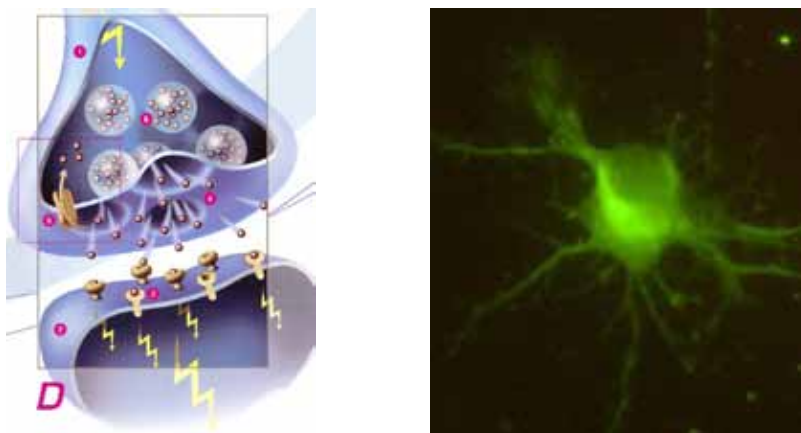
Every cell is connected to its neighbouring cells through a delicate branching network of hundreds of extensions. These convey either arousing impulses or inhibiting, calming ones. One could simplify the picture by talking about *brakes* and *accelerators*, but you must imagine a car which is provided with hundreds of brakes and accelerators. You would need a computer to work out when and how the car should move. However, this is what is happening in each nerve cell many times a second. When the arousing stimuli predominate, the cell begins to fire a staccato of impulses across its nerve fibres. When the restricting signals predominate, it becomes calmer.

The Miracle of the Synapse

Earlier, the brain was thought to be a great electrical system. With the help of graphs of brain electrical activity (E.E.G.) it was possible to identify the »jamming stations« in the brain of an epileptic person, which led to the uncontrollable muscular spasms of a fit. It could also be demonstrated that an impulse was conducted as a weak current along the nerve fibre. But how could the signal be communicated to the next cell? Research with the electron microscope revealed the existence of bud-like thickenings at the end of each nerve fibre, which were separated from the membrane of other cells by a minute gap. This bud became known as the »synapse«. This small invisible thickening is so wonderfully made that the synapse soon took the centre stage in brain research. Figure 3.2 shows a diagrammatic representation of a synapse.

Biochemical substances are stored permanently in the little vesicles. When a nerve impulse arrives these vesicles empty into the synaptic gap. The substances that are stored within them act in a similar way to hormones. They are thus the essential carriers or messengers between the nerve cells. For this reason they are called neurotransmitters. These neurotransmitters can pass on quite specialised information to the neighbouring cells. They work like a key which will only fit a certain lock, but this means

Figure 3.3: Diagram of the synapse and microscopic picture of a nerve cell.



that there has to be such a lock, or receiver, on the membrane of the neighbouring cell. The interplay between transmitter and receiver is regulated by a whole range of other substances (neuromodulators). So far, science is only partially able to unravel the exact code. Nevertheless researchers have already made sensational discoveries.

Valium – A Synthetic Neurotransmitter

It has been a well known fact that not everyone experiences pain in the same intensity. A friend described an interesting experience to me. He was on a mountaineering expedition, on a steep face when a storm blew up. Time was short. He banged the irons into the granite with all his strength, in order to reach the summit as quickly as he could. When he reached the top, he noticed a strange throbbing in his thumb, and was shocked to find that it had been badly bruised, quite blue and bleeding – yet during his climb he had felt no pain. How was that possible?

The neurotransmitters give us the explanation. Today we are aware of various substances in the brain which we call »endorphins« or »encephalins«, which display a distinct pain-restricting effect. Many encephalins produce a calming effect. Others can release anxiety. Research teams succeeded in demonstrating specific receptors binding with the widely available tranquilliser valium. There must be substances in the brain therefore,

produced by the body itself, which exercise a calming action, like valium. The opposite is also possible, that valium prevents anxiety releasing substances from binding themselves to these receptors.

One thing is certain: biochemical substances play an important role in our feelings, whether it is panicking anxiety, or cheerful relaxation, nervous unrest or inner calmness. However, resorting too hastily to tranquilising pills may be a dangerous shortcut to inner peace. The person may become calmer, but no longer learns to grow through the adversities of life.

On the other hand, one should not conceal the fact that even Christians can fall into a crisis where the nervous system is in such an uproar that the »furioso« of the anxiety arousing substances overrides the »piano« of the calming neurotransmitters. The result: the person becomes nervous, tense, anxious, and cannot sleep. Even despairing cries for help in prayer do not subdue the agonising fear and bring the sleep they long for.

This is a situation for introducing the responsible use of tranquillisers and antidepressants within the framework of a Christian understanding. These medications can open the way for a person to become so much more at peace that they can listen to God like before. Of course, in the process the individual needs instruction to become aware of unhealthy life patterns and how to contribute towards relaxation.

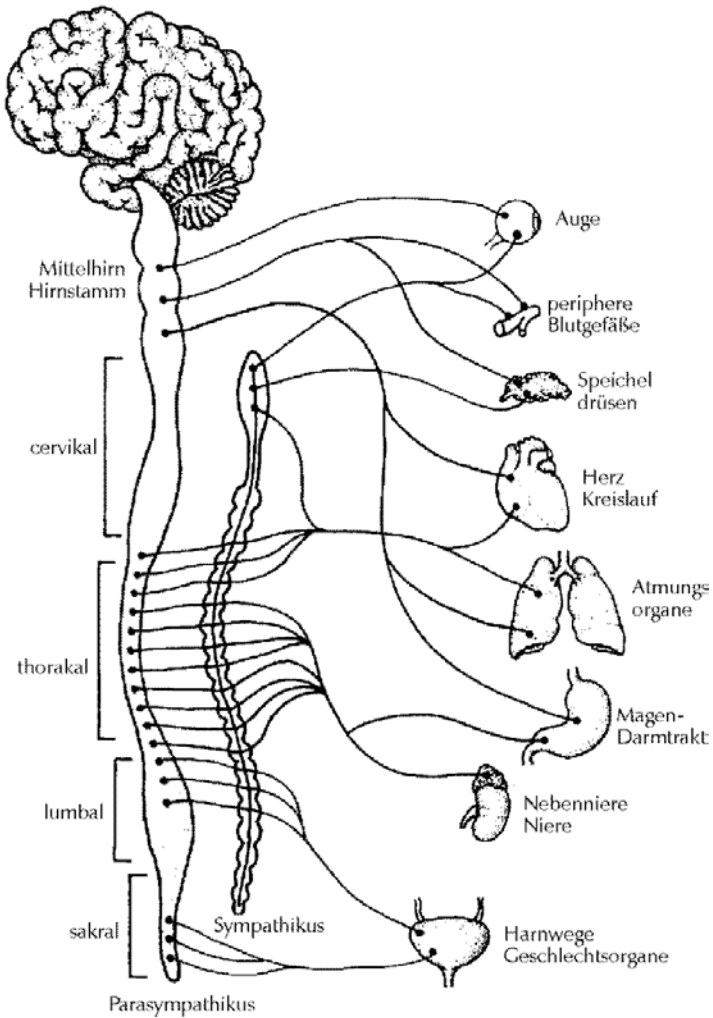
The Autonomic Nerve System

Feelings are not limited to the head. Fear is more than just a thought, and depression involves more than just simply looking at things through dark glasses. Often body language can tell more than words can express. These are age old observations, but they have been freshly understood and scientifically researched during this century through psychosomatic studies. Our speech is rich in images which give expression to the relationships between body and soul:

- We rack our brains over a problem which gives us a sinking feeling in the pit of our stomach.
- We have a heavy heart and sorrow brings a lump to our throat.
- Someone gets cold feet and their hair stands on end.

Such figures of speech are not just flowery ways to describe feelings; they say something about the connection between the brain and the body. In the last decade, brain research has succeeded in lifting the veil to some degree from this psychosomatic area. It is, of course, a well known fact that

Figure 3.3: The autonomous nervous system



every person possesses two nerve systems:

- the motor system, which directs the movement of muscles,
- and the autonomic (or vegetative) nerve system.

The autonomic nerve system weaves its way through all our internal

organs, with the most delicate threads, and reaches every lymphatic organ, however small. It is supported in this by a wide variety of hormones (neuropeptides). Today we are aware of dozens of message carrying substances which control digestion alone. A small quantity of one newly discovered hormone can lead to massive suppression, of the appetite and may possibly have a role to play in anorexia nervosa.

Others alter body temperature, breathing, or the heart beat. These substances are released in the central region of the brain, where the seat of the feelings is thought to be, in the thalamus and hypothalamus, and it is now known that they are closely connected with the encephalins. So it is no wonder that psychological moods often lead to alarm signals in the autonomic nerve system: A beating heart, difficulty in breathing, hot flushes and cold shivers, constipation, or loss of appetite. Stress puts the whole autonomic nervous system into an uproar, and this »wailing siren« in the organs reinforces anxiety and depression in a vicious psychosomatic cycle and often brings the patient for the first time to see the doctor who then speaks of vegetative dystonia or a psychosomatic disorder.

The Brain – A Computer?

We have now learned some of the brain's secrets: the nerve cells, the synapses, the neurotransmitters and the autonomic nervous system. But what does it need to integrate this accumulation of cells and biochemical substances into what we know as the human brain? Basically, the interaction of millions of brain cells makes it possible for us to think, feel, and act. I will quickly admit that the precise details of how the brain is governed are so far hidden from us. We cannot increase our knowledge as we would like, because any interference would destroy these delicate structures.

Nevertheless, we have in broad brushstrokes an idea of the important reactions in the brain which allows us to make better guesses as to how and why major disturbances can come about in the context of psychiatric illness. By way of illustration, I would like to briefly outline a model of the brain as a biological computer. In doing this, I do not want to reduce the human spirit to the level of a simple machine. That would be mistaken and stupid. However, the new discoveries in brain research show that many of the brain's activities do resemble those of a computer, for instance:

- Information gathering (through the sensory organs).

- Information sorting (is that shiny thing on the floor a piece of glass or a coin?)
- Storage of information (memory).
- Information retrieval (e.g. knowledge in a test) application of information (e.g. knitting a pullover according to a pattern).

Many disturbances can be better understood with the help of this model, schizophrenia for example (see chapters 9 through 11). In the process they lose their aura of the sinister and demonic, making room for a more compassionate viewpoint through which genuine help will be possible for the first time.

The requirements of biblical pastoral counselling must not be diminished through this way of thinking about the brain. God has made our brain much more wonderful and complex than any computer will ever be. The way in which the brain processes information can be compared to a computer programme which can at times be disrupted and distorted. But which information determines the brain's thinking and behaviour will depend on a person's life history and inward attitude.

Spirit, Soul or Brain?

What then is the significance of the human brain in a Christian view of humanity? Has modern brain research rendered the soul an unnecessary myth? How can the discoveries of biological psychiatry be harmonised with spiritual concerns? If the brain is the control centre of a human being, what is the significance of the soul and spirit?

Many people seem to look at a person as a purely organic being controlled by an immensely complex computer called the brain. They believe that with the progress of brain research, human behaviour and its disorders will be understood more fully and even better treated. On the other hand, the serious scientist is aware of the provisional nature of his knowledge – »We know in part«. This sentence from the Apostle Paul is still valid in the twentieth century. The results of brain research have revealed something of the wonderful construction and complex functioning of the brain, but hasty conclusions about the nature of the human existence would be premature.

For this reason I find no contradiction between the discoveries of brain research and what the Bible says about human nature. The »spirit or the

brain?« question is as complex as the existence of a symphony. What makes a symphony unique? The way the instruments are constructed, or the notes in the score? The dots of printer's ink on the paper, or the sound waves? All these are needed if we are to experience the glorious sound of a concerto. So it is with the human spirit. It needs the brain as an instrument, to communicate itself to others, but the spirit in itself is eternal, beyond material constraints. Personality is like a symphony. The question is:

Who writes the score of a person's life? Whom does the person allow to touch the chords of his instrument?

Again, the sound of a symphony is not only dependant on the virtuoso skill of the musicians, but on the creators of the instruments. Instruments can go out of tune, become warped or even broken, and they cannot always be repaired. This is where we find the limits of the symphony of our lives.

Here we see the significance of our view of human nature. *Damaged instruments are worthless and distressing. For materialists everything stops with the extinction of the brain function, and for the society of the strong, the weak are unimportant and inconvenient. But for God, even a broken harp with hanging strings is of eternal value.*

References chapter 3

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4

How mental disorders develop

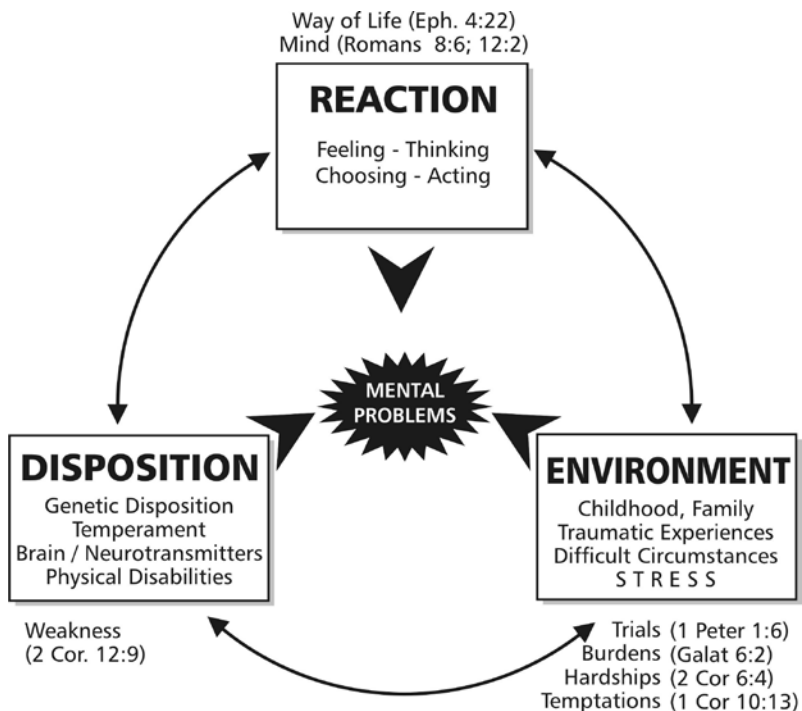
How do psychiatric problems really come about? Is there a common outlook, a comprehensive model on which our understanding of the development of mental illness is based? Is it possible to develop explanatory models which will help us understand people suffering from psychiatric disorders, but which remain true to the reality of life? Is there a biblical view of humanity which not only explains wrongful behaviour, but can also be applied to severe illness?

These questions have taken up a great deal of my attention over the past years. While psychotherapeutic models certainly explain milder disorders, they often do not lend themselves to be applied to severe psychiatric conditions. On the other hand biological psychiatry often does not answer people's personal problems and questions.

I would like to present a simple model of the development of mental illness which is both academically sound and biblically based. This is not so much a question of fundamentally new ways of looking at mental illness, but rather a didactic model which will attempt to tie together in a new way things which are already known. The reader will be already aware of much of it. Other aspects will be unfamiliar. Don't allow this to deter you from following my train of thought.

In figure 4.1 three important areas are outlined which may lead to the development of a mental illness. In the past, one segment of the circle would often have been emphasised in a one-sided way and presented as the sole cause of all mental illness. Today we are increasingly aware that all

Figure 4.1: The Building Blocks of the Model



these factors are tied together and interact mutually on one another. They are known as the »Bio-Psycho-Social Model of Psychiatry«. I have picked out two levels of understanding:

1. GENERAL CONCEPTS as they are commonly encountered in our culture and language, thus: *disposition, environment, and reaction*.
2. BIBLICAL CONCEPTS which correspond to these three areas, thus: *weakness, troubles, trials, burden and testing, along with way of life and mind*.

In the following pages we are going to consider the significance of each area from both the medical and biblical viewpoint. In the process we will gradually build up a mosaic-like picture which will make it easier for us to

understand mental illness.

This will furnish us with a comprehensive basic model which not only explains severe illness where hereditary factors and brain chemistry are of primary significance, but also provides pointers to help us understand less severe disorders which are only on the perimeter of this book's field of interest. Obviously, the emphasis is on the negative causes of disorders which eventually need psychiatric treatment. Yet pastoral counsellors and psychiatrists must never forget that every person also has *resources*, in other words attributes which help them better cope with their difficulties.

The question posed in psychiatry and pastoral care is often expressed in a causal, therapeutic form: »How has this person come to be so disturbed, and how can we make him or her better?« However, I would like to argue for a further question to be asked which is *goal-orientated-rehabilitative*: »How can this person manage to cope with life in spite of his or her weakness and the burdens life she has to bear?«

Even people with severe mental illnesses still have healthy areas which it is valid for us to discover and nurture, as far as is possible. In the course of this book I will try to give directions about the resources which can be used and encouraged by pastoral counsellors who have the confidence of the mentally ill. However, at this point we need to make an inventory of the factors which lead to psychiatric disorders as their final outcome.

1. Disposition: The Stuff We are Made Of

»I can never understand why I am so weak«, complains Mrs. Klermann. »Even as a child I preferred to play on my own, because I could relate best to my dolls. I had dear parents. It wasn't any fault of theirs. I was simply not as robust as my brothers and sisters. I had difficulty with gymnastics at school because my left hand was crippled from birth. During puberty I was often melancholic and couldn't get off to sleep until midnight. I had no reason for it. My mother had also been a sensitive woman. If we children got a bit out of hand she would burst into tears. Sometimes I can be as capable as other women, but if I don't get enough sleep, everything inside me starts to tremble. My stomach seizes up, and I can hardly eat anything. I often have terrible migraines since that accident with the scooter. I have tried many tonics but they've been little use. I can just about get my work done... I haven't strength for anything more.«

Mrs. Klermann consulted the psychiatrist during a depression following the birth of her second child. What clues can we pick up from these

few sentences? What did she say which will help us to understand her depression?

Please refer again to the figure 4.1. The area of difficulty in Mrs. Klermann's case has less to do with her *reaction* (her thoughts and behaviour) but obviously more to do with her *disposition* and her *situation* (the birth of a child brings with it changes of circumstance which are not always easy to cope with).

If we consider for a while first the *disposition* of the patient, this can be divided into four areas:

- a) Hereditary factors
- b) Birth trauma
- c) Physical illness and autonomic nervous reactions
- d) Temperament

Many physical and psychological weaknesses are inherited. Time and time again it can be observed that a patient's family members have had similar difficulties to his own. The most important mental illnesses, schizophrenia and severe («endogenous») depression, are often (though not in every case) found in the ancestors and relatives of an affected person. This can be demonstrated in case studies of twins and adopted children. In the case of certain brain conditions, for example in certain forms of Alzheimer disease, DNS markers have been found which lead to the fatal degeneration of the brain.

Mrs. Klermann made two statements about her family history. Her delicate mother had a tendency to depression (this came to light in the course of an interview with her). An uncle had to undergo psychiatric treatment several times because of depression. These statements gave a clue to the fact that a tendency to depression was already present in her genetic inheritance.

However the functioning of the brain is not only affected by hereditary factors. *Birth traumas* often lead to physical and mental disabilities as well. Being deprived of oxygen can be especially serious, and can lead to brain damage in the baby who suffers it. This will result in learning difficulties and behavioural abnormalities which may last into adulthood, even when they receive frequent and exceptionally good treatment.

Mrs. Klermann did not suffer severe trauma at birth. She is quite intelligent, but nevertheless she continually experienced hindrance from her lame hand when she was doing gymnastics and many practical tasks. With

her depressive nature she withdrew (*reaction*) and increasingly became an outsider.

Then came the scooter accident when she was sixteen. She suffered a concussion of the brain, followed by searing headaches and bed rest for two weeks. Since then Mrs. Klermann has been sensitive to weather changes. She often has to sit down and can't cope with her work. Migraine brings the whole body into uproar. She feels sick, she perspires, her heart pounds and she burns with hot flushes. These symptoms are caused by the autonomic nervous system which weaves all the internal organs together like a fine net. Emotional upsets often set off alarm signals in the autonomic nervous system, which then goes out of its normal rhythm. Many people are sensitive as a result of hereditary factors and often suffer as a result of their physical problems which are then labelled as »nervous breakdown« by the doctor.

Temperament – Inherited or Acquired?

Since ancient times researchers have been concerned to better understand and classify human behaviour. The most famous system originated with the Greek physician Hippocrates, the »father of medicine«. Through his keen observation he created the teaching about the four temperaments: sanguine, choleric, melancholic and phlegmatic. Since then, of course, we have come to realise that human character can be described by using many different words.

Every personality has its own strengths and weaknesses. No type comes in a »pure« form. One person will often combine qualities from many sources into one unique whole. And above all, no type is worse than another.

Where does personality come from? Is it inborn, or formed through our upbringing? Is it the result of our natural disposition, or of what we experience in our environment? Nature or nurture?

The question of intelligence has in particular been a subject of keen investigation. So far, psychologists have not been able to reach a common conclusion. Many indications favour the idea that intelligence is a gift, which can however be developed by upbringing, although it cannot be increased (or reduced) at will..

Things are somewhat different when it comes to personality traits. Many observations indicate that basic pattern of our personality is laid down from birth and early childhood.. Spirited, outgoing children will also be extrovert at a later stage. Quiet, withdrawn children will equally

tend towards introversion at a later stage. Children often show a similar temperament to their parents or grandparents. However the data to hand indicates that our temperament more clearly than is the case with intelligence is formed by our environment. A child is still enormously capable of development. Fearful boys can grow up to become brave men. Well behaved, placid girls can later suffer from nervousness and anxiety. The basis for these developments has yet to be fully explained.

Let's come back to the example of Mrs. Klermann with which we began. She already showed a tendency to introversion as a child. She preferred to be alone and could play with her dolls for hours while her brothers and sisters were running about outside with other children. In spite of a loving home and the foundation of a good I.Q., she developed a sensitive personality with a tendency towards depression, the foundations of which were already to be discerned in her disposition.

My Strength is Made Perfect in Weakness

Is there a term used in the Bible which equates to what modern psychology and psychiatry would label as »disposition«? Yes and no. Certainly, the authors of the books in the Bible would not have recognised the terms we use today. There is no talk of genetics of the brain or of »temperament«. But they nevertheless continually describe people who, through no fault of their own, were weak and disabled, whether as the result of birth or later experiences. In the Bible we meet people with various personality traits, from impetuous Peter to doubting Thomas. We read of Timothy's digestive problems, and of the raging pain that brought Paul to the edge of doubt.

The Christians in the New Testament churches were not all »heroes of faith«. Many struggled not only against their sinful nature, but against their inability to equal the achievements of the »strong« in the church. That's why Paul exhorts the Christians in Thessalonica »to encourage the faint hearted, to help the weak, and to be patient with everyone« (1. Thessalonians 5:14).

He knew what he was talking about. He understood weakness from his own life experience. Three times he had pleaded with God to take away his terrible pain, the »buffeting of Satan's messenger«, but his prayer was not granted. But God promised him His support in spite of his weak physical disposition. »Let My grace be enough for you, for My strength is perfected in weakness.« Paul goes on: »For this reason I will boast above all about my

weakness, so that the power of Christ may dwell in me. That is why I am happy in weakness ... for when I am weak, then I am strong.» (2 Corinthians 12:9-10).

2. Environment: Life's Burden

The second life forming factor which contributes to our understanding of psychiatric disorders is *environment*. Everyone passes through burdensome experiences, whether it be abuse in childhood and youth or disappointments and illness in later life. On top of this, »fate« deals unforeseen blows, and trying situations come about which affect the course of your life. Often a person will be given a burden which she will have to carry for the whole of his life. All these burdens are nowadays summed up under the label of »stress« or »life events«.

A person's life history will often give the psychiatrist or pastoral counsellor a better understanding of the mental troubles experienced by a client. I would like to classify these burdens under the following headings:

- a) Family background
- b) Childhood experience
- c) External limitations
- d) Trying circumstances
- e) Unforeseen events
- f) Continuously tense relationships

Childhood Influence

A child's personality is formed for the most part in the family. This is where the foundations are laid. So much depends on the experiences it has in the first three to six years

... whether it experiences security and love, care and warmth

... whether it learns with the passage of time to set aside its own needs and take thought for others

... whether, on the other hand, it undergoes strife, violence and even sexual abuse

... whether it knows what rules govern the process of living together

... whether it is spoiled and »molly coddled«.

But is it really true that the future is decided by those childhood experiences? Many depth psychologists would answer to the positive, but recent studies contradict this thesis. In an outstanding book German psychologist Hansjörg Hemminger asked the provocative question: »Is childhood destiny?« Supported with many examples he showed that childhood experiences alone do not determine the course of a person's life.

He writes: »A child from a problem family begins its independence with a smaller capital of good experiences, helpful ways of thinking and appropriate emotional responses than others ... research over a long period showed us children who overcame a hard destiny and matured through it. It showed us others who broke down after a sheltered childhood as a result of their refusal to become independent. There were those people who made good use of the capital of their good childhood, and others who were unable to resolve the conflicts in which they had been locked since their troubled childhood.«

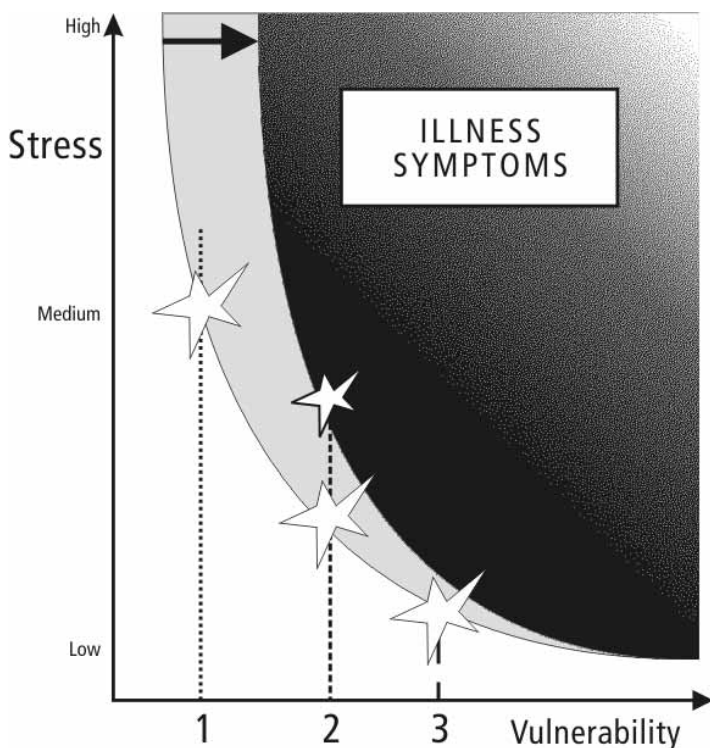
He pleads for people to live in the present: »Only present behaviour, present decisions and present thoughts have reality. Each nostalgic look backwards to a beloved or hated past, and every forward look towards a hoped or feared future becomes an illusion, if the present is blotted out and lost sight of.«

Living With Stress

Even so, the present can be difficult enough, so difficult as to make a person feel they just can't go on any more. In the course of my work I meet men and women who have been brought to the end of their resources by external experiences and have developed mental problems ranging from depression to psychosis. I remember the pastor who had to stand by helpless while a girl drowned at a youth camp in Sardinia. I think of the mother whose child lay in the children's hospital for almost a year. The daily visits sapped her energy. The constant uncertainty robbed her of sleep and in the end led to a temporary psychosis which made a stay in hospital necessary.

STRESS is one of the most important factors contributing to the development of illness in our time. Stress can lead to the development of severe psychiatric crises in people who have a hereditary weakness and little opportunity to overcome their problems. In modern psychiatry

Figure 4.2: Stress and Vulnerability



people talk about *vulnerability*, by which is understood the degree of sensitivity a person has to react under pressure with either psychiatric disturbances (e.g. depression) or physical symptoms (e.g. heartburn) or behavioural changes (e.g. withdrawal, fits of anger). The relationship between stress and vulnerability, or to use biblical language, between testing and weakness, can be represented by a curve.

From figure 4.2. it can be easily seen that under increased stress a Person comes nearer and nearer to the edge of mental dysfunction. How soon they reach this point depends on their hereditary sensitivity. A person with strong nerves (line 1) can hold out if he suffers a car accident, he is criticised at work, or if he loses his dog. He will not develop

any psychiatric problems. But if someone suffers a higher sensitivity (line 2) they will find that even relatively insignificant problems will lead to disturbances of sleep, anxiety and psycho-somatic difficulties. However, this diagram should not be interpreted too literally. Each person not only has their own level of sensitivity, but their own internal resources cope with stress.

Mentally healthy people can learn to meet stressful situations with a new attitude and grow through them. Yet in my medical career I have come to know many individuals who, despite all their best efforts, simply could not succeed in countering stressful situations with just a prayer or a change of their attitude. They had to learn rather to avoid unnecessary stress and so prevent themselves wandering too near the danger zone of mental distress.

Patient in Tribulation

The Bible knows about the stresses people can undergo. It talks about tribulation and burdens, about opposition and testing. The Psalms present us with some of the most splendid prayers from people trapped in inescapable situations. Paul writes: »We are hard pressed on every side, but not crushed, perplexed, but not in despair, persecuted, but not abandoned, struck down, but not destroyed.«

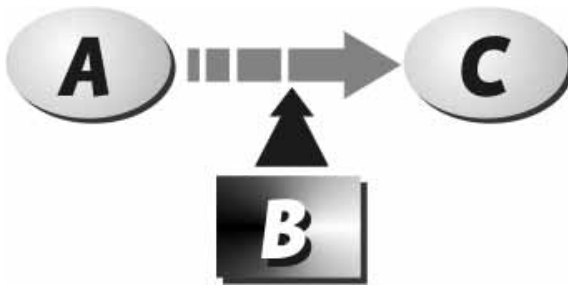
The descriptions in these passages echo those given in psychotherapy. The trouble is named, and feelings are given free, even dramatic, expression. However, in contrast to the purely one-sided, self-centred approach of psychotherapy, biblical pastoral counselling does not set about stirring up the mud and analysing the wounds of the past. Again and again the light of hope shines into the helplessness. The divine »*nevertheless*« becomes a foothold in the midst of stress and opposition.

3. Reaction: The Power of Thought

A person's inward attitude to personal weakness on the one hand, and adverse circumstances on the other represent the third factor affecting the development of psychological disorders. In the figure 4.1 this is summed

up under the keyword »*Reaction*«. The situation and the environment do not mean that a person has to be a helpless pawn to the circumstances of his life. Rather the manner in which a person learns to cope with stress determines the way things develop. To a large extent their thought, will and behaviour help to determine what effect an experience has on their psyche.

A person's reaction to an experience is determined by what they think about it, how they evaluate it. This simple concept has been described in *Figure 4.3: The ABC-Model of cognitive therapy*



psychiatry by Aaron Beck's cognitive therapy.

An Experience (A) gives rise to a feeling (C) For instance someone may become depressive (C) because he has been criticised by his boss (A).

But between A and C stands an important connection, the way the person evaluates (B) an experience, the significance they assign to it. One person will say at the end of the day: »The boss had a bad d day today, never mind, things will be better tomorrow.« Another will blame himself and be afraid of losing his job. Both had the same experience, but evaluated it quite differently.

Our Belief System

There is nothing new about the idea that the way we see things affects our psychological reaction to them. Way back in antiquity the stoic philosopher Epictetus wrote »People are not disturbed by experiences but by their perception of those experiences.«

So, what forms our view of experiences? Each person develops ideas during the course of his or her life, a system of beliefs about how to become

happy and to cope with life. Everyone longs for love and recognition and strives to find some way of satisfying this longing. Yet on the road to fulfilment lie many hindrances. Again and again people have to learn to live with unfulfilled wishes and come to terms with the reality of a harsh world. So life is a continual learning process. Early negative experiences have a particularly formative effect, as do later experiences which are accompanied by intense feelings or strong physical stress symptoms.

To give an example, imagine you are bitten by a dog. The terrible feeling of menace and fear, as you are caught in the teeth of an angry growling dog is something you don't forget too quickly. Even the thought of it makes your heart beat faster and the sweat stand out on your forehead. It will be a long time before you dare to approach even a little lap dog again.

Feelings of hostility and rejection can work the same way. The result for your basic attitude: »I will never get in a situation like that again. I will not allow it to happen.«. The result for behaviour: you avoid every encounter which carries with it the risk of a fresh rejection. In this way the rejection changes not only your inner life, but also your contact with your environment – a vicious circle develops, a whirlpool which can eventually draw you into serious psychiatric problems.

A New Way of Thinking

The earlier the foundations for a mature way of life are laid, the better a person is able to cope with living. I am personally convinced that the wisdom of the Bible gives us the best foundation for a fulfilled life. The Bible uses two key words which equate with the psychological concepts of cognition (thought) and behaviour.

It continually speaks about the importance of »mind« and »way of life«. King Solomon once said in Proverbs »Be careful how you think; your life is shaped by your thoughts.«

So a Christian will be keen to allow his world of ideas to be shaped by the testimony of the Bible. That means more than just positive thinking. God's word requires us to put off the old nature, to »walk in the Spirit«; to grow in love and put on the new nature. That can only happen if we open ourselves clearly to God's working and allow all our thinking and behaviour to be shaped by His word.

But is it that easy to change our thinking? Even people who are self aware cannot simply forget rejection, snuff out the memory of tragic ex-

periences and replace them with a »hallelujah!«. The healing of memories takes time.

And for many people – I am thinking here of my schizophrenic and severely depressed patients – the biochemistry of the brain is sometimes so severely disturbed that they are no longer able to control their thoughts.

This situation is not foreign to the Bible. David knew times when the thought of God no longer comforted him, but rather cast him down, and Paul knew of the presence of God even in times when he could no longer pray. Herein lies hope for believing Christians who go through the severe mental illnesses which I will describe in the following chapters.

References Chapter 4

The following Bible references have been quoted:

1 Thessalonians 5:14
 2 Corinthians 12:9-10
 2 Corinthians 6,4
 Galatians 6:2
 1 Peter 1:6
 1 Corinthians 10:13
 Examples can be found in psalms 22, 25, 28, 31, 38, 71, 73 and many more
 2 Corinthians 4:8-9
 cf. Romans 8:6 und 12:2; Philippians 2:5
 cf. Ephesians 4:22; 1. Peter 1:15
 Proverbs 4:23
 Galatians 5:16
 Ephesians 4:15
 Ephesians 4:24
 Colossians 3:16
 Psalm 77:3 - 11
 Romans 8:26 - 27

Psychiatric textbooks and internet resources give more information on the topic.

Part II

Descriptions of Mental Disorders

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5

»Neurotic Disorders« - An Overview

Mr. Morton takes things quite seriously. Everything has to be in order. His day is rigidly timetabled, without a free moment. He knows how many minutes it takes him to get from home to work, and he has counted the number of traffic lights which might hold him up on the way. There are exactly 39 divided among five intersections. Mr. Morton is a librarian, and in his profession, a conscientious attitude is vitally important.

However, not everyone is completely happy about him. His wife, for instance. She often suffers as a result of his excessive demands. By the time he comes home, the children are already in bed. He can't come home earlier, because he has to tidy up the library. »All he's doing is standing looks on end again!« says his wife, bitterly. »He can't abide books leaning at an angle. But he never thinks about me and the children.« Even his boss has expressed concern, because in his craze for orderliness he neglects more important duties in the library. He has threatened to cut his wages.

Mr. Morton is finally visiting the psychiatrist, under pressure from his wife. Has Mr. Morton just got a kink, or is he neurotic? Is he eccentric, or is he a sick man? Is his behaviour merely peculiar, or is it sinful? Can he change, and should he ... and if so, how?

Are We All Neurotic?

Minor anxieties, compulsions and depressions are part of everyday life. Nearly everyone has »illogical« fears and inhibitions in certain situations. Do you know that uncomfortable feeling of fear when you cross a bridge? You know perfectly well it will bear your weight and the balustrade will prevent you falling off, but even so, you are glad when you reach the other side.

Fear can also influence relationships between people. How often do we hold back from doing something because we are afraid of being rejected, or of failing. We all know the strange feeling of butterflies in the stomach before an exam – in other words, in a situation where we are not completely in control. In these situations fear leads to psychosomatic reactions, even among healthy people.

Other people discover compulsions within themselves. A tune refuses to go out of your head. You try to read every car registration number, or you adjust your steps to fit the pattern of the pavement slabs. Some have difficulty in leaving a room, unless it is cleaned and tidied up. And what housewife has not checked and double checked that she has turned off the oven?

Normally we can suppress these fears and compulsions. We can stop the thoughts, divert our attention, think about something else and forget the disturbing impulses. Added to this, the fear on the bridge never becomes as strong as in a person with an anxiety neurosis who will make a gigantic diversion to avoid the bridge. The housewife only checks the oven once or twice. She doesn't fall into the hour long rituals of the obsessive compulsive person. During a difficult meeting you may experience a rise in your pulse rate, but it is nothing like the physical collapse which takes place in psychosomatically over sensitive neurotic. You can put up with critical remarks without turning them over and over in your mind like a person with a depressive personality (formerly called »neurotic depression«).

The frequently stated opinion that everyone is fundamentally a little neurotic constitutes an unjustified extension of the concept of mental illness. »Not every conflict situation which is difficult to resolve and is accompanied for a while by mood changes and autonomic nervous reactions, is to be labelled as a neurosis,« writes German professor R. Toelle. »The more unique a person is, the more complicated and susceptible to disruption her life will be. We do not need to talk about a pathological disturbance. As long as the criteria for neurotic reactions and symptoms cannot be esta-

blished, it is better to speak of a »crisis situation«.

Psychological Reactions in a Crisis

The psychologically healthy person is in a position to control his thoughts, enjoy life, cultivate relationships and fulfil the duties with which life presents him. He can order and direct his thoughts and feelings in such a way that they contribute to his achieving a conscious adjustment to the circumstances of his life.

In a crisis, things change. Tense relationships or excessive demands at work, severe illness, or the sudden death of someone you love can lead to mental exhaustion. Then more and more energy is needed to deal with the burdensome circumstances and thoughts. This energy is then unavailable for coping with everyday life. You become sensitive, physically and mentally. The autonomic nervous system goes into uproar and presents the whole spectrum of psychosomatic reactions from heartburn and racing pulse to trembling hands. Sleep is disturbed, and this leads in turn to further exhaustion.

In this weakened physical state, depressions, fears, compulsions, hysterical reactions and aggressive outbursts can surface, which you would not otherwise have recognised in yourself. Somehow you don't quite have yourself under control any longer. Impulses suddenly find expression, which in good days you were able to keep shut up in the »junk room« of your mind.

A middle-aged man undergoes considerable suffering when his wife seeks a divorce from him. His zest for life is extinguished. Sometimes he wakes during the night bathed in perspiration after a nightmare. Long forgotten experiences from his childhood come to the surface of his memory. At the office, he continually has the feeling people are talking about him behind his back. He feels inadequate, and avoids his colleagues.

A young mother is plagued during her quiet time by the horrible thought that she might do something to harm her baby. »I would never do it, but the thought just won't leave me alone. It is like a compulsion«, she complains.

It seems that every person has certain weak points in their make up, typical patterns of emotions, thoughts and behaviour, which only break out under pressure. That explains why, in the examples above, one person reacted in a resigned, depressive manner, while the other reacted to difficulty in an excited, dramatic way. But crises pass, and these typical symptoms slip into the background once more as they go. The help of a doctor or me-

dication is not needed in every case to overcome a crisis. God has created us with many ways of conquering mental crises and their disturbing »neurotic« symptoms. Often the simple old proverb holds true: »time will heal«.

It's a different matter for people whose whole life is controlled and overshadowed by neurotic symptoms, often without an obvious external trigger. For them good advice, as helpful as it may be in times of crisis, doesn't lead to the desired improvement. The source of their suffering is in themselves and their own restrictions and weaknesses. Friends and relatives don't understand them, in fact their behaviour can be a burden for their relatives and those around them. In these cases the psychiatrist talks about »neuroses« and »personality disorders« in the strict sense.

Exactly What is a Neurosis?

Neuroses are the most common psychiatric disorders and can be found in about 10% of the population. Women are affected twice as often as men. The boundaries between slight and severe cases are fluid. Milder versions are labelled as »Personality disorders« and if these are included in the total, you arrive at a figure of something like 30% of the population suffering from »psychogenic disorders«.

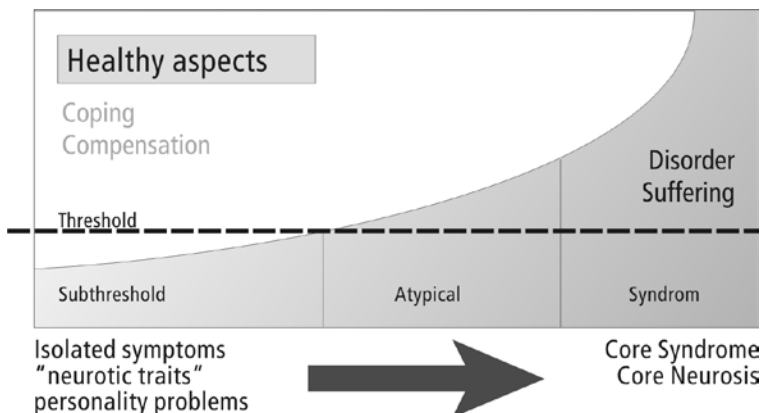
Under this heading a confusing diversity of human behavioural weaknesses are lumped together, ranging from relationship difficulties to sexual problems, from overwhelming anxieties to psychosomatic troubles. The existence of the »neuroses« has been disputed in psychiatry to this day. New text books go so far as to completely delete the term from their diagnostic vocabulary and to talk about »personality disorders« along with anxiety, obsessive-compulsive syndromes or major depression.

When I still use the term neurosis, I do so according to the traditional understanding of the term which is still to be found in many textbooks of psychotherapy. However it has to be clearly stated:

Severe neuroses, such as those I am about to describe in the following pages, are genuine illnesses with circumscribed symptoms and consequences which, like other similar mental illnesses, can lead to considerable disability.

As Figure 5.1 indicates, most people who suffer from their own self and their behaviour, also have healthy aspects. With the exception of the most severe states (to the extreme right of the diagram) their situation allows them to live self sufficient lives. So one seldom sees neuroses in hospital,

Figure 5.1: The spectrum of »neurotic« disorders



chiefly because they do not run such a dramatic course as, for instance, psychoses. But the ordinary G.P. and the pastoral counsellor will meet these disorders with a greater frequency.

The course of neuroses is manifold. Basically it is a matter of long lasting disorders which can become stronger or weaker in phases. You can often observe a basic personality disorder onto which a more severe disorder is »grafted« from time to time. Not infrequently this will involve a change of symptoms, that is to say passing across from one symptom to another, so for instance someone who begins with anxiety symptoms can later move into a chronic depression. Research has shown the following pattern in the development of symptoms:

- 20% are eventually cured
- 60% eventually improve, and
- 20% become more established.

The outcome in the case of the last group often involves complete invalidity, where those afflicted are no longer able to fulfil their duties and to follow their vocation in life. Neurotic disorders are most common between the ages of 20 and 40 years. Thereafter symptoms begin to tail off and those afflicted find a better equilibrium. Often a vestigial situation develops – a life within limits which still allows a bearable existence.

Many neurotically ill people are of course capable of work, but most allow for limitations in the work they do. They are often lacking in energy and enthusiasm for life. They live a retracted life and lose most of their

earlier interests. So a neurotic person will find a certain relief in a general withdrawal from life, which has to be paid for by the sacrifice of their earlier desires, dreams and relationships.

The Causes of the Neuroses

In the course of history whole libraries have been written about the possible causes of the neuroses. Nevertheless even today, we still know little about the conditions which give rise to these disorders. While many schools of psychotherapy rely on hypotheses which only see one cause and one therapy, modern psychiatry tends towards a multidisciplinary approach which allows for the problem of the neuroses to be tackled with impartiality. One fails to do justice to the neuroses by representing their suffering merely as a failure to react properly at a psychological level. Neurotic disorders like other mental illnesses are caused and influenced by many different factors.

For a long time and until today, it has been assumed that neurotic disorders developed during early childhood. Unresolved conflicts, often with sexual colouring, led to fixation at immature levels of childhood development. More recent research has not been able to confirm these theories. In my opinion false conclusions have been drawn from correct observations. Neurotic people do, in fact, manifest strange patterns of behaviour which often appear to be immature and child-like.

The person with an anxiety neurosis won't dare walk along the street alone. The histrionic makes a drama out of the smallest event. Yet this does not mean we can deduce that the disorder developed from damaging experiences in childhood. Once again we need to distinguish between interesting comparisons and demonstrable causes.

Disposition – Environment – Reaction

The development of the neuroses and personality disorders involves a complicated interplay of disposition, environment and reaction (see figure 4.1 in chapter 4).

Disposition: Numerous findings suggest that hereditary factors play a part even in the development of neuroses. Large scale studies of twins have shown a significant tendency for neurotic symptoms to coincide in them,

particularly anxiety and stress syndromes.

Another factor that can foster neurotic development is mild brain disorder (e.g. following meningitis or lack of oxygen at birth).

Those affected are less mature in the way they cope with the conflicts of life than are people with unimpaired brains. They more frequently manifest difficulties in adjusting, and inappropriate behaviour, which provoke others to a counterreaction driving them further into isolation.

Environment: Surprisingly, neurotic people do not undergo stressful experiences to any greater degree than other people. However, it seems that the neurotic hypersensitivity leads to altered perceptions of relations and events, making average interactions stressful to the individual. Neuroses seem to occur more frequently among people from sheltered and pampered families. Our prosperous society with its almost unending freedom openly encourages the development of neurotic behaviour. The more possibilities open to a person, the more frequently they will fall into internal conflict. Conversely, neuroses recede into the background in times when there is an external threat (e.g. in war time).

Reaction: Emotional wounds can cause a person so much stress that he wraps himself increasingly with a neurotic shield to protect himself from further hurtful experiences. Every attempt to lay aside this »protective shield« is accompanied by enormous feelings of anxiety. These make it difficult for the afflicted person to enter relationships with other people in a relaxed way. Only when the person feels a deep trust can he or she dare to lift the visor a little and show another, more mature pattern of behaviour.

Neurotic people are often imprisoned within the tensions of their neurotic conflict. On one hand they suffer as a result of it and struggle to get free. But on the other hand, the inner tensions it produces do not allow them to develop alternative ways of thinking and behaving, even when these can help them to greater freedom.

Under mild levels of stress these inappropriate reactions can be identified, and worked on. But in extremely stressful situations it is simply impossible for the patient to react any other way, however much he would like to do so.

Diagnostic Features of Neurosis

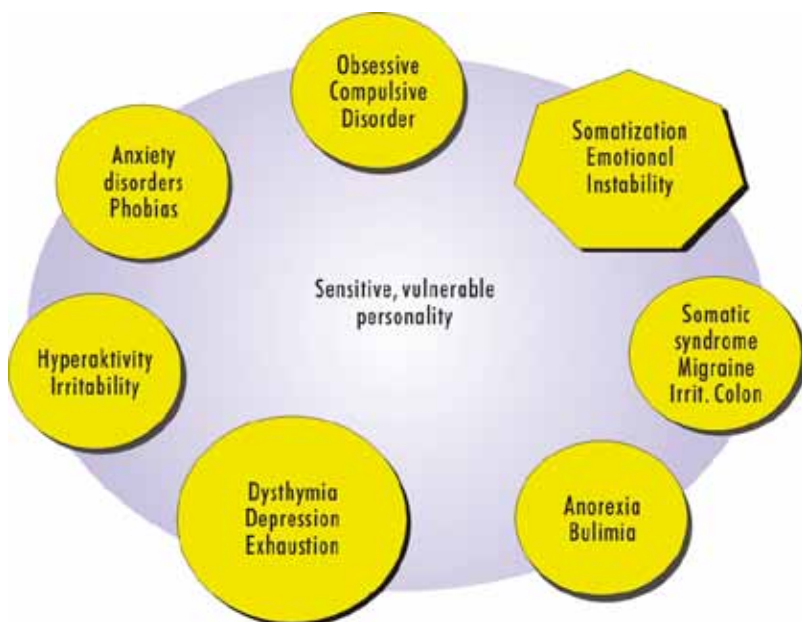
The diagnosis of neurotic disorders is made from the person's life history, and the difficulties they describe. Many disorders, for example obses-

sive-compulsive disorder, are easily recognisable. In other cases it is necessary to spend a long time with the patient and if need be, to rule out other illnesses, before the nature of the illness can be determined.

A neurosis is hardly ever found in an absolutely pure form. Almost always several other »neurotic strands« are in interplay with it. So depressive people usually also suffer from anxieties and compulsions. Compulsive personalities, in spite of their suffering, are hardly depressive, but people with anxiety disorder are often bothered about their bodily functions in a hypochondriacal way. To simplify things, you could imagine the neurotic character traits as a kaleidoscope which continually shows new patterns of light, colour and form as it is turned.

In spite, of their manifold expression, there are common threads which

Figure 5.2: The kaleidoscope of »neurotic« disorders



run through and link individual disorders. The following signs of illness occur in most types of neurosis:

- insecurity / ambivalence
- inhibitions
- disturbances in making contact
- mood swings
- reduced efficiency in performance of tasks
- accompanying physical changes related to the autonomic nervous system.

To describe the individual forms of neurotic disorders in detail would exceed the limits of this book. The interested reader will need to refer to psychiatric textbooks for further information. From conversations with pastoral counsellors and people who are suffering from neurotic disorders, I know that those who suffer from physical problems and depression can nowadays count on a great deal of understanding. But there is much more difficulty in getting people to accept anxiety, compulsion and hysterical behaviour as illnesses which can occur even among Christians. In their less severe forms they often cause great difficulties to those who suffer from them, for their relatives, and for their pastoral counsellors. Those affected suffer not only from themselves, but also from lack of understanding and inappropriate attempts to heal them on the part of many fellow Christians.

For this reason, the next chapter will explain these syndromes in a brief and general way and give help for pastoral counsellors in dealing with these individuals.

References Chapter 5

The following articles and books give some further information on more recent research on »neurotic disorders«. As the term is being replaced by »personality disorders«, »affective disorders« and »anxiety disorders«, the literature in this field continues to provide more recent information on contemporary research.

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6

Anxiety, Compulsions, and Hysteria

We live, they say, in an age of anxiety. In spite of all progress, modern society is full of anxieties and insecurities. They range from worries about ecology to fear of a nuclear catastrophe, from fears that are justifiable in a dangerous world, to groundless anxieties about contracting an incurable illness. Of course, fear has always been around, indeed, it is just part of human existence. Anxiety takes many forms and affects even committed Christians, yet it does not seem to be unconquerable. Although many people suffer from anxiety especially in times of personal crisis, they still manage to find ways of living with the fear and doing, what they have to do. Normally they are open to receive encouragement, and comfort, and after a short time they regain their inner peace.

For a »neurotic« person, it is different. Her thoughts, feelings and behaviour are moulded by fears of an abnormal intensity, which she is unable to put into words. Not without justification, German author Riemann has described the neurotic personality disorders collectively as »basic forms of anxiety«.

Anxiety as an Illness

For many people, fear becomes a disease which overshadows their whole life. When this happens, the doctor will diagnose an »anxiety syndrome«. Often no adequate basis for the anxiety can be found. Even in the

simplest of situations, the afflicted person becomes tortured by overpowering feelings of confinement and threat which at times grow to the level of absolute panic, all with little reason – from the normal point of view. These fears give rise in the process to accompanying physical symptoms, which are as intense as if the afflicted person really was facing immediate danger.

A woman described her anxieties to me in the following memorable way: »If I look out of the window, I'm afraid of falling out. I never get into an elevator, because I'm afraid it might get stuck. I'm continually afraid of an accident when I'm in the car, and at work I worry that I may make a mistake and lose my job. For years I've sent my husband to do the shopping. If I go to church, I'm afraid of the crowd, my heart goes into my mouth and I can't catch my breath. If I read my Bible, I get afraid that I'm not saved, or that I'm possessed by an evil spirit, even though I really know I'm in God's hands. I simply can't fight against these fears. Things do improve when I take medication ... but even then I'm afraid of becoming addicted.«

Imprisoned by Fear

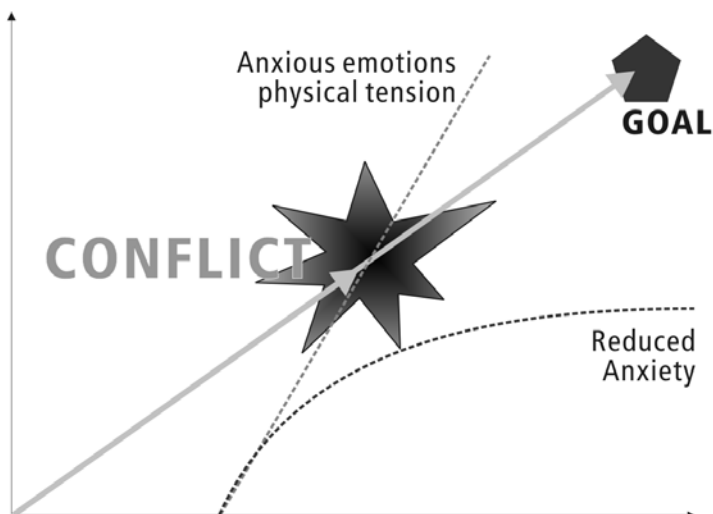
People who are afflicted in this way often live in a panicky fear of fear. For this reason, they avoid everything that provokes fear or increases it. A gifted young man will not dare to accept a further promotion because every time he has to take on increased responsibility, he is attacked by massive anxieties and headaches. A housewife will prefer to stay in the security and peace of her home, rather than go shopping and be constantly plagued by the fear of fainting and falling down in public. Every heartbeat, every feeling of nausea, increases her fears and drives her more and more into isolation.

People with anxiety syndromes suffer enormously as a result of their limitations, but they would rather live alone and withdrawn than set in motion the terrible feelings of anxiety which they remember from previous experiences.

Quite often a patient with an anxiety syndrome will find enough resolve to gradually allow himself to face situations which would previously have caused him to be afraid. He dares, perhaps with the help of a pastoral counsellor or a therapist, to try to make the first few steps. To begin with, he is able to suppress the slight unease which rises up inside him, but then the old fears begin to surface once more. In the end he reaches a point where he is no longer able to blot out the distressful inner tension. Time af-

Figure 6.1: Fear as a hindrance on the path towards a goal

The thick line shows the path to the goal (e.g. going shopping alone). After a few steps the fear level rises (broken line) and becomes stronger and stronger until the sick person decides to withdraw from her intention. The dotted line shows the fear suppressed (e.g. through medication), making the attainment of the goal possible.



ter time, he gives up in resignation and draws back into the security where he still feels reasonably comfortable. Figure 6.1 represents this state of affairs in the form of a diagram.

Help With Anxiety Syndromes

Is there then any way of suppressing this anxiety far enough to allow the afflicted person at least the possibility of reaching simple goals with a tolerable level of anxiety? Could they not relax, if they really wanted to? Perhaps they could become free of their anxieties, if they worked through their childhood experiences or received »inner healing«?

I would be really glad to answer with a simple »yes«. But anyone who has shared the pain and futile search for healing of a person with a severe

anxiety syndrome will be more cautious and compassionate. With less severe anxieties, relaxation techniques of various kinds can certainly be of great help, yet they have no effect with severe anxiety syndromes. In fact, the experience of getting only marginal alleviation by their conscious effort to relax, leads patients into new fears of never finding relief at all. The same kind of frustration is experienced by people with anxiety neuroses with regard to those forms of psychotherapy which try to use strong emotions as a way to change a person. These often achieve exactly the opposite of the desired effect, namely increase of fear, and further withdrawal into resignation.

There then remains the question of directly influencing the biochemistry of the brain through medication. Today we know that there are receptors in the brain which bind with tranquillising drugs such as Valium, but also with alcohol, and lead to an obvious relaxation. Against this background it can more readily be understood why alcoholism and misuse of tranquillisers is so widespread.

Although the risk of addiction is a factor which should not be overlooked, professional support and the right choice of medication minimize this risk in patients with anxiety disorders. Medication can bring enough relief to the patient to keep the fear at a bearable level. Recent studies in the development of addiction have shown on the whole that the problem has been exaggerated. Many patients do not increase their dose, and use the drugs very responsibly.

This reduction of fear by medication can be achieved much more easily, if those afflicted feel themselves to be accepted by their doctor, and are encouraged to live within the limitations which are imposed on them by their fears. Herein lies an important role for the pastoral counsellor. The Bible describes human fear with sympathy and yet realism in a way that no other book does. Jesus does not always promise his disciples complete freedom from anxiety, but says to them: »In the world you will have tribulation, but be of good cheer, I have overcome the world.«

Obsessive Compulsive Disorder (OCD)

The 25-year old bank employee looked in the peak of health. Yet he had been incapable of work for the last six months. His suffering had begun several years earlier. When he was counting money, he began to be plagued with the thought that he had made a mistake. Often he had to fight to make

sure he had counted the bank notes correctly.

He was weakened further by an attack of influenza. He didn't dare to go to work, for fear that other people would notice his problem. If he was putting a piece of paper in the typewriter he had to repeat the process ten times. If he received post addressed to him, he had to check every letter typed on the envelope. Often it would take him half an hour to open it. If he went to the toilet, his family knew it would be occupied for an hour.

The compulsion spilled over into his spiritual life. He had to kneel to confess every little sin straight away (with his knees in line with the pattern on the carpet and his face in his hands). He often had to repeat the prayer several times, because he wasn't sure he had done it right.

His day became full of complicated rituals and agonising mental compulsions. Only when he was asleep did he find a few hours respite. He knew well enough that his thoughts were irrational and his behaviour unnecessary, but if he tried to resist them, an uncomfortable tension and fear surged within him, which only subsided when he gave way to the impulses.

This example illustrates the suffering which can be caused by obsessive-compulsive disorder (OCD). This syndrome is fortunately rare (around 0.5 % of the population) and does not always take such a dramatic form as the case I have just described.

We distinguish between obsessive thoughts, compulsions, and compulsive behaviour. *Obsessive thoughts* are determined by fears (for example, that something will happen to you or someone else) or by feelings of guilt (you might do something wrong, or be responsible for someone else's misfortune). *Compulsions* are often ruled by the pressure to do something dangerous or improper (for e.g. sticking out your tongue) or – especially tormenting for Christians – to say something obscene or blasphemous. Of course, the sick person does not act on the impulse, but suffers enormously as a result of her oversensitive conscience.

Compulsive actions, finally, manifest themselves in repeated acts, for instance to do with counting, controlling or washing.

The causes of obsessive compulsive disorder have long been in the dark, and we still do not have all the answers. However, recent research has brought fourth exciting new evidence that there are biochemical processes in the brain involved with OCD. In these patients, the brain is obviously not capable of properly processing and containing information (for instance concerning the cleanliness of the hands), thus repeating behavioural and thinking impulses outside the control of the conscious will.

How these compulsions come about has so far been only inadequately explained. There is mounting evidence that there is a complicated func-

tional disturbance of the brain. In these cases the brain is obviously not capable of properly holding a piece of information (for instance concerning the cleanness of the hands) in such a way that it sends out new behaviour and thought impulses regularly and without the control of the will.

Therapy for OCD

To date therapy for the obsessive compulsive disorder syndrome is limited. Release from compulsions cannot be forced. Throughout the decades all the great psychotherapists have advanced theories about the causes of obsessions and compulsions yet the success of the therapies has been modest. »Compulsion«, so it is said, »is the favourite, but most difficult, child of psychoanalysis.« The same holds true for the attempts of pastoral counsellors to help with severe compulsions. Antidepressant medication, such as Clomipramine or Fluoxetine (Prozac), can bring about substantial relief in about 40 per cent of the patients. Thus, even if success is only limited, treatment should be attempted in order to make the inner tension bearable. In addition, cognitive-behavioural therapy can be very helpful to stop the obsessive circle of thoughts and compulsions.

There is hope especially for those patients who suffer from passing obsessive compulsive symptoms, which can occur under stress in a fragile person. In these cases the distressing compulsions can abate in the course of weeks or months without any specific treatment being given.

What can the doctor and the pastoral counsellor do for the person suffering from OCD and for his or her relatives? To start with, it is of immense value for them to be just *accepted* with their affliction. Because of their healthy appearance, the afflicted person often experiences little understanding. People find it hard to believe that they are unable to stop those thoughts and actions. An important task for the carer is therefore to take the sick person seriously and to strengthen the healthy aspects of life (e.g. encouraging to work or occupy herself with activities which are distracting the person from her impulses). The afflicted person will find real relief in being able to talk openly at regular intervals, even if the problem of the compulsion remains. Behavioral therapy and medication can be of additional value, although they are not always as effective as we would wish.

The Histrionic Personality

While people with neurotic fears, compulsions and depressions withdraw from others, »hysterical« personalities try to gain the attention of the world around them. Doctors and pastoral counsellors encounter here not sad and inhibited »wallflowers« but attractive, spirited and articulate personalities, for the most part women.

Before we continue to describe their emotional and behavioural patterns, a note on terminology has to be made: Until the 1980s the term for this disorder was »*hysterical*«, derived from the female uterus (greek: *hysteros*), as these persons often suffer from lower abdominal complaints. However, there is another feature: the dramatic expression which can be found in men and women. Thus the new term is »*histrionic personality disorder*« (from latin: *histrion* = actor).

Histrionic persons have anxieties too, but unlike the disorders described so far, they are afraid of »the final, the inevitable, of the urgency and the finiteness of our craving for freedom.« (*Riemann*). They show a pattern of excessive emotionality and attention seeking. Even minor events are met with intense, yet superficial feelings, ranging from rapturous enthusiasm to deep disappointment and temper tantrums.

Nothing bores them more than the routine of an ordered life. They are easily impressed, often responding in an overly trusting way to any strong authority figure. They tend to accept new convictions and beliefs strongly and readily, but without being firmly rooted, often changing their minds after a disappointment.

These characteristics lead to great problems in relationships with other people. Histrionic personalities, as they are called in the DSM-IV, make a charming impression to begin with and make friends easily. But once a relationship has been built, they become demanding, self centred and inconsiderate. In their longing for unconditional acceptance and recognition they make themselves excessively dependent on others. However, if the other person tries to create more space there will be reproaches and dramatic demonstrations of emotion. Helpless clinging to people can reach such a level that it leads to attempts of suicide, just to demonstrate the dependence. By their immature behaviour they destroy the very relationships they long for so intensely.

Sexual problems occur frequently in this context. Histrionic people of-

ten suffer from excessive expectations of themselves and their partners and tend to escape into sexual fantasies. The reality is usually quite different and disappointments are inevitable.

Often they also complain of bad health, general weakness and headaches. In times of great stress this can include uncanny experiences which resemble psychotic symptoms. One lady complained to me during a breakdown that she saw the world around her completely distorted, as if seen through warped glass. Often she felt like a spectator in the theatre of life. When she recovered, these disturbances receded.

It is not surprising that histrionic people often suffer from intense disturbances of mood, especially when external circumstances change and as a result relationships are broken. Depression can be the result.

In some cases, so called *conversion symptoms* can occur, where, for example, afflicted people express their inner helplessness in such a way that motoric weakness develops in the legs which cannot be explained organically. These syndromes have been termed »hysterical neurosis« in older textbooks.

Setting Boundaries

Histrionic patients are a particular challenge for the doctor and the pastoral counsellor. Frequently it is hard to tell what is genuine and what is acted out. The pastoral counsellor often has to experience for himself how the person normally behaves with other people. They are often unpredictable, even for the carer.

Initially, one is overwhelmed with compliments: »You are the first person who has taken me seriously and listened to me. You understand my problems and sympathise with them. You are a wonderful pastor!« But gradually, more and more is demanded: frequent phone calls, often at unusual times, the wish for home visits and other signs of special interest. They often present their complaints in a dramatic form during the consultation, garnished with elaborate details which always, leave you wondering if there isn't some exaggeration. Yet these people are totally convinced about their experiences and react to probing questions from the pastoral counsellor with complaints and doubts about his ability to understand them.

Christians with histrionic traits will tend to explain their experiences in terms of supernatural influences. Often they introduce occult powers into their presentation, so that they can give the most colourful descriptions of

demonic oppression. They then require the pastoral counsellor to deliver them from their »possession«. In the process, dramatic scenes are played out which are intended to demonstrate to those present the demonisation of the patient. If the minister tries to set limits on the fulfilment of their request, the afflicted person can react in a demonstrative way, going into a »huff« and showing annoyance and exaggerated disappointment. Often they will then turn to a pastoral counsellor who has a »greater anointing«.

This doesn't mean that the role of spiritual help during a hysterical crisis has to be played down. Words of scripture and prayers can lead to an impressive calming and release from inner conflicts. On the other hand the »ordinariness« of conveying comfort and empathy of regular pastoral care often seems »too tame« to the afflicted person because it doesn't lead to the instantaneous change they want to see.

It is wrong to dismiss the behaviour of histrionic women as »theatre« though. Here also, we are dealing with a pattern of behaviour in highly sensitive people, which they are not always able to control. Indeed, in hindsight, they are often appalled themselves at the way they have allowed themselves to be carried away by their feelings. With a general calming of the circumstances of stress there usually comes also a subsiding of the histrionic symptoms.

What these people need amid the tossing waves of their feelings is a rock which can provide them with security, protection, and a haven

... a pastoral counsellor who takes them seriously, but reacts to their feelings with relaxed moderation and sets the necessary boundaries.

... a pastoral counsellor who quietly remains firm in response to their immature, angry reactions without rejecting them, and

... a pastoral counsellor who encourages and helps them to be self-sufficient in spite of their desire for dependence.

Does Faith Make You Neurotic?

Neurotic conflicts and insecurities often lie concealed behind the questions and concerns of faith. The pastoral counsellor is affected in a particularly painful way when someone's spiritual life is controlled by anxieties, compulsions and histrionic behaviours, since these do not only affect people who are hostile to the faith. Even upright and serious Christians can suffer from neurotic symptoms which are coloured by spiritual content. It is no accident then, that in literature one finds the idea of »ecclesiogenic«

(church-induced) neuroses or »toxic faith« being put forward.

In a comprehensive study, German theologian and psychotherapist Helmut Hark describes the problem of religious neuroses. He defines the idea of »ecclesiogenic neuroses« in the following way: »The term 'ecclesiogenic neurosis' designates those, in the many layered spectrum of mental illnesses, which take on a religious form and are induced by excessive religiosity. Whether piety and faith act like a poison in the mind or work like a medicine to produce happiness, depends on the dose administered, and the religious education received from parents, school and church.« He contradicts the widespread assertion that religion makes people ill, and backs this up statistically. By means of a comprehensive questionnaire, he compared 139 patients who were seeking therapy because of mental difficulties with 234 people from a »healthy« control group. He reached the following conclusions:

»In the group of patients an inverse correlation could be observed between psychoneurotic problems and religious orientation. This can be statistically demonstrated: The more pronounced the psychological problem, the smaller the level of religious orientation and piety. Conversely it can be demonstrated that increased religious orientation reduces psychological difficulties. *Our study confirmed the observation made in individual counseling and psychotherapy, that neurosis disturbs religious life, whereas positive religiosity contributes towards healing.*«

The available data and clinical experience do not allow for the assumption that neurotic disorders are more common in any subcultural group, including religious subgroups. Rather, they seem to be equally distributed in the population. Lower social status and increased marital break-ups seem to be associated with the disorder, as marital failure can serve both functions: as a stressor, contributing to further neurotic development or as a consequence of severe interpersonal dysfunction.

Interestingly enough, there seems to be a reciprocal relation between the severity of mental disorders and the support that a patient experiences through Christian faith. Patients suffering from minor neurotic symptomatology seem to struggle more with religious faith, some of them indicating a negative impact on their well-being, experiencing religion as hindering their inner freedom and self actualization. On the other hand, patients with severe neurotic syndromes such as chronic anxiety syndromes or long-standing depressions seem to find support and understanding through their faith although they are often handicapped in their desire to actively take part in religious activities.

Chances and Limitations of Pastoral Care

What possibilities then are open for the pastoral counsellor to help a person suffering from a neurosis, from a biblical perspective? Much has already been alluded to in the sections on individual illnesses. Acceptance by the counsellor, having the opportunity to talk, and to receive special prayer can have an enormously helpful and calming effect for the sick person. In personal one-to-one conversation, and in pastoral preaching, the pastor has a wealth of biblical examples at his disposal, which demonstrate that God chooses to show his power among the weak with their suffering and their limitations. It is often important to help the enquirer towards a new understanding of God.

Yet in severe cases, the goal is not always so clearly visible for the pastoral counsellor. Ought he to be satisfied in these cases with just comforting and supporting the client? Does he need to confront him with his unconscious conflicts and hidden motives? Should the client not at least give expression to his pent up feelings? Or is he simply lacking a fulfilled spiritual life?

The therapeutic ideas found in the literature of psychiatric and pastoral counselling are legion. Yet is noticeable how many neurotically sick patients eventually abandon their odyssey from therapy to therapy and withdraw once more into isolation without their treatment having brought the healing they desired. These failures are hard for the pastoral counsellor and the secular therapist to cope with. Often they end up blaming either the sick person, the parents, or themselves for their own inability.

Indeed, are people just unwilling to change, or are the therapists perhaps expecting too much? I often ask myself whether a delusion of manageability typical of our technological age is not being carried over into the pastoral care and therapy of neurotic patients even if camouflaged by a thick covering net of Christian and psychotherapeutic jargon.

Empathic Compassion

The empathic compassion of the pastoral counsellor seems to me to be of particular importance in the care of a person who is suffering with a long term neurosis. He should be in a position to recognise the client's overly

sensitive personality behind the presenting questions concerning faith and doubt, and to respond appropriately. The following quotation mirrors something of the basic attitude of the pastoral counsellor in dealing with nervously weak people. The author was Johann Christoph Blumhardt, who had a widely respected counseling ministry in Southern Germany, more than 100 years ago:

»As a rule I don't make too many demands on the afflicted person, pressuring them to pull themselves together. For I have already seen bad results from that approach. I stick with the advice: 'Do what you can, and if you can't manage something easily, leave it and keep calm. And don't be afraid, either, that everything will soon be lost. Don't worry if you feel yourself bound up against your will and in a bad mood with God and the things of God.'

Furthermore, I would like to say something more to comfort you. In hard affliction, you must not immediately try to apply yourself to the Bible or some other book for your edification. If sometimes you feel that every word applies to you, I understand, but, if all you find there is strangeness, you will get no blessing, read what you will. So it is when your inclination is set against prayer. What good does it do to force yourself? Then I often say 'leave it!' If you really have to pray like that because people tell you you must pray on your own, well, you can very easily do it in such a way that the irritation hardly finds a way to hinder it. Think how you have the whole Bible already contained in the simple '*Our Father*'. There you will find reference to the Name, the Kingdom and the Will of God, the generous care of God in giving us food, the forgiveness of sins, and as you also forgive, and the prayer against temptation.«

Notice with what obvious sympathy Blumhardt takes up the pressures of the »afflicted« without lapsing into spiritualisation or psychological jargon. He takes up what the client says at the level of his problems of faith and relieves his burden by pointing him to simple basic biblical truths.

This keeps the pastoral counsellor from condemning and rejecting the sufferer as a »miserable sinner« and »doubting Thomas«, even if the desired healing is not achieved for the time being. It helps the counsellor develop the ability to steer the client through his weaknesses with patience and love.

References chapter 6

Knowledge on mental health issues is continually being expanded and updated. The disorders discussed in this chapter are described in many useful internet sites. Thus, instead of quoting literature, I would encourage the interested reader to search further information on symptoms and treatment in the net.

Regarding the question of pathogenic aspects of religion, here are a few articles with additional literature references:

Meissner, W.W. (1991). The phenomenology of religious psychopathology. *Bulletin of the Menninger Clinic* 55:281-298.

Pfeifer S. & Waelty U. (1995). Psychopathology and religious commitment. A controlled study. *Psychopathology* 28:70-77.

Pfeifer, S. (1994). Faith-induced neurosis – myth or reality? *Journal of Psychology and Theology* 22:87-96.

7

Depression – An Overview

I don't know what's wrong with me. I haven't had any energy for the last two months at least. Nothing gives me any pleasure nowadays.« The once confident businessman spoke in a low monotone voice, his eyes downcast. „I wake up as early as four o'clock in the morning ... filled with an agonising fear about the day to come. I'm no use for anything any more. I'm a complete failure. I can hardly summon up the courage to telephone a customer ... no one's giving me any orders nowadays.«

He took a deep breath. »But the worst thing is, God has deserted me. I used to get so much out of reading the Bible, but now it doesn't speak to me any longer. Every time I try to pray I feel condemned. I'm full of unbelief. God can't carry on listening to a person like me. I can't see any way out. Is there any help for me?«

A Desperate Search for Help

When his problems started, Mr. Brown tried to cope on his own. He swallowed vitamins and went out to jog every morning. But the pressure grew. His wife didn't know how to encourage him when he complained about his difficulties. He picked up a book on conquering depression from someone in his home Bible study group. He praised and thanked God, even for his difficulties. He tried to pray more, recognised his self pity, but the dark clouds didn't disperse. Even a prayer for deliverance from demonic oppression failed to bring the peace he longed for.

Mr. Brown was so aware of the sins in his life that he didn't expect to gain any help from the doctor. So he only told him that he was having pains around his heart, and said nothing about how he felt inside. The E.C.G. was normal, and the doctor didn't pursue the problem any further.

After a few conversations with him, the lay pastor of his church realised that he was dealing here with a severe depression, and referred him to me. Happy ending? No way! It took months of consultations and treatment with antidepressant medication. The road to healing was lined with pot holes. Days of hope were cancelled out by renewed darkness. But, in the end, the dark clouds did weigh less heavily on his mind. Increasingly, Mr. Brown opened what he once referred to as »windows of joy«. Today he is fully back in business again, and what is more important to him, he can read God's word with pleasure and take an active part in the life of his church. His odyssey from one therapy to the next is typical of many who suffer from depression.

Christians with depression often seem to find it difficult to understand their condition and to take the measures that are needed to deal with it. They suffer because even the faith in God which used to shape and motivate their life is unable to stop them walking into the valley of the shadow. They want to make sense of their trouble in the light of the Bible, but this isn't always easy for them. They do not fit the cliché of the victorious Christian. How can anyone understand someone not living in continuous joy, peace and hope, when these things are promised in the Bible? And how can anyone help a person who is suffering, not just from a passing mood, but from a severe depression?

Most Christian books deal with circumstances which in psychiatry would be labelled as mild to moderate depressions. The advice they contain is helpful, effective, and even biblical, in overcoming temporary oppression. But with two exceptions, I have found little help in them for Christians who suffer from severe »endogenous« depressions. My goal in the following two chapters is thus to show:

- the criteria by which a severe depression can be recognised;
- the connections which exist between biochemistry, environment, experiences of life, and behaviour;
- the course usually taken by a severe depression;
- the effect of a depression on a person's spiritual life;
- how to give pastoral help to someone with severe depression, and
- how to work together with the G.P. and the psychiatrist.

How to Recognise a Depression

Depression has many faces. A dark veil with a complicated woven pattern darkens the view. So before we talk about the forms, causes and treatments of depression, we first of all need to recognise the different »woven patterns« which eventually allow us to diagnose depression.

The diagnostic criteria of depression will be given in table 7.1. Notice in particular the duration: to justify the diagnosis of a typical (severe) depression at least four symptoms must be present for a period of at least two weeks. Milder depressions on the other hand last a shorter time and show fewer distinct symptoms. For instance, we would not talk about a severe depression if someone was in low spirits for a few days (but remained capable of work) and slept badly as a result of his worries. Nevertheless one should treat this complaint seriously since a mild disturbance of mood can develop into a severe depression in the course of time.

The accompanying physical symptoms are summarised in table 7.2. Both tables show how closely soul and body, »Psyche« and »Soma« are interwoven. The autonomic nervous system follows the swing of each upheaval of the soul. Breathing, pulse and digestion change their rhythm and each in their way give expression to the soul's distress.

Some *key questions* can quickly provide better contours to the disorder. Here are some questions, which the pastoral counsellor or the doctor should ask:

- Are you still able to enjoy yourself?
- Are you still interested in things you were interested in before?
- Are you less able to take initiatives than you were several weeks or several months ago?
- Do you feel exhausted during daytime?
- Do you feel nervous, tense or anxious inside?
- Do you find it difficult to make decisions?
- Have you been experiencing disturbances of sleep?
- Do you experience any pain? Do you notice a pressure on your chest?
- Do you notice any loss of appetite? Have you lost weight?
- Is there a decrease in your sexual desire?
- Have you had a tendency to be more thoughtful or worrying recently?
- Are you plagued by the thought that your life has become useless?

Table 7.1 Diagnostic Criteria for depression (adapted from DSM-IV)

At least four symptoms have to be present over at least two weeks:

- depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). (In children and adolescents, this may be characterized as an irritable mood.)
- markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
- significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
- insomnia or hypersomnia nearly every day
- psychomotor agitation or retardation nearly every day
- fatigue or loss of energy nearly every day
- feelings of worthlessness or excessive or inappropriate guilt nearly every day
- diminished ability to think or concentrate, or indecisiveness, nearly every day
- recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

DSM-IV = American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders, fourth edition. Washington, DC: American Psychiatric Association.

Table 7.2 Physical Symptoms Accompanying Depression

(somatic symptoms are frequent but not always present)

- Headaches, dizziness, dryness of mouth.
- Feeling of pressure or tightness in the neck or chest.
- Outbreaks of perspiration, pounding heart, palpitations, disturbances in the rhythm of the heart, pain in the region of the heart.
- Frequency of micturition, pain in the lower part of the body, disturbances in sexual function.
- General loss of energy and absence of freshness.

In addition, Christians will complain that they have »lost their joy in the Lord«, that the Bible doesn't speak to them any more and that they have difficulty with prayer. They will no longer be certain of their salvation and have the impression, because of their sense of guilt, that God might have rejected them. As well as being afraid of other people and the demands of everyday life, they will be afraid of a God who, in the distorted view of a depressive person, is angry and vengeful. Depression is often associated with social withdrawal and growing loneliness.

Everything which previously gave purpose to life disintegrates and no longer gives support. Often even a person's faith goes through a deep crisis. The dark veil of depression lies not only over everyday life, but also over the experience of God's presence.

All of these afflictions can occur in varying degrees of severity, in diverse gradations of grey tones, like the boards of a weathered wooden house. A valuable tool for measuring the severity of the depression is provided by the Beck Depression Inventory (BDI). If a client registers less than 11 points, they are not depressed in the strict sense of the definition. 12 to 19 points indicate a mild depression, 20 to 26 points represents a moderate depression, and more than 26 points indicate a severe depression, provided that the symptoms also last more than two weeks.

The Forms of Depression

Depression can occur in the most diverse forms (see Figure 7.1). These extend from illness which has a purely physical cause to depression occurring as a reaction to external circumstances (loss of a dear person or of other valued relations and things).

The diagram shows that in every depression there is an interplay between two components, namely the physical-biological (endogenous) component and the psychological-reactive (psychogenic) component.

The organic constituents of depression are most obvious. These occur as a result of brain damage, meningitis, interruptions of blood supply to the brain, etc. Severe depressions can also result from debilitating illness. A prolonged depressive condition can follow a severe bout of influenza or a long course of hepatitis. In these cases we talk about a symptomatic depression..

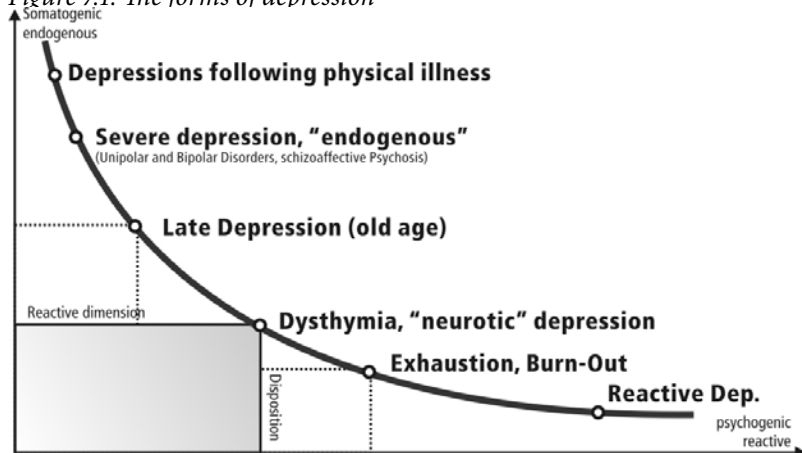
By »schizoaffective depression« psychiatrists understand those depressive conditions which occur within the context of a psychotic (for instance,

Table 7.3: Some questions from the Beck Depression Inventory

<p>1. Sadness</p> <p>0 I do not feel sad.</p> <p>1 I feel sad much of the time.</p> <p>2 I am sad all the time.</p> <p>3 I am so sad or unhappy that I can't stand it.</p> <p>2. Pessimism</p> <p>0 I am not discouraged about my future.</p> <p>1 I feel more discouraged about my future than I used to be.</p> <p>2 I do not expect things to work out for me.</p> <p>3 I feel my future is hopeless and will only get worse.</p> <p>3. Past Failure</p> <p>0 I do not feel like a failure.</p> <p>1 I have failed more than I should have.</p> <p>2 As I look back, I see a lot of failures.</p> <p>3 I feel I am a total failure as a person.</p> <p>4. Loss of Pleasure</p> <p>0 I get as much pleasure as I ever did from the things I enjoy.</p> <p>1 I don't enjoy things as much as I used to.</p> <p>2 I get very little pleasure from the things I used to enjoy.</p> <p>3 I can't get any pleasure from the things I used to enjoy.</p> <p>5. Guilty Feelings</p> <p>0 I don't feel particularly guilty.</p> <p>1 I feel guilty over many things I have done or should have done.</p> <p>2 I feel quite guilty most of the time.</p> <p>3 I feel guilty all of the time.</p>	<p>6. Punishment Feelings</p> <p>0 I don't feel I am being punished.</p> <p>1 I feel I may be punished.</p> <p>2 I expect to be punished.</p> <p>3 I feel I am being punished.</p> <p>7. Self-Dislike</p> <p>0 I feel the same about myself as ever.</p> <p>1 I have lost confidence in myself.</p> <p>2 I am disappointed in myself.</p> <p>3 I dislike myself.</p> <p>8. Self-Criticalness</p> <p>0 I don't criticize or blame myself more than usual.</p> <p>1 I am more critical of myself than I used to be.</p> <p>2 I criticize myself for all of my faults.</p> <p>3 I blame myself for everything bad that happens.</p> <p>9. Suicidal Thoughts or Wishes</p> <p>0 I don't have any thoughts of killing myself.</p> <p>1 I have thoughts of killing myself, but I would not carry them out.</p> <p>2 I would like to kill myself.</p> <p>3 I would kill myself if I had the chance.</p> <p>10. Crying</p> <p>0 I don't cry anymore than I used to.</p> <p>1 I cry more than I used to.</p> <p>2 I cry over every little thing.</p> <p>3 I feel like crying, but I can't.</p>
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The Beck Depression Inventory is a self-rating instrument and contains 21 items, which cover the following topics: Sadness, Hopelessness, Past failure, Anhedonia (=unhappiness), Guilt, Punishment, Self-dislike, Self-blame, Suicidal thoughts, Crying, Agitation, Loss of interest in activities, Indecisiveness, Worthlessness, Loss of energy, Insomnia, Irritability, Decreased appetite, Diminished concentration, Fatigue, Lack of interest in sex. If a client registers less than 11 points, they are not depressed in the strict sense of the definition.

Figure 7.1: The forms of depression



12 to to 19 points indicate a mild depression, 20 to 26 points represents a moderate depression, and more than 26 points indicate a severe depression. The full text can be found in the Internet (www.google.com) or in Aaron Beck's book, *Cognitive Therapy of Depression*, Guildford Press.

schizophrenic) affliction (see chapter 9 to 11). This diagnosis can only be made after a prolonged period of observation. In any case, the term covers severe forms of depression in which the patient's contact with reality is clearly disturbed.

I will deal with unipolar and bipolar depressions later. By a *«late-onset depression»* we understand a severe depression which occurs beyond the age of 60 years. It is more difficult to define the *«neurotic depression»*, also termed *«Dysthymia»* in newer textbooks. In these cases depression usually is not very severe, but takes a prolonged course (more than two years). These patients suffer particularly from the emotional wounds which they have experienced through other people. Traumatic experiences in childhood and youth are often put forward as the trigger for this kind of depression, but time will reveal that those who are affected generally find life more difficult and react with extreme sensitivity to both real and imagined let-downs. However, one does these patients an injustice. by portraying their depression as simply a false or sinful reaction.. The diagram shows that genetic factors also play a part making it more difficult for the person affected to cope with the normal disappointments of life.

How Does Depression Develop?

There are many theories about the causes of depression. I will restrict myself in this chapter to informing the reader what is known within the current state of medical science, and what the pastoral counsellor can observe in dealing with depressive people.

In the outline above, the distinction between the individual forms of depression seems clear and unequivocal. However, inward and outward causes, soul and body, do not allow themselves to be separated as neatly and completely as we would like them to be. They have a mutual influence on one another. I have tried to present these connections in figure 7.2.

I have consciously placed the brain in the centre, because it is here that the processes which lead to depression are controlled. We have already looked at the miracle of the human brain (see chapter 3) and seen in the process the role played by biochemistry in the understanding of a psychological problem. Quite a lot of people have a moderate hereditary disorder in the metabolism of their brain (a so called *disposition*) which makes them vulnerable to external pressures, so that when they come under stress, they are likely to react with a depression.

The body is intricately tied with the mind. Even in young people depressions are often accompanied by physical complaints. On the other hand, physical disorders may trigger depression. In older people the condition of the blood vessels and the heart plays an important role. The human brain can only function when it is provided with a sufficient supply of blood (and hence with oxygen). But high blood pressure, arteriosclerosis and weakness of the heart all result in less oxygen reaching the nerve cells – depression can be the result. With appropriate treatment it can completely disappear.

There is also a close connection between thought and the biochemistry of the brain. On the one hand the disturbed biochemistry of the brain during a depression reduces the ability to experience joy and see the world from a positive viewpoint. On the other hand it is also influenced by the person's thoughts and belief system.

Mild and Moderate Depression

In mild and moderate depressions the reaction component is often pre-

dominant. How people work through bereavement or stress depends on the way they think, and on the value they put on particular experiences.

Physical reserves of strength also play an important role. Experiences such as the sudden death of a friend, or long periods of tension such as examination pressures or marriage problems can erode the »nerves« and lead to an exhaustion of the supplies of biochemical substances in the brain.

As a result a dark veil falls over the person's whole emotional life and they begin to see everything – themselves, their environment, their future – in a dark perspective. Situations of depressive exhaustion do not happen by accident. Often a depression is also to be understood as an alarm: »Stop! You are overdoing it! You are expecting too much of yourself!« Or perhaps: »Why can't you get the better of this misfortune? What are you allowing to rule your thoughts? What is it that gives you a feeling of self worth?«

Even in milder depressions it can be observed that negative thoughts can strengthen the depression. But Christian faith changes thinking to the positive. It fosters hope, comforts, encourages, and directs the view on things above. So faith can be a very real help in overcoming a depression.

The troubles of a depression snatch a person out of the daily routine and make her think about the real meaning of her life. So the crisis can also provide the chance for a new beginning.

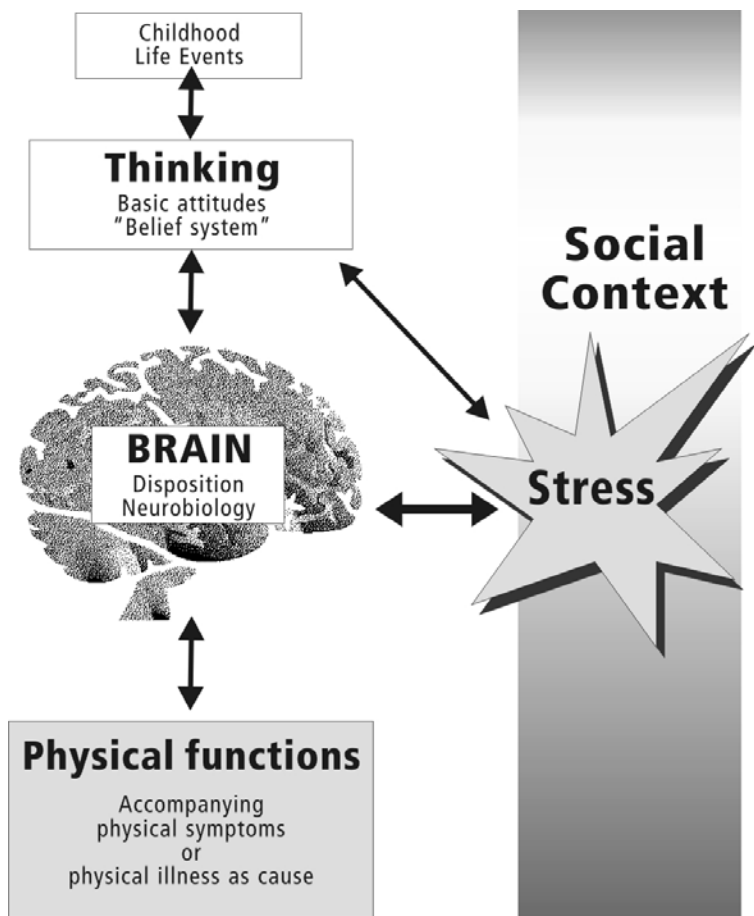
Severe Endogenous Depression

In my work as a psychiatrist I am seeing patients who become ill with the deepest depressions, far beyond the normal level, *without any external cause*. At any time about 1.3% of the population will be suffering from a severe depression. The risk of undergoing a severe depression at some time during the course of one's life lies at about 5 to 10%.

Those who are affected in this way have the impression that they have been suddenly, out of the blue, wrapped round with a gloomy fog of darkness of soul. »Look, I have everything I could wish,« a woman told me: »I have a dear husband and three bright children. Things are going well for us materially, and we have no cause for worry. We are both believers, and are active in our church. I can't understand why I have become so dejected, anxious and depressed.«

Another woman, who fell into a deep depression after the birth of her third child, complained: »I should be happy about our baby, but I can only see myself as a failure. I worry that I could harm this child. It would be best if we were all dead.«

Figure 7.2: Factors in the development of depression



Mostly there is nothing to be found in their life history to account for a severe depression of this kind. Of course, these people have not gone through life experiencing only sunshine and happiness. Indeed, hardly anyone has an ideal, burdenfree life behind them. But there is no relationship in these patients between the cause of the depression and their circumstances. Often there is an increased occurrence of depressive disorders or a history of suicide in the wider family.

The condition is not only characterized by a depressed mood, but also

by sleep disturbances and somatic complaints as they are described in tables 7.1 and 7.2. In these cases, the physician will think of an endogenous, biochemical cause for the depression.

The Course of Severe Depression

There are four possible courses that an endogenous depression can take. There may be one or more episodes of severe depression which may last weeks or even months, with free intervals in which the person affected lives, thinks and feels as normal. In this case the psychiatrist will talk about a *unipolar depression*.

The other form of endogenous depression shows a wave pattern, not only below normality but also above it. The agonising depth is followed by a high which patients experience as a release from their unbearable situation. Here we talk of a *manic-depressive psychosis*, or of »*bipolar depression*«.

Finally, there are also *chronic* depressions. These last more than two years and respond only in an unsatisfactory way to medical and psychological treatment.

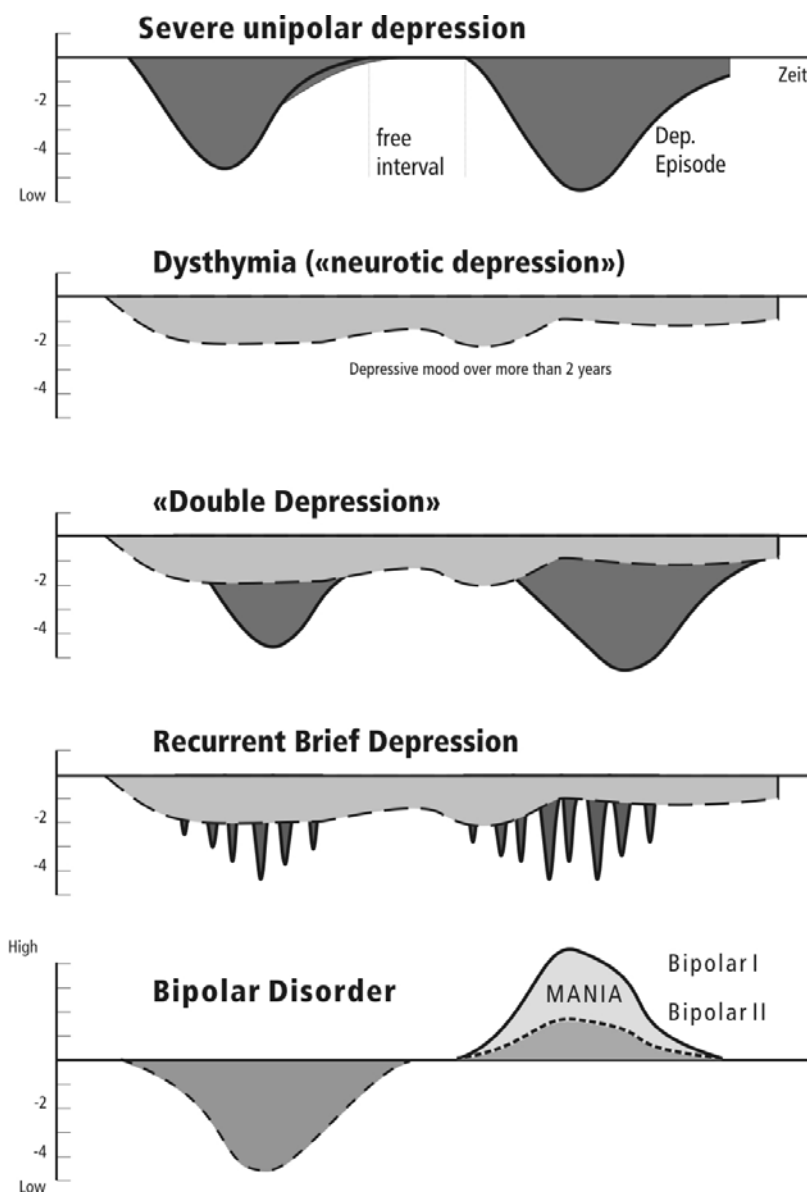
It has been estimated that 10 to 20 per cent of depression take a chronic course. These cases do not always consist of the worst depressive states. Even a moderate feeling of depression can be enormously oppressive, when you see no light at the end of the tunnel. Chronically depressed people often meet with little understanding from those around them which drives them into the additional isolation.

Depressive delusions are a particularly alienating symptom in a severe depression. Rather than simply looking at everything through dark spectacles, the patient loses touch with reality completely.

I vividly remember an old man who stayed in the hospital for a period during a severe endogenous depression. He believed he had lost all his possessions. With a sad voice he complained to me: »I've nothing left. I'm in complete poverty. I can't provide for my family. My wife will have to go through the streets in rags. I don't even have any clothes to wear my-self.« Yet, his wardrobe was full of clothes. This condition is called »Delusion of Poverty«. Other typical delusions are:

- *Hypochondria*. The conviction that you are suffering from an incurable illness.
- *Self condemnation* beyond any real context. The sick person blames herself for having broken something, for which she must be punished.

Figure 7.3: Various courses of depression



A man believes he has ruined the hospital because he didn't finish eating his meal, and so now he is going to be punished for it.

- *Ideas of failure.* The patient believes his or her life to be a complete failure. All their earlier achievements no longer count for anything. They have nothing to offer in comparison to everyone else. They have failed with regard to their job, civic duties, etc., etc. A young woman complained »I don't even know how a radio works. My life isn't worth living any more!«

Delusions of Guilt and Sinfulness

Finally, there is yet another form of depressive delusion which afflicts Christians: Delusions of sinfulness. »My guilt stands like a wall between me and God,« complained one woman. »I'm a useless mother, I can't cook, I'm not cheerful enough, I'm afraid of people. I cry out to God, but he doesn't hear me. I try to cling on to a promise, but God can't accept a failure like me.«

Certainly, there are people who have every reason for remorse and fall into a depression (usually a mild, and reactive one) as a result of genuine guilt. But in this case it was different. There wasn't a single remaining sin, even a really tiny one, which this woman hadn't already confessed umpteen times. Yet her »sin« still towered before her like a gigantic mountain. When the milk boiled over she saw it as confirmation of her vileness. She lamented the terrible sin of not sending a card on time for her sister's birthday. This delusion has nothing to do with real conviction of sin. What we are faced with here is a pathological condition.

You may ask »What can be done for someone who suffers from a depressive delusion? How can a man with a delusion of poverty be helped?« I will go over the therapy of depression systematically in the next chapter, but let me anticipate this by saying that it takes patience, lots of patience. Every attempt to reassure the patient that the opposite of their delusion is true leads to a reinforcement of the ideas. However, usually, as the depression becomes less severe, the delusions also subside of their own accord.

In some cases such ideas may persist and may trouble the afflicted person into old age. These people will need a special degree of understanding and patient care by doctor and pastoral counsellor alike.

Table 7.3 Diagnostic Criteria for a manic episode (adapted from DSM-IV)

- A) A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
- B) During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
 - inflated self-esteem or grandiosity
 - decreased need for sleep (e.g., feels rested after only 3 hours of sleep)
 - more talkative than usual or pressure to keep talking
 - flight of ideas or subjective experience that thoughts are racing
 - distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
 - increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.

Mania: From joy to derailment

Emerging from the dark sea of melancholy is a powerful experience for any severe depressive. They will describe the change as »like being unchained«, indeed, »like a new life«. Yet for many people, depression is followed by a swing into mania. This is characterised by heightened mood, increased drive and accelerated thought processes.

A woman wrote the following words at the beginning of her manic phase: »I feel like nature itself at this moment. Progressing from its long winter sleep it sprouts from every tip and joint, sending out new buds. The birds trill and promise a new warm time to come ... a new year, a spring with blossom, soft, green meadows with bubbling rivers and streams ...«

Yet the joy soon turns into a nightmarish high altitude flight. The same woman paid an enormous amount of money for a new wardrobe of clothes with strident colours, because her »depressive clothes« no longer suited her new found joy. With her unbounded creative energy, she started getting up at four in the morning, and didn't go to bed until one.

She wasn't at all bothered that the loud music from her apartment bothered her neighbours. In her elation she lost all moral restraints and got herself involved with men who were complete strangers. The once with-

drawn, decent and quiet lady spoke in a loud voice, and called her friends at all hours of the day and night to tell them how good things were going for her. In the end her behaviour became such a burden for people around her that she had to be admitted to a psychiatric unit.

The manic phase is thus the reverse side of the depression. Where before there was a lack of energy, the sick person now shows almost super-human energy. Where before he was controlled by the worries and cares of life, he no longer sees any problems or dangers. Where before he withdrew into his shell, now he wants to embrace the whole world. Where before he struggled under his guilt and sinfulness, now he is incapable of experiencing guilt and sin, even though his behaviour frequently transgresses moral boundaries.

Relatives experience enormous suffering through their manic spouse or child. Parents often don't know any way to help, other than to ban their son from the house »until he comes to his senses«. Marriages are frequently shattered by the manic phase of a partner. The wife of a manic husband once wrote to me: »I find it such a torment, I don't know what to do. What I'd really like to do is to make a final break with him and leave him. But should I do that? All the time I keep praying and asking the Lord for a miracle, and for him to make things clear to me, but somehow I feel lost and alone.«

You have now read a lot about the forms, causes and the course of severe, endogenous depression. You may be asking yourself, what hope is there for severe depressives? Is there any hope for the hyperactive manic person? Is there hope for their suffering relatives? I would like to answer with a cautious »Yes«, and in the next chapter I shall look into the pastoral care of depressive conditions and the various possibilities for therapy.

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plus internet resources (www.google.com)



Therapy and Pastoral Care for Severe Depression.

Depression does not have to be an unchangeable fate. The doctor and pastoral counsellor can offer hope even to the depressive person which sees no way out. What the depressed need, is the confident reassurance that there are passable routes out of depression, and that indeed, the road through darkness can even bless and help in one's personal growth.

In the previous chapter I have explained the factors contributing to the development of a depression. In the same way, there are many different routes and levels in therapy. We have established four important areas in the development of a depression:

- Thinking, or a person's belief system
- External stress (loss, rejection, disappointment, etc.)
- Physical reactions and disturbances
- The neurobiology of the brain

Correspondingly, the therapy of depression can be divided into four sections:

1. Counselling (Listening, Talking, Guiding)
2. Practical help and support
3. Treatment of physical symptoms and physical activation.
4. Pharmacotherapy (Medication).

These forms of therapy have a mutually intensifying effect on each other. No one approach should be taken without the others. It is possible to do without medication in mild depressions, but the doctor should always be consulted in more severe situations.

A depression is not only a crisis of emotion, but also a crisis of belief. For this reason, pastoral input is indispensable and helpful alongside the medical treatment, provided the pastoral counsellor knows the points to be careful and where his limitations lie.

Guidelines for Counselling the Depressed

Helping severely depressive individuals makes considerable demands on the patience and empathetic skills of both the doctor and the pastoral counsellor. These qualities are indispensable for counselling depressives. I have compiled a list of seven points to which attention should be given when counselling them. These are as follows:

1. Accept the depressive person in their illness and trouble, and show them your readiness to accompany them through this difficult time.
2. Talk over the patient's life history with him or her. Explore with them the experiences which triggered the depression. Give them the opportunity to empty their heart.
3. Emphasise the hopeful outcome of the condition. Most depressions improve after a certain time.
4. Explain treatment options and send the patient with a severe depression to their G.P.
5. Encourage the counsellee and speak about God's love, even at times when he or she feels little of it. There are many helpful passages to be found in the Psalms, as well as in many scripture promises.
6. Prepare the counsellee for occasional mood swings. I often tell my patients, »The road out of depression is lined with 'pot holes', but in the end it leads up to the light.«
7. Be patient! Set one goal for therapy at a time, so that the patient keeps having little successes. Don't expect too much at once. Remember, depressed people are often so hemmed in, that they are scarcely aware of pastoral conversations, and can take in only a little at a time.

Avoidable Mistakes

There are a number of concealed traps and pitfalls in conversation with

depressive people which it is necessary to avoid. Most mistakes are related to the following points:

Demanding »Pull yourself together«: Depressed people are already placing themselves under a massive burden of self imposed obligations, and suffering as a result of their supposed failure. It is of little help when the pastoral counsellor adds to this pressure, backing it up with verses from the Bible. You can't simply order someone to be happy!

Sending them on holiday or on leave: Even in their familiar surroundings, it is difficult for patients to make contact with people, enjoy beauty and fill their day on their own initiative. But that is exactly what will be required of them on a holiday. The person will feel trapped and overwhelmed.

Allowing them to take important decisions: Often during a depression a patient is not capable of properly evaluating his situation. He sees everything through »dark glasses«. His problems tower over him like a mountain, and he underestimates his abilities. Decisions taken during a depressive phase will often be recognised afterwards as wrong, and regretted.

Superficially asserting »Things are already better«: It is often difficult for the carer to understand that for a depressed person things are the same week after week. You will often find yourself trying to encourage them with cheap words, but the result is to leave them feeling they haven't been taken seriously. It is better to recognise that they are still going through the »valley of the shadows«, and to affirm the presence of God in the midst of their darkness.

Casting doubt on delusional ideas: Many people suffer from the delusions of guilt and failure. No argument can move them away from these delusions and each attempt to assert the opposite leads to new arguments to support the delusion. What is needed here is to be patient and convince the sufferer through the way they are personally valued by the pastoral counsellor and the grace of God. I often encourage my patients with the biblical promise from 1 John 3:19-20: »We can set our hearts at rest in his presence, whenever our hearts condemn us. For God is greater than our hearts, and he knows everything.« Then I close the conversation without further dis-

cussion and give them a new appointment. The sick person needs time to digest what he has heard, even if he still carries a lot of »ifs« and »buts« about it.

Entering too deep into the depressive condition: The depressive person is often completely imprisoned by his cares and fears. There is great danger in allowing yourself to be drawn into this twilight world and completely forgetting to ask what he is still capable of and what gives him security. We find the right balance in the Psalms. Time and time again the divine »nevertheless« breaks into the personal trouble of the praying person and directs his gaze above.

Making too many spiritual demands: God's word should be like salt in a tasty meal. Without reference to God's promises, pastoral care is reduced to idle talk. But an abundance of words from scripture which lacks relationship to every day life and to the depressed person's suffering, is like a salty concentrate. Indeed it can add to the sick person's feelings to such an extent that he becomes unable to receive God's Word and feels condemned.

When studying the Bible intensively, a severe depressive will tend only to read the thoughts which are endorsed by his darkened perspective. The most beautiful promises will only awaken the thought »This no longer applies to a sinner like me!« and despair will grow.

For this reason, I deliberately advise depressed people not to immerse themselves very deeply in the Bible any more, but to read just one verse each day, preferably with an explanation in a devotional book. God's love does not depend on the number of chapters you read and how many hours you spend in prayer. God holds us in His hand, even when we lack the power to hold on to Him.

Practical help and encouragement

Counselling alone is not enough in many cases. The pastoral counsellor must be ready to climb down from lofty spiritual conversation into the »lower regions« of everyday life and give very practical help. It may be necessary to relieve an overburdened housewife of some of her responsibilities or a depressive husband will need to be encouraged to hand his committee responsibilities over to someone else until he is on his feet again.

It is often important to call in relatives and to discuss with them how

the sick person can be relieved of some of their burdens. So for instance a young woman's mother may come in two days a week to do the washing and ironing while the husband helps a little more with the housework. In this way the burden is shared and rests on several shoulders.

On the road to health the depressed person will need to be slowly re-activated. Work out a daily schedule with him and encourage him to take part in small activities. Regular walks and some kind of sport stimulate the circulation and so have a positive effect on depression. In time the depressed person will begin to take up new responsibilities for himself once again. The more the numbness of depression is released, the freer he or she will be to be active and enjoy achieving things again.

Pharmacotherapy: Help through medication

About fifty years ago, the first drugs were discovered which had a pronounced influence on depression. We assume that they have a positive influence on neurotransmitters in the brain (especially serotonin and norepinephrine), restoring a balanced mood. However, many questions are still unresolved and need further research.

Not every depressive needs medication. You can do without medication in mild to moderate depressions, if the person receives regular help through counselling. Studies have shown that psychotherapy (especially interpersonal and cognitive-behavioral therapy) may be equally effective as antidepressant medication. Another possibility are herbal remedies based on St. John's wort.

In severe depressions, however, modern drugs are an enormous help, undergirding psychotherapy and counselling, enabling the person to stabilize to a degree that he or she is able to follow through with the goals they set in therapy.

With the prescription of antidepressant medication, the physician hopes to achieve the following goals:

- release from inward nervousness and tension
- reduction of crippling feelings of anxiety
- lightening of the melancholy mood
- reestablishment of adequate sleep
- improvement in the patient's ability to cope with tasks and social roles
- relapse prevention in recurrent unipolar and bipolar depression.

There is a broad range of antidepressants available to help in the achievement of these aims. Which drug the doctor chooses will depend on the characteristics which he observes in the patient. Is he suffering from restlessness, anxiety and insomnia? Or is she feeling weak and lethargic? Is she overwhelmed by feelings of sadness, or complaining that her feelings are totally numbed? In each case the doctor will prescribe a corresponding drug, either a more sedating or a more activating antidepressant.

It is important to instruct the patient that the drug will take five to ten days time to take effect. Nevertheless, the medication should be taken at regular intervals in order to facilitate the build-up of the therapeutic level in the brain which is needed for it to be effective.

I often explain this situation to my patients with the help of the following analogy: »Imagine a water reservoir, where the dam has been broken. The water has run out ... the reservoir is empty. In the same way, you are suffering from an exhaustion of your resources of physical and emotional strength. The antidepressants are now filling the hole in the dam, but it will take time for enough water to build up to drive the turbines again.«

However it often makes little sense to just wait a whole week for the drug to take effect. That is why the antidepressant is often supplemented with tranquillisers and sleeping tablets.. Patients are enormously thankful when at last they are able to sleep properly and their inner tension is relaxed.

The *side effects* of antidepressants vary according to the drug and the dosage (please check the Internet for details). Most patients take the prescribed drug without any problems Others quickly become accustomed to it and stop experiencing the side effects. A little constipation and dryness of the mouth is a small price to pay for a lightening of the depression. However, if the side effects continue to be very distressing, it will be necessary to change to a different remedy which may produce fewer undesired effects.

Lithium plays a particular part in the therapy of depressions. This simple mineral salt can prevent a relapse in cases of recurrent severe depression and manic-depressive psychosis. The reason may very possibly be that Lithium stabilises the ability of the nerves to conduct electricity. Many people who previously suffered from regularly recurring depressive and manic phases are today, thanks to Lithium, free from trouble and able to live and work normally.

Personality Change Through Antidepressants?

I have been asked repeatedly by both lay people and theologians, whether antidepressants and tranquillisers alter a person's personality, and whether on these grounds they should be rejected from a Christian point of view. From my observation, I would say that exactly the opposite is true. It is depression, which alters the personality and leads to despondency, despair, nervousness and anxiety which the afflicted person would otherwise never have known. The medication helps the person to regain their capability to think and feel the way they did in their healthy time before the depressive episode.

Some patients complain that they experience a numbing of their feelings while taking antidepressants. But often it is not easy to discern whether the calming effect is due to the medication, or due to the depression itself.

Personally, I am convinced that modern psychopharmacotherapy can be a valuable help in conquering depression, even for Christians, if it is supplemented by regular counselling and practical help.

The problem of Suicide

This chapter about the treatment and care of depressive people would be incomplete were I not to refer to the recognition and treatment of suicidal tendencies.

Thoughts about death and suicide are part of the picture of a severe depression. They become a particular danger for depressed people who feel excessively hemmed in and isolated. To begin with, they may simply long to be able to sleep and not wake up again. But then they start to think more and more about how to end their life, and if the net of hopelessness is pulled closer together it often happens that the thoughts begin to actively control them, so strongly that they no longer know how to resist them.

For many Christians it is not easy to give expression to such thoughts. They are afraid of how their fellow Christians will react, expecting to be condemned »because a Christian doesn't have any thought of suicide«.

Some pastoral counsellors regard such thoughts as signs of a lack of devotion to God, or even as evidence indicating demonic influence in the afflicted person. But this is exactly the kind of attitude which can

drive a person deeper into hopelessness. It is therefore important to recognise suicidal tendencies quickly, if effective counselling is to be given to the depressed person. The following questions can help in this:

SUICIDAL TENDENCY PREPARATION	Have you ever thought of taking your life? How would you do it? Have you already made preparations? (The more concrete the idea, the greater the risk).
COMPULSIVE THOUGHTS	Do you think about it of your own choice, or do the thoughts force themselves on you, even when you don't welcome them? (Thoughts which press in on someone passively are more dangerous).
WARNINGS	Have you already talked about your intentions, with someone else? (Always take warnings seriously!)
RESTRICTION	Have your interests, thoughts and social contacts become more reduced and restricted?
AGGRESSION	Do you have feelings of aggression against anyone, which you are forcibly suppressing? (such suppressed feelings can be directed against one's own person.)

There is a great deal of help to be gained from a book by Bill Blackburn, which deals with the subject from a Christian point of view. He enters in a very sympathetic way into the difficulties of those who are afflicted, and also the problems of their relatives and those who care for them. I would only want to add a few pieces of advice from a medical point of view. Table 8.1 shows the risk factors for suicide in depressive patients

Helping People at Risk From Suicidal Tendencies

The inexperienced helper is often too inhibited to address suicidal thoughts when he or she is talking to a depressed person. But these impulses can become stronger, precisely because they are not talked about and covered with embarrassed silence (implicitly indicating: »Such a nice

Table 8-1 Risk factors for suicide

A) EARLY INDICATIONS OF SUICIDE

1. Previous suicide attempts and indications of suicidal tendencies
2. History of suicide among family or other contacts
3. Direct or indirect suicide threats
4. Concrete plans or preparations for a suicide
5. »Uncanny calmness« after previous unrest and talk of suicide

B) SITUATIONS

1. Onset of a depressive episode (or towards the end of an episode)
2. Signs of anxiety or agitation
3. Prolonged disturbance of sleep
4. Biological crisis periods (puberty, childbirth, menopause)
5. Severe feelings of guilt or rejection
6. Prolonged or incurable illness
7. Hypochondria
8. Alcoholism or drug addiction.

C) ENVIRONMENTAL FACTORS

1. Broken family relationships in childhood
2. Absence or loss of human contact (loneliness, loss of 'roots', disappointment in love.)
3. Redundancy, retirement, financial worries
4. Absence or loss of supportive religious relationships.

Christian like you could not possibly have such thoughts!«).

The first principle, for dealing with suicidal people is thus:

1. *Give voice to thoughts about suicide.* Talking naturally about the desire to die will make it easier for counselees to express their innermost troubles and worries. The burden will be shared and preventive measures can be discussed.

2. *Ask questions which probe beyond the hopelessness.* Suicide is only an option for a person who can see no other escape. Reviewing the situation through the counsellor's eyes can raise the question: »Is my situation really so hopeless?« The tiniest glimmer of hope can persuade the suicidal person to at least postpone taking their life for the time being.

3. *A strong relationship between the pastoral counsellor and the patient* is extremely important during a suicidal crisis. The feeling of being supported and taken seriously can weaken suicidal thoughts. You can work out a promise with the depressive person not to attempt suicide, at least until after the next counselling session. In addition you can offer the possibility of phoning every time thoughts of suicide start to come. In an emergency there are telephone counselling services which offer the opportunity to talk with a trained helper at any time, day or night. In Britain, the »Samaritans« provide this service and the number, which varies in each area, can be found in the local telephone directory. The equivalent service in some countries can be obtained by dialling a particular number nationwide.

Emergency calls like this are not always easy for the pastoral counsellor. I well remember an evening when the telephone rang about ten o'clock. A young woman was on the line whom I had already been helping for a long time through a severe depression. »Doctor, I can't go on any longer,« she said in a toneless voice. »The thought of killing myself is getting stronger and stronger. I can't resist any more. But I just wanted to ask you before I do it, can you help me?«

Don't think for a moment that I sat by the telephone and gave sound advice in a calm and professional way. I sweated and prayed inwardly for God to give me the wisdom to know how to help that woman. After a few minutes I noticed that the person I was talking to was calmer and in the end we managed to arrange for someone to call and see her that evening so she wouldn't be completely on her own. The telephone conversation, with God's help, had broken the spell of her suicidal thoughts.

Such telephone calls take a lot out of you, but the committed pastoral counsellor must be ready to share this burden as much as lies in him.

4. *Consult with relatives and friends.* A person who is strongly suicidal should never be left on their own. Admission to a psychiatric unit is not always necessary. In shorter crises their parents or partner can be asked – with the permission of the patient – to watch over the suicidal person and give him or her more attention. This constant supervision will become too much of a burden for the relatives if the risk of suicide is serious or prolonged. Then the courageous decision has to be taken to admit them for intensive supervision and treatment in hospital.

5. *Give therapy at frequent intervals.* Give the suicidal person an ap-

pointment to talk further at the earliest date possible. Encourage them to have medical treatment from a doctor including medication which will calm them and lead to reestablishment of normal sleep patterns.

6. *Admission to hospital.* When the measures described above are insufficient, a stay in a specialized hospital will be unavoidable.

In acute crises, a psychiatric unit has much to offer to every patient, the believer included: additional possibilities for therapy, increased attention and supervision, and a refuge from the fears and life situations which are felt to be unbearable. These measures can prevent the worst from happening in the majority of cases. Nevertheless, we always have to live with a residue of uncertainty. Unfortunately, a psychiatric unit cannot give the ultimate security. It comes as a shock to the pastoral counsellor and the psychiatric social worker alike when they experience their powerlessness to help as – in spite of all efforts – a patient succeeds in taking their own life. Often the pastoral counsellor will, as a result, carry wounds of his own which will take a long while to heal.

Help for the Pastoral Counsellor

A client's depression has an effect on the pastoral counsellor. It is his or her duty to help the depressed person, and he feels in part responsible for him. If as so often happens the pastoral counsellor becomes infected by the hopelessness and helplessness of the client, the counselling sessions become an increasing burden. For this reason I would like to conclude this chapter by giving some advice as to how this outcome can be avoided.

1. Keep the facts about depression in view! Don't allow yourself to be drawn along by the patient's temporary hopelessness.
2. Be on guard against untrue, depressive ideas in yourself, as well as in the patient. Are your thoughts always in tune with the Bible and with reality?
3. Learn to counter the client's suffering with a healthy objectivity. For instance, just accept tears as signs of inner distress. Consciously limit the length of each counselling session, otherwise it will be too taxing

for you as well as the sick person.

4. Don't accept responsibility for the thoughts, feelings and behaviour of your client. They have to carry this responsibility themselves. You can certainly give them a push here and there, but change in the patient has to come about through God's grace (and according to His timing).
5. Don't set too high goals for therapy. Keep reminding yourself that helping depressive people takes a lot of patience and always involves setbacks.
6. Have the courage to face your own helplessness and talk with another pastoral counsellor about your difficulties in caring for a depressive person (this is called »supervision«).
7. Take enough time for personal fellowship with God and with your family. Nurture contact with friends and enjoy time for hobbies, sport or music.

By far the greatest encouragement for any doctor or pastoral counsellor is to hear from former patients about how they survived their depression. The inward brokenness of a severe depression often leads to a deeper relationship with God, and the rebuilding of a faith which proved itself even in the time of trouble.

A woman with a prolonged depression recently said to me: »I wouldn't have wanted to miss this time. God broke my old, proud nature and directed my gaze back towards Him. I have nothing in this world that I can rely on. But He endures for ever. Sometimes I am afraid, at the beginning of a new depressive phase, that my clear, certain faith will be darkened again. Yet I know God comes with me, even when my path leads through another dark valley.«

References Chapter 8: Treatment

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Internet ressources: The Internet is rich in ressources to answer all your questions regarding the treatment of depression.



Schizophrenia - Understanding the Illness

No other illness provokes so much controversy as schizophrenia. Its varied forms make it hard to understand, indeed, many people find it rather repulsive and scary. Physical illnesses are much easier to understand and deal with. The horrors of previous centuries, such as the plague, are now reduced to the status of common infectious fevers. Even lay people understand nowadays how physical illnesses come about and how they can be treated.

With schizophrenia it is different. The sick person's strange behaviour, the voices they hear, the fears they express, do not immediately point to a disorder of a physical organ. In spite of costly research we are still, faced here by many unsolved riddles. Schizophrenia was first identified as a separate illness at the turn of the century. The German psychiatrist Kraepelin talked about a »dementia praecox«, an premature dementia. Eugen Bleuler, medical director at the »Burghölzli« Psychiatric University Hospital in Zurich, was the first to describe and list the diverse symptoms of this peculiar disorder. His name for the illness was »*schizophrenia*« – the split mind.

The name was new, but not the illness. Schizophrenia is not confined to our age. Time and time again, history leaves us descriptions of people who manifested the typical disorders which we would label »schizophrenia« today. Equally, schizophrenia is not confined to particular geographical areas. It occurs in every land and nation, among all races and social classes. And it also occurs among believing Christians. Their fellow Christians often have difficulty understanding the changes which take place in those

who are affected. How is it possible for their thoughts, feelings and behaviour to be so deeply disturbed? How does it come that someone feels he is being followed by the secret service, or sleeps only on the floor, because he is afraid of radiation, and feels he is constantly guided by voices no other person can hear?

In recent years, schizophrenic people have become especially favourite patients of mine. It has been my privilege to walk with them and their relatives on their path through illness. Time and time again I have been amazed by their heroic struggle – both the struggle with their illness, and with the incomplete understanding by the world around them. I am writing this chapter for them, to moderate the injustice to which they are still continually subjected in modern society, inclined as it is towards success and normality.

Definitions and Statistics

Schizophrenia belongs to the group of illnesses known as psychoses. This term comprises severe disorders, which are recognisable by abnormal experience and behaviour as well as marked alteration of the personality, leading to the loss of the normal capacity for work. The person affected is no longer able to separate external events from their personal perceptions. Psychoses can last for a few hours or for years. They can be slight or lead to a complete breakdown of personality. Psychoses include:

- Organic psychoses (triggered by toxic substances, e.g. drugs or infections such as syphilis).
- Transitory psychotic reactions to stressful life events.
- The results of severe disturbances of the brain in old age.
- Manic depressive illnesses.
- Schizophrenia.

In this chapter I will deal with schizophrenia. The other disorders may be mentioned here and there, but not fully described. The interested reader should consult text books of psychiatry or the internet for further information.

Schizophrenia is a comparatively common disorder. About half the patients who require admission to psychiatric hospitals suffer from it. Two statistics will give an idea of its frequency.

Research has shown that about 0.4 per cent of the population suffer with symptoms of schizophrenia (acute or chronic) on any particular day. For comparison, about 15 to 20 per cent are depressive on any particular day, and about 12% suffer from symptoms of anxiety and personality disorders.

Schizophrenia affects 1 in 100 people in their lifetime. Every year, there are 6000 new cases in Britain alone. Schizophrenia has an irregular hereditary pattern. Table 9.1 shows the risk of suffering from schizophrenia when another member of the family is already afflicted.

Table 9.1: Hereditary risk of schizophrenia

Probability of inherited schizophrenia schizophrenic:	per cent
If one parent is schizophrenic	15%
If one brother or sister is schizophrenic:	10%
If both parents are schizophrenic:	20 – 40%
If an identical twin is schizophrenic:	50%
If a second degree relative (Uncle, nephew, cousin) is schizophrenic:	3 %

These figures may be disturbing, but if we look at them another way, it means that even if a mother who suffers with schizophrenia had seven children, statistically, only one would suffer with the same disorder. All the same, in such families we often observe an increased incidence of other psychological disorders, which point to an underlying disposition for psychiatric problems.

What allows the diagnosis of Schizophrenia?

Today the diagnosis of schizophrenia is made with careful (even reluctant) discernment. In the 1960s in America every kind of conspicuous behaviour and transitory psychosis was labelled as schizophrenia. But for two decades now strict criteria have been introduced for this diagnosis to be made. These are laid down in the DSM-IV, the Diagnostic and Statistical Manual of Psychiatric Disorders (4th revision). Yet even for experienced psychiatrists it is difficult to be accurate in borderline cases, particularly at the beginning of an illness. Often it is better just to speak of an »adolescent

Table 9.2: Diagnostic Criteria for Schizophrenia

DURATION: Total duration at least 6 months. Various durations are possible for the individual phases. **ONSET:** Before the age of 45 years.

A. PRODROMAL PHASE

Obvious deterioration in comparison with earlier level of ability (performance at work, social relationships; care for personal appearance and hygiene). At least two of the symptoms listed below, which are not due to a disturbance in mood or to a psychoactive substance.

Symptoms During the Initial and Residual Phases:

1. Social isolation or withdrawal
2. Marked impairment of work, home life or studies
3. Marked peculiar behaviour (e.g. collecting rubbish, hoarding rotting food, uninhibited behaviour ...)
4. Marked neglect of hygiene and grooming
5. Apathetic, shallow or unconventional expression of feelings
6. Wandering, vague, over elaborate or circumstantial speech
7. Odd beliefs or magical thinking, influencing behaviour and inconsistent with cultural norms. Feeling of being influenced or being able to influence others, imagining significant connections between unrelated things or events.'
8. Experience of abnormal perception, e.g. repeated illusions of the presence of an invisible person or power which cannot be experienced by others.

B. ACTIVE PHASE

At least one of the following characteristic features:

1. Bizarre delusions (essentially and obviously absurd and with no possible basis in reality.) For instance, feeling of being influenced or having special powers, or being able to read people's thoughts, or having thoughts extracted from your brain.
2. Delusions related to the body, delusions of greatness, religious, nihilistic or other delusions.
3. Delusions of jealousy or being pursued, combined with hallucinations.
4. Hearing voices (either commenting on the afflicted person's behaviour, or talking among themselves).
5. Distracted thought, marked tendency for mental connections to be seen much more loosely, marked illogicality of thought, and pronounced deterioration of verbal abilities, if this occurs together with at least one of the following features:
 - apathetic, shallow or unconventional expression of feelings
 - delusions or hallucinations
 - catatonic or otherwise severely disorganised behaviour.

C. RESIDUAL PHASE

(Residual = remaining). At least two of the symptoms listed under A, which continue after an active phase of the illness and are not caused by a bad mood or by drugs.

(adapted from the DSM-IV)

crisis« or simply a »psychotic condition«.

Three phases are distinguished in the course of a schizophrenic illness which are described more fully in table 9.2.

- | | |
|---------------------------|--------------------------------|
| A. Prodromal phase | (gradual deterioration) |
| B. Active phase | (acute symptoms) |
| C. Residual phase | (stable situation) |

Forms and Cause of Schizophrenia

It is not always easy to define individual symptoms of schizophrenia. Currently, the tendency is to distinguish three forms of schizophrenia which are briefly describable as follows:

1. HEBEPHRENIA (or disorganised schizophrenia)

Onset in younger years, childish, silly behaviour, breakdown of personality, often aimless, clearly reduced ability to work,

Example: 17-year old Sylvia from a well ordered family is experiencing various pressures. She is in the middle of the end of year exams, on top of which her friendship with a young man has just been broken off. Her personality changes increasingly. She becomes obsessed and pesters her ex boyfriend day and night with telephone calls. She feels sad, but laughs constantly and without reason. At work, she makes frequent mistakes. In the end she runs away and spends the night in the open air in the pouring rain. This leads to her being admitted to hospital.

2. CATATONIC SCHIZOPHRENIA:

Marked disturbances of movement are prominent over other typical symptoms of schizophrenia (e.g. remaining for hours in an unusual posture, or an agitated state).

Example: A 35-year old mechanic, Mr. Francis, is intensely occupied in building his own home. Tensions with the architect lead to a court case. Mr. Francis is unable to sleep, stops going to work, and spends all his time brooding over his building plans. One, morning his wife finds him sitting

at the table as if petrified. He constantly utters the words »watermain«, and knocks meaningfully on the table. The condition normalises with the help of medication after a three week stay in hospital.

3. PARANOID SCHIZOPHRENIA:

The patient suffers from a system of delusion which is beyond any real context (e.g. delusion of grandeur, delusion of being an inventor, delusion of being followed).

Example: 22-year old painter Thomas K. is convinced that four years ago he has discovered the laser beam. With the aid of a magnifying glass he has now developed a »computerised video magnifier« as well as a »photo driven helicopter«, which the police can use for tracking criminals. When he touches the table with his finger tips, he can store his feelings on the surface of the wood. He spends more than 5,000 Euros on tools and instruments to continue developing his inventions. He makes a lot of mistakes at work, because he continually feels distracted by murmuring voices and laser beams.

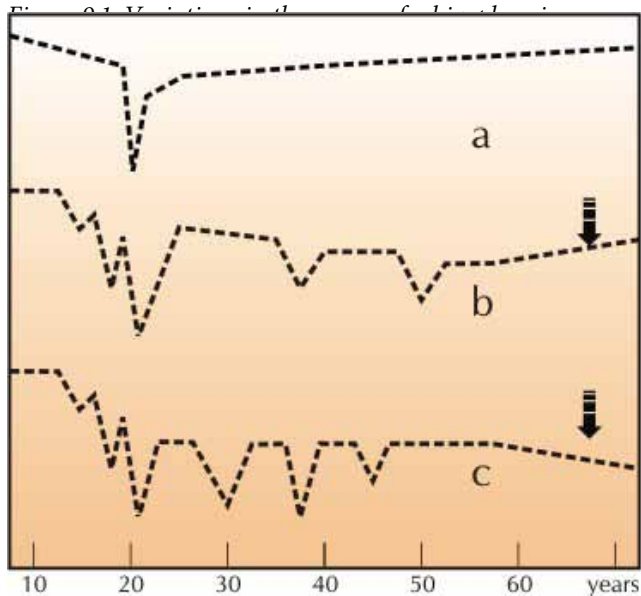
It is not always possible to categorise a condition under one of these forms of schizophrenia. In the hospital we observe the most diverse mixed forms for which there are yet other names. Two of these are named here: an insidiously developing schizophrenia with few symptoms will be labelled as »*schizophrenia simplex*«. If schizophrenic symptoms are combined with severe mood changes (severe depression or mania) we talk of a »*schizoaf-fective psychosis*«.

The Course of Schizophrenia

Research into the course of schizophrenia has shown that the prognosis for this illness is considerably better than has generally been thought.

There is no cause for unnecessary pessimism. Basically we can observe three possible courses for the development of schizophrenia, as outlined in Figure 9.1.

1. Single episode with no recurrence
2. Repeated episodes with resultant disability



3. Chronic deterioration leading to a severe residual state

1. In about 20 per cent of cases, an episode of schizophrenia does not lead to any further relapse, although these individuals experience heightened sensitivity under stress. Particularly favourable are the following features:

- normal adjustment before the illness.
- sudden onset with many symptoms.
- relatively good health after an episode
- harmonious conditions in the family / social system
- motivation towards regular treatment with medication.

2. In about 60 per cent of patients, further episodes occur over the years. During the intervals, these people live normal lives, even if in retrospect, they are less able to cope with stress. Unfortunately their ability is somewhat reduced after each episode. A so-called residual or defective condition remains, which makes it more difficult for them to operate effectively at home, at school, or in the workplace. It is not uncommon for them to have

to come to terms with a more modest goal in their career.

I think of Liz, a nurse who could only work to 70 per cent of her capability after a psychotic episode. After a further episode she was transferred to work at a convalescent home, where the demands made on her were less stringent. Every few years, when she was under unusual stress, she experienced a short crisis. Once it was an unfulfilled love. Another time an exhausting trip to Tunisia. She would feel better after a short stay in hospital. In her lovely, sympathetic way she was a great blessing to many patients.

3. Finally, about 20 per cent of patients develop a complete personality breakdown. Even under medication, they are not free from delusions and hallucinations. They are no longer able to work. Often they are incapable of caring for themselves and living on their own. Because of their bizarre behaviour and marked lack of personal hygiene and grooming they become such a burden for their relatives that they require continual supervision in a psychiatric hospital or another form of mental care.

The Psychosis as a »Jamming Station«

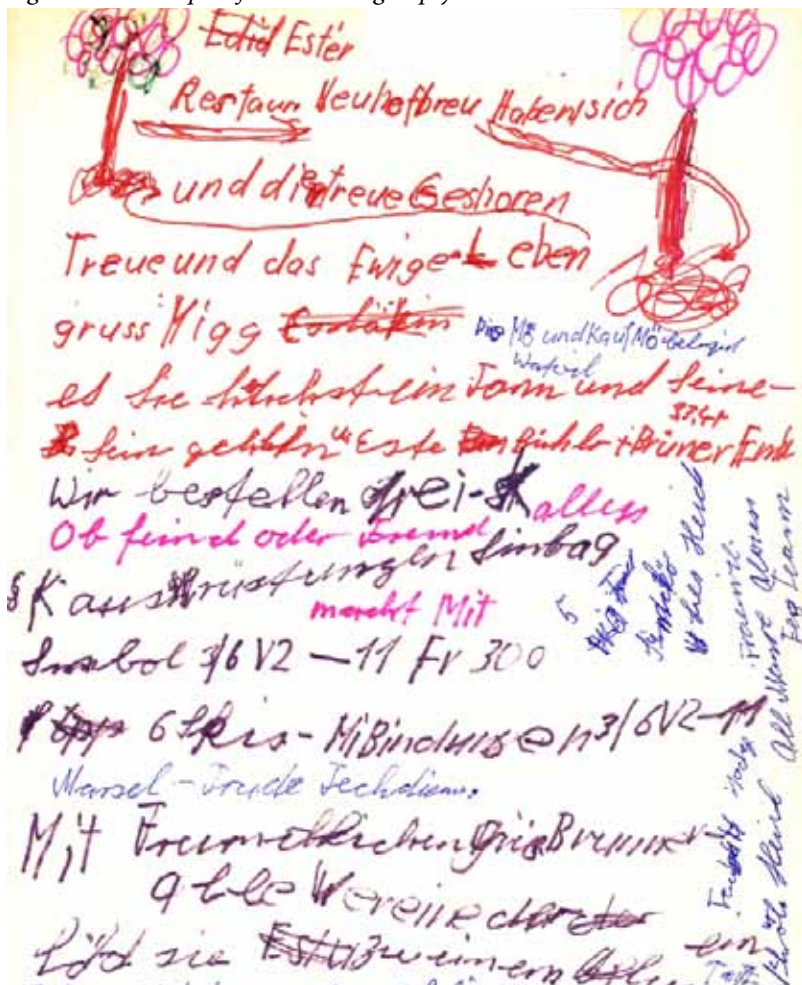
The research of the last few years has shown that at the roots of all forms of schizophrenia lie common disturbances which especially impair the thought processes of the brain. Additional difficulties, such as altered and suppressed expression of feeling, social withdrawal, alteration of self-awareness, delusions, hallucinations and motor disturbances, all follow from these disorders.

What do we mean by »thought disturbances«? Someone who has never experienced the mental changes in a person who is undergoing an episode of schizophrenia can hardly imagine it. I vividly remember a 28-year old woman, who developed a psychosis after having delivered a healthy baby. At her admission interview, communication was barely possible. Her thoughts were like a broken stained glass window. Word fragments sparkled out, but they didn't fit together, and no longer formed a picture for the person looking on.

»I feel like I am an N. N for necessity. But I can't get it, because there is an F in the way. I can't tell you what an F is just now. I don't feel myself any more. The dot in my »i« is missing. (She knocks her head pointedly to indicate the dot.) The word »marriage« has a special meaning, M for Marriage. If you turn the M upside down, there are three marks that look into the sky.

That's what I tripped over. Look at the R in marriage. I fell down the R. I fell down deep... a long, long way, until I came to the doctor. He gave me a tablet (the patient draws an R on the table, then an arrow underneath, and finally a circle to represent the tablet) and here I almost fell apart.»

This fragmentation of the thoughts is often underscored by a peculiar disturbance affecting handwriting. Figure 9.2 shows an example of the handwriting of a man during a psychotic episode, before he was treated with medication. Notice the uneven lines, the broken sentences, the desperate



rate attempt to make himself understood to the reader.

The affected patients are aware that they can't connect their thoughts any longer, especially when too many impressions crowd in at once. »My thoughts greet one another, but I don't know which one I should shake hands with«, is how one young woman expressed it. Often at the height of an episode patients will become so absorbed with what is going on in their mind, that they are unable to turn their attention to another person, let alone apply themselves to a job. They seem completely »gone out«. But you do these people an injustice to describe them as »insane«. They are just incapable, for a certain time, of processing the impressions that bombard them from within and without, in a normal way.

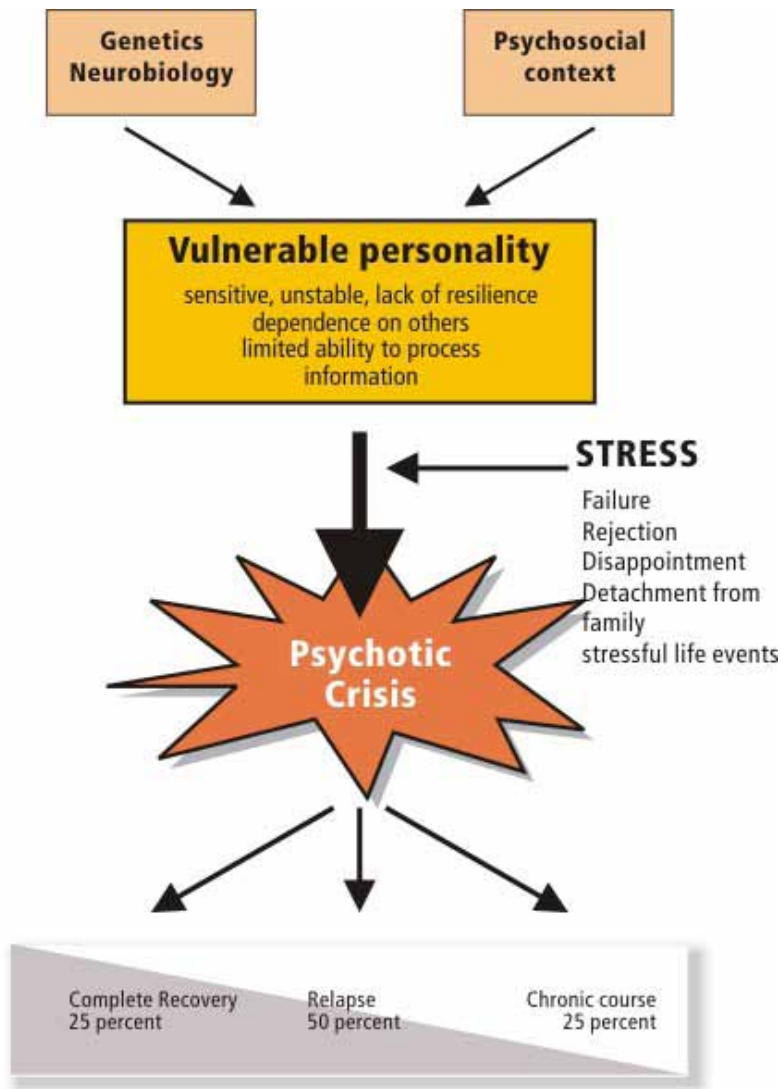
Yet, many aspects of their personality remain healthy. The healthy person is not lost, merely hidden behind the psychosis which takes the front stage. The psychosis often »jams the programme« so persistently that it can only be understood in a fragmentary way. It is precisely those who depend on the orderly processes of their mind for a career (e.g. teachers, engineers etc.), who suffer most when they can no longer make use of their ability. It is much more difficult for them to find suitable employment, than it is for a simple factory worker who remains capable of routine work after the acute phase has subsided.

How Does Schizophrenia Develop?

For decades now, researchers have been working on this question. Every year thousands of articles and books appear addressing this subject. Research is being carried out into many areas, from neurobiology to behavioural studies. The workings of our brain are so complex that so far we have only been able to propose models which may help us understand schizophrenia. Nevertheless, a number of main guidelines have been established, which can be supported by extensive research. The Swiss psychiatrist, Professor Ciompi has summarised these factors in a model (figure 9.3) which I will briefly describe as follows:

The *hereditary influence* can be regarded as established by the studies that have been made of twins and adoptive children. Schizophrenic patients obviously have an inherited weak point in the metabolism of the brain. The influence of the environment in turn chips away at this weakness. Over months and years they develop a *vulnerable personality* which is less able to cope under stress. This in turn can be recognised by the following cha-

Figure 9.3: A Model for the Understanding of Schizophrenia



adapted from Ciompi 1991

racteristics, among others:

- Impaired resilience and sensitivity
- Abnormal anxiousness
- Reduced ability to experience joy (anhedony)
- Reduced ability to express feelings
- Withdrawal into an inner world (introversion)
- Reduced self-reliance
- Difficulty in making and keeping up relationships
- Reduced performance at work or in school
- Limited capacity to process information.

When this vulnerable personality comes under pressure or stress, it ceases to be able to cope with the thoughts, feelings and responsibilities which arise, and a »nervous breakdown« occurs, a psychotic crisis such as has already been described. The triggers for this can be very diverse:

- failure (e.g. at school)
- rejection (e.g. by a person they love)
- disappointment (e.g. in attaining a career goal)
- excessive pressure (e.g. during a divorce)
- leaving the family to take up a new assignment or role (e.g. military service, the birth of a child)
- any other difficult experience (e.g. bereavement)

The relationship between vulnerability and stress can be presented in a simple diagram (see figure 4.2). Notice the distinction between *triggers* and *causes*. If a bridge collapses when a lorry passes over it, the weight of the lorry is only the final trigger for the bridge's collapse. The cause will lie in some weakness, perhaps the fact that for years the pillars of the bridge have been rusting without anyone noticing.

It is the same with the experiences which lead to the onset of schizophrenia, however stressful they may seem. The problem is not in the first instance with the experiences themselves, but with the way in which a person responds to those experiences. How many feelings of guilt, how many accusations, and how many empty clichés could be avoided by this way of viewing things! This is especially valid with regard to the religious triggers of schizophrenia, of which I shall speak later.

Schizophrenic Phenomena and their Explanations

How can we explain a person hearing voices which make negative comments or give her orders? How can we explain the situation of a young woman who refuses to eat because she is afraid of being poisoned? How is it possible for a man to become violent, just because his father asked how he is getting on? What causes a grown man to stop washing himself, never change his clothes and sleep every day until noon?

We have seen that medicine assumes that schizophrenia is basically a disturbance in the neurobiology of the brain. In chapter 3, I proposed a model of the brain as a computer. In so doing I was careful to make sure that this way of looking at it does not exclude pastoral concerns, but rather extended them, and particularly where schizophrenia is concerned, leads to a better understanding of the illness.

Let us briefly recall what is involved in the *information processing in the human brain*. First of all comes perception. We continually receive impressions through our sense organs (ears, eyes, etc.). In the brain's control centre this information is interpreted, sorted, and stored. We call this process *thought*. In connection with this we distinguish between the *content* of thought, and thinking as a *process*. The sentences you are reading here are part of the »content« of this book. However, what you do with them, how you take up the information and hold it in your memory, would come under the heading of the thinking process.

Now let us turn to our schizophrenic patients whose control centres so to speak have been disturbed. Their thought process is no longer capable of correctly interpreting, valuing, sorting and storing the information which keeps pouring in. Perceptions are distorted and linked with inappropriate feelings retrieved from the memory. Hallucinations are the result. The contents of the memory are called back to the conscious mind (on to the projector screen) without the voluntary command of the control centre, and then combined with other things. For example the sick person may suddenly hear his own thoughts, but in the tones of his sister's voice.

Experiences and ideas, fears and desires, are called out of the memory store without obvious reason and thrown together as if in a gigantic jigsaw puzzle. For near relatives the individual ideas and words still, more or less, make sense. They know the experiences of their sick relative and can still draw together threads from the bizarre comments but the outsider is a stranger in this world. During a schizophrenic episode, the divisions

between real experiences and the inner world becomes permeable. Fantasy and reality are melted together into a chaotic system of delusion. The afflicted person tries in vain to drag his surroundings out of the deceptive world of his madness and into reality, but again and again waves of psychosis break over him.

It is no wonder that this also leads to reactions in the patient which can be difficult to understand. He is no longer in a position to apply his faculties and his behaviour to a concrete situation. Once I waved to a patient in a friendly way. But he ducked as if I had thrown a stone at him. He had noticed my movement, but interpreted it wrongly, and linked it with feelings of fear and threat. For him, his reaction was logical, but from my point of view it was bizarre.

So now we understand better how schizophrenic symptoms come into being. But in Christian circles there are further questions to ask: What is the explanation of religious mania? How should schizophrenic symptoms be categorised from a spiritual perspective? I will deal with these questions in the next chapter.

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A wealth of information can be found in the internet (www.google.com).



Schizophrenia and Christian Faith

Doctor, I'm in terrible trouble,« an elderly lady complained to me. »Tonight I should have gone to heaven, but my room mate stopped me. God allowed her to torment me, and now I can't forgive her any more. Do you know, two years ago, I committed a terrible sin. The doctor wanted to take my blood, but I wouldn't let him. I didn't realise at the time that I should have made a great sacrifice. It's because I didn't give my blood that God hasn't taken me to be with him yet.«

What sense would you make of a story like that? How would you advise the woman? Would you teach her about the once for all true sacrifice that opens the way to God? Would you encourage her to forgive? Or try to help her see that she was imagining it all?

These are the kind of questions which will face a pastoral counsellor who is dealing with schizophrenic people during a delusional phase. It is not uncommon to meet sick people who use a Christian vocabulary and thus have what in the broadest sense of the word could be termed as »religious mania«. This observation throws up a host of questions for christians as well as non-believers.

Often, false conclusions are drawn from the use of religious terms. Even among physicians and other members of the caring professions one can hear the widespread opinion that a person's psychosis has been caused by religious involvement. At very least, the impression is given that »religious mania« is a negative outcome of religion's impact on society.

These assertions are based on prejudice, rather than on careful scienti-

fic research. I will look into a few studies on the theme of religious mania in a later section, but first of all I will explain how religious delusions develop, and how they can be understood.

Explaining Religious Delusions

Basically, three forms of religious delusion can be distinguished:

- a) Religious images used to explain schizophrenic experiences
- b) Delusive distortions of genuine religious faith
- c) Mistaken interpretation of religious terms and unusual beliefs on the part of the therapist.

The first two are to be regarded as characteristic ways in which schizophrenic people make sense of their experience. The third form of religious delusion derives from the prejudice and lack of understanding of a therapist who is faced with expressions of religious faith with which he is not familiar.

a) Religious images used to explain schizophrenic experience.

To those affected by them, the experiences involved in a schizophrenic mental disorder seem very eerie, »supernatural«, strange and menacing. They are plagued by ideas and fears which they cannot explain in terms of their previous frames of reference. They feel as if they have abilities and a calling which is more than normal, yet they also notice the destructive influence of the illness on their work, their relationships and eventually, their own personality.

How can a person like this make sense of the experiences which break over him during a psychosis? Often earthbound images are no longer sufficient for this task. However, in religious teaching he has heard about angels and demons, prophetic messages and signs and wonders. In this way even people who are not normally influenced by Christian faith develop the most fantastic religious delusions. When the schizophrenic episode subsides, their faith also returns to its previous level.

b) Delusive distortions of genuine religious faith.

The patient has a healthy faith before his or her illness. Nevertheless like other aspects of life, this comes to be experienced and expressed in a distorted way. I am reminded of a young woman, a believer, who suddenly felt a need to be »on fire for the Lord«, in contrast to her earlier behaviour. She became motivated more and more by thoughts about »the lost«. She reached a point where she could hardly sleep, and she gave out piles of tracts. One day, out of the blue she injured her wrist with a knife. She explained to her shocked parents that she had shed her blood for the lost because it was Good Friday. Under treatment, the disturbance subsided in the course of a few days, and her spiritual life suffered no harm as a result. Today the young woman is married and an active member of her church.

Depressive delusions, which can take on grotesque forms, such as thoughts of having committed terrible sins, also belong to this category. In this connection, please refer to the chapter on Depression in this book.

c) Unusual expressions of faith

Unusual expressions of faith are sometimes misunderstood by professionals as an expression of the illness in schizophrenic patients, in spite of the fact that these may express the actual beliefs and practices of his church or religious group.

At this point a great deal of understanding of unusual forms of Christian thought is necessary to avoid doing the patient an injustice. If a Bible College student expresses the desire to »tell everyone about Jesus«, it doesn't necessarily mean he is suffering from a »missionary mania«, even if he is also suffering from a schizophrenic disorder. He has simply been trained to pass on the gospel to other people, just as the Bible teaches.

It becomes more difficult, when a German lady explains that she has been »delivered from a Hitler demon«. In order to be able to decide whether this is a delusion or just a strange teaching, you need to know that this was said by a certain »pastoral counsellor« who in a routine way persuaded many other mentally healthy fellow believers of German origin that in order to grow spiritually they needed deliverance from a »Hitler spirit«. (This happened in Switzerland in 1985).

Granted, teachings like this strain the understanding of the most tolerant psychiatrist, and they make it easier to understand why people who work in the field of psychiatry are often prejudiced against believers. It is

especially important here to distinguish between belief, superstition and delusion. Nevertheless, a Christian has the right to be taken just as seriously in a psychiatric hospital as an environmental campaigner, or a psychotic peace activist, whose opinions may be closer to those of the staff.

Does Christianity Make You Sick?

This question can be clearly answered in the negative in regard to schizophrenia. Over the last 30 years there has been quite some research in the field underlining that religion has primarily a stabilizing effect. Two research projects in Swiss psychiatric hospitals have specifically dealt with the interrelatedness of psychosis and religion. They both demonstrated that no connection can be established between religious upbringing and religious mania. One author comes to the conclusion: »In this way the surprising result of our study indicates that a strong religious interest in the parental home is more often linked with a weak religious element in the psychotic theme than with a strong one.«

Generally it is true to say that religious delusion is only one of several themes of insanity. One should never conclude from the *content* of the delusion that the *cause* of the schizophrenic illness is to be found within it. This would be just as absurd as holding technology responsible for the onset of a schizophrenia in which the patient felt himself influenced by lasers and computers, or blaming environmentalists for the development of a »ecological mania«.

What does influence the theme of delusions? Much evidence points to the probability that the dominant ideas and world view of a culture in turn influence the content of the delusions which occur. Krantz, a German psychiatrist, researched the contents of patients' delusions in 1886, 1916, and 1946, and could demonstrate how the discovery of new technologies (e.g. radio) or equally the rise of the Führer, coloured the delusive ideas of the mentally ill. More recent studies have established that over the decade a change has taken place in the frequency of particular themes of delusion.

Delusive ideas are often formed by the experiences and activities which for the patient are bound up with strong feelings (fear, love, failure or rejection). In our age, where life is no longer shaped so much by faith in God, we also find fewer religious delusions. In contrast, in recent years, against a background of dying forests, chemical accidents and nuclear catastrophes, a delusive environmental fear has clearly taken hold.

To sum up, it can be said that a delusion may have a religious slant to it, but no conclusion can be drawn from this about the cause of the illness. The development of a delusion can be better understood by reference to a sick person's life situation and personality structure, but never completely explained by it.

Schizophrenia in the Literature on Pastoral Care

Having offered some explanations of schizophrenic symptoms from a scientific viewpoint, I would like to briefly examine one or two theories found in Christian books. Anyone who thumbs through the available literature on the subject of pastoral care will find three main approaches:

- a) Recognition of schizophrenia as a sickness, with no particular pastoral point of view.
- b) Emphasising sin and irresponsibility.
- c) Emphasising a demonic cause («occult bondage»).

It is necessary to comment briefly on these models, in order to shed light on an area which causes many Christians insecurity, and extra difficulty with their sick relatives. From what I have said already it will be clear that schizophrenia is to be viewed as an illness which requires medical treatment. However, establishing that schizophrenia is an illness does not exclude the need for pastoral care. Concepts must therefore be developed which enable us to counsel and care for the needs of fellow christians with schizophrenia.

Schizophrenia and Sin

Jay Adams' school of pastoral counselling emphasised the role of sin and personal responsibility. Psychosis was seen as an avoidance of confrontation with biblical truths and a flight from responsible living. For instance, if a young man became psychotic after a failure at school, this was seen as a way to avoid facing the fact of his failure and the responsibility of disciplined work.

I would not wish to question Adams' basic intention to bring biblical truth back into pastoral care. Unfortunately his writings show an outdated

and one-sided reading of the nature of schizophrenia, even at the points where he still admits the possibility of an »organic« cause. Although the sinfulness of human beings is the cause of many difficulties, this concept cannot be applied in a simplistic way to the complex phenomenon of schizophrenia.

It can be very misleading to link two statements with the word *»because«*. Consider the following sentence: »Car accidents occur because cars pollute the environment.« Both statements are absolutely true, but the link made between them isn't. All cars pollute the atmosphere, but in only a tiny per centage of cases does the pollution become the cause of an accident. In addition to this, we know that there are many other contributory causes for accidents, besides pollution of the environment. Now consider the following fact: All human beings sin, but only one per cent become ill with schizophrenia. Are we then to blame the afflicted person's sin for his illness, without looking for other causes?

Schizophrenic people are capable of sin, as we all are. It may seem banal, but they can also be forgiven, as we all can. In less severe situations in particular, schizophrenic people enter an intermediary phase where they can be accountable in a normal way. In chronic cases, much of the patient's behaviour is affected by the sickness and not caused by any evil intent. So I have to ask: Is it sin, if a chronic schizophrenic continues, even after many warnings, to clomp around at night in clogs and never wash himself? In my opinion, no, although I agree that such behaviour is disturbing, perhaps so much that it would no longer be possible to keep the patient at home because those who live with him can no longer cope with his unrest.

Schizophrenia and the Demonic

A few writers of books on pastoral care suggest a causal connection between schizophrenia and demonic influence. The following quotations are all taken from the same book:

First, the author asserts »all the descriptions of psychosis which we find in the Bible show the characteristics of guilt and occult bondage.« From this basis he argues that all psychoses in our time are connected in the same ways. To the question, »Why are not more Christians aware of this?« he replies, »So the chief reason for this mistaken understanding of the psychoses would seem to lie in the fact that the sensitisation of the spirit, which is needed for the demonic powers to manifest and become active,

was clearly never, or only seldom successful.«

There are still more problems of explanation. How can a person who has never allowed themselves to become involved in occult practices still become prey to a psychotic condition? The answer: »The occult problem of a psychotic person never has its beginning in his own lifetime. I was always able to trace a line of demonic oppression back for at least two and usually three to four generations.«

This has consequences for treatment. Deliverance ministry will be necessary, but unfortunately, usually unsuccessful. The explanation: »Deliverance ministry to a psychotic Christian is tiring, and usually time consuming. If the foundation of faith needed for active progress in deliverance has not been laid in the pastoral counsellors and the church, it is better to send the sick person to the hospital for medical treatment. The time for a spiritual offensive will come later.«

So now the church is to blame for the fact that the psychotic person hasn't improved. The patient is finally shoved into the hospital where »worldly« people can look after him until he has recovered enough for the pastoral counsellor who specialises in deliverance ministry to plague him with the next spiritual offensive. I would like to leave the reader to judge whether such an approach is helpful, compassionate, or even biblical.

So does occult activity not play any role in schizophrenic people? Here the same applies as with the question of sin and schizophrenia. Schizophrenia can also be mixed up with occult involvement. But confession and deliverance ministry do not bring release of the whole problem. It is a great injustice therefore to believers who are experiencing a crisis, to brand them as »demonised« and subject them to stressful exorcism rituals. Exorcisms in this situation often lead to a worsening of the psychosis.

So far I have not been able to recognise any improvement in the external situation and spiritual life, let alone the basic illness of patients, resulting from models of pastoral care which refer to sin or occult bondage as the primary cause. Much more frequently the relatives' and patients' trust in the pastoral counsellor is destroyed to such an extent that any co-operation between the psychiatrist and the pastoral counsellor is rendered impossible.

So, how can we deal with schizophrenic people in a pastoral context? Are there alternative approaches? Can psychiatric and pastoral help be integrated? What possibilities lie open for biblical pastoral care of schizophrenic people? These are the questions we shall address in the next chapter.

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Schizophrenia – Therapy and Pastoral Care

The treatment of schizophrenia has changed dramatically in the last fifty years. When I look through the case notes of my patients I am always moved by the terrible impasse in which schizophrenic patients found themselves prior to 1950. There was hardly any means to ease their restless anxiety and delusive ideas. Doctors and medical staff grasped at doubtful straws in the attempt to make life more bearable for these patients who frequently would become so absorbed in their psychotic inner world, that conversation from outside no longer reached them. The thought of a return to their family was out of the question.

Even mild schizophrenic episodes which nowadays subside in a matter of weeks used to last months or years without medication. Hannah Green gives a striking picture of this period in her book »I never promised you a rose garden«. Today the time when patients were calmed down by being wrapped in wet sheets or sat in covered hip baths is long since past.

In our time most patients with schizophrenia live outside the hospital. Their care is the responsibility not only of psychiatrists and caring professionals, but of pastoral counsellors and the relatives who live with them. In the following pages I will show some possible approaches to the care of schizophrenic patients, which take account of medical and social as well as pastoral aspects. The best possible care can only be achieved when all work together for the best of our patients.

Three Pillars in the Treatment of Schizophrenia

The multitude of different approaches to the treatment of schizophrenia can be divided into three main groups:

1. Medication (with neuroleptic drugs)
2. An ordered daily routine
3. An emotional climate conducive to improvement.

1. Medication

Since disturbances in the neurobiology of the brain play an important role in schizophrenia, medication has a fundamental influence on the condition. Neuroleptic drugs are the medication of choice (such as Halidol, Risperidone or Zyprexa, to name a few). They generally lead to a calming and ordering of the thought processes. Continued medication under the supervision of a doctor is the most important pillar in the prevention of a relapse.

Unfortunately, not all problems can be solved even by the regular intake of medication. To be honest, severe and insidious forms of schizophrenia are only affected to an unsatisfactory extent. Nevertheless, if the schizophrenic patient is only rendered a little calmer, it can make it easier for relatives to take care of him at home, instead of having to have him treated at the hospital.

Neuroleptic drugs, like all drugs have side effects. Muscle cramps, drowsiness, and restlessness in the legs are the most common in the »first generation neuroleptics« (e.g. Halidol). However, these can be controlled by additional medication in the majority of cases. The newer drugs often cause major weight problems (e.g. Zyprexa). As a general rule of thumb, the drugs are given in the correct dosage if the acute symptoms are under control and normal sleep patterns are maintained.

2. Daily Structure

Patients with schizophrenia frequently find it difficult to order their day. For this reason, modern psychiatric practice will be to encourage a program of occupational therapy during the week, whether in the hospital or outside in a sheltered workshop. They need protection from stress on the one hand, but training for their remaining abilities as well as contact with other people on the other. A regular daily routine is important for the following reasons:

- a) A clear timetabled programme helps the patient to be orientated and breaks up the monotony of a long day.
- b) It communicates to the patient the sense that he is needed and can do something useful.
- c) It provides a break for relatives and spreads the burden of care so that it rests on more shoulders.

3. Emotional Climate

People who suffer from schizophrenia are generally less able to cope with pressure than others. The reaction of their environment, especially that of their relatives, can contribute to the prevention of a relapse. It is necessary to accept the patient with his limitations, without taking all responsibility away from him.

That is not always easy. A few years ago now, researchers thought they had established that the reaction of relatives was an important factor in coping with the illness. »E.E. research« (expressed emotions) confirmed that the relatives of patients who made a good recovery accepted them better, criticised them less and gave them more independence. The conclusion was drawn from this observation that patients recovered well because their relatives behaved in this way. However, it is becoming increasingly clear today that the opposite was the case. The relatives found it easier to behave in this way because the patient was improving so well. Nevertheless the relatives and carers need continual encouragement to show the sick person love in the right way, and to set appropriate boundaries.

A Word about the Psychotherapy of Schizophrenia

In support of the three pillars mentioned above, supportive conversations and sympathetic advice can be very valuable for the patient. Particularly in times of crisis, they are grateful for the support of a professional person who can help them overcome the problems they face.

However, psychotherapy in the strict sense has not proved valuable with schizophrenic patients. For most schizophrenic individuals psychotherapy is an excessive burden, indeed it can cause a great deal of damage. Attempts to release feelings, and to work through hidden motives are particularly dangerous. I have observed several relapses and even suicides which have been triggered by psychodynamic group therapies, transactional analysis, primal scream therapy and similar approaches.

At this point it needs to be said that intensive approaches to pastoral care can have the same results. Treatment of schizophrenia belongs properly in the hands of the psychiatrist, supported by sympathetic carers, pastoral counsellors included, who know their limitations. What contribution can be made to the therapy of schizophrenia patients by biblically orientated pastoral care?

Pastoral Care for the Schizophrenic Person

Counselling depends on the ability of a person to take part in a conversation, on his ability to understand, properly interpret and apply the things that are said. However, when it comes to people suffering from schizophrenia – particularly during an active phase – the severe illness-related disturbance to their thought processes means that there are severe limits to what can be achieved through counselling sessions.

The conversational ability of schizophrenic people can be differentiated in accordance with the various phases through which the illness passes. A patient is least capable of receiving benefit from counselling during an acute psychotic episode. In the times between episodes normal conversation is often possible. The same applies to the spiritual life. This is severely disrupted by the disturbed thought processes but can nevertheless become completely normal again, and when it returns, it can be an important support for the patient.

In view of this I would like to deal with the possibilities and limitations in the pastoral care of schizophrenic people in two sections, namely

- a) in the acute phase and
- b) during the residual phase (including the residual intermediate phase).

How to Respond to Acute Symptoms

1. Keep calm and try to keep bringing the person back all the time to the level of reality, in other words, talk to them about the real situation, even when they find it hard to receive what you are saying. The circumstances under which admission to a hospital becomes necessary, can be very dramatic. As a result the pastoral helper can easily get left out of the picture at this point.
2. Be logical and do everything to motivate the sick person to receive me-

dical treatment. These sick people basically need to be cared for by a medical specialist. Only rarely can someone with an acute episode of schizophrenia be successfully treated as an outpatient. As a rule these people have no insight into their illness. For this reason in certain circumstances it is necessary for this decision to be taken out of the hands of the sick person. If you have to do this you should not show any sign of personal uncertainty. Since these patients have been disorientated, as counsellors we have to give them clear direction.

3. Behave in a natural and unobtrusive way. Don't put on a kind of protective patronising manner, but behave in a friendly way to the sick person, talking as naturally as possible with them.
4. Visit the sick person during their stay in hospital so that they doesn't lose contact with the normal world. It is important, in this connection, that during his hospital stay the sick person is prepared for the time after discharge. It will be important both during the stay in hospital, and even more so afterwards, to talk in an encouraging way about God's love and the love of the people at church, and to stress God's ability to carry him through.

One word of caution is needed, however: Visits should be arranged, to begin with, in careful consultation with the medical staff. For a sick person whose psychological condition is weakened, visits can be very stressful and lead to a further worsening of his condition.

Pastoral Care on the Return From Hospital

Medical treatment does not render careful pastoral support unnecessary. On the contrary, the very thing a believer needs when he or she has gone through the distressing experience of a psychosis, is to understand and work through the illness in the light of their faith. What questions will they be likely to bring to the pastoral counsellor? In the consultations I have had, the questions I have encountered fall into three groups:

1. Questions of meaning and of faith
2. Questions about the illness: it's causes, prognosis, medication, etc.
3. Questions about coping with life:
 - a) Coping with reduced ability to endure stress
 - b) Practical arrangements for living
 - c) Advice and comfort for relatives

Questions of Meaning and Faith

The experience of a psychosis raises questions for the believing patient and his relatives, which they are not usually able to voice to the psychiatrist. Here are a few examples:

- Why has God let this happen?
- Where does the illness come from? Is there sin or occult bondage involved?
- We have tried everything. Why isn't prayer working?
- Why is the spiritual life so disturbed?
- (Dora, a 23-year old clerk): »I don't have any assurance of faith any more! It seems as if my neighbour has stolen it. She's always looking at me with a dark expression on her face.«
- (Richard, 32, a former teacher): »I'm often so tired that I can't make sense of the Bible any more. I just lie around all the time. Can God really still help me?«
- and finally: »Is there still hope?«

You will notice that there is no simple answer to any of these questions. We often have to struggle with the suffering of the schizophrenic patient in much the same way as with that of the cancer victim. In this phase pastoral care needs to be characterised by compassion and patience. Not in a resignative kind of waiting, but actively »helping the weak« in the knowledge and certainty of God's Word. Christians have a hope which reaches beyond such things as health, the ability to work, or riches and happiness!

There is no need to pay too much attention to religious delusions, because in most cases they will fade away of their own accord. The best thing you can do is to hold the patient to the biblical facts in simple words, full of conviction. For example, you could respond to Dora's question in this way: »Maybe sometimes you're not able to hold on to your faith the way you used to. But Jesus is faithful. He is stronger than all the powers of darkness. He holds us even when we don't have the strength to hold on to Him any more. You will get your joy back again. It just needs time for you to get better.«

Richard used to be a teacher, who has already been unfit for work for eight years (residual state). He needs continual reassurance that his value to God does not depend on his career. For him the promise is especially relevant which says »The Spirit of God comes to our aid. We are weak and do

not know how we should pray. For this reason the Spirit approaches God on our behalf with groans which cannot be expressed in words«.

The answers in these situations are similar to those in the care of people who suffer from severe physical disabilities. I have continually experienced how patients in the weakness of a residual schizophrenic state learn to trust God and draw strength from His Word. Of course, it goes without saying that pastoral counselling should not stand in isolation from practical support and advice for the patient and his relatives.

Questions About The Illness

As schizophrenia is so difficult to understand, the pastoral counsellor, no less than medical personnel, will be confronted with questions about the illness, and will need to be in a position to give well-informed answers. If you have read this book carefully, you will be able to answer the most important questions about the causes, understanding, and course of schizophrenia.

Often the sufferer will also want to hear what the pastoral counsellor thinks about the medication. »Do I still have to take tablets?« they may ask, »I don't want to become an addict!« Under no circumstances should someone seeking advice be encouraged to stop taking neuroleptic drugs. Always direct them towards their doctor and explain to them how helpful medication can be, even when it means putting up with a few side effects.

It is better to be able to live, work and attend church outside the hospital, than to slip into a psychosis without tablets or injections. Regular use of neuroleptic drugs should not be compared with an addiction. A better comparison is with the regular administration of insulin to a diabetic, who also suffers, of course, from a disturbance of the body's metabolism. As a general rule, the ability to regularly get sufficient sleep is a good sign that the time may be right for a reduction of the medication. If you notice that a schizophrenic person is suddenly sleeping less and is more strongly driven, get in touch with their doctor.

Compassion and Patience

Relatives often need to talk as well. How often they find themselves in the dilemma of asking »To what extent is the patient's behaviour caused by the illness, and to what extent is it intentional? How should we respond? And at what point does it become necessary to admit the afflicted person to

hospital again?« Even experts are not always able to answer these questions. Often it is not, in the first instance, a matter of right and wrong, but more a question of how much the carers can cope with in a particular situation.

Pastoral counsellors who care for schizophrenic people need a great deal of patience and a willingness to carry the burdens of sick people and their families, without seeing spectacular changes. Nevertheless, this does not imply that there is any reason to lose hope. Do not forget that, with correct treatment, 75 per cent of all cases improve, though it takes considerable time. Those who share these burdens should be encouraged by the promise, »so will you fulfil the law of Christ!« It isn't enough to give them admonitions from the Bible. If you really want to help people who have a chronic psychiatric illness, you will need to discover afresh the meaning of comforting and supportive pastoral care.

Rehabilitation: Support or Burden?

Often well-meaning pastoral counsellors (not to mention behaviourally orientated social workers and psychologists) tend to overstretch the patient and his family. I once asked a doctor who was a committed Christian, »What is your goal in the treatment of schizophrenic patients?« I was dismayed by his answer: »For them to be as healthy as I am!«

Why was I dismayed? Is this request unreasonable? Certainly, the wish is good, but the effect of it can be that you expect too much from the patient, and hence from yourself. In the long term, the result is always disappointment, for the patient as much as the helper.

Schizophrenic patients who already have gone through several episodes and show an obvious reduction in their general performance are less capable of handling pressure, even in their »good« times. The personality of a chronic schizophrenic patient is sometimes described as »silted up«. That is a good way to describe these emotionally flattened people who are incapable of handling pressure and have little self initiative. Such people can be activated to a pronounced degree through the kind of committed care that can be provided in residential homes and communities.

Nevertheless, it is essential to recognise the boundary between encouragement, and making excessive demands. It is certainly possible to train these patients to a certain degree and spur them on to a higher performance, but in the process they are often placed under an uncomfortable pressure to succeed, a tension which can lead to a further relapse. Without

constant supervision they do not have the power within them to apply independently what they have learned before. They are like crumbling sandstone, which cannot be returned to its former shape.

Therapists who do not recognise these boundaries remind me of children, who apply themselves to build a sandcastle with enthusiasm and effort, but almost as soon as their work is left to the wind and the waves the signs of decay begin to show. The beautiful towers and carefully excavated gateways are washed away.

This is why we need to ask »Where are the limits of what can be attained in our chronically ill patients? And which is of more value: A person who lives within their limits and is content with them, or a chronically overtaxed patient who can only maintain his level through the constant efforts of a number of carers?« If attempts at rehabilitation have shown that a patient is pushing his limitations, we have to accept these and help him to make the best of them. It can no longer be the carer's job to groom him to be a star performer in a competitive society. We are not called to build impressive sandcastles, but to lovingly create a context in which the fragile sandstructures of the chronic schizophrenic person can survive. To protect them, care for them and carry them, in the full knowledge of their weakness.

Part III

Helping The Weak



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 appendectomy.

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 precisely 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.

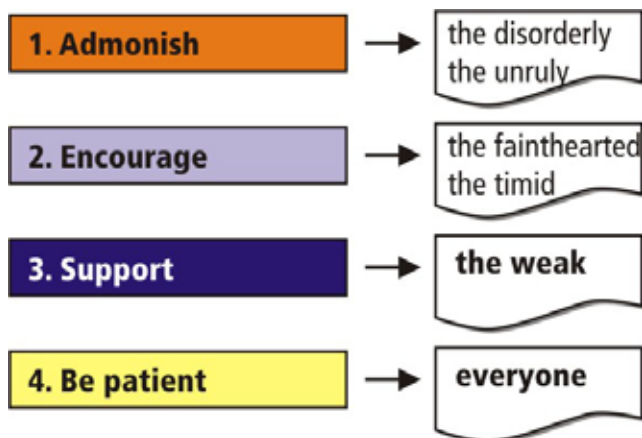
The Bible reflects a whole spectrum of helpful approaches which can assist a sick person, and a mentally ill person in particular, in coping with life. Paul admonishes the early Christians to develop a wide ranging programme of pastoral care (1 Thessalonians 5,14):

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

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

Figure 12.1: A biblical model of differential counselling strategies



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.

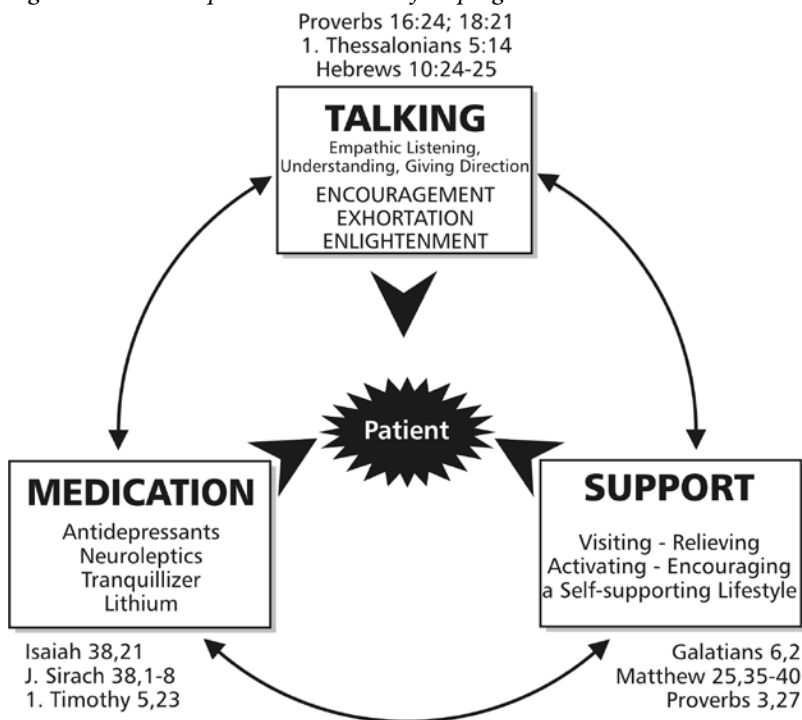
Evangelical pastoral counsellors in particular, are in danger of emphasising only the admonishing, correcting kind of pastoral care. But when you are dealing with individuals who are suffering from a mental illness, it is more appropriate to draw attention to the *comforting* words of the Holy Scripture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

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

Figure 12.2: A comprehensive model of helping



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 individuals 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 per-

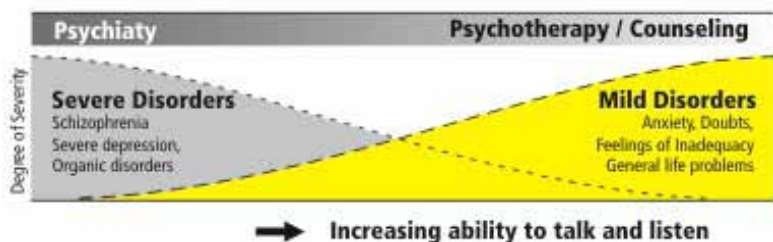
son to grow inwardly and cope better with life?»

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.

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

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



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 difficulties 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 from mental illness. They refer to the gospels where Jesus drove demons out of individuals with odd behaviour resembling schizophrenia or epilepsy.

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 deteriorated. 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 which are 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 episode.

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 sub-

stances 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 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 demonic influence

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

13 Living with Limitations and Weakness

In our time, everybody is looking for quick and easy solutions. Immediate and complete healing – such is the goal of society in the 21st century. Modern medicine evidently seems to make this possible. Fast acting drugs, daring operations and electronic aids have pushed death and suffering to the back stage of physical illness. On top of this, when medicine fails, practitioners of alternative medicine and spiritual healers offer their help with the promise of a miraculous cure.

Even Christians are affected by the power crazed attitude of our time. Healing is the only valid sign of genuine faith and only signs and wonders reflect the work of God. It is the spectacular successes which hit the headlines, not the patiently born suffering in homes for the chronically sick and the long term wards of psychiatric hospitals. The triumphs of somatic medicine and the proud promises of healers of all sorts often cause us to overlook the fact that suffering which takes a tedious course without dramatic improvement still remains with us.

Five Stages of Grief

Fortunately many psychiatric disorders consist in one temporary episode during a lifetime, which improves in the course of time and lingers only as a distant dark memory. But in many cases the mental changes which are involved set the starting points for the sick person and their relatives switching to another life, shaped by the disability, which is difficult to bear.

It is as if you have to endure a parting from the person you used to know. It takes time to come to accept a life with limitations. Hardly anyone has the ability to make the adjustment without emotional pain and in a mature way from one day to the next. Often five phases can be discerned in the reaction of patients and their relatives:

1. *Negation and concealment*
2. *Search for causes, blaming others or self-condemnation*
3. *Desperate search for help and healing*
4. *Insecurity and resignation*
5. *Acceptance and re-establishment of relationships.*

The person who understands this grieving process will find it easier to work with the sick person and his relatives without reproaching them for their reactions which can be difficult to understand at the best of times. For this reason we will briefly examine each of the steps.

1. *Negation and Concealment:* To begin with it is difficult for most people to accept a mental illness in themselves or their loved ones. They cannot and will not believe it. Often, they desperately try to hide it from friends and neighbours. Along with this goes a characteristic shame which allows the existence of a mentally ill relative to become a secret which they expose only with reluctance. But this makes the inward tension even worse.
2. *Search for Causes, Blaming or Self Condemnation:* The speechlessness of the initial shock is released by digging over the causes of the illness. While one person will project the blame outwards (from the »mother who didn't love him« to »demonic oppression«) others will lay the blame on themselves. How many parents agonise over questions like »where did we go wrong in bringing up our child?« Reproaches are also directed towards the hospital and those who are caring for the patient, especially when the desired improvement doesn't come as quickly as expected. This difficult behaviour is easier to put up with, when it is seen as an expression of the insecurities of relatives who themselves are at the end of their tether.
3. *Desperate Search for Help and Healing:* For many individual it is simply unbearable to watch helplessly while their loved one's personality changes. They are on the receiving end of thousands of words of ad-

vice as to how they can help the sick person. These come from friends, neighbours, and fellow Christians, and can give rise to an unhelpful tug of war between helpers which can harm the sick person rather than helping him.

4. *Insecurity and Resignation:* With the passage of time, in the face of the futility of all the efforts, helplessness and hopelessness begin to take hold. Interviews with doctors and social workers, as well as pastoral counsellors and lay helpers do not always bring any relief. One mother complained »What else can I do for my son? Whatever I do, it's always wrong.«
5. *Acceptance and Re-establishment of Relationships:* It often takes months and years until the afflicted person can accept the new limitations, and until relatives can lay aside their reproaches and self-condemnation and learn to live with him.

Can Faith Give Support?

These stages of grief are to be observed among committed Christians as well. It is only natural that, like anyone else, as weak human beings, Christians will threaten to break down under the pressure of a burden suddenly placed on their shoulders. As Paul once put it so strikingly, »The burden I had to carry was more than I could bear. I had no hope any longer.« However, his testimony doesn't finish at this point. He continues »But this happened so that I wouldn't rely on myself, but only on God...« The Bible doesn't lie about the reality of suffering. On the other hand, it doesn't stop at a stoical endurance of the inevitable. Rather it points to the comfort and power in suffering which finds its ultimate meaning in God. Faith can give support. Not only does the Bible bear witness to this message, it is repeated every day by individuals who turn to God for help.

Time and again, I have been moved by interviews with the relatives of my chronically ill patients. I can still vividly remember the elderly parents of a psychiatrically disabled man who required care from them day and night on account of his fears and compulsions. They were often at the end of their tether, and yet they always seemed so confident. I asked them what gave them the ability to cope. They answered: »Our friends, the help the doctors give, and above all our daily prayer time where we can unload our cares to God. If we didn't have God, we don't know what we would do.«

Faith Healing

While one person will claim God's help to cope in the every day situation, many Christians look for more: They hope for a *miracle* from God – not simply getting through, but *complete* healing of the sick person through faith. What gives them the power to cope is hoping for God's supernatural intervention.

Doctors and lay people, psychiatrists and pastoral counsellors, have different definitions of what they would describe as a miracle. The physician tends to apply rigorous scientific standards and only to accept as a miracle a situation where a sick person is completely healed against all odds. This definition of »miracle« has also been adopted in many Christian circles. So we have to ask: »Is God only at work when someone becomes in every degree as capable of work and just as happy as they were before? This approach holds within it the danger of squeezing God into a mould which, in spite of Christian rhetoric, lies nearer to the success mentality of the world than to what the Bible says about God's purposes with weak, suffering individual.

It cannot be denied that miraculous healings do still happen today, where illnesses take a course which goes against all human expectations. But often these do not come about as dramatic changes under the spotlight of a special healing service. Even today, God meets individuals as he once met discouraged Elijah, not so much in the tempest of a great meeting as in the soft breeze of a gradual healing in the stillness.

While listening to individuals who told me about miracles in their life, I discovered a wider outlook in their understanding of miracles, which is not covered by the strict medical view. Miracles seem to have many facets. Thus I tend to see complete restoration only as the highest level of the miraculous. God's work is manifold. His miracles take place on a daily basis in a broad spectrum between the extremes of all and nothing.

The experience of a miracle is personal to an individual or maybe a group of people who have got together to pray for a sick person. For them a supernatural healing takes place when they experience God's intervention in a serious situation in response to their prayers, even if the change is not a lasting one. I recall a young woman who struggled under the most severe depressions. After months in hospital without any noticeable improvement she was taken home by her parents against medical advice. Her mental abilities had declined to a point where she could hardly carry out a simple task for more than an hour. Yet gradually her situation became brighter, indeed,

she improved to the point where she was able to start an apprenticeship and tackle a whole day's work in a sheltered workshop. Now she had recovered her radiance. Within her new limitations she had found meaning for her life. She no longer seemed to be the same person I had previously got to know in the hospital. »Doctor,« the parents said to me, »what has happened to our daughter is a miracle. The doctors gave us no hope that it could ever improve, and now she is doing so well!« I had to agree with them, even though from a strictly medical point of view, I knew that such remissions can take place, and a year later I had to treat the daughter again during the course of a further episode.

Often God does not just alter the afflicted person's physical condition but also their inward attitude to life and to the sickness. He walks patiently with the patient and his relatives and friends along the pathway of the bereavement process from the stage of rebellion against the illness to the point where they begin to re-establish their life. And that in itself is a gift, indeed, a miracle from God.

The Limitations of Manageability

But what happens when there is no noticeable improvement, when no great miracle takes place? Are there still answers to the questions which are raised by those who are weak in soul and their relatives? Do doctors and counsellors still have hope and help to offer?

The goal of complete mental health often becomes an obstacle to effective long term care. Not a few helpers, psychotherapists as well as Christians committed to pastoral care are shipwrecked on the rocks of chronic illness. When the goal is set too high, failures are programmed. These are difficult for pastoral counsellors and therapists alike to cope with. Some will feel a failure themselves. Others will lay the blame on the sick person and their environment, but that benefits no one.

In their helplessness they grasp at the most diverse theories and magical ideas about the causes of psychiatric illness. Sentences are to be heard over and over again which in many forms always include the same few words: »If only ... then!«

If only he had kept to his diet, *if only* she had been able to scream out his inner wounds, *if only* she had believed the right things ... *then* she would have been healed! All of these methods may have their significance, but the excessive application of them to individual who are weak and suffering

from psychiatric illness brings nothing but tears of disappointment.

Only when helpers and patients learn to accept the reality of human weakness and the limitations of the possible, when they learn to endure the tensions of incompleteness and of those aspects of this life which are ultimately unexplainable, only then is effective long term care a possibility. The »WHY?« of suffering is still one of the most difficult questions facing mankind. Even the Christian is not promised a problem-free life on this earth. He lives in a world where he painfully runs into boundaries from time to time. He is afflicted by »troubles«, experiences »trials« and has »burdens« to bear. Neither the best therapy nor the most biblical pastoral care can remove these limitations. Change and healing cannot be »produced«.

I would like to point out four important underlying causes for these limitations:

1. *The nature of fallen creation.* Pain, fear and suffering are part of the substance of our early life. Paul, describes vividly the anxious suffering of the created world, its mortality and its longing for redemption in a new world.⁷ biblical pastoral counselling also has to come to terms with this fact and draw it into a comprehensive approach.

2. *The nature of physical illness.* Like the other organs of the body the brain (and hence also the psyche) is subject to mortality and weakness, by which Christians are also afflicted, through no fault of their own. So it is necessary for us to accept patients with severe disorders once they have been thoroughly diagnosed and treated, and help and support them.

3. *Fallen human nature.* Even when a person is healthy from a psychiatric point of view, they will only be ready to change his lifestyle to a certain extent. They have received a free will from God as the greatest of his gifts. As a result, the best advice achieves nothing, even among patients who are capable of conversation, unless they are able and willing to put it into effect.

4. *The limitations of our knowledge.* This pertains not only to psychiatry, but also to the significance of biblical pastoral care. The dilemma of contradictory explanations for the causes and therapy of psychiatric problems affects the Christian therapist as much as any other, and demands that we show humility and keep an open heart when we encounter new theories.

Weakness: God's power in earthen vessels

I can well understand that these thoughts may awaken feelings of helplessness in the reader, perhaps feelings of discouragement and even some sort of anger. Establishing these limitations calls the philosophy of life of many Christians into question. Many readers will contradict me, with some justification, by saying: »What use is the faith, if it cannot remove suffering? If Christianity cannot bring release from depression and mental disorders, then what else can?« It is at this point, however, that *rethinking* has to start. A new approach to life, inspired by trust in God, can grow at precisely the point where an attitude limited to this life alone falls short. The Bible not only shows us the limitations of our existence, it also shows us how deeply valuable human beings are, even in their weakness.

God's power in the weakness and suffering of this world – the theme runs through the whole gospel. Even the prophets began to describe the coming Messiah in a way which didn't fit the prevailing attitude of the world based on beauty and success, on wealth and power. Christ unites in Himself both the shining glory of Heaven and the stuffy constriction of the stable in Bethlehem, the absolute power of the judge of all the earth, and the mercy of the reconciling high priest. He is the holy God, and a »Friend of sinners«. He lives in »a high and holy place«, but also with those who are contrite and lowly in spirit, to revive the spirit of the lowly and to revive the heart of the contrite.« He drives the tradesman out of the temple by force, but »a bruised reed he will not break, and a smouldering wick he will not snuff out.«

The Bible represents a picture of the human condition radically different from the contemporary standard of this world. Jesus is on the side of the weak. God often chooses not to reveal himself through what is strong, but rather to work through those who are aware of their weakness. The weak person gains value in the first place, not from achievements, but from trusting in God's grace.

In his second letter to the Corinthians, Paul uses a wonderful picture to illustrate this fact. He describes the weak person as a vessel made of clay in which God keeps his costly treasure to demonstrate »that this all surpassing power is from God, and not from us,« and he continues:

»We are hard pressed on every side, but not crushed; perplexed, but not in despair; persecuted, but not abandoned; struck down, but not destroyed... therefore we do not lose heart. Though outwardly we are wasting

away, yet inwardly we are being renewed day by day.

For our light and momentary troubles are achieving for us an eternal glory that far outweighs them all. So we fix our eyes not on what is seen, but on what is unseen. For what is seen is temporary, but what is unseen is eternal.«

Here we encounter a genuine ability to cope with life and a real hope, which reach far beyond a one sided desire for external healing. Christians who take God's Word seriously will not simply fold their hands in their lap in resignation. They are receiving extra strength from a new source. For them, healing is much more than mere external change. Their hope *remains* even when natural energies have been exhausted. If doctors, pastoral counsellors and fellow human beings see the person with a psychiatric illness from this perspective, then their weakness takes on a practical function, as was described in the previous chapter. They become fellow workers in undergirding the process which God Himself initiates and which renews the weak person's strength from day to day, even when he has to live with limitations.

The outward limitations often open up a new inner freedom. Where rebellion against the disability stops, a person's energies can be gathered for inner growth. Viktor Frankl, the founder of Logotherapy, once observed: »Life proves to be basically meaningful, even if it is neither creative nor rich in experience. There are values which can only be discovered as individual adjust themselves to a restriction of their life. In their personal response to this restriction of their autonomy lies the key to open up a new and unique realm of values which certainly belong to the highest of all.«

A fresh glimpse of hope

»Is there still hope?« How often doctors are bombarded with this question by patients and relatives alike! Frequently, before I answer, I myself first pose a counter question: »What does 'hope' mean for you?« Do you mean hope of a cure through psychiatry? Hope of healing through God's intervention, or just hope of some improvement in the condition?

Often patients and their relatives on the one hand, and doctors on the other, are not speaking the same language. As a result people talk too often of a »hopeless case«, simply because it does not fit the category of hope for complete restoration. But there are no hopeless cases with God. Faith cannot always provide complete mental health, but it can provide strength and comfort in the midst of weakness, fear, and feelings of rejection.

The Bible points to a hope that reaches beyond the helplessness of our earthly existence to give a person the courage to bear the simply unbearable. At the very point where doctor and pastoral counsellor, medical staff and lay helpers alike run against the barrier of external things that cannot be changed ... at that point, in God's eyes fresh doors open.

I am often asked: What hope can you offer your patients as a psychiatrist and as a Christian? I would like to group my answer into two main areas, namely the medical human perspective (1 to 5) and the biblical point of view (6 to 10).

1. *I have hope* for individuals with psychiatric problems and illnesses, because experience shows that most disorders improve after a certain time.

2. *I have hope*, because today, in comparison with earlier times, the suffering involved in psychiatric illness can be moderated or even healed through the help of medication in many more situations than was previously the case.

3. *I have hope*, because psychiatric problems often provide the opportunity for a new beginning. A crisis in a person's life may be needed, in order to recognise the fragile basis of one's existence and to build one's life on new, firm foundations.

4. *I have hope*, because I have experienced in many cases that individuals can live a fulfilled life, even with a psychiatric weakness. This applies even with individuals who have pronounced changes of their personality. Even if they have to undergo very difficult experiences, they eventually find their way to a new life within their limitations, after the passage of time.

5. *I have hope*, because initiatives are increasingly taking place today to provide residential homes and work opportunities for individual suffering from psychiatric illness, in order to ease their lot and support them in shaping their lives. In this connection relatives' support groups also bring hope for those who are afflicted and for their families.

However, my hope goes beyond these medical and human considerations. Only the person who knows God's presence and his promises has ultimate hope.

6. *So, I have hope*, since it continually remains true that »all things work

together for the good of those who love God», even when we are prevented for much of the time from looking behind the curtains of suffering to see what is really going on. A woman with a son who was severely ill once said to me: »I keep hoping, because I know God doesn't make any mistakes.«

7. *I have hope*, because God can do miracles when he wants to. In the letter to the Ephesians it says »God can do far more exceeding abundantly above all that we can ask for or even think of, so great is His power which is at work within us.« Sometimes the miracle is already there in the fact that the individuals who are afflicted and their relatives do not succumb to bitter resignation.

8. *I have hope* because God loves and accepts individuals with psychiatric weaknesses, even if they cannot completely grasp this truth and express it in words.

9. *I have hope*, because God can even work through weakness. He pours His power into »earthly vessels« and says to the weak person: »my grace is all you need, because my power is made perfect in weakness.«

10. *Finally, I have hope*, because our existence in this world is not to be compared with the eternal life which God promises to those who put their trust in him. Paul writes: »I consider that our present sufferings are not worth comparing with the glory that will be revealed in us.«

Supporting and being supported

In these ten statements lies hope not only for the weak, but also for those who help to carry their burdens. God alone knows how much we can cope with and for how long. He not only helps in the weakness of the person needing help, but also in the weakness of the helper. He grants »the serenity to accept the things which I cannot change, the courage to change the things I can, and the wisdom to know the difference.«

It is my hope that this book will give you the courage to bear those burdens which God has allowed to remain in your life. And my desire is that you may learn to know the strength of the One who gently draws near in times of discouragement, putting Himself alongside you under the cross your life gives you to bear: namely Jesus Christ, who calls people, saying »Come to me all who are weary and burdened, and I will give you rest. Take

my yoke upon you and learn from me, for I am gentle and humble in heart, and you will find rest for you souls. For my yoke is easy and my burden is light.«

Because He puts himself under the yoke with us, we can both fulfil our practical responsibilities in everyday life, and also find rest in the knowledge that He rather than we, has the final responsibility for the success of our efforts. Being rooted in God sets the helper free to be open for others, a thought which is strikingly expressed in an old prayer:

Lord, open my eyes,
To wonder at your glory
And to see the need of my fellow human beings.

Lord, open my ear
To receive your word,
And to hear the cry of the poor.

Lord, open my lips,
That my mouth may proclaim your praise
And find kind words to say.

Lord open my heart,
So that I may have room for you
And welcome everyone I meet.

The End

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Bible verses quoted in this chapter:

2 Corinthians 1:8-9

1 Kings 19:11-13

Romans 8:18-25

Hebrews 4:14-16

Luke 7:34

Isaiah 57:15

Isaiah 42:3

2 Corinthians 4:7-9; 16-18

Romans 8:28

Ephesians 3:20

Romans 8:26

2 Corinthians 12:9

Romans 8:18

Matthew 11:28-30

Recommended Literature

The following references contain some of the material that is referred to in the text. Unfortunately, the turnover in textbooks is high. Thus a book that is on the market today will be gone in two years, no matter how good it has been. An additional source for information is the Internet. I would recommend that you look for more specific information by using a search machine such as “Google”.

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