# What does the Bible have to say about caring for those with mental health struggles?

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[0:00] ...time together to think about this topic. I'm very glad to have been invited because it's a subject that I feel passionately about and love any opportunity to help us together to see whether the church can do better in this area.

Here's how we're going to go about this. We've got two sessions from me and Corey in between those. The two that we're doing, which is on the next slide, is this first one, which is kind of a framework setting talk to try and help organise our thinking, try and bring a Christian perspective to this area, but also to lay out the territory, think a little bit together about...
...what we mean by struggles in the area of mental health and how our world understands that at the moment. And then in the second session that I've got, trying to think a little bit more practically about, well, how do we do this well in our churches?
How do we care for one another in this area of mental health struggles really well? So that's the way that we're going to come up to this.
I am conscious that as we do this, that this is a personal topic. I'm conscious that it touches all of us in some way or other, some more personally and more directly.
[1:34] And I want to try and be really sensitive to that. It's a lot, you know, there's so much to say in this area and even giving over a full morning to it.

In all sorts of ways, we're going to be scratching the surface and we're going to be moving through pretty sensitive things pretty quickly. I will do my best to avoid treading clumsily, saying things too quickly, which makes it sound as though I'm somehow minimising things.
I will do my very best to avoid that. Please know that I am conscious that for many of us here, these are things that are very personal.
Either we ourselves or others that we care about deeply are struggling or have struggled in these kind of areas. So I will be conscious of that.
And we do so in the presence, as it were, of a God who knows about this as well. The reason I wanted to start with Psalm 88 is to remind us that the Bible is full of very direct and very vivid portrayals of distress.
[2:54] Psalm 88 is an extraordinary psalm. You will know that the typical pattern of a lament psalm is of a psalmist who is wrestling with their relationship with the Lord, trying to understand how a good God can be allowing hard things in their life, asking questions, grappling.

And then usually in a lament psalm, the usual pattern is that there is then some sort of a breakthrough. Some sort of a sense as the psalmist turns towards the Lord, they are reminded of. They remember something of who God is, what he promises, his character. And then there is a sort of uptick at the end of the psalm, leading to a new resolution of faith.
It's a typical sort of arc of a lament psalm. Psalm 88 is different. There's no uptick. It lands in distress and difficulty.
It lands heavily. Why has God put it there? Why would God choose to include a psalm like this that seems to have no hope, seems to be the expression of a psalmist who is just awash with distress, dismay, despair?
[4:18] The last time I preached from Psalm 88 was at the funeral of a woman in our church family who'd taken her own life.

And she and I had often, as she grappled with a deeply crushing depression that would come at times through all of her adult life.

She and I would often talk about this psalm. And it seems to me that waving in with this psalm and what I was saying at her funeral service was this is an expression of a believer desperately clinging on to faith.
Because even this expression of despair and desperation is spoken to someone. There is a sense that there is a God to be bewildered by.
So faith is still there somehow, even in the midst of the deepest despair. Because this is a sort of personal subject, I want to kind of start with three individuals, if I can.
[5:25] Three individuals from my past. Susie was a woman who I met while working in psychiatry. She, this was a long time ago, because I'm quite old now.

So we're back in the 1980s. And in that time, people with eating disorders often had very long stays as inpatients. Different sort of approach to managing people who struggle with eating disorders now.
She was an inpatient on the acute psychiatric ward where I worked. At the beginning of my six-month stay there, she was still there at the end of my six-month stay. I used to talk to her two or three times a week.
So lots that I began to understand about eating disorders began there. I remember one particular conversation where she told me that she used to go on weekend leave back to stay with her parents.
And she told me one time that on her weekends, on her way walking back to her parents' home, she would sometimes take her route via a public toilet.
[6:35] And in the public toilet, she would drink from the toilet pan, water, and then make herself sick. And she told me that she did that because somehow that repulsive act captured something of how disgusted she felt with herself and her body.

Very vivid expression of just the awful internal distress that somebody with eating disorders might have.
Second person, a man called Jin, who was a new father. And you'd expect, you know, sort of full of joy and excitement about becoming a dad, having a daughter of his own.
He wasn't joyful. He was deeply distressed. Why was that so? Because he was plagued with thoughts that he was going to sexually abuse his own daughter.
He didn't want to do that. The very idea of it was repulsive to him. But this thought that he might kept popping into his head. To the degree that he thought, well, if I'm thinking, perhaps I do want to.
[7:43] And I don't realize that I do want to. And he was now arranging it so that he was never alone with his daughter. So that if he did abuse his daughter, somebody would be there to stop him. And he couldn't bear the idea that perhaps he had, and he'd forgotten that he had.

Or he somehow didn't realize that he had. And he would be plagued with these horrible thoughts of how terrible it would be for him to do such a thing. The terrible impact of intrusive thoughts that people experience in what we identify as obsessive compulsive disorder.
David was depressed, convinced that he had made an error at work, which had led to many people in his firm being made redundant.
And couldn't bear the shame and guilt that this mistake had ruined so many people's lives. Only it wasn't true.
He hadn't made a mistake that had led to lots of people being made redundant. This was an extrapolation of his depressive thinking, which led him into forced beliefs about what had taken place.
[8:58] Deeply distressed. Susie, as I say, I met while working in psychiatry. The other two I met in part of my pastoral ministry. And I could add many more in.

It is deeply distressing. I begin with those three stories. Just to emphasize that the pain and the upset of mental anguish is hard to overemphasize.
And I guess you know that. And that's why you've given up a Saturday morning to come and think about these things. It is also common. So the most commonly quoted survey is now quite old.
It's from the charity Mind from 2014. And they identify that one in four are experiencing a mental health problem each year. One in six in any given week.
Remarkably high statistics for distress in this area. Now I know that kind of raises issues of where's your cut off? What do we identify as being a mental health problem?

[10:08] And we'll loop back to that. And these things also got worse during the pandemic. This graph shows report of levels of anxiety and depression that people had.

The green is pre-pandemic. And the blue is the level during the pandemic. And although it's settled down a bit, it hasn't actually settled back down to pre-pandemic levels.
So the pandemic did something to us in terms of its impact on mental health struggles. Or take another measure. Take a measure of the use of antidepressants throughout the UK population.
You see there the figures for the rising over the decades of prescriptions for antidepressants. And you see a really startling increase over those 30 years.
To the extent that currently, 16% in a given year, 16% of the adult population in the UK receives at least one prescription for an antidepressant.
[11:29] That's one in six of us. All sorts of concerns within the medical profession about the sort of exponential use predominantly of SSRIs, the selective serotonin reuptake inhibitors, the Prozac family of drugs, and how much they are being used.

And it's also uneven. So more women than men and areas of social deprivation. So the levels of use of these drugs is much higher as well.
And as I say, the medical profession bothered by that. But it's not changing. And of course, the obvious thing to note is, it's not as though this phenomenal use of antidepressants is somehow getting rid of depression.
As though we're seeing a downturn. Quite the opposite. We're seeing a steady rise in reports of surveys of the level of depression in our communities.
So the use of these drugs isn't solving things. All of which means that it raises issues for what the church could do in this context.
[12:53] You'll be aware that there are reports in the press, you often read newspaper articles speaking about a crisis in our mental health.

Because the rise in the number of people describing struggles with mental health, particularly in the kind of under 25s, is really pronounced at the moment.
And I try to think how this looked like graphically. And if you think about this sort of pyramid representing people who are struggling with their mental health.
And the wide base bit means sort of milder problems. And the tip of the arrow means the more severe problems. Well, you will understand that to get specialist input, which is limited, you need to have some of the more sort of serious problems.
That makes sense. So that line represents the threshold. And the specialist input just chops off the top of the pyramid. Well, if we're seeing, and we are seeing, this phenomenal increase in the number of people reporting mental health problems.
[14:01] Well, the next slide sort of shows, well, the pyramid just got bigger. But we haven't got masses more specialist input. If anything, the amount of specialist input available in our health service is on the decrease.

So we're still just slicing off the top bit. So what does that mean? That means that the bulk of people below the line who are not getting any specialist input has just got much bigger.
People in our churches, people in the communities around our churches, who are struggling with very significant mental health issues without any specialist input.
It represents a huge kind of responsibility for the church to care for one another and a tremendous opportunity for the church to be a blessing to the communities around us.
The mental health services, they are well aware that they desperately need, kind of as it were, sort of external agencies, voluntary groups, stepping into the very big gap that exists.
[15:12] And they are very receptive to that. Any sort of preciousness about saying, well, we don't want people with religious beliefs getting involved in this. They've long gone. Anyone, help.

Because the level of difficulty is such. So there is great opportunity. Now, I don't know about you. I find it very boring listening to myself for a long period of time.
So intermittently, I will just get you to do a little bit of thinking and talking to the person next to you or around you, if that's okay. You don't have to, if you want to just sort of sit there quietly and think on your own.
But I just find that sort of keeps us going through a morning. So here's my first question to you.
What do you think people in your church believe? Do you think, if you would take a survey of the people in your church, do you think the people in your church would say, mental illness is a spiritual

issue and the solution is repentance and faith?
Or do you think, alternatively, that the people in your church would say, no, mental illness is a brain and biology issue and the solution is medication? Which of those two do you think the majority of people in your church would go for?
[16:25] Have a quick discussion with somebody next to you and decide what you think. Thank you.

Thank you. Okay, that's enough time.
I just want your gut reaction. So I'm really just interested in your gut response to this. And because it's nice to sort of, you know, just sort of force you into decisions.
Okay, so hands up if you reckon the majority of people in your church would say mental illness is a spiritual issue, the solution is repentance and faith. Okay, hands up if you think the majority of people would say, it's a brain and biology, the solution is medication.
Hands up if you're really annoyed by me making you choose. Yeah, okay, all right, all right.
[18:06] We will come back to that. I appreciate that it's very irritating being forced to choose one of those two because most of you are thinking, well, it's not as simple as that. And yet, to an extent, we do need to notice those two sort of strands of thinking, both contemporarily in the church but also historically in the way that the church has looked at these things.

How do we think spiritually about that, about these kind of struggles, is an important issue for us to come to. And I'll loop back to that.
But before we think about that, though, let me point out that, and Louise mentioned this in her introduction, thinking us and them isn't terribly helpful either.
I mean, imagining that in our churches there's a group of us who are kind of normal and sane, and then there are a group of people who are abnormal and sort of, you know, sort of, well, they're not completely mad, they're certainly quirky.
And imagine that that is some way of approaching this topic. Now, this is one of the points where I'm in danger of speaking too quickly and feeling clumsy. I'm caricaturing in that kind of way because there are still people around who think like that.
[19:25] But when it comes to mental health struggles, just recognise so much of what we're talking about exists on a spectrum. Let me very quickly illustrate that by asking you how you are with spiders in a bath.

What do you do when you find a spider in the bath? I mean, some of us pick the spider up and put it out of the window. Some of us get a bit of toilet paper and pick the spider up and put it out of the window.
Some of us go for the cup and card trick. Put the cup over the spider. Depends on the size of the spider. It's a big spider. Definitely. Cup over. Bit of card underneath to window.
Exit. Discover spider is still in cup. Exit again. Some of us would not even do that. Some of us would prefer to say, help, there's a spider in the bath.
Somebody else in the house needs to come and deal with the spider because it's in the bath. Some of us would feel even more distressed than that. Some of us would think, wow, spider in the bath.
[20:28] I know where they come out of. They come out of the little drainy plug. That's terrifying. That could happen when I'm in the bath. I'm not having baths anymore. I'm just going to have showers.

But some of us would then think, well, if they can come out of the drainy thing in the bath, they can come out of the drainy thing in the shower. That's terrifying. I couldn't bear that. I'm not having showers anymore. I'll wash with a washing up bowl of water.
And some of us would think, but it's not just showers and baths where spiders turn up. And they can turn up anywhere. However, my friend clearly doesn't deal with things very well.
I've seen cobwebs in her house. That must mean there are spiders there. I'm not going to her house anymore. Others would say, they come up around the cracks in our skirting boards.
I'm going to get some polyfiller. I'm going to fill every crack on every skirting board. Try and keep the spiders out. But even then, one might appear. So I'm going to wear rubber gloves.
[21:33] All day, every day. Just as some extra protection in the crisis. Now, I take it that in what I've just done, I've captured everyone in the room.

All of you are somewhere in the spectrum that I have just drawn of response to spiders. Where we draw the line and say, here is spider phobia.

Here we will make a diagnosis of somebody having spider phobia is arbitrary. It would determine on interference with life is the way that the psychiatrist would do it.
My point being that so much of the way, so many of the things that we experience, whether it's depression, whether it's anxiety, that these things exist on a spectrum.
Diagnoses are not as crisp and clear as we might sometimes imagine. So let's think a little bit about definitions for a moment. Here is the World Health Organization.
[22:45] Mental health. So this is a positive statement. Mental health is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn well, work well, contribute to their community.

This is a very strong and positive expression of mental health. And as soon as you drop below that, you're not working well, you're not learning well, you're not contributing to your community as well as you could do.
Well, then you're no longer functioning at maximal mental health-ness. It raises the question of how healthy are we all?
Or look at this historical definition. Mental health consists of the ability to live happily, productively, without being a nuisance. Now, that is a historical definition, but recognise that it introduces the notion that our understanding of what mental illness is has a sort of cultural, social element to it. You know, what our culture says is OK or isn't OK at this particular period in history. And that changes with history. It also changes depending on which political regime you're in.
[23:58] You don't have to go back very far to remember how the former Soviet Union used psychiatric illness and used detention in psychiatric hospitals to deal with their dissidents.

Because if you didn't believe that the Soviet Union was marvellous, then clearly you were mentally unwell. So the power that resides in the field of psychiatry is very considerable, to determine somebody to be unwell and detain them against their will.
It's not straightforward how we make these definitions. And it's also fair to say that what the psychiatrists do is that there are two sort of, two major sort of ways of, or sort of manuals for defining mental illness.
One is called the Diagnostic and Statistical Manual, which is predominantly used in the States, and then there's an International Classification of Diseases. Some of you work in the field and you know all this, but others of you don't. And those give very strict criteria by which you make your diagnosis. And that's useful because then it makes sure that schizophrenia in South Africa is the same as schizophrenia in the UK, etc. And so we can do our research and make comparisons. But these are the manuals that enable us to make these diagnoses.
[25:29] But there is a concern of a broadening of terms, of a widening of the categories that capture more and more people.

Hence the question about, you know, when we say one in four of us have a mental health problem in a given year, what are we saying is that problem? The revision...
So the DSM is now in its fifth edition. And the man who was involved in working at the fourth edition had this to say about the fifth edition. He said, many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and behavioural addictions will soon be mislabeled as psychiatrically sick.
So otherwise, it's sort of the medicalisation of normal life, the beginning to describe our normal struggles with psychiatric labels. And many within the mental health world have concerns about the way that this is happening.
There's a psychologist called Richard Hallam who writes very strikingly on this. Abolishing the concept of mental illness is the title of his book.
[26:57] And whilst I wouldn't walk with everything that he says, it's a very penetrating analysis. And he wants to return to the language of a woe. He says, for a person who suffers from or has to endure a woe, you know, tough things in life, hardness that we all know exists in life, for somebody who suffers from or has to endure a woe, a label of mental illness can be confusing.

Their woe becomes an it, an object that must be passively accepted rather than understood and confronted as something that can be changed. Do you see what he's saying?
He's saying, look, move you into a patient category, move you into somebody with a problem that the medical profession needs to sort out and you move into a sort of passive patient mode, losing our capacity to help ourselves.

And there are many who think that this medicalisation of life that is taking place is creating this kind of problem for us. Now, I know that I'm sort of, I'm deliberately messing with your thinking a little bit at this stage.
So, understand that I know I'm being a little bit provocative and we've got a question time for you to come back at me at some of this. But I think this is important. I'm not doing it sort of casually. I think something is happening in our society about the way in which we are rethinking our problems, the way in which we address those problems and what that therefore does to our own capacity to help ourselves and help other people around us.
[28:31] some of you, in response to me being a little provocative, are now thinking, well, hang on a minute. I mean, mental illness is mental illness.

You know, I mean, it's an illness. You know, people have clinical depression. You can't go just sort of, you know, I mean, you're not going to tell me that diabetes is a construction of our society.
It's a real thing. And clinical depression, well, it's the same. That's another illness. Well, the thing is that psychiatric diagnoses are different to other diagnoses.
Generally speaking, when a doctor makes a diagnosis, of a physical illness, he or she will invariably have some biological marker, some CT scan, some biopsy with analysis of cells that then provides them with the data on which they make their diagnosis of bowel cancer or diabetes or whatever it might be.
Psychiatrists hardly ever have that. And a psychiatric diagnosis is based on what a person describes to you and what you, as a psychiatrist, observe.
[29:56] Now, that doesn't make them kind of less important. It doesn't make them less real. I'm not minimizing the experience at all.

I'm just saying it's a different kind of thing that we are dealing with when we think about psychiatric illness. And that matters.
And one of the reasons it matters is because it sort of affects where we might look for solutions.
Because I've taken a long time to get here. But I now want to sort of ask, how do we think biblically about these kind of experiences?
And the first question to ask is, do we really have a place at all? You know, why have we gathered to do this this morning? You know, why have you come to have a morning thinking about mental health and the church?
Because my guess is, had this been a morning on gastrointestinal disorders! and the church, I might be here on my own.
[31:02] And yet, strangely, actually, if we were doing gastrointestinal disorders, I would feel a little bit more confident about having biblical mandate to do that.

Because I have a verse. Here is my verse, 1 Timothy 5, stop drinking only water, use a little wine because of your stomach and your frequent illnesses. You see, there you are, I have biblical data to put in front of you to help deal with your gastrointestinal problems.
But where will I go in scripture for the verses about anorexia nervosa? Or obsessive compulsive disorder? Or bipolar disorder?
You know, where are those verses? It's tricky, isn't it? You can't find those. And that becomes part of our problem and we sort of, so these two areas separate.
You know, I've got my faith and then we've got mental health problems. And I don't really know how to put these two things together. And I think that's one of the things that pushes the church onto the back foot, pushes believers onto the back foot because I think, well, it's not really our territory.
[32:14] And in the final session we're going to think more about how we deal with that sort of reticence in this area. But let me first persuade you that this is legitimate territory for us.

See, think about the field of psychology. What is psychology? It's the science of mind and behaviour. Put very briefly, you could say psychology tries to work out why we do what we do.
You know, to explore what is it that people do, you know, noticing our behaviour and then trying to find explanations and understandings for why that behaviour or those thoughts take place.
Now, given that, psychology is inevitably going to ask some very fundamental questions about people because it's so broad, isn't it?
psychology, you could say, has got to address at least these four fundamental questions. You know, what is a person? You know, how do we understand a person?

[33:28] Are they, are we complicated animals? So that basically the way that we train our dogs to walk neatly behind us with some sort of behaviour and treats and doggy sweets and all the rest.

Basically, with us, are we sophisticated animals? And so it's the same kind of stuff. Is behaviourism the way to go? And it's all about learning theory. Are people kind of, kind of a bit like complicated computers?
You know, is that the way that our brains work? And so cognitive psychology, that's the way to go. And we'll think about thought processes and sort of logical sequences. And so the therapists that spill out of cognitive psychology are going to be the way that we operate.
Or are we meaningless people in a meaningless world in which there is nothing after death, that we are mere accidents and that in the face of utter meaninglessness we have to be bold and try and create meaning for ourselves.
Which is what existential psychology would say. And the humanistic psychologies that spill out of that area and the humanistic therapies that spill out of that area like existential psychotherapy, well, they're trying to help somebody to come to terms with the meaninglessness of life and live boldly and bravely despite that.
[35:02] So you see, who we think we are as a person profoundly affects how we will then go about trying to help somebody. Let me push on to the other questions more briefly.

What goes wrong with us? Is it errors in our thinking process? is it stuff from the past? And until you make a decision about what has gone wrong with us, you won't know how to fix us.
Because your remedy will spill out of your conviction about what has gone wrong. And then, perhaps the most fundamental question of all, what's the goal of life?
Because if you're offering somebody therapy, you are trying to help them to get somewhere, aren't you? Well, where? Is your goal for people to be happy?
Is your goal for people to get on well with one another? Is your goal to help people be successful? Your aim, your understanding of what a person is for, what the goal of life is, profoundly affects the direction of travel of your therapy.
[36:20] course it does. Because what is the ideal state that you're trying to help a person to arrive at? Now, clearly, if you're a Christian believer this morning, then you have answers to all of these questions.

Because they are fundamental questions. The Bible tells us who we are, creatures made in God's image. Talks to us about the problems that rebellion against God has brought into our lives.
Has lots to say about God's remedy and the way that that remedy plays out in a community of believers together. And there's plenty to say about the goal of life, to bring glory to our creator.
So the idea that I've got my faith over here and then mental health problems over here just doesn't quite wash. Christianity speaks directly into this territory of thinking and academic research and study.
And the best psychiatrists know that. Here's Stephen Hyman, who was the head of the American National Institute of Mental Health, which is the pioneer organization of the States.
[37:47] He had this to say, we psychiatrists have been given an impossible task. Our medications are sometimes able to alleviate symptoms, though they often come with side effects, but we cannot give people what they really need.

People need meaning and relationship. That's a delightfully humble statement from a psychiatrist at the very top of his profession. that he recognizes that actually there are limitations to what the field of psychiatry and the mental health enterprise is able to offer.
And something more is needed. And if we sort of lose our nerve and think we haven't got anything to contribute because this is kind of specialist stuff that we need to take hands off, then I think we're letting people down.
Because in the gospel and in the community of the church, we have fantastic, we have the most glorious things to offer, which make a profound, please understand I'm not being simplistic at this point.
I'm not imagining that just tell people that Jesus loves them and their depression will go away. You know I'm not saying that. I'm not being simplistic. But I'm saying that we need to find a way to take the riches of Christ's mercy to us and bring it to bear upon every aspect of every one of our lives and the lives of people we care about and that we're in danger of not doing it very well in this area.

[39:19] That's the point I'm making. We've got to do the hard work of working out how, but we can do it. Thank you. Very briefly, I know we've slightly overrun.

Oh, yes, that slide. Okay, I'm going to do this. The model that you're going to hand out, I think I'll save that for the second session. Take four sort of very broad categories of struggle that people have.
Think about people who are depressed. Well, despair, lack of purpose, guilt, all of those things would be very prominent in the experience of depression.
Well, the Bible has lots to say about hope in the face of despair. I mean, what is despair? Despair is lack of hope. The Bible has plenty to say about hope. Think about the experience of anxiety and fear.
Think about jinn that we talked about earlier with his paralyzing terror of what he might do to his own daughter. Well, anxiety is a form of fear.
[40:34] And we think about Jesus' teaching in, say, Luke 12. You have a heavenly father who cares for you. It speaks to the experience of anxiety and fear.

Or PTSD, post-traumatic stress disorder, where there is a profound disturbance to my sense of safety and security because of traumatic things that have happened in my past.
And I am disturbed by, is this world safe anymore in some way or other? Think about psalm after psalm.
my quiet time this morning. I read one. You know, your refuge. The Lord is your refuge and your strength. You know, that kind of language comes again and again.
Or think about addictions and how you would hear somebody who struggles with an addiction speaking in terms of, I'm just, you know, I can't help myself.
[41:38] You know, when these addictive urges come over me, I can't manage to resist them, this sense of powerlessness that people have. And you think about the way that, say, in Romans, Paul explores the idea of slavery to sin, of somehow being trapped by sin, being under its mastering power.

And you can't help thinking that there must be something there. There must be some connections that we can uncover if we begin to explore that carefully and thoughtfully. Now, again, I've done those four very quickly.
And I want to say again, because I'm terrified that you go away from this thinking that somehow I think this is simple and quick and easy to do, and I don't.
But I do think that there have to be connections. And if we work hard at working out what those connections are, how to bring the riches of Scripture to bear upon the realities of these struggles, we've got things to say.
We'll save the model for afterwards. Let me, I can't remember what I'm doing now, I'm going to pray and I'm going to hand over to, back to Louise. Let me leave this in a prayer, can I?
[42:57] Father God, we've travelled very quickly across a whole range of areas, touched on different experiences of mental distress and struggle, mental illness.

Pray that you would help us to think increasingly well in this area. And I pray that you would grow our compassion, you would grow our wisdom, and you'd grow our confidence that we, in our churches, with the riches of Christ's grace to us, that we have precious things to offer as believers and as church communities.
And through the day, through all the different things we're going to think about, through the conversations we're going to have now over a short break even, pray that you would be prompting us to think how we can do better in this area.
In Jesus' name, Amen. Amen.