Practical Ministry Skills:

Mental Illness

Leader's Guide

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Welcome to BUILDING CHURCH LEADERS: Your Complete Guide to Leadership Training. You've purchased an innovative resource that will help you develop leaders who can think strategically and biblically about the church and issues related to ministry. Selected by the editors of Christianity Today, the material comes from respected thinkers and church leaders.

"Practical Ministry Skills" is completely flexible and designed to be easy to use. Each theme focuses on a practical area of church ministry and comprises brief handouts on specific aspects of that ministry. The handouts give a succinct and practical overview of the issues most relevant to your goals. You may use them at the beginning of a meeting to help launch a discussion, or you may hand them out as brief primers for someone new to a particular ministry.

This theme on mental illness is designed to help you prepare to minister to those suffering from mental illness in your church. You may use this download for training sessions or give it to key people involved in leadership. Simply print the handouts needed and use them as necessary.

For an introduction to the challenges and stigmatization that surround mental illness in the church, read "De-stigmatizing Mental Illness" (pp. 3–5) and "Creating a Culture of Openness" (pp. 6–7). For wisdom on what it means to minister to people on medication for depression and other psychological issues, read "Members on Meds" (pp. 8–10) and "Probing Questions" (p. 11). In "Bipolar Priest" (pp. 12–13) a priest shares how his personal experience of mental illness shaped the way he understands and approaches the topic. Read "Principles of Ministry to the Depressed" (pp. 14–15) and "Visitation Checklist" (p. 16) for advice on ministering to the mentally ill. "Making Effective Referrals" (pp. 17–19) and "When to Refer" (pp.20–21) offer practical tips for knowing when and how to refer people to mental health professionals.

We hope you find this theme eye-opening and useful as you and your ministry team seek to love and serve the mentally ill in your midst.

Need more material, or something on a specific topic? See our website at www.BuildingChurchLeaders.com.

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De-stigmatizing Mental Illness

How does your church think about and minister to those suffering from mental illness?

2 Corinthians 12:9–10

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According to the National Institute of Mental Health, "26.2 percent of Americans ages 18 and older—about one in four adults—suffer from a diagnosable mental disorder in a given year." That means more than 50 million people.

Serious mental illness is less common, but it is present among 6 percent of the population, or 1 in 17 adults. And antipsychotics are now the top-selling class of drugs in the U.S. If your church is typical of the U.S. population, on any given Sunday 25 percent of the adults in your congregation are suffering from some form of mental illness and many are under the influence of antipsychotic drugs.

Leadership Journal recently conducted a survey of 500 churches, using the National Alliance on Mental Illness definition of mental illnesses: "medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning" and "often result in a diminished capacity for coping with the ordinary demands of life."

In this survey, 98 percent of respondents indicated they'd seen mental illnesses or disorders in their congregations.

The mentally ill might feel as if they are on the margins of society, but they're actually in the mainstream. And with the drugs available today—and future improvements to come—mental illnesses can be treated and managed effectively for most people. And yet the *Leadership Journal* survey also found that only 12.5 percent of respondents said that mental illness is discussed openly and in a healthy way in their church. Fifty percent said mental illness is mentioned in their church's sermons only 1 to 3 times per year; 20 percent said it is never mentioned.

Persistent Stigma

It should be no surprise that people in the church aren't sure how to respond to the mentally ill. We live in a society that is still deeply confused about mental illness. Have you ever paid attention to the way the mentally ill are portrayed in popular media?

While some, especially more recent, works treat mental illness with honesty and sensitivity, most popular media treat the mentally ill as either frightening or funny or both. For people with loved ones who suffer from ongoing serious mental illness, such portrayals are hard to ignore. Most people don't give it a second thought, but try watching movies like *Psycho*, *Strange Brew*, *Crazy People*, *The Shining*, *Misery*, or *Fatal Attraction* through the eyes of someone who struggles with mental illness.

Or turn on the TV this week. On any given evening, you should be able to find at least one show that either reinforces terror of the mentally ill, or makes light of their illness for a cheap laugh. Even amusement parks use mental illness to entertain and terrify, with rides like "Psycho Mouse," "Psycho House," "Psycho Drome," "Dr. D. Mented's Asylum for the Criminally Insane," "The Edge of Madness: Still Crazy," and "Psycho Path."

And in everyday conversation, it's common to stigmatize the mentally ill by casually calling people "crazy" and "psycho." The mentally ill are widely believed to be more violent than the general population, even though studies have shown that this is not true. No wonder people in the church—and outside the church—have no idea how to relate to a real person who acknowledges or displays a mental illness.

In addition, other factors contribute to the stigmatization of mental illness in the church.

• **Social discomfort**—the church is a community drawn together in love by a common Spirit. But made up of imperfect and sinful people, that community often feels fragile and sustains itself by polite behavior and exaggerated piety.

In such an environment, mentally ill people can upset the balance and intimidate the rest of the community because their behavior can be unpredictable and socially unacceptable. And while people might show patience with a short-term difficulty, the prospect of ongoing interaction with someone suffering from a chronic mental illness may be more than most people are willing to endure.

Pastors too can be put off by the ongoing nature of a chronic illness: "Sometimes clergy distance themselves from people with mental illness because they realize the problem can be long term. To become involved with this person may mean a lengthy commitment. Perhaps this person will never be cured. Such a problem is contrary to contemporary Western ideas of being in control of one's life and destiny. People in modern day America expect to find a rational solution to any problem. And yet, in this case, there may be no solution. It is tempting, if an answer is not apparent, to avoid the person for whom one has no answers" (quoted from www.pathways2promise.org/family/pastorandperson.htm).

• **Referral for treatment and care**—the increased professionalization of psychiatry and counseling reinforces pastors' feelings of inadequacy to help the mentally ill and their families. Pastors and others often refer those struggling with mental health to professionals inside or outside the church, and then assume that the person's needs are met. But the need for pastoral care remains, even if ill people are being treated by professionals.

We're tempted to see mental illness as something we're not qualified to deal with, so we ignore it. But when someone is struggling with a different type of physical illness, the church doesn't ignore the people who are suffering, even though they may be under a doctor's care. The mentally ill and their families still need pastoral care and the love of a Christian community.

• **Theological challenges**—seeing people suffer with mental illness brings up troubling theological questions many people would rather avoid …

- Suffering—how can a good God allow people to endure the kind of suffering mental illness can produce? How can his followers suffer psychological terror, anguish, and despair?
- Accountability—can mentally ill people be held accountable for their choices? Are they responsible for their sin if they are delusional or under compulsion? How lucid is lucid enough to be responsible? And how can God hold mentally ill people accountable for their spiritual choices?
- Demonic attack—is mental illness caused by a demon? If so, how should it be handled in the church? If not, what role does the person's spiritual condition play in his or her mental health? (The difference between mental illness and demonic influence or attack is discussed in our Spiritual Warfare download.)
- Punishment—is mental illness God's punishment for sin? Is it a sign that God's judgment has fallen on the suffering person? And if so, how should the church respond?

Such questions are troubling, especially in the face of illnesses, like schizophrenia, which are at least largely caused by biological conditions/tendencies present at birth. Such realities are not inconsistent with Christian theology—all creation is groaning under the weight of sin—but can present a great test of faith.

Leaders who feel uncomfortable with raising questions they can't easily answer are unlikely to bring them up. And yet people in every congregation must face these questions—with or without the church's guidance. Perhaps if our theology is too small to allow us to wrestle with them, we need to repent for our lack of faith.

• **Overspiritualization**—for some Christians, every problem and every solution is spiritual. In this environment, mental illness is evidence of a lack of faith. Medical and psychiatric interventions are suspect. When "just have faith and pray more" doesn't work, they turn away, and the mentally ill are shamed and alienated even further.

Redemption

I don't know exactly where we get our ideas about the mentally ill or why we tend to simultaneously laugh at them and believe they're all dangerous criminals. I don't know why we believe mental illness is so much rarer than it is, or why we have such a hard time accepting the presence of psychosis in a world pervasively poisoned by sin.

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I do know, though, that the mentally ill get a bad rap. And the people who love and care for those with mental illness often feel a shame they can't explain and a terrible burden to keep secret what they most need to share. This doesn't stop at the doors of the church.

I'm not trying to minimize the confusion and revulsion we can feel when dealing with someone whose brain is giving them a skewed picture of reality. But like any suffering person, the mentally ill should find solace and acceptance, love and redemption, in the church.

May God's redemptive work cause the struggles of people in your church to blossom into loving ministry toward the suffering.

—AMY SIMPSON is editor of GiftedForLeadership.com; adapted from our sister publication *Leadership Journal*, . For more articles like this, visit www.LeadershipJournal.com.

Discuss

1. How is mental illness talked about in your church? Is it talked about at all?
2. Why might the mentally ill in your church be unwilling to admit and/or seek pastoral help for their illness?
3. How would you respond to each of the four theological challenges listed here? How have you addressed these challenges in your church? What steps can you take to more intentionally address these challenges?

Creating a Culture of Openness

Ways your church can help the mentally ill.
Colossian 3:12–14

If you want your church to be more faithful and effective in ministering to those with mental illness, what can you do besides referring people to the professionals? Here are nine suggestions.

• **De-stigmatize**. Make a determined effort to rid your church of the stigma and shame associated with mental illness. Talk about it. Acknowledge the struggles of people you've known, and your own struggle if applicable. Contact some local organizations to see how churches can better support the mentally ill. And if necessary, repent privately or even publicly for the way your church has handled mental illness.

• **Talk publicly about mental illness**. When was the last time you mentioned mental illness in a sermon or class? Have you discussed the tough theological questions that mental illness can raise? Is your church a community of imperfect people growing in relationship with a God who is not confused or threatened by our imperfection? Or does your church inadvertently send the message that it's a place only for the mentally healthy? You can make your church a relevant, accepting place for those who struggle with their mental health by talking openly about it. One note of caution: no "crazy" or "psycho" jokes. Making light of mental illness alienates those who suffer and reinforces the stigma and shame associated with mental illness.

• **Encourage relationships and ask questions**. I asked my parents, who have had to deal with my mother's mental illness, what the church has done right in ministering to them. They both focused on the open and genuine relationships they have had. Small groups have been lifelines for them, especially when they have been able to talk openly about their struggles, mention their therapeutic work, and relate their experiences to the Bible.

My parents also mentioned how helpful it is when curious people ask questions, learning about their experiences and seeking common ground. Questions like "what it's like to be on medication?" or "what's it like to attend group therapy?" might seem intrusive, but for my mom, they open the door to genuine conversation and provide relief from feelings of isolation. Because these are her everyday experiences, they are easy for her to talk about if someone shows interest.

Genuine and mutual relationships are irreplaceable. Encourage the ministry of honest relationships in your church so that when mental health struggles and crises arise, those who are suffering have friends to walk through the suffering with them.

• **Ask what you can do to help**. You must be willing to actually help if the individual or family expresses a specific need. People in crisis don't always know what they need, but sometimes they do and they feel as if no one is available or willing. You may not be a mental health professional, but you can help—organize meal delivery, visit someone in a psychiatric hospital, provide a ride or child care. Be especially attentive to the people who are caring for or living with a mentally ill person. They may be better able to communicate what's really going on and what they need, and like anyone who loves and cares for the suffering, they are suffering themselves.

• **Be present**. This sounds simple, but it's powerful. When an individual is struggling with mental illness, and when the person's family is in crisis, the earth can feel as if it has come loose from its proper orbit. They need something stable in order to help them keep their faith. A pastor who refuses to abandon a family in crisis powerfully demonstrates that God has not abandoned them either. Make yourself consistently available, even if it's not clear what else you can do to help.

• **Radiate acceptance**. Refuse to reject the person or family in crisis. Be the person who represents Christ's tenacious and bold love, refusing to be driven away by what you don't understand. Don't ignore them because

you've given them a referral to a mental health professional. Like others in crisis, people affected by mental illness need to know you care.

Try to treat them as you would a person who suffers from arthritis or diabetes. Ask questions: Are you managing your illness? Caring for yourself? Is the family healthy? A diagnosis or hospitalization doesn't change who a person is; it just changes your understanding of what someone needs.

• **Draw boundaries and stick to them**. Just because someone is mentally ill, you do not need to suspend standards of morality, biblical theology, or respectful behavior in your church community. Overlooking inappropriate behavior or beliefs is destructive to your congregation, and it does no favors for the mentally ill.

Regardless of how they respond to social expectations, mentally ill people do need structure and boundaries to grow in independence, understanding, and management of their illness. They need healthy people around them to give them objective feedback and an example of mental health. Help them pursue and maintain health by insisting on a healthy community around them. Communicate agreed-upon expectations openly and lovingly, and hold to them consistently.

• **Know when you are in over your head**. Sometimes you need to call in a professional to either handle an immediate crisis or provide long-term care. If you suspect a person in your congregation is struggling with mental illness, refer him or her to a professional counselor or psychiatrist.

Compile and keep a list of trusted professionals and their specialties: from depression to eating disorders to bipolar to schizophrenia. You'll have a relevant referral at your fingertips when someone in your church needs it.

And obviously if someone in your church is in danger or is endangering another person, call 911. This is not a situation for you or your congregation to handle; it's a situation for the police. Once everyone is safe, you can move to referrals and pastoral care as appropriate.

• **Get help if you're struggling**. If you or a member of your family is struggling with your mental health, seek professional help. You cannot effectively minister to a congregation without addressing your own needs. And your first ministry is to the family God has entrusted to your care.

—AMY SIMPSON is editor of GiftedForLeadership.com; adapted from our sister publication *Leadership Journal*, . For more articles like this, visit www.LeadershipJournal.com.

Discuss

1. In what ways do you see people in your church engaging those with mental illness? How could you encourage healthier relationships that acknowledge the struggles of sufferers without stigmatizing them?
2. What would it look like for your church to "radiate acceptance"? That is, what are the characteristics of a church that demonstrates love and acceptance toward the mentally ill?
3. Does your church tend to set boundaries that are too strict or too loose on the mentally ill? Why are boundaries important for the mentally ill? How can they be communicated in a loving way?

Members on Meds

Pastoring people on medication for mental illness.
Psalm 34:17–20

In any given week, 81 percent of adults in the U.S. are taking at least one medication, from insulin to Ritalin, from blood pressure pills to Prozac (according to the 2005 Boston University Slone Epidemiology Center survey on the patterns of medication use in the United States).

Given that staggering number, it's obvious that a sizable percentage of the people in our congregations are on medications, some of which are mood altering or psychotic behavior stabilizers.

Does this change the way we counsel? Does this change the way we preach?

A Series of Unfortunate Events

Something was really different about "Tammy," one of our church's regular attenders. She had a hard time making eye contact. She was disheveled and unkempt. She talked in an agitated and staccato pattern, as if she already knew you weren't listening and assumed you didn't care. She had obviously been hurt, scarred, or violated, and her tone told me she didn't trust authority or believe I could possibly be sincere.

I slowly pieced together her story through conversations with other women in the church. As the years passed and her church relationships grew, Tammy began to blend in as one of our own. She developed some close friendships, and she often stopped by the church office to talk with me and to pray.

Then about a year ago, and for a period of about six months, her life turned tragic. Every week there was a new development: She told us she had developed a liver disease that led to hospitalizations and the medical staff had shaved her head; the death of a close family member produced traumatic grief; she reported a clandestine relationship that turned from romantic to violent; she had wild and crazy phone conversations in my presence with people I'd never heard of. Those ministering to her tried to love and nurture Tammy through all these dramatic episodes, but we were all overwhelmed.

Her story of the death of a second family member sounded too strange to be true. It was.

With a little research, we found all her histrionics were based on lies. Even the phone calls were faked. When we confronted her with the truth, she didn't fight us. She was defeated and broken and agreed to take steps toward recovery and mental health.

Tammy signed the release forms and agreed for us to discuss her mental health issues with past therapists and caseworkers.

What we discovered in those conversations was that Tammy's story, like her illness, was many layers deep. The eye-opener was that Tammy had been off her medication for the last six months and had slipped back into psychotic episodes familiar to her former counselors and well-documented in her records.

We loved Tammy as best we could, in ways we thought Jesus would, but we could have served her better by recognizing her medical issues earlier.

Off Their Meds

I am an experienced therapist who specialized in crisis work, and still I was blind to some obvious signs that

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Tammy was off her meds. I should have noticed some of the changes, but I think I was caught up in the day-to-day spiritual and relational issues and missed the bigger picture. In review, here are some signs that people are having meds issues—either they need meds, or are off them:

1. Significant and drastic changes in mood.
2. Impulsive or random behavior that is contrary to normal functioning.
3. Inconsistent verbal or non-verbal behavior.
4. Increased difficulty making eye contact or finishing sentences.
5. Repeatedly canceled appointments.

Creating a Safe Place

How common is this in church life? Do people who struggle with interpersonal relationships and exhibit strange behaviors actually need to be on some kind of medication? As pastors, how can we find out this kind of information? After we do, who do we tell?

Key to addressing this issue is creating an environment where it's okay to admit you have medication and mental health issues. I am now communicating with our congregation in a similar way I did with the staff and students at the college campus. Mental health is a reality, and so is mental illness. We all know people with phobias and disorders. In fact, we are those people.

I try to reduce the stigma by referring to standard mental health issues like depression and addiction in my messages. I use dramatic stories I've read as introductions or illustrations. And I try to communicate that mental health issues are not spiritual failings. God heals in many ways, including regular, carefully regulated doses of mood stabilizing drugs. And God can use these conditions to draw people closer to himself.

For some people in our congregation, such as those who ministered to Tammy through an accountability group, mental health is a ministry field. I don't reveal names or imply that we have such cases in our church, but occasional references to mental and emotional wellbeing are encouraging to the hurting and to those trying to help them.

Counseling Mental Illness

More important is how we handle mental health issues in our office, specifically when dealing with parishioners who come in for counseling. In most of my pastoral counseling appointments, I ask about medication history and current medications as a routine part of the intake process (see "Probing Questions" on p. 11).

This may seem intrusive, but most people are very comfortable with this line of questioning these days. If they aren't, I simply move on. Some folks still feel guilty about taking medication for what they perceive to be "a spiritual issue," but at least they know I'm open to discussing medications in the future. Because I raised the issue initially, they may feel free to bring it up later.

If they answer the medical questions, I take the time to research the condition on the Internet, learning what each medication does and its side effects. Sometimes I call mental health professionals to ask how to deal appropriately with someone using that kind of medication. I don't reveal names or specifics, just ask for some basic guidelines.

Once I know more, I follow up by giving the counselee tools for better self-awareness and accountability. And I encourage the counselee to reveal the condition to at least one other trusted person in the congregation. The pastor should not be the only one who knows.

I give the counselee a copy of the information I gathered. If appropriate, I will challenge him or her to get involved with a small group that deals with such issues—whether that is available at our church or another

church in town. In Tammy's case accountability has proven to be life altering. Although she now lives in a different city, she stopped by last week to visit. She is doing much better, she says, and her mood and behavior have stabilized. It was good to see her smile and to hear her laugh. It was encouraging to know that she has received help and that she is seeing her counselor and doctor as prescribed.

Wait a minute … I have a phone call. It's one of Tammy's accountability partners. Tammy's counselor just called and said Tammy skipped her appointment again. The partner wanted me to know she would be confronting Tammy. It's good to know that the system we worked hard to get in place is helping us care for one of God's children.

—ELLIOTT ANDERSON is senior pastor of Elgin Evangelical Free Church in Elgin, Illinois; adapted from our sister publication *Leadership Journal*, . For more articles like this, visit www.LeadershipJournal.net.

Discuss

1. Think of a time you had an experience similar to the one Anderson had with Tammy. How did you handle the situation? What did you do right? What do you wish you'd done differently?
2. What warning signs can you look for to clue you in to congregants who might need to seek medical attention for mental illness?
3. What resources and support does your church offer for those who are suffering from mental illness? How are you actively helping to plug people into these programs? Focusing on the insights found in this article, what changes might you need to make to more effectively help the mentally ill?

Probing Questions

Necessary questions to ask when counseling someone with mental illness.
Galatians 6:2

Here are the baseline mental health questions I ask during an initial pastoral counseling visit:

1. Are you currently taking any medication for this condition? If so, what and how much? If not, have you considered it?

2. Does your family have a history of this condition? Has anybody else in your family taken medication for this issue?

3. Are your parents/children/other family members aware of what this issue is doing to you? Do they think that you should be on medication?

4. Do your parents/children/other family members want you to be on medication?

5. Have you had a mental health evaluation? If so, what were the findings? If not, are you interested in having one?

—ELLIOTT ANDERSON is senior pastor of Elgin Evangelical Free Church in Elgin, Illinois; adapted from our sister publication *Leadership Journal*, . For more articles like this, visit www.LeadershipJournal.net.

Bipolar Priest

Reflections on mental illness from a pastor who lives it.
Mark 12:10

I found out I have bipolar disorder two weeks after I was ordained a deacon. It started several years earlier with a breakdown while I was on a trip to Appalachia with two high school classmates and a Franciscan Brother. We were off to save the world.

It was there I began that roller coaster ride from manic behavior to deep depression. I spent days eating and sleeping too little and praying too much. In my mind I thought that if I ate less, there would be more for the poor. If I prayed more, I would be holy. I wanted to be a saint and decided that I would kill myself in the process if need be.

Within two weeks I was on a flight back to New York with some unknown illness. I had lost a lot of weight, I wasn't sleeping, I experienced delusions, and I rambled on about anything. The plane ride only added to my agitated state. When I arrived home, my parents took me to a psychiatric hospital.

I spent a long and painful month in the hospital. The goal was to slow the chemical imbalance in my brain and bring me to an even pace. I left never knowing why I was admitted. Everyone hoped it was an isolated event. It was not. It was five years before I even mentioned my illness to anyone. Eventually the cycle repeated itself, and again I was hospitalized; by this time, though, I was a priest. That's when they called me bipolar.

Heavily medicated this time, I was a virtual zombie for about two weeks. I could not carry on meaningful conversation or deal with reality. The shame remained, as my family and friends were told I was having my appendix removed.

I cried myself to sleep. I felt as if I had descended into hell. Questions flooded my mind: Why is this happening to me? Where is God now? I thought God was on vacation or something, for he certainly wasn't with me. I felt abandoned.

What I didn't realize was that God was right there beside me, crying with me and for me. Even so, I focused my anger on God. I was reminded of Jesus' innocent suffering, but that doesn't always help when you're aching.

I wanted God to reveal saving love by telling me that I didn't need the medicine anymore. But God didn't say that, and I do need it, because loving who I am means taking the medicine.

Some time later, while on retreat, the line from Mark's Gospel hit me: "The stone that the builders rejected has become the cornerstone" (Mark 12:10). These words haunted me. The rejected stone in my life was the disease. The Lord invited me to accept and embrace my disease so that God could continue to build me into the person God intended. The shame was lifted, but the scars remained.

It has taken 20 years to "let go and let God," but it has made all the difference. I have now been able to recognize mental illness as one, and only one, aspect of who I am. Once I could embrace that, I could be more in tune with who I am, and who God calls me to be. I was able to live life without shame.

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My greatest fear was that I would experience another psychotic attack and never regain my health. Now I am confident that if this should occur, it would not change my relationship with God. My love for God and God's love for me is so strong that when my body finally surrenders in death we shall embrace again.

"Nothing will separate us from the love of God …" Not even mental illness.

—JERRY DISPIGNO is priest at Mary Immaculate Church in Bellport, New York; adapted from our sister publication *Leadership Journal*, . For more articles like this, visit www.LeadershipJournal.net.

Discuss

1. How might the author's experience help you better understand and respond to individuals dealing with mental illness?
2. What is the goal of treatment and counseling for mental illness? Is your goal to "cure" the individual of mental illness or help them manage life with it? How does the Bible shape your response?
3. Why is medication so important for the author? What effects might medication have on a mentally ill person's spiritual life?

Principles of Ministry to the Depressed

Serve the depressed by following these strategies and knowing your limitations.

Psalm 25:17

Don't Ask People to Simply Make Choices

All of us have three components to our psychological system: thinking/cognitive, feeling/emotive, and willing/volition. It is important to understand that the depressed person's problems reside in all three areas, but because of flat feelings and faulty thinking, it is not easy to make decisions. Motivation and energy are a struggle, so it is hard for the depressed person to choose to engage in particular behaviors.

In light of that understanding, reflect on the following open-ended statements: "All you have to do is just..." "Why don't you just..." "If you would just..." Any piece of advice that has the word "just" in it is usually problematic. Each of these statements presupposes that a simple choice will move people out of depression. But if it were that simple, no one would be depressed. As sensitive helpers we need to offer solutions that do not reside primarily in the will.

Show Compassion by Prayer and Presence

It is very difficult for most depressed people to share their story with friends or family. Although changes are occurring, a stigma against depression still permeates our culture. I have known many people who have taken the risk and shared their depression journey only to find that others don't want to hear it. This builds on the sense of alienation and isolation many depressed people have already, particularly if the nonresponse has come from a parent, sibling, spouse, or close friend.

Christians need to remain open to hearing about depression in others. When the story is out, it needs to be met with compassion and sensitivity, along with a commitment to pray, in order that the individual experiences the mediation of God's presence through his body—the church.

Make a Thoughtful Referral

Because of the multifaceted nature of depression, and because there is often a physiological and biochemical component, it is important that friends and family demonstrate care by having humility about their own abilities to help. One of the dangers in Christian circles is that we can bring a spiritual paradigm to bear on the depressed person and forget the fact that other dimensions are playing a significant role.

Because of the nature of the difficulty, depressed people struggle with motivation and energy. Simply telling them to go for help is not going to guarantee that this will happen. They require support, coaching, and, in some cases, help making an initial connection with the professional.

Bring Hope into the Situation

Depressed people feel hopeless. It is important to understand that this is not a statement of whether they are in fact hopeless. In response to people who feel hopeless, others will often seek to cheer them up with pithy phrases like: "But you have so much going for you." Because a negative view of self, the world, and the future is at the core of the experience of depression, superficially positive statements do not easily penetrate to that core.

Promote a Holistic Approach to Life

Because depression is comprehensive in its effect, it is important that we care for people by promoting health in various areas of life. I encourage depressed people to get a physical as soon as possible.

Careful attention to diet and exercise will not solve depression, but it will certainly help. Because of motivational and energy difficulties, depressed people will not readily change their diet or begin to exercise, but they can be helped to make small modifications in these areas. These gentle and consistent interventions in the physical, relational, and emotional sides of life will not remove the depression, but they make a contribution to lessening its intensity.

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Stimulate Realistic Thinking and Be an Educator

Out of a deep desire to help a depressed person, friends will often overdo their advice giving and not be as attuned to understanding. This may be truer with depression than any other of the difficulties that people experience. Because we all go through down times and periods of feeling less than our best, we readily assume that clinical depression is very similar.

What we need to offer friends who are struggling with depression is realism and education. Helping our friends understand the nature of depression is very freeing for them. Rather than expending energy and effort trying all sorts of simple solutions, they will be able to relax a little, having some understanding of what they are going through.

Do Not Function As an Expert on Medication

Research in the past 20 years has confirmed that, no matter what the initial trigger might be, one of the major factors in depression is the imbalance of a brain chemical called serotonin. If correct amounts are not present, our thought processes, memory, sleep, and eating are all influenced. Newer antidepressant medications help to adjust the levels of serotonin in the brain and relieve the symptoms of depression.

I regularly hear well-meaning Christians talking about the need for people to stop taking their antidepressant medication. This advice often stems from a belief that taking medication reflects a lack of trust in the Lord. In many senses, this is comparable to telling a diabetic to stop taking their insulin or advising someone with extreme respiratory problems to shut off their oxygen. Instead, we can see antidepressant medication in the same light as the insulin and oxygen: a gift from God, provided to sustain life and well-being.

Support Those Who Live with a Depressed Person

Living with a depressed person is difficult. Everyday life can be unpredictable. Some days they may have energy and interest and then, almost without warning, they will be irritable, edgy, and flat. It is hard to plan life when someone is in a depressed state. At times, family members need to receive education about depression as well. There is nothing more devastating for a depressed family member than to receive no support from those who are supposedly close. Spouses of depressed individuals, along with children and any others that are immediately impacted, need to be contacted and nurtured.

—ROD J.K. WILSON is president and professor of counseling and psychology of Regent College in Vancouver, British Columbia; adapted from *How Do I Help a Hurting Friend* (Baker, 2006). Used by permission.

Discuss

1. What resources does our church have to educate congregants about ministry to depressed friends and family members?
2. How can we apply the principles from this article to our ministry to the depressed?
3. How can we make our church a safer place to talk about depression?

Visitation Checklist

How to conduct a visit that helps and encourages.
Psalm 57:1

I think people generally don't know how to treat the mentally ill in the hospital. They are too nervous and uncomfortable to understand that the mental hospital is a respite for the mentally ill and that visitation should be no longer than 15 minutes. People think that the hospital is a boring place and that patients need conversation; in fact, hospitals are exhausting. Nurses, roommates, and new medications, are constantly interrupting sleep. For the mental patient, talking to anyone can be difficult.

The visitor should always inquire about the patient's health. Don't start complaining about your own problems or even someone else's just to have something to discuss. Follow the patient's lead. If she wants to talk about meaningful things like her symptoms, fears, and worries, inquire further. But don't pry. Remember that for the mental patient conversation itself can be an uphill battle.

Offer to read Scripture, to pray, to anoint her with oil, or provide Communion. That should be about all. Be out of there 15 minutes later to leave the patient to recover. Come every week while the patient is hospitalized, unless she requests otherwise.

Use the following checklist when preparing to visit the mentally ill in the hospital:

- ❑ *Visit for approximately 15 minutes.*
- ❑ *Understand the exhaustion the patient feels from being in the hospital.*
- ❑ *Do not try to be entertaining.*
- ❑ *Inquire about the patient's health.*
- ❑ *Focus the conversation on the patient (without prying).*
- ❑ *Offer to read Scripture.*
- ❑ *Pray with the patient.*

—KATHERINE GREENE-MCCREIGHT is the author of *Darkness Is My Only Companion*; adapted from *Darkness Is My Only Companion* by Katherine Greene-McCreight. Used by permission of Brazos, a division of Baker Publishing Group, copyright © 2006. All rights to this material are reserved. Materials are not to be distributed via e-mail, published in other media, or mirrored at other sites without written permission from Baker Publishing Group.

Making Effective Referrals

Answering three common questions.
1 Thessalonians 5:11

Ministers frequently find themselves lacking either the time or the qualifications for a given situation. They need to make a referral. But most have never been trained in making referrals. Having served both as a pastor and as a full-time counselor, I've seen the matter from both sides. Here are some insights into the three questions pastors usually ask.

Should I refer?

In deciding whether to refer a person to someone else, I ask three questions:

Do I have the skills necessary to help this person? This doesn't mean I have to have professional training in every area of need presented to me. It does mean I want to be sure I'm the right person at the time. I ask about the history of the situation, what help has already been sought, and exactly what the person wants to receive. These questions can reveal a great deal about what type of person should be providing help. When a need is clearly outside my area of expertise, referral is the obvious choice, but at other times it's a matter of someone else being better equipped to help.

Can I give adequate time to this situation? A counseling case can easily take up five hours a week, even if the client and I are meeting only once a week for an hour. Thought, prayer, phone calls, background research, and consultations all take time. When you add the possibility of crisis calls, it becomes clear that most pastors can take on only a small number of these commitments. My experience and research suggest most ministers should avoid handling more than half a dozen counseling cases at a time.

Given the roles I fill, am I the right person in this situation? One pastor, in referring a case, told me, "I feel comfortable dealing with the situation itself, but I think I'm too close to the couple." His role as a "father figure" to the couple made it difficult for him to be objective. His referral allowed the couple to get the help they needed while still receiving support from him as their pastor.

Counselees should also be referred if there is any sexual attraction between them and the pastor.

To whom do I refer?

I develop a list of available resources for various types of needs. Many communities make referral directories available at little or no cost, but you can also make your own. In any event, no referral should be made to someone with whom you haven't talked personally. Screening takes time, but it pays great dividends when you're assured of the qualifications and character of the person to whom you are referring. Making one new contact a week is usually workable.

In assessing potential resource people, you'll want to learn the type of help they offer, their academic training and experience, and special characteristics of the service provided (including fee structure).

Where appropriate, you'll also want to know such personal information as philosophical biases and spiritual convictions.

How do I make the referral effective?

Each situation is unique, but I try to follow a few basic steps:

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1. *Ascertain where the real need is*. When you're asked for help, your primary task is to decide what help is needed and who is the best person to meet the need. This will usually mean at least one meeting or extended conversation with the counselee. Ask enough questions to be sure you know what the need is.

The most common experience I've had concerns the difference between individual and marriage or family counseling. A man I'll call Cliff, for example, called to ask if I would counsel his daughter Jeri, age 13. Jeri had become increasingly hostile to other family members and was spending a lot of time with "the wrong crowd." Jeri was physically well developed for her age, and her parents were afraid she was becoming sexually active. I agreed to meet with Jeri to hear her perception of the problem, with the understanding that I would discuss with her parents how to proceed after the initial interview.

When I met with Jeri, I was candid about her parents' concerns. She explained she had been feeling pressure to measure up to her older sister. She also said her parents didn't really care about her. When I asked why she felt this way, she told me her father never spent time with her, though they had been close a year earlier.

When I asked Cliff about their time together, I discovered he was uncomfortable around Jeri. He confessed he used to love wrestling with her, going camping, and just sitting around talking with her. But when she began to mature physically, he felt ill at ease and began to withdraw. He said he hadn't hugged Jeri in the past year.

On the surface, the Johnsons' need was individual counseling with Jeri. But the real need was for family counseling to explore and heal the fears that Cliff, Jeri, and other family members had regarding Jeri's growing up.

2. *Make the referral personal*. In making a referral, I've learned to refer to a person or persons-not to an institution. One time I referred Joan, a member of my church, to an agency in our community for specialized counseling. I knew and respected the director of this agency. After the referral was made, however, I found that Joan was being counseled by a person I didn't know. At the end of the third session, Joan came to me and said her new counselor had spent the last two sessions telling Joan about her problems. Joan was feeling frustrated and overwhelmed, and she decided to discontinue counseling. Had I done my research on this counselor, and not just the agency, I would have learned she wasn't qualified.

3. *Make the recommendation clear*. As you make your suggestions to the counselees, be ready to explain exactly why you believe it's best to refer them to someone else. You'll greatly increase the likelihood of a successful referral by answering all legitimate questions straightforwardly. Give them time to think about the referral if they need it. In many cases, you will want to assure them that you'll continue to be involved, but in a different role.

4. *Make the first contact, if necessary*. Kate had been a widow for six months. It took all her strength to get out of bed, get the kids ready for school and the sitter, and go to work. She knew there were resources available to provide the emotional and social support she needed, but she was immobilized by grief. After waiting several weeks, I called the leader of a local support group and suggested she visit Kate. She did, and Kate began attending the support group meetings and making friends there.

It isn't always necessary to make the initial contact with the resource person. In some situations, it might be important for the counselee to take responsibility for making the call. We need to be sensitive, however, to those situations in which it's better that we take the initiative.

5. *Ensure communication with the new helper*. In one community I served, an agency providing a wide variety of counseling services rarely got referrals from area ministers. The reason: when ministers tried to follow up on referrals, no one was willing to talk to them. I never refer people to anyone who is unwilling to communicate with me. This doesn't mean I need to know all the details of what's going on, but I have a responsibility to the people I refer; I need to be sure they are truly being helped.

6. *Specify to the new helper, before the referral is made, what his or her role is to be.* If you want a specific type of help to be provided, this should be spelled out clearly. I'm often asked to do parent education with families who are undergoing therapy with someone else. In such cases, it's vital that I know exactly what I am and am not supposed to be doing.

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For example, the Gypsums were referred to me for parent education, specifically, discipline from a scriptural perspective. The minister made it clear that any questions about Scripture that didn't relate directly to parental discipline should be referred to him. In such a case, it was important for the minister that I agreed to abide by the limitation on my role.

When referring people to doctors or therapists for technical counseling, such as sex therapy or treatment of depression, I request that any questions related to moral or spiritual issues (e.g., birth control or abortion) be referred back to me.

7. *Follow up on the referral*. John and I saw each other at a ministers' meeting, and he asked how my work with the Jones family was going. I asked who he was talking about. He was surprised; he had referred a family to me a month earlier. They had promised to call me, and he assumed they had. They had not. In fact, they had called no one, and their situation was getting worse.

Because of this and similar experiences, I try to follow up within a week after a referral, and periodically thereafter. Has the counselee made contact? How is the work going? How can I best support the process? If I'm still working with the person, how can my work complement the efforts of the other helper?

None of us can meet all the needs of everyone who comes to us, but we can guide people to other qualified helpers. And making appropriate referrals can save us from overwork and provide the best resources available for those who need them.

—RANDY CHRISTIAN is pastor at The Lord's Church in Celina, Ohio; adapted from our sister publication *Leadership Journal*, . For more articles like this, visit www.LeadershipJournal.net.

Discuss

1. What situations do you feel comfortable counseling? Which are outside your area of expertise and require referrals?
2. How many professional counselors have you personally met and appraised? Do you have professionals to whom you could refer mentally ill individuals?
3. What is your process for following up after a referral? How could you make this more effective?

When to Refer?

A checklist for what situations require referral.
Proverbs 1:1–3

It is essential that pastors working with the mentally ill: 1) get enough clinical pastoral education—or attend workshops with other professionals—where you will discover the usual reasons that a referral must be made, and 2) discover by experience or in a clinical course the amount of anxiety that will prompt a referral.

One of the quickest ways to feel confident about a referral is to analyze your own anxiety. Remember, in your first meeting with a person in trouble, it is not only the counselee's anxiety that must be managed but also your own anxiety as well.

What are the areas of living in which you feel more comfortable in discussions with someone who needs help, and other areas in which you must make a referral to a more specialized or professionally competent helper? When a church staff of 20 people considered areas of personal concern, they made the following distinctions:

Almost always refer:

- Questions about the mysteries of life that have medical implications, such as abortion, unplugging a life support system, or deciding whether or not to get pregnant against medical advice.
- Behavior or situation that is scary or really peculiar like the young man who sat staring at the ceiling for a few minutes, then said he was finished with life. His father was with him and said the son had just bought a 38 caliber revolver.
- The husband who says there's nothing wrong with him sexually, even though his wife is sitting right there and says that he demands a separate bedroom, and spends every weekend and all his vacation time with an unmarried friend down the street.
- The daughter who starts yelling at her mother, "You're ruining my life," when the mother says in anguish that she just wants to keep her daughter out of a known drug dealer's "safe house."

Often refer:

- People who say they keep waking up with a nameless dread that weighs on them all day long.
- Couples who ask for prayer to keep their marriage together and then hurl verbal abuses at each other until you get one of them out of the room.
- A single mother who confesses that she spends most of the nights in tears, most of the day avoiding people at work, and yelling at her children in the evening.
- Lonely and pious church members who says they have committed the unpardonable sin, or behave like they have.
- People who raise questions in areas where they need help now, but we may not be experts in areas such as legal matters, what kind of job to look for, or how to get on welfare.

Sometimes refer:

- People who ask about the meaning of life but aren't able to be more specific about their concerns
- People who say they can't forgive.
- Pain and suffering beyond anything we have ever been called on to bear.
- A friend who says she prays and prays but has no hope for the hereafter.

—ROGER HESUER AND SAMUEL SOUTHARD are professors of Church Leadership Studies at Vanguard University of Southern California, adapted from *Caregiving Leadership* (CMR Press, 1999);

Discuss

1. How has your own anxiety impacted previous counseling relationships? How would you go about analyzing and managing your own anxiety before entering a counseling situation?

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2. Do these distinctions of when to always, often, and sometimes refer match up to your experience? Which would you place in different categories? What kinds of situations would you never or rarely hesitate to serve as the key counselor?
3. Are these kinds of distinctions communicated to others in your ministry who counsel or refer people? If not, what is your plan for discussing and communicating these distinctions?

Further Exploration

Books and other resources to help deal with mental illness.

BuildingChurchLeaders.com: Leadership training resources from Christianity Today.

-"Giving Help to the Hurting" Assessment Pack
-"Depression" Survival Guide
-"Ministry for Depression" Practical Ministry Skills
-"Leaders & Depression" Women Leaders

ChurchSafety.com: Safety resources from our sister site.

-"Lay Counseling Safety"
-"Keeping Your Counseling Ministry Safe"

LeadershipJournal.net: Our sister website offers practical advice and articles for church leaders.

Darkness Is My Only Companion *by Katherine Greene-McCreight.* Combines anecdotes, theology, and practical advice—helpful for those who have a mental illness or for those who minister to the mentally ill.. (Brazos, 2006; ISBN 1587431750)

Mental Illness and Psychiatric Treatment: A Guide for Pastoral Counselors *by Gregory Collins.* This guide will help pastors better serve people suffering from depression, anxiety disorders, chemical dependency, reality impairment, or personality disorders. The book's format is designed specifically to help pastors grasp the principles of intervention in each of these disorders. (Haworth Press, 2003; ISBN 9780789018809)

Ministry with Persons with Mental Illness and Their Families edited by Steven D. Thurber. Psychiatrists and pastoral theologians come together in an interdisciplinary, collaborative effort to ensure accuracy of information concerning the medical dimensions of mental illness, interpret these illnesses from a faith perspective, and make suggestions relative to effective ministry. (Fortress Press, 2012; ISBN 9780800698744)

The Quick-Reference Guide to Biblical Counseling by Dr. Tim Clinton and Dr. Ron Hawkins. An A-Z guide that provides pastors, professional counselors, youth workers, and everyday believers with access to a full array of information to assist with (formal and informal) counseling situations. (Baker, 2009; ISBN 9780801072253)