

A  
CHRISTIAN  
GUIDE  
TO  
MENTAL  
ILLNESS

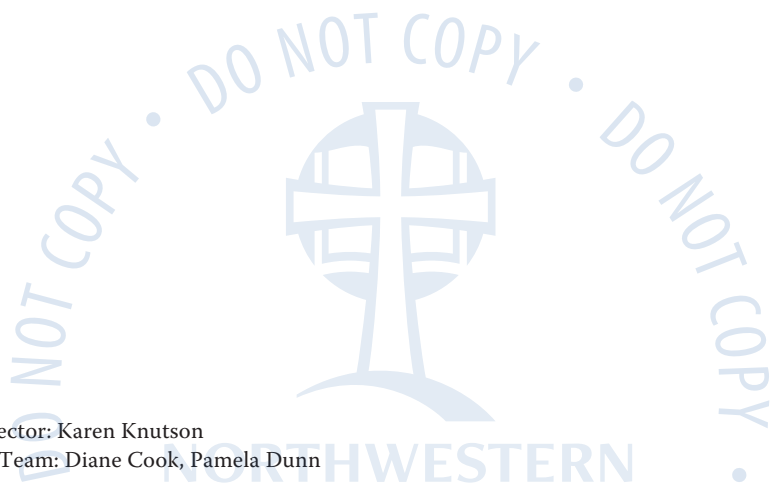
VOLUME 2

**HELPING CHRISTIANS OBTAIN  
TREATMENT FOR MENTAL ILLNESS**

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## Preface

*Let the wise listen and add to their learning,  
and let the discerning get guidance.*

(Proverbs 1:5)

(The following continues the saga of my treatment sessions with the Howards, which I spoke about in the preface of the first volume.) I was somewhat surprised to see Mr. and Mrs. Howard for a third session. She expressed such great anger with me the previous week, and I mostly expected them not to show. Mr. Howard explained that after they left the previous week, Mrs. Howard wept the entire 20-minute ride home. She went to their bedroom, and he put their children to bed. He then joined her and essentially insisted that they return to see me the following week. She never explicitly agreed, so he was pleased and somewhat surprised when she came with him to the session.

As with an individual client, my first task was to build a working alliance with this couple. I needed them to learn to trust me in several different ways. I needed them to trust that I understood what they were going through. I needed them to believe that I cared enough to do my best to help. That is, I needed them to see that I was not being judgmental or disparaging of them—even though I understood all the bad things that were happening to them, some of which were self-inflicted—but instead that I genuinely liked and respected them. Finally, by communicating understanding, I would hopefully encourage them to anticipate that I had the expertise to help.

To build the alliance, I asked a lot of questions, I actively listened to their answers in order to get them to expand and expound, and

I actively, openly empathized. I learned that they had not had success in previous efforts to help her overcome her depression, to which I opined that this must have been extremely frustrating and potentially frightening. Her general physician had prescribed a suboptimal dose of an antidepressant, to which she did not respond. At one point the physician said to her, “Sometimes it seems you are enjoying this depression.” I realized that this comment affected her in an extremely negative way—she would not have recalled it otherwise. Also, she had since wondered if others, such as her husband, also believed that about her—that she was somehow terribly flawed. I told her directly, “That was a cruel and ignorant thing to say. I don’t know if you like your physician or not, and she may generally be a very good physician. Maybe she was having an off day, but that was a cruel and ignorant thing to say. No one who is depressed enjoys being depressed. It must have made you ashamed of being depressed.”

As part of trying to build the alliance, I tried to demonstrate that I had substantial expertise regarding depression. I explained that depression has a variety of causes, none of which are self-inflicted or self-caused or somehow sought by the person suffering from depression. I asserted that depression is an extremely serious illness that needs to be taken seriously, meaning that anyone with depression should see a professional with expertise in its treatment.

Mrs. Howard’s depression and the quality of their marriage were affecting each other. I invited them to return for marital therapy because that’s what they were seeking.

Over the course of the next three months, we did just that. One of the first recommendations was that Mrs. Howard consult a psychiatrist about her medications. She reacted with some surprise at that, wondering why I could not make recommendations about medications. I explained the difference between psychiatry and psychology.

Using cognitive therapy and behavior therapy techniques, I helped Mr. and Mrs. Howard understand how thinking and behavior affect mood, and they completed various homework assignments between sessions that were intended to help both become more rational in their thinking (e.g., “I’m sometimes an imperfect mom” versus “I’m a terrible mom!”) and more healthy in their behavior (e.g., scheduling times to do fun things rather than waiting until they feel like doing something fun, which was unlikely given their marital problems). Using similar techniques, I helped both of them become more open and honest with

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each other, mostly by educating them about what it means to listen until understanding is achieved.

### **Issues in Mental Health Care**

This second volume of *A Christian Guide to Mental Illness* focuses on causes and treatments of the mental illnesses. Many of the issues covered in this volume are shown in the case of the Howards.

First, mental illness and mental health problems are sometimes relatively easy to alleviate, but frequently they are not. In the same way that some toothaches go away over time and others require a visit to the dentist, and in the same way that some illnesses get better on their own and others require consultation with a medical doctor, consulting with a mental health professional about a mental health problem is not always necessary. But if a mental health problem has endured for a while and if self-help or non-mental health professional help does not help, consulting a mental health professional is necessary. *Volume 1* describes the mental illnesses in detail, and it will hopefully help readers distinguish between cases that need specialty help and those that are likely to improve without it. The Howards problem required professional help.

Second, Mrs. Howard felt intensely ashamed of her depression. As related in the preface of *Volume 1*, she was extremely sensitive to the idea that she was the cause of all their problems, which she believed her husband assumed and which her physician had implied. In order to convince her to enter treatment, which is a challenge that many readers will face, I had to address directly her sense of shame and self-blame. As noted in the previous volume, ministers and other church workers are at the “front lines” of mental illness, as people suffering will often turn to them first when facing mental illness or other mental health problems. If you are reading this book, you have presumably accepted your duty to help and have probably already had the experience of trying to get someone to accept a referral to treatment.

Third, the case of the Howards demonstrates the association between putative causes and recommendations for treatment. The physician implicitly ascribed the cause of Mrs. Howard’s depression to a biological issue when she prescribed antidepressant medication that was intended to change the neurochemical composition of her brain. In contrast, my exploration of their issues was based on my belief that the depression and their marital problems were intricately related. Helping either would help with the other, and directing professional attention to both issues

would help most of all. To be specific, I used the psychological postulate that thinking, behavior, and feelings are related to one another and that her depression (an intense, long-lasting, negative feeling) was likely related to the way she was thinking and behaving, so I directed attention to changing the way she thinks and acts. Likewise, their thinking and behavior towards each other was problematic, causing intense distress in their relationship, so I directed efforts at changing those as well. Note also that I referred Mrs. Howard to a psychiatrist, in acknowledgement of research suggesting that depression (and most mental illnesses) has at least some biological basis.

Fourth, the mental health professions exist within what I call the *mental health service system*, which comprises many different professionals and many different treatment settings (e.g., clinics, hospitals). The system includes matters of payment, such as copayments, coinsurance, deductibles, preferred provider organizations, and many other issues. These confuse most people, and they are covered in this volume.

Fifth, if you are to refer someone to a mental health professional, as I did for Mrs. Howard, you will want to be assured that you can trust that the mental health professional is qualified to help and, perhaps as important, that the mental health professional will be respectful of your parishioner's religious beliefs.

Finally, the case of the Howards demonstrates the importance of understanding what proper mental health care looks like. It would be wonderful if I could assure you here and now that all mental health professionals are properly qualified and are capable of helping everyone. Unfortunately, that is not true of any professional, whether doctor, lawyer, accountant, plumber, or car mechanic. Based on what she said her physician stated, I asserted to Mrs. Howard that she did not receive proper care. If you refer someone to a mental health professional, you will likely have an enduring interest in helping that person decide whether the care he or she is receiving is of good quality. Of course, this can be extremely difficult to do in some instances, but for the most part, it is not that hard. There are certain things that should happen and there are other things that should not happen in the course of proper mental health care.

## **Helping You to Help**

These books are written to assist you in helping others recognize and obtain treatment for illness. The first volume addressed how to *determine*



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whether someone has a mental illness, the *defining features* of the different mental illnesses, and the *effects* of mental illness on the person and on the person's family. This volume addresses the many issues related to getting someone into treatment, including:

- Understanding the *causes* of mental illness.
- Understanding the various *treatments*, including biological treatments; psychological treatments directed at individuals; and psychological treatments directed at couples, families, and groups.
- How to talk to someone about your concern or belief that he or she may have a mental illness and how to encourage him or her to seek treatment, including addressing issues of shame and stigma.
- How to help a family cope with a member who has a serious mental illness and is refusing to enter or is reluctant to participate properly in treatment.
- Understanding the various mental health professions and understanding the mental health treatment system (including payment issues) so that you can help someone in need obtain treatment that is most appropriate.
- How to interview mental health professionals to whom you may refer people.
- Understanding what proper mental health care looks like so that you can help someone you referred for care to decide whether what is happening is helping or not.

### **Preview of Volume 2**

Part 1 covers the history of mental illness before and after the scientific revolution. It discusses ancient ideas about the causes of mental illness and ancient attempts at "treatment." It sets the stage for the truism that treatment is based on the notion of cause. For example, a psychiatrist is trained to believe that mental illness is the result of dysfunction in the biological processes of the brain, and her attempts at treatment will target such putative dysfunction (e.g., by prescribing medications intended to alter brain chemistry). In contrast, a family systems therapist is trained to believe that both intrapersonal and interpersonal problems are the result of a dysfunctional family "system," and he will attempt to improve that system in order to alleviate the problems.

Part 2 describes the mental health treatment system. It attempts to show that patient needs determine where they will be directed for treatment, what type of treatment they need, and which providers will likely provide that treatment. It describes treatment settings and the various providers. It also reviews the ethical rules, obligations, and professional standards of practice to which mental health professionals hold one another. The last chapter attempts to provide some clarification about the often-confusing ways that mental health treatment is paid for, including advice for persons who may use insurance.

Part 3 covers the treatment process. The chapters describe formal psychological evaluations; the intake process (by which mental health professionals bring patients into treatment); and the basic outline of treatment from psychiatrists, advanced practice psychiatric nurses, psychologists, social workers, and other mental health professionals.

Part 4 reviews what is now known, after centuries of scientific research, about the causes of mental illness. It covers biological causes, psychological causes, and environmental causes. It provides a general review of biological and psychological treatments, as well as a review of research into the effectiveness of the various treatments.

Part 5 includes advice for talking with parishioners who have mental health concerns and helping them obtain treatment. It includes advice on how to discuss mental health problems and illnesses and how to encourage the person to seek treatment. Since readers are encouraged to refer persons in need to a good mental health professional, this part defines what that means and offers guidance on finding one. It includes advice on handling mental health emergencies, as well as advice on distinguishing between mental illness that needs to be referred for professional care and milder issues that readers may be able to handle with brief, focused mental health first aid. Part 5 also includes suggestions for helping parishioners obtain maximum benefit from mental health care and some suggestions for providing spiritual comfort and consolation to those suffering (whether it be the individual, family members, or caregivers). The last chapter includes advice for conducting church outreach to attempt to make persons with mental illness feel more welcome at your church.

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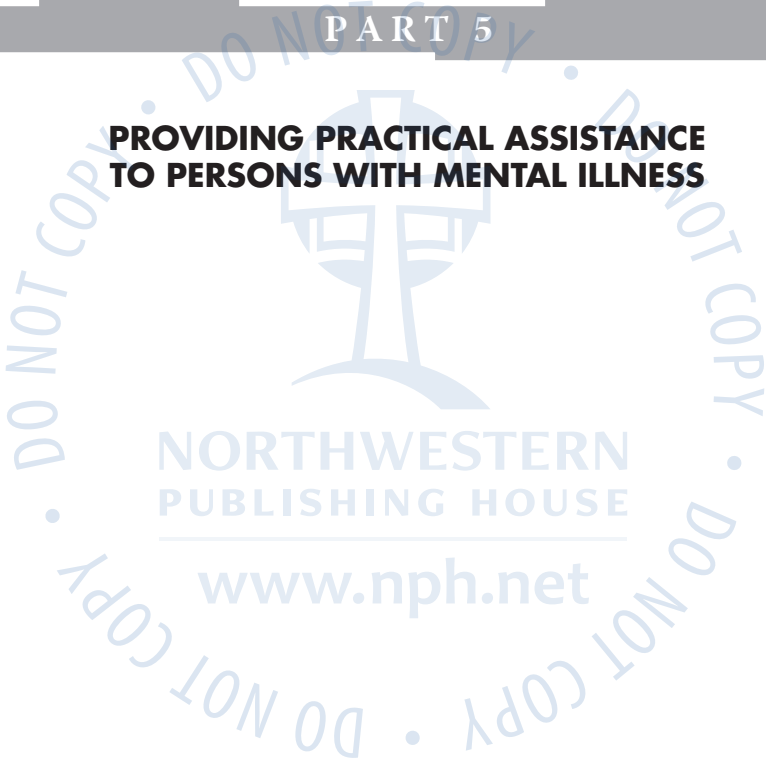
PART 5

**PROVIDING PRACTICAL ASSISTANCE  
TO PERSONS WITH MENTAL ILLNESS**



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## Preview of Part 5

The previous chapters have provided information about the mental health treatment system. The information will hopefully assist readers in encouraging persons with mental illness to seek appropriate treatment. Part 5 provides practical advice for that task.

Chapter 21 has advice for holding a helpful conversation, which is a conversation that helps a person recognize that he or she has a mental illness and helps the person recognize that care must be sought. The chapter describes the ways that a helpful conversation might start as well as the practical, interpersonal, and thematic aspects of a helpful conversation. It reviews strategies for encouraging someone to seek treatment.

Chapter 22 covers three issues that may arise during a helpful conversation. It has advice on determining whether the person actually needs referral for professional care or whether the person's needs can be met informally by you within one or two meetings by providing *mental health first aid* (encouragement and practical advice). The chapter also covers mental health crises, which require getting the person experiencing a mental health emergency into necessary care.

Chapter 23 reviews the potential burdens borne by the relatives, family members, and loved ones of a person with mental illness. It offers suggestions for understanding and helping these persons through time, empathy, encouragement, and advice. There is also advice for understanding and helping family members and caregivers cope with crises that might arise for a loved one with mental illness or confronting the difficult situation of a loved one with mental illness refusing treatment.

Given that readers will be referring persons for care, chapter 24 contains suggestions for finding professionals to whom readers would feel confident

and comfortable referring members. It defines a good mental health professional as one who will be respectful toward the Christian faith, sensible, friendly, well-trained, and competent. The chapter has strategies for interviewing mental health professionals regarding these characteristics.

After referral is made, readers should understand their obligation to stay involved in two ways, which are covered in the subsequent two chapters. Chapter 25 has suggestions for readers to help someone they referred for mental health care to be a good consumer. This means deriving benefit from good quality care, recognizing when the care is not of good quality, and insisting that the service not be allowed to cause harm through violations of privacy, which is a particular concern with formal psychological evaluations. Chapter 26 contains advice for providing persons with mental illness and their families spiritual comfort and consolation. It includes a review of the theology of glory and its depredations.

Chapter 27 contains suggestions for making it easier for persons with mental illness and their families to come forward to their church for assistance. It discusses “outreach” strategies that churches might implement to encourage members to accept that mental illness, like any other physical illness, is part of every Christian’s life—either directly or indirectly—and that the proper response is to seek professional help.

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## Chapter 21

### Having Helpful Conversations With Parishioners About Mental Illness: Practical, Interpersonal, and Thematic Considerations

*Always give yourselves fully to the work of the Lord, because you know that your labor in the Lord is not in vain.*

(1 Corinthians 15:58)

#### *Sisters From the Altar Guild*

Shirley is a long-time member of your church. She has called and asked to come talk to you as soon as possible. When you meet with her in your office that afternoon, Shirley, with obvious reluctance and uncertainty, starts to tell you about her sister, Maureen, who is also a church member and with whom she has lived for the last 50 years. Both are in their 70s and have served on the altar guild for over a decade. It seems that Maureen, who has always been uncooperative in the best of situations, has become increasingly difficult. Over the last two weeks, Maureen has been refusing to get out of bed in the morning. In that same period, however, Shirley has awakened in the middle of the night to find Maureen kneading bread dough in the kitchen, weeding the garden outside, and rearranging the cupboard in the basement.

Also worrying, Maureen is becoming withdrawn and secretive. She sometimes does not answer Shirley's questions or even acknowledge attempts at conversation. At the same time, Maureen seems to be more and more angry lately, responding with sarcasm and biting comments. Last week, she actually screamed at one of the neighbors about his dogs, whom Maureen has always loved. Shirley is becoming more and more upset. "I am at my wit's end. I don't know what to do. She leaves the stove on, but then gets angry if I say anything about it. She screams at the neighbor about his dogs, which are the friendliest things ever, and then screams at me if I try to get her to calm down. Sometimes it seems like she's going to get violent, she gets so mad."

Shirley stops talking and looks at you. What do you say?

### *Becky's Body Image*

Becky is 20 and has been attending your church for about two years, ever since she came to the area to attend college. Intelligent, mature, and very nice, she doesn't have the typical optimistic, happy (if occasionally exhausted) look of a college student. The fact is, you cannot recall ever seeing Becky exhibit a genuine, spontaneous smile. One Saturday afternoon, after a youth event at which Becky volunteered, she stays to help clean up and the two of you begin to talk.

Becky tells that she is not enjoying college and is considering dropping out. Becky went to college hoping that things would improve for her socially, but they have not. She says she had a lot of friends in grade school, but she and her mom moved to a different state before ninth grade, after the divorce. She never made many friends in high school, and she still doesn't have many friends.

Becky says that all college students drink too much and sleep around, and she doesn't want to do either, so she keeps to herself. She says, "I'm overweight and girls nowadays are supposed to look like a model." She tells you she wants friends, but she also gives you many reasons to reject the possibility of her having friends at college. It occurs to you that she has rehearsed these reasons many times, perhaps to herself or to her mom, but that they don't sound particularly sincere. You wonder if she may be rejecting the possibility of friends—and likewise condemning all college students as promiscuous drunks—out of fear of being rejected. It also occurs to you that Becky has probably told no one else what she is telling you.

What can you say that might be helpful?



### *His and Her Pain*

Dennis, Connie, and their two boys have been members since before you came there. Being similar ages as you and your spouse, over the years, as sometimes happens, you have also become friends. Two years ago, Connie had a hysterectomy, which is so common a procedure that many—including Connie and Dennis—fail to realize that it can have serious and long-lasting negative effects. In the case of Connie, she experienced excruciating pain for several months. All of this is known to you. You also know that Connie has not been to church regularly for quite a while and that the couples have not gotten together since before the surgery.

What surprises you when Dennis comes to see you one afternoon after work is the rest of the story. Dennis tells you that Connie's pain has never let up and that she has been in daily pain since the operation two years prior. Four months after the procedure, the gynecologist insisted that Connie wean herself off of the pain medications. Since the pain was unrelenting, Connie turned to alcohol. Now there is plenty of pain to go around the whole family. Connie starts drinking in the morning after the boys go to school, and she maintains a steady state of pain-numbing intoxication throughout the day. The boys will come home and find her asleep on the couch or drinking wine at the kitchen table. When he gets home from his job, Dennis makes dinner and drives the kids to their events. The boys are worried, and being responsible for the household is taking a toll on Dennis. He has tried to talk to Connie about the alcohol use, but so far it has not gone well.

Then Dennis says the words that you hoped he would not. "Would you be willing to talk to her? Perhaps don't tell her that I came to see you, but rather use the excuse that you haven't seen her in church lately. Would you be willing to do that? She may listen to you."

### **Helpful Conversations**

This lengthy chapter describes *helpful conversations*. It begins with some examples of persons who are in need of guidance to deal with a mental illness. After defining what is meant by a helpful conversation, the chapter then describes the two requisite steps for obtaining help with a mental illness, which provides an outline for a helpful conversation. That is, first the person needs to recognize the mental illness; then, the person must seek care for it. The chapter then describes the ways that a helpful conversation may start. The bulk of the chapter discusses the practical

(e.g., time, space), interpersonal (e.g., attitudes, nonverbal communication), and thematic (i.e., information that should be communicated) aspects of a helpful conversation. The last section reviews strategies for encouraging someone to seek treatment.

### **Defining the Helpful Conversation**

The three previous examples illustrate the common needs of persons in your church who may seek your help with regard to a mental health problem.

#### *Address Distress*

By definition, someone who talks to you about a problem they are experiencing within themselves or that is being exhibited by a loved one is in a great deal of distress. The fact that they talked to you about their concern makes this definite. Consider that most people do not share that they are distressed. We greet someone with the usual, “How are you?” and the usual answer is, “Fine, how are you?” But Shirley, Becky, and Dennis shared with you something bothering them: Shirley is scared, Becky is unhappy, and Dennis is worried. They are in distress and are asking for your help. You can provide it with a helpful conversation.

A helpful conversation will help the person feel cared for and understood, which will result in less shame, confusion, and fear, as well as a lessening of the sense of isolation. In this way, a helpful conversation will also reassure the person that he or she did the right thing confiding in you, and he or she will feel more confident in the potential benefit of confiding in others.

#### *Address Confusion*

But these persons are more than distressed; they are confused. Shirley said it most clearly (“I don’t know what to do”). Becky seems to be acting contrary to her expressed desire (she wants friends but not those losers that surround her at college). Becky is not unique in not understanding what is going on while struggling with an emotional problem. It may be because mental illnesses tend to endure that persons experiencing or witnessing one becomes accustomed to it. If you live with an alcoholic or abusive parent, then it becomes “normal” to have others ignore your needs or treat you badly. Becky has lived with depression so long that she does not understand that depression is abnormal. On the other hand, Dennis knows what is going on and how it started, but he does not know what to do to help.

A helpful conversation will help the person acknowledge that the distress or impairment is due to mental illness. Out of shame and embarrassment, many persons struggle to admit that they have a mental illness. For some it is impossible to do so, which may be the situation with Maureen, who seems to suffer anosognosia. Others, such as Becky, have not yet admitted that they may have a mental illness but may be able to do so once prompted by a kind listener. For yet others, it may be very embarrassing to admit a mental illness, as it will probably be difficult for Connie to admit that her physical pain has transformed into a substance use disorder. But recognizing the mental illness is not enough.

#### *Point the Person Toward Help*

Finally, a helpful conversation will help the person understand that seeking the assistance of a mental health professional is the appropriate thing to do. The ultimate goal of the helpful conversation is that the person accepts a referral for treatment with a qualified mental health professional. There are many reasons a person who acknowledges that he has a mental illness will refuse or hesitate to seek professional treatment. Some may be mortified at the idea of acknowledging a mental illness to another person (an obvious requirement of obtaining help). Others may hold disparaging attitudes toward the mental health profession based on misunderstanding, stigma, or previous bad experiences. A helpful conversation will address these misapprehensions.

In summary, after a helpful conversation, the person will feel less distressed, have a better understanding of what is happening, and have a clearer idea of what resources exist and how they can help. The helpful conversation will give the person hope that things will get better.

#### **Practical Considerations**

There are important practical considerations to attend to when striving to hold a helpful conversation with another person. This section reviews how helpful conversations may start, including when readers are obligated to initiate one (and the subsequent risk of being wrong about concerns that prompted you to do so). Other considerations entail pragmatic issues of place (privacy), time, and space.

#### *How Helpful Conversations Start*

There are two ways that a conversation may begin with someone for whom there is concern about a mental health problem. In either case, if

at all possible, the conversation should happen at a prearranged time and meeting place so that adequate attention can be paid to being helpful. These conversations may be about the person with whom you are interacting or about someone in the person's family.

Most likely the person will come directly to you. He or she may request a meeting or may simply show up at your office. Even if the former occurs, the person will probably not preview the purpose of the meeting. As with other ministerial meetings covering difficult topics, such as the recent diagnosis of a serious illness or news of an impending divorce, it is not particularly difficult to be prepared for these spontaneous meetings. To be prepared means to not be surprised that suffering exists in Christ's church, to have words of spiritual comfort and counsel, to possess a good understanding of what someone trying to cope with mental illness is likely enduring (e.g., confusion, shame, embarrassment), and to have accurate information about mental illness and its treatment. For example, you hopefully now understand the experience of coping with mental illness. You know that, even though the person requested the meeting, he or she may find it difficult to bring up the topic because of confusion about what is happening or out of fear of what others will think, say, or do. Mental illness can be extremely confounding, and there is much negative experience to justify this fear. A helpful conversation, as outlined in these chapters, will both provide illumination about the situation and directly contradict fear and embarrassment.

However, there will be times when you are obliged to approach someone about a mental health concern. It may be that you notice something or someone else talks to you about concerns for another person. These conversations are initiated by you and thereby require more attention to sensitivity and discretion.

#### *Arrange a Meeting*

Quite obviously, a helpful conversation should happen in private. Therefore, invite the person for a chat at the church or invite yourself to his or her home for a visit. When extending the invitation, preview its intent by gently sharing observations with the person, such as, "You seem really down lately" or "I'm wondering how things are going for you." Then, ask if it would be okay to meet to talk about things. If the person demurs, drop the subject with assurance that you are willing to talk at any time.

*Begin by Expressing Concern*

Whether you or the other person requested the meeting, it will be important to express loving concern on the part of yourself and others. This thematic consideration is detailed later, but since it may start the meeting, it is now briefly discussed within that context.

If you asked for the meeting, express concern at its beginning. As with the invitation to meet, if the person is unwilling to discuss the issue, he or she will likely nonetheless express appreciation of your concern. Respect his or her need for privacy, regardless of the reason, and thank the person for meeting. Assure him or her of your willingness to talk about things at any time in the future.

Probably most will be willing to talk and, indeed, may have been waiting for someone to notice, care, and ask. There are many possible situations that may be uncovered. First, the person may acknowledge the mental illness, in himself or the family member. They may or may not be in treatment, and if they are in treatment, they may or may not be being helped by it. Your task is to encourage treatment, whether by seeking it, adhering to it, or helping change it if necessary (see chapter 23). Alternatively, the person may be aware that there is a problem, but they may not recognize it as a mental health issue or be doing anything for it. The person may be suffering without knowing why, and you can perhaps help them properly identify it. In the latter instances, proceed with the helpful conversation described over the following pages and provide a referral to a competent mental health professional.

Do not start a meeting by making a referral to a mental health professional, as doing so may unintentionally suggest to the parishioner that you want to be rid of him or her as soon as possible. Instead, spend enough time to communicate empathy and concern, which will have the immediate effect of alleviating his or her distress.

*Be Willing to Be Wrong*

You are obliged to approach someone about whom you have concern, however, you must be prepared to be wrong about those concerns. There is the chance that there is no real concern and that your or others' observations are off the mark. In these instances, the person may genuinely be surprised at your concern, but they are unlikely to become upset. You can simply assure them that you were concerned and approached them in the spirit of Christian love and fellowship. Likewise, say that you are glad that everything is actually going well.

There is also the chance that you will be right but are told you are wrong. It may be that the person is unable to recognize the issue or outright denies any concern, even if it actually exists. This is most likely with regard to the substance use disorders and the mental illnesses for which anosognosia is an issue (such as bipolar disorder, schizophrenia, and the personality disorders). In these instances, the person may become upset that their efforts to hide their mental health issues have failed. If someone denies that they have a mental health issue, allow it. State that you regret causing them stress and that you are glad they are not experiencing such a problem. Again, it will be appropriate to state simply that you approached them in the spirit of Christian love. In this last instance, at worst you have opened the door for a future conversation. Do not be surprised if the person approaches you in the future and states something to the effect, “I wasn’t ready to talk about this before, but I am now.”

### Regarding Domestic Abuse

It is highly likely and very unfortunate that, at some point or two (or more), most readers will be required to address concerns related to domestic abuse. This issue raises very important considerations that are covered in extensive detail at the end of this chapter.

#### *Time*

First, it will take time to accomplish what is necessary in a helpful conversation. For this reason, it is recommended that you invite the person for a meeting at church or that you invite yourself for a visit so you can schedule adequate time. It takes time to listen empathically, to correct misapprehensions, to offer spiritual comfort, to inform, and to encourage treatment seeking. Spending adequate time for a helpful conversation is, in and of itself, a demonstration that you care and that you take what is being discussed seriously.

Second, the person with whom you are visiting may be anxious about taking your time, believing that they are inconveniencing you (an indication of low self-esteem, which is common in mental illness). In like fashion, you cannot and should not spend an open-ended amount of time with the person. Concerns about too much time can be distracting for both of you, so establish time parameters. That is, indicate when you must end the meeting. This will help alleviate the opposite concern on the part of the person, which is that you are ending the meeting because

you are appalled at what they are saying, you think them foolish, or you don't care. For these reasons, it is recommended that you set aside at least 30 minutes but no more than 50 minutes for such a conversation.

In addition, for similar reasons, to impress upon the person how seriously you take the conversations, do not allow there to be any interruptions during your meeting, such as phone calls or other business. Schedule the meeting or visit during a time when you can devote your entire attention to the person. (Even better, to be honest, is for you to ignore phone calls or knocks on the door, which will impress the person even more that you are attentive and caring.)

#### *Privacy (and Confidentiality)*

Of course, any sensitive conversation should be conducted in private, out of earshot of anyone else. If you have a private office and the meeting is there, this will be accomplished easily by closing the door (but be careful about the appearance of impropriety—see box).

Privacy is a right of the individual being helped and refers to the desire of the individual not to have information about them disclosed to others. Confidentiality refers to the duty of the person to whom private information is necessarily disclosed (e.g., health professional) not to share that information with others. At times, someone's desire for privacy is nullified by obligations to disclose information to protect the life and well-being of the patient or of others. For example, medical doctors are obligated to inform the Center for Disease Control and Prevention (CDC) after they diagnose a patient with certain infectious diseases. Mental health professionals are not obligated to disclose information about mental illness, but they are obligated to report certain behaviors. To be specific, most states mandate mental health professionals to make a report to state protective services when they uncover instances of the abuse or neglect of children or of vulnerable adults. Most mental health professionals will break confidentiality to prevent a patient from hurting himself or others, meaning they may have the patient involuntarily hospitalized. In some instances, a mental health professional concerned about dangerousness to another may make a report to the police.

#### *Space*

Pay attention to space when meeting someone about concerns for mental illness. Intentionally or not, the orientation of chairs and desks can send messages to the person. Mental health professionals always

consider the space before a meeting (it can be awkward to delay starting a meeting so you can move furniture around or pick up off books the floor), and they follow some basic suggestions in this regard. The detail of these suggestions may strike some as amusing, but they are important for setting an ambience of comfort and reassurance.

### **The Appearance of Propriety**

Mental health practice, like all health care, happens in the privacy of an office. Mental health professionals are usually unconcerned that it may look untoward to others to meet with another person, including someone of the opposite gender, in a private office. On the other hand, many mental health professionals, including the author, are reluctant to meet with a patient of either gender unless there is someone else in a nearby office or at the reception desk. Moreover, most will inform the patient that there is someone else present. Simply put, it is too easy to be accused of improper behavior or, more likely, to have a patient become uncomfortable about the situation or even to mistakenly interpret the clinician's behavior as improper if it is only the two of them.

Readers should probably adopt an equally cautious attitude when seeking a private meeting with someone about whom you have concern for mental illness. It is advisable that you inform someone with whom you are meeting that you are concerned for privacy and that no one can hear your conversation. But also demonstrate that there is one or more other persons in the vicinity who are aware of the meeting. It is likewise advisable that you ask that external person not to leave the vicinity during your meeting. (This is especially important if you are meeting with someone you think may be a victim of domestic abuse.)

For persons about whom you have concern for mental illness, having a desk between you and her may communicate that you are fearful or repulsed, such that you want a barrier to protect you from her. A small table between chairs is fine.

Also, face-to-face interactions, where the two persons are directly looking at each other, can be uncomfortable. It is a common posture when someone is attempting to demonstrate authority over another. Thus, drill sergeants go toe-to-toe with recruits to establish dominance, and parents insist children look them directly in the eye to try to get at the truth. Therefore, arrange the chairs so that they are at a slight angle to each other to demonstrate that you are with the person, not "above" the person. Sitting across from a person at a slight angle makes it easier for either of you to, naturally and briefly, avert your gaze, which may be helpful when painful topics are discussed.



Finally, be sure to place the person's chair so that he or she has easy access to the door. It is highly unlikely anyone will run away in fear, but this spatial detail will nonetheless subconsciously make the other person more comfortable. It communicates that the person is free to leave, meaning they are there of their own volition.

### **Interpersonal Considerations**

Someone with a mental illness may be reluctant to talk out of fear that you will think as badly of her as she thinks of herself, will reject her, or will tell others what she says and how weird you think she is. This reluctance can make having a helpful conversation difficult. Accordingly, primary tasks during a helpful conversation are to convince the person that you are interested, that you care and are trying to help, and that you can be trusted. This section reviews both the necessary attitude and the nonverbal and verbal behaviors that facilitate helpful conversations.

#### *The Proper Attitude: Be Steadfast in the Work of the Lord*

A helpful conversation with someone who is concerned about mental illness, either personally or in a loved one, can appear a daunting task. The following are suggestions for attitudes that should be adopted and, even more, gentle reminders of who you are and what you can do to help.

First, workers for the Lord, as opposed to those who have human masters, do not shrink from or shirk their obligations to brothers and sisters who are suffering. Apply the pastoral attitude already possessed—you care enough to help—which sometimes means talking about something that makes you uncomfortable.

Second, remember that the church offers a comfort to those who struggle with mental illness that cannot be obtained elsewhere. Church members may be ashamed and embarrassed about their sinful human nature, but they should know their sin so that they may believe and rejoice in Christ's redeeming sacrifice. In the same way, the church corrects those who fear that mental illness means that God has stopped loving them. Certainly, mental illness, like any other human suffering, is due to humanity's fallen nature—as all have sinned and fall short—but mental illness is not set apart as an indication of a special type of sin. In the same way as with physical illness, mental illness is to be acknowledged so that it can be addressed by those called to be mental health professionals.

Finally, adopt the proper attitude regarding what you can and cannot do for the person with mental illness. You will offer them spiritual com-