Session 2: Ministry and Mental Health

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Preacher: Andy Farmer

[0:00] Now we're going to go into the mental health world. Yesterday we went to the Valley of Vision.

! It's a book of Puritan prayers. This is one of the prayers in Valley of Vision.! Interestingly, he uses the word mentally ill, the concept mentally ill, and this is probably 1630 or 40 when this is written.

So this idea of mental illness is not new. What it means, how it's understood, has changed dramatically. But it's not new.

If you're ministering to people in this culture, in some way you're going to engage what I would call the mental health world. Whether you're ministering to people who are taking psychiatric medications, sorting through mental health diagnoses, struggling with issues that raise question about whether they might need inpatient care, it can be a confusing world.

So what we're trying to do is we're trying to look at the experience of people in the mental health world and how we relate to it and how we can minister within it.

[1:38] When we looked at the previous world, the worldview areas, what really was required, I think, was theological discernment. You need to be in theological discernment, biblically informed, gospel-oriented theological discernment into understanding those worldviews.

When you're in this world, you'd be more of the category of biblical wisdom. How do we understand how to relate to this? Because this is a stream-level reality for a lot of people.

You may have had your own experiences or people in your family. I've had members of my family committed to institutional care. I've had issues in my family with other kind of mental health disorders.

So it's not hard to see. The big picture, how do we come into contact with this world? Just some ways.

You might have parents who are told they have a child with learning or behavioral disorder like Asperger's or ADD or ADHD. People struggling with depression and anxiety attacks.

[2:50] You have teens who are self-destructive behaviors or relationships or unable to control emotional responses. Suicidal people. People who are susceptible to delusions.

Addictions requiring inpatient treatment. A legal situation requiring a psychiatric evaluation or assessment. A mental breakdown non-necessicating interventions or hospitalizations.

Self-destructive bipolar behavior. Postpartum depression. Profound grief and loss. PTSD. Early onset Alzheimer's. You'll find this all around you.

This idea that we live in a world where understanding what is the mental health issue related. And I would see that, well I think, you can tell I'm not a huge fan of Western materialistic culture.

I am very grateful in this affluent culture that we have a mental health system. I'm very grateful that people don't just simply suffer without help.

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[3:54] Because it is profound suffering. So things considered in the area of mental health, we need to be able to interact with the world of psychology without integrating. We talked about that before. Same goes here.

psychiatric pharmacology is a common go-to option when other things don't seem to be working. But it can't change all that needs to be changed to resolve complex problems.

I like to compare the mental health, social services field with the legal or law enforcement world as a system of dealing with people in their troubles.

They're both systems that are social responses to life in a sense that you don't enter those systems if everything is going okay. At their very best, they extend common grace, but they'll never have redemptive impact apart from the intervening mercy and saving grace of God.

They are limited. They're both complex and bewildering to people who find themselves having to engage in them. If you've ever walked with somebody through a trial, a legal trial, you will find that it is a very unsatisfying experience.

[5:21] The system itself makes it unsatisfying. And it's bewildering. Why is this? What are all these terms? What does this mean? Who do I talk to? Who do I go to?

Who's in charge? It's very similar. These systems, the mental health system and the legal system, are full of gaps in quality of service.

Competence in those fields can vary tremendously. So you might end up with a wonderful attorney or a terrible attorney. You might end up with a wonderful therapist or a wonderful psychologist or a terrible psychologist.

I'll give you a quick story. I had a man who was attending our church and he wasn't really involved, but he had a work-related accident where a propane tank blew up in his face and it burned his face off.

And so he needed... So I got involved and I ended up going over there once a week for about a year.

[6:37] He just all banged up. I didn't know what he looked like because he was banged up. The fascinating thing about it is that he had had this lifelong skin condition which meant his skin was constantly flaking.

And it actually created a regenerative experience of his face returning. So that was amazing. Wow. You couldn't tell today that he had any... Wow. But he was living.

His ears were burning off and everything sort of returned. But what happened is because of this, it was such a trauma for him that he had a psychiatrist who prescribed medication to deal with the trauma.

So long after he started getting physically better and everything came off, he still was just this kind of shell. And we were talking about, well, maybe you need to talk to the psychiatrist about your medication.

And so finally he called the psychiatrist and the guy had left. He just quit. He never told his patients that he needed anything. He just quit. And so he had to scramble to find another psychiatrist.

[7:43] That psychiatrist said, this guy was medicating you into a living. Wow. He changed his medication and within two weeks he was coherent and fine. Wow. I'm not blaming the system for that.

I'm just saying in complex systems you have, you have, not everything works the way it's meant to work. Laws that govern these systems can be difficult to navigate.

There are federal, state, county, and municipal laws that make where you live crucial to what you receive. One of the biggest examples of that is whether you live in a city or outside of the city.

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The services you're able to get in Philadelphia are not nearly as good as the services you're able to get in the surrounding counties which are more affluent. And the overwhelming nature of the services, of the need in most urban areas mean that they're stretched far more than if you go to a suburban facility.

Money matters significantly in the quality of what we receive. That may mean cash or may mean just insurance. You have good insurance or not. It can matter significantly. People who have access, have to access these systems are profoundly discouraged by their experience.

[9:05] Often they're, they may be their help ultimately. you have somebody who's in a civil suit. They sue an insurance company. They sue somebody. For years it drags out.

At the end they get, they get a, they get some kind of settlement. But it's very unsatisfying for them. The system itself they felt was broken. Same can happen with the medical field.

I have so many people, a lot of the people we get, we have what we call the bridge program which is our, our, it's an outreach program where people commonly do, it's evangelism.

So many people are coming and they've, they're burnt out on the mental health system. I just don't have confidence anymore and I'm looking for something different.

And that drives them to the church. And whether somebody's been involved in the legal system as a victim, as a perpetrator, or in the mental health system, they need care, humility, and support when they engage them.

[10:11] So if you know somebody who is involved in some sense in treatment in the mental health system and we'll kind of broaden that out what that means, just recognize they don't need your critique.

It's hard. It's difficult. And it's very difficult to know how I get done. What is, how does this end? How do I get out of this?

And so, so we want to have that in mind. So, these are reflections of components of the mental health world. Causality.

One of the popular Christian critiques of psychological diagnosis is that this really isn't about a disease. We talked about, you know, everything that seems to be a disease in the mental health world.

And so, Christians will often critique because there's no biological cause. How can there be a disease if there's no biological cause? We have to be very careful when we talk about causes.

[11:15] Be careful not to make statements like if you can't find an underlying biological cause, then it can't be considered a disease. It's scientifically short-sighted. Just because there is an identifiable underlying biology or condition known now does not mean there won't be one discovered in the future.

It's also historically dubious. Medicine has always had a problem with disease, cause, cure concepts. Even today, there are a lot of medical conditions where there isn't a clear understanding of cause.

Migraine headaches, fibromyalgia, Alzheimer's, chronic fatigue syndrome. Ultimately, a full biblical understanding of personhood is not confused by the lack of clarity on whether disease categories are appropriate for psychiatric mental health type problems.

I don't think this is going to be a big issue, you guys, but in certain parts of the country, this is a huge issue because there's a tendency to make this about, well, it's clearly not medical because you can't find a cause, so therefore, it's all sin.

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We just don't go there. We don't go there. Is sin involved? Certainly, sin involved in everything we do and everything we experience, but we don't speak in terms of causality when we're dealing with this.

[12:36] What is mental illness? Let's start with terms. I was just reading about this fresh last night. Terms for mental illness are very fluid and there's a number of different terms that are overlapping conceptual meaning and actually work in different contexts.

I'll just say this. Mental health, the definition of mental health, this is Dale Johnson who's ACBC. I think this is good. It's a long quote, but I think it's good.

The definition of mental health is basically just regarding some sort of condition that an individual has that gives them some healthy state of being. The idea is we're to look at the social environment, we're to look at the context of a person and what is in the environment that provides for them a way to live healthily from a mental standpoint.

What we must be careful of there is this. What do we mean when we talk about the term healthy? That's the question. Is the culture defining that? Is the individual defining that?

What is healthy? What Josh is getting at in this is something you find a lot of times when you're trying to relate to this. These terms that are used are not, they're not scientifically specific.

[13:58] They're descriptive terms. And they're relative to other factors. So healthy is one of those terms. Certainly in a Western culture he says we see that what defines human health is does a person feel good about themselves.

So he goes on and talks about that. And so whatever the culture thinks healthy is is the way we understand mental health. So different cultures have different understanding about what healthy is and wouldn't necessarily use those terms.

The point I'm making, the point he tries to make here is the way we understand mental illness is when mental health is somehow impaired from what we generally in the culture will think it should be.

The term mental illness is the common language to most people. American Psychiatric Association says mental illness refers collectively to all diagnosable mental disorders, health conditions involving significant changes in thinking, emotion, and or behavior, distress, and or problems functioning in social work and family activities.

So that's how the APA defines mental illness. Some things from that definition. Note that mental illness is not a have or have not.

[15:27] condition. You don't have it or not have it. Mental illness is experienced in changes to a typical state of mental, emotional, cognitive, or relational function relative to that person's experience.

So if someone is being assessed, they're looking at how does this person typically function, or how do people typically function, and where is deviant from that.

That may be how something is assessed. Though it's technically diagnosed this way, it's not technically diagnosed this way, mental health is understood as a continuum.

How much someone deviates from what would be considered typical indicates whether or not they're experiencing a mental health illness. mental health illness is a health condition that expresses itself in thinking, emotion, or behavior.

The diagnosis of mental health illness is not done through physiological or biological testing. There really aren't reliable biological or physiological tests for most mental health conditions.

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[16:46] But through an assessment of a person's reported or observable behavior or mental state. We'll talk about that more below. It doesn't mean there are not physiological factors involved. It just means that diagnosis, at least at this time, is not based on testing or biology.

This is a big issue with National Institute of Mental Health. We've struggled with the fact that most mental health diagnoses are not based on any objective diagnosable criteria.

they're based on self-reporting. And so NIH is trying to address that.

So I like to talk about mental or emotional disorders than mental illness. I think that's more accurate. So you'll hear me use both, but I like the idea of mental disorder as a category for talking about this.

huge question is this. Why does it seem so many people now struggle with mental disorders to the point that some researchers believe that over the course of a lifetime everyone will experience some form of diagnosable mental disorder?

[18:05] Why is that? I think there's some reason for it. One is there's clearly better awareness more data better diagnosis prevention and treatment.

Things are getting picked up on before. This progress has led to more humane understanding of mental illness. The stigma associated with mental illness is giving way to more social acceptance so people are willing to talk about it and people are willing to be open up about it.

A lot of times in previous generations anybody who had a mental disorder was kind of shuffled away, was hidden away. Now people are getting treatment for it.

People are willing to live and talk about something that was considered taboo. This is a good thing. The fact that these things are being identified in our culture is a good thing. It means people aren't suffering in the same way they suffered in the past.

The downside however studies are also showing that as a society moves away from values like character and community and faith there are mental and emotional social causes.

[19:13] This is showing up in studies. We're embracing a toxic combination going back to what we talked about before about expressive individualism.

We're embracing a toxic combination of demand for uninhibited fulfillment and unbounded personal rights to have those demands met. You see what's happening in our culture I have this imperial sense of self that needs to be recognized but I can't impose that recognition on anyone and so I live with various kinds of anxiety.

I have to perform. I have to do things. It doesn't mean that this underlies every depression or anxiety but there's a reason why it's depression and anxiety that are the most prominently diagnosed now because we live in a culture that is going to that is driving values that when people aren't getting those whether they're a sense of belonging a sense of connection a sense of validation a sense of affirming a sense of closeness a sense of self-agency those are natural responses.

We're psychologically and emotionally vulnerable to a culture that most values that things at least satisfy. And I think you guys you live in a hyper productive world I think this is what you'll see.

You'll see people who just assume they need to achieve a certain level they assume they need to have a certain stance in whatever their field is.

[20:59] And they're living with anxiety and depression and that's not happening. You'll promise things that can't be delivered.

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If we want to get to the hard unvarnished truth it's this. We have disorder because we are human beings and are fundamentally disordered. You, I, we are all fundamentally disordered.

That's how the Bible describes it. We were created to love and glorify God to find our meaning and joy in Him. Sin is the denial of that fundamental reality in the vain search for self-worship and self-glory.

So you see what the problem is. If you want to know the foundation of mental illness, don't read Freud, read Romans chapter 1 through 3. the ugly truth is this.

To the extent that we seek to live life apart from God, we are not sane. It is in fact the most insane thing anyone can do to live this God if we don't stand before God and He's not our judge.

[22:06] No matter how well adjusted we may be in this life, that's the fallacy. Well adjusted in this life can still be damnation in the life to come. The fundamental insanity of human condition is the rejection of the God from whom all life and meaning come.

The fact that science can identify genetic propensity toward mental illness and observe it in brain scans doesn't challenge the truth of scripture. It confirms the pervasiveness of sin at the deepest core of who we are.

So whatever's happening in the world of mental health, there's a deeper reality that needs to be factored in. Even if you're able to help somebody who is disordered become functional and live more typically apart from Christ, they have no hope for this world or for the world to come.

So that's how we need to understand mental disorder. It doesn't exist, it's a fabrication. No, it exists but it exists at a much deeper level than even the mental health world wants to acknowledge.

It doesn't mean that everything you see in somebody is sin, but sin is the ultimate cause out of all our disorder.

[23:40] When someone receives, so any questions about that before I move on, on the concept of mental illness. Great.

So what happens in the psychiatric diagnosis? When someone receives a legitimate psychiatric diagnosis, it means that someone qualified to do mental health diagnosis has observed a person's behavior or descriptions of behavior, and based on the predetermined criteria of the Diagnostic and Tistical Manual, DSM-5, believe the person fits a sufficient number of the symptoms for a particular disorder to warrant a diagnosis.

So it's a criteria that trained people are looking at. Does this description or observation of behavior or thinking or emotional response warrant a formal diagnosis?

A psychiatric diagnosis is a description of behavior and experience, not an explanation. It tells you what.

It doesn't tell you why. The DSM-5 itself says, a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or the individual's degree of control over behaviors that may be associated with this disorder.

[25:05] two things that are not addressed in diagnosis that often create challenges for the person or those involved are motivation and morality.

Let's take, for example, someone who is bipolar and they're in a manic state. And in that manic state, they do things, they steal. people, I've had people in manner states do all kinds of crazy things that put other people in peril.

And the diagnosis doesn't address the fact that you did these things and other people are now in peril. It just addresses what you did.

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It can't address the morality of them. One of the great problems with addictions these days is the drive to make it entirely a disease model does not fit what the average addict understands about what they're dealing with.

And they're uncomfortable calling it disease. You'll have to hear some people do it, but they're almost defiant because they know the amount of deception and lying and selfishness that goes into pursuing an addiction.

[26:33] And they don't, their own souls are struggling with the idea that you're just calling this a disease. So, the benefit of the DSM, currently the DSM 5, fifth version, is that it standardizes descriptions of mental health problems so they can be studied and treated with some level of consistency, apart from this, it really is just the wild, wild west in terms of what you're dealing with.

And that's a good thing for our complex culture. So, I want to say, first of all, I'm grateful for the DSM 5. I think, I think, apart from the Lord knows what we're going to have.

It's a responsible act on the part of the mental health community to create some sort of standards to draw from some basis of research to have some sort of commonality and understanding particularly complex issues.

The problem is what gets in and what gets in and what gets out is always to vote it on. And it depends on culture, sometimes it takes votes, what's considered a disorder, what's not.

So it's not scientifically derived. So from within the psychological community, I'm not interested in critiquing from the outside. From within the psychological community, here are some critiques.

[27:55] Psychiatric diagnosis is popularly understood to have the same basis as medical research, but it isn't fundamentally based on medical research. I could go into, when you talk about brain scans, when you talk about those kind of things, where is that going?

Well, here's an interesting fact. Big, large meta study. The understanding, the data from studies on mental health issues, where do you think that comes from?

Where does that data come from? Who is being studied? Well, it used to be who's being studied was prisoners.

because they could be forced to do the studies. There's civil rights being violated. They changed that. Nobody can be forced to be in a study.

Who's being studied now? Those who think that there's... Everybody around here. College students. 70% of all the data that creates the categories of mental health and psychological categories is derived from studying college students in American universities.

[29:33] Why? Because you get graded for it. Because you get paid for it. So, when you think about what is typical, what is understood as typical, think about your average college student on these campuses.

That's the typical of which everybody is being evaluated. So, it's a bit of a skewed approach. But the fact is, it's real data.

And they try to make allowances for that. but it's very difficult to do studies and find another population significant enough to be able to do voluntary studies at the level.

And where are the studies being taking place? At universities. Right? So, the system is weighted, and it's not even what European is.

It's American college students. Brainstance. Similar. They talk about brain scans. Brain scans show. First of all, brain scans do not show, based on an individual brain scan, this is how an individual, this indicates what an individual is dealing with.

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[30:53] Brain scans show population. They can derive information about population. They can't derive information about individuals from brain scans. Second of all, most brain scans, about the same number, 70%, are done voluntarily through college students.

I want to say that we talk about data, the difficulty in gathering data upon which to develop theories and diagnoses is a profound challenge in the world of psychology.

It's not something you have to deal with. also, in terms of critiques of the DSM, since the DSM is used to determine insurance coverage for treatment, there's an inherent tendency to make symptoms fit the diagnosis.

I have a number of psychologists and folks in the church who then do diagnoses, and they'll say, listen, we know that unless we fill out the box with a category, we're not getting paid.

That doesn't mean they're being irresponsible, but they approximate. Nothing really fits this here. I'm not sure they really, if I really diagnosed him, would say, yeah, this really does match this, or sufficiently match this, but they need a category for insurance to work, so they put a category in.

[32:29] So, what does it mean when someone receives a diagnosis? Psychiatric diagnosis is not the answer to problems we've been unable to address through our counseling and discipleship.

It may offer a fresh category of experience and open up options for help, but it's not the definitive statement on a person's life. So, you're going to hear me over and over, and the tone you're going to get from me is, don't struggle with someone's diagnosis.

Don't fight the battle of should you be diagnosed or not. I don't think it's going to help in what we're trying to do to help somebody. Diagnosis can be a helpful common ground when we begin to talk about complicated feelings, thoughts, and behavior patterns, with mutually understood categories.

Ed Weld said this, people have cried when the DSM initially identified them. They found relief, even something close to joy, in finally having words for their struggle.

They found comfort, though the instrument was only a definition in a book. We can understand how this could happen to a person who has long been misunderstood, but we might not foresee the consequences.

[33:50] As a general rule, whoever understands you best will have the most influence. One of my struggles with pastors who go after diagnostic language is they're not going to be as persuasive as whoever's diagnosing them.

And a pastor's going to lose their voice when their voice should really matter. And so I just don't, when I teach in the past, do not be confrontational over diagnosis.

diagnosis. It doesn't do any good. Diagnosis can be a helpful doorway into targeted treatment and support that's available in the mental health community. So if you have someone who's diagnosed bipolar, it does create a lane, creates a direction for them to go in so that they can be, so the medical treatment is helpful.

And actually with bipolar, medication can be very important for bipolar tendencies. It can be a way to objectify a problem so that we can begin to look beyond it to the deeper issues of the heart.

When someone comes in and says I've been diagnosed with this or this or this, it's part of their story to me. It's part of their self understanding. It's not the whole package. It's not everything about it.

[35:00] It's not the thing I focus on. This is part of your package. If you came in and you said I, you know, I start with homosexual thoughts and tendencies or past, that's not your whole story.

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It's part of the story. I live as a minority in a majority culture. That's part of your story. It's not defining it. I don't want anything like that to be the thing that sets up between us in relationship.

And diagnosis can allow us to identify and work with risk factors that are known to be associated with the diagnosed condition. So if somebody is diagnosed with something, it might help us see that they may be vulnerable to suicidal tendencies in a way that didn't present themselves before.

And it gives us ways to extend compassion. When someone talks about a diagnosis, Ed Welch advocates, we simply ask, how can I pray for you with that? You know, turn the diagnosis and I'm going to pray.

Bottom line, presence of a diagnosis is a factor in ministry. It's not the determining reality in ministry. Don't fear it. Don't denigrate it. Fold it into the bigger picture of someone's experience and orientation as you help them find grace in time of need.

[36:20] So any questions about diagnosis? things about this? So we move on. A lot more I can say, but I'm just going to give you a feel. Psychiatric medication.

Mike is a medical doctor and a counselor. He says, the realm of psychiatry is trying to determine pathology in the most complicated area of the human body, which is the brain.

I'm going to abbreviate this a bit. What's known about the use of psychotropic medications is unclear compared with the proliferation of use.

I've already mentioned the tendency as a go-to, particularly for non-critical cases, people who are able to function in general in the world but maybe struggle with depressive tendencies or struggle with anxiety tendencies.

Medication is a go-to. The amount of medication people get. My concern about medications is not that they're used, it's that they're misused.

[37:43] They're used to deal with lifestyle problems rather than dealing with lifestyle. They're not prescribed by people who understand it.

A lot of times these days it's general practitioners prescribing medication but they're not managing and monitoring it. Anytime you're using a psychiatric medication you need active management.

Somebody needs that. When I'm talking to somebody who's on medication the first question I ask is are you getting managed for that? Who's managing that for you? Often you'll see stacked medications. This is having this effect.

Let's add this medication over that effect. I had one at one time she had seven stacked medications. Because a lot of times she's going to different specials. people are not looking at their charts.

They're just prescribing. Individually not irresponsible. Collectively irresponsible. People don't recognize that this medication with alcohol is a disaster.

[38:52] Or drugs. Or sleep patterns. Or other things. Or the nature of your environment. The idea that the tendency to want to use medication fits people who want to solve the problem and move on.

But I'll use depression for example. Depression is probably the most difficult issue to diagnose and treat.

Prove in that way. Medications are having very little effect on depression. A good medication of any kind should not eliminate the issue. it should help somebody go from extremes to a manageable level so that lifestyle can take over.

That's what you want medication to do. If someone is really struggling with depression, a medication can help them come up enough to deal with the other life. If you want to know what the go-to treatment right now for depression is, exercise.

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That's what people say is the most effective thing. Or service. depression is your mind out of yourself. Really, a combination of things.

[40:04] What they see with depression increasingly is all these factors. It's a lifestyle-related disability.

It doesn't mean that you don't have a revelation toward it. It doesn't mean you don't even have reasons for that. depression itself defies reason.

It's a denial of everything in the pursuit of one thing, which is I can't function. It's just incredibly difficult.

Anxiety is emerging as the other one. Why are some people anxious over this, other people not? Why are some people depressed over this, other people not? Why are some people resilient other people aren't?

It looks like people who are in community, if they struggle with these things, they struggle better than people who are not in community. It seems like if people spend all their time doom searching, they're more likely to start with this than people who don't spend time doom searching.

[41:13] It seems like these are all factors. They're social factors that play into this. The problem is medication wants to alleviate it all. There's a quote from Brad Hamrick, I'll just summarize it.

He basically says, medication can function for you, but it will never improve the standard to which you're capable of living. It will keep you at a state where you can make choices to improve that standard, but medication alone will never improve your standard.

That comes from other things. Any questions about medication? Okay, and then personal ministry in the mental health world.

How do we minister to folks? We first of all understand, particularly for some of these struggles that create isolation, that complicates someone's life and their choices and decisions.

A person who's experiencing something that has mental health implications is suffering, even if they don't experience the suffering. One of the challenges with dealing with someone who's manic is they don't think they have a problem.

[42:34] They're great. I'm finally great as they're trashing their lives and the lives of people around them. I'm dealing with a woman in our church right now who's carrying on delusional.

I get daily emails from her about what her neighbors are doing. They're boring through my walls. They came in and they burned my computer.

This man who used to want me to be his wife is now walking around my neighborhood. I have no idea what's true. her. I just interact with her over it.

Why? Because if you deal with people who are delusional, you will find that if you confront delusion, it actually reinforces the delusion. Now you become part of the delusion. Now you're wrapped in.

Now you can't help them. My job as a pastor is to stay in touch, stay in contact, because I want to see if those delusions become dangerous to her and to other people.

[43:37] up to this point, it's pretty clear the pattern is whenever she has life stress. If I gave you my own diagnosis, I would say that she's a woman, a very bright woman, who has never been able to acknowledge wrong on her side.

And I've dealt with two or three people who have this tendency to be delusional. The thing I've seen coming out is they don't, they can't say I'm wrong. And that may have been something that happened in their past, maybe something that don't mean to train, whatever it is, may just be the sin of pride.

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But I find that when they're clearly, or something isn't going right, like they lose a job or something like that, the delusions kick in. Because they're rationalizing their problems outside of them in a way that's increasingly irrational.

that's still my stuff. She's able to function. She can hold a job. Right now she's between jobs, she's looking for a job, and I can almost tell when she got an offer and when she has an interview and when she doesn't, it makes them what she sends them.

It has nothing to do with work. It has to do with the level and intensity of those who are after her, who are paranoid. For me, the basic thing to do is keep her in the church, keep her, let's help the church community become a place where a delusional person can be saved.

[45:11] I'm not going to solve it. God can deal with it. So that's what we have to do. We have people, and she doesn't know she's suffering.

This all makes sense to her. So she's rationalized something that's irrational, and that makes sense to her, and that's how she's managing her life.

the mental health world is very complicated, convoluted, overwhelming. An experience of short-term clarity and help, even if you get a diagnosis, is often followed by frustration and experience working in the system.

If medical treatment is actually helpful, it's often helpful at the expense of considerable physical side effects, including parts of a personality that someone likes. I was dealing with a couple of actually friends of mine, and the husband was a gifted, he passed away cancer a few years ago, but he was a very gifted artist.

He was a photographer, he was a musician, very gifted, struggled with depression, as creative people sometimes do. And so he was being medicated, and I met with them because the deliverance was this.

[46:22] He wanted to come off his medication, and they had kids, and he was saying, he was saying, I need to get off my medication because it's just dulling me, I have no creative energy, I know, I just, I can't do my job.

And she was saying, but if you get off your medication, it's going to create havoc in our home, and your kids won't know who you are. And he was saying, but I don't think they know who I am right now, they only know the medication.

And so these things are complicated relationships, and we want to be careful not to just treat it like it's medicine, it's medicine that has significant relational and personal implications.

We can learn from the mental health world, but we must hold to the categories of scripture for our fundamental understanding of human predicament. I love what Ed Welch said here, it's his quote, we are created of physical, also known as body, flesh members, and spiritual substance, mind, soul, spirit, heart, inner person.

These are all biblical categories. Scripture speaks of the soul and heart as guiding us by the way of its affections and allegiances. body. It's activity is identified as disobedience, godly or ungodly.

[47:44] The body is the material equipment for living in the material world. It is never identified as right or wrong, but as strong or weak.

Mental illnesses, in other words, can be broken down into more elemental categories. They sense the intersection of the human heart and an erratic brain. A basic rule for this ontological duality is that the body can make life very complicated, but it can neither make us sin nor in most cases keep us from following Jesus.

With this woman who's delusional, the way I help her is I say, what does it mean for you to follow Jesus? I don't question, I just say, what does it mean? How do you love your neighbor?

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Who are your enemies in this situation? How do you love them? How is God caring for you? And if I get her locked onto that, the delusions dissipate.

Because now she has answers for things, because they're not really true, and because they're not true, she doesn't have substantive experience to keep on drawing from. They're created in her mind and they dissipate, but they need help.

[48:56] Truth helps dissipate the delusion. And she centers herself in there. If you're really interested in helping people who are circling in these areas of mental disorders, you should be familiar with the language and terminology, but you should be familiar like someone who is part of another culture, who's going to a culture, learning enough of the language to be able to relate, but not imbibing the languages of your own.

We want to be fluent enough to speak, but we don't want to have the language shape how we talk. We still have a different language. We have Bible language. There's no grand unifying theory in the mental health world.

We have nothing to fear as Christians that there's some of this monolithic world of psychology that is opposing Christianity. The reality is the Bible world is coherent and unified and grand.

The world of psychology is fragmented and is cobbling together theories in response to cultural realities and those cultural realities affecting it.

We wanted to help people engage this area tethered to Christ and tethered to the church. I would love for you, because you're coming here and expressing interest in this.

[50:25] For you to be people, the same ones coming into your church who has been diagnosed with something or is struggling with something, that they would find safe with you.

That you'd be able to relate to them and for the first time, maybe I'm among Christians who don't evaluate me. You see me as more than what I am.

But what other people see me? Any disability, really. But middle disability, which can often be hidden in first notice, that they would be able to find in people who say, they receive me.

They need something more than what they're given. They need Jesus. They need the gospel. They need the word of truth to reorient their lives. So their struggle can look more like what every other believer struggles.

The struggle for sanctification. At some point, for someone to work through mental illness and diagnoses, they need the doctrine of sanctification.

[51:30] That they are being recreated from the inside. That God is working with the deepest level of the heart. That's going to go from inward to outward.

I see it with addicts all the time. I see it with people who struggle with mental health issues all the time. I had a woman up close with this. But it's 25 years ago. She came to our church. She had six different dives.

She was a mess. She was all loaded. Depending on the day, what you got from her, personalities, all kinds of things going on. But she had very loving friends, and they just didn't.

They just didn't let her craziness drive them away. But they also didn't let her craziness control.

They loved her as a sister, which meant they also brought confrontation, but they brought encouragement. Over time, you just started to see change.

[52:31] And it was so subtle that you'd sometimes forget about it. And on the first day, and I still have it in my office, she brought me a framed letter from her psychiatrist saying, you no longer need medication.

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We had loving else that's true. And she would say this has just become deep. So I'm not saying that Jesus heals all the same way.

People, Charles Spurgeon dealt with progression through the end of his life. Luther most likely dealt with it through the end of his life. Christians will struggle with these things.

But God is a sanctifying, loving God. He is caring for his children. And he's inviting to see more of his life here. So that's it for this session.

Any questions before we take time? Yeah, just out of curiosity when, for example, either if the church member bring up, they have their diagnosis, or if you notice there are some symptoms on them, what is your advice on how we should interact with them?

[53:39] Is it more if we just be there to accompany, to listen? Or we should bring out some solution. Yeah. That's ways to do it. We'll talk a little bit about what someone uses diagnostic language and it depends on what they're saying.

One of the things you're doing is you want to be conversational so that you have a better idea. They're saying, you know, I started with depression. They haven't really told you anything yet that can really help you understand what they're talking about at that point.

So, you know, conversation. And so conversation in seconds. And if they're just describing the diagnosis, and you relate to them, it's just a part of who they are.

If you see behaviors that concern you, particularly suicidal behaviors, you know, harm yourself or others, then I think you need to get a pastor involved.

You need to, how do you do it? I want to make sure safety for me or others is the issue. It might lead to intervention. It might lead to, but it could just simply lead to, have you talked to your doctor about it?

[55:00] I've noticed this, have you ever, you know, developed a relationship where you can bring that kind of thing up? A lot of people live with the stigma they don't want to be diagnosed, in the field. And you want to help them.

So if somebody's, if their behavior concerns you, the basic question is, potential harm to self or others.

That's the basic thing. If we're not there, then we just do it through fellowship. fellowship, it seems like, it seems like you have these mood swings, and sometimes you're like, have you ever thought about that?

How do you tell me about that? Tell me. What makes it high, what makes it low? You know, and I don't ever say to somebody, I think you may be struggling, but I don't have the ability to diagnose.

I don't want to ever get a loose diagnostic language. But I'll talk about the experience. Have you ever talked to anybody about that? And someone says, yeah, I don't know if I want to take medication.

[56:03] I get that. People have different ideas about medication. Some people with bipolar in particular, if it's a mild bipolar, they don't need medication, they should be very conscious of sleep. Patterns.

Patterns in life do. Depression, anxiety. I get more concerned about people using that kind of language to describe normal human struggle than people using it as if it's diagnosis and they're self-diagnosed.

So you're trying to listen to that. You don't want anybody to feel like you're evaluating. We're always coming alongside. We're never over or opposed to.

We're always coming alongside and trying to relate out experience. Somebody's grieving. You'd expect depression. depression. One of the things in diagnostic role right now is how much reading is appropriate for the foresight of us.

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What is reading unhealthy? So all those things, it's very muddy, but I think it's dangerous for others or behaviors that can put somebody in a vulnerable position.

[57:21] That's what I'm looking for. Your point about grieving kind of made me think about this, but what do you think is the biblical difference between depression and sadness?

Because if you're grieving, is that sadness or is that depression? Yeah, I don't like, I like those kind of words that are descriptive, not definitive.

So to me, sadness is, what is that? What are you feeling? What do you think? I think the sense of loss, in some cases if someone has, you know, they've lost somebody and they have no emotion, that's a concern.

Right? Again, you get into this murky world of what's appropriate, what's typical, and a lot goes into that. So I would say that when someone is, what we know about loss, particularly loss of grief, something that, not attached to a job or sometimes relationships, but is the, you'll see sometimes when people have a significant relationship to break up, the sense that I had identity, that identity has been taken away.

It can take a while to who am I, is a fundamental issue. Whether, my mom passed away in, in January, she was 93.

[58:46] At that point, I was anticipating, there's not much grief, there's memory, there's appreciation, but I had adjusted to it. But if you lose a, a parent when they're in their 40s or in their 50s or you lose a, all those things play into it, the circumstances of grief.

And usually what they look for, what you don't want to do is sort of say you should get over it. Sometimes people draw identity from grief that can be unhelpful and unhealthy.

And that's where you might need to say, listen, how are you understanding this? How do you, where are you going with this? Could be they're angry with God.

Could be that they're angry with the person who's gone. A lot of times grief, like real intense grief and long standing grief is they're angry with the person who dies.

And they don't have a reference on that. So I think grief has its own rhythms. And sadness is just a description of one of the experiences that can come from grief or anything else.

[59:56] You know. Any other questions? Good. Great. So we're going to, after lunch, our next session will be really down to how do we administer.

How do we actually administer? So I sort of give this as sort of the context of people living in a complex mental health world and how do we do that. So I important. Thank you.

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