

**MADNESS  
&  
GRACE**



# MADNESS & GRACE

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*A Practical Guide for Pastoral Care  
and Serious Mental Illness*

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# Introduction: Engaging the Crisis

**M**adness, or what today we call serious mental illness, has been part of the human experience throughout recorded history. Families, both in the present and distant past, have struggled to understand the strange thoughts, emotions, and behaviors displayed by their afflicted loved ones. More often than not, these ill individuals and their families have been stigmatized, shamed, and mistreated by the fearful and naïve. However, one light in the dark history of madness has been the involvement of the church in the care of the broken. Long before there were effective treatments or an understanding of the role of the brain in mental illness, Christian communities stepped forward to care for the “least of these.” One of the best examples of this happened in the famous “*village of lunatics*,” the Belgian town of Geel.<sup>1</sup>

The story of Geel (pronounced *Hyale*) begins in the seventh century with a young Irish princess named Dymphna. The daughter of Damon, a tribal king of Oriel, Dymphna and her mother were devout Christians, while her father still followed the ancient pagan rites. When Dymphna was fourteen years old, her mother suddenly died and her father was

overcome by grief. As time passed, Damon sank deeper into depression over the loss of his wife, making it difficult for him to effectively rule as king. To raise his spirits, the men of his court suggested he consider a second marriage. Damon agreed on the condition that his new queen be as beautiful as his former wife. Searching throughout all of Ireland, he could find no woman as beautiful as the former queen, with the exception of Dymphna, who was the very image of her mother. Mad with grief, Damon decided that Dymphna should become his wife and take her mother's place as queen. To escape her father's sinful passions, the young princess fled during the night with her priest, Father Gerebran, and two loyal servants. Finding Dymphna gone in the morning, an enraged Damon sent his men out across the countryside to find her.

A year would pass before a small band of Damon's men, still searching for Dymphna, stopped at an inn outside the Belgian village of Geel. While paying their fees, they were intrigued to find that the innkeeper had seen their strange Irish coins before. The innkeeper explained that a group living nearby paid for goods with the same type of coins. Dymphna had been found! The men immediately sent a messenger back to Ireland to inform Damon. When the king learned of Dymphna's whereabouts, he personally traveled to Geel to retrieve his runaway daughter. Threatening Dymphna, the king commanded that she return home to become his wife or he would have Father Gerebran killed. Dymphna refused. Damon ordered his men to kill the priest in front of her. Again, Damon demanded his daughter take her mother's place as his wife, and she refused. Overcome by rage, Damon struck down the young princess with his own sword. Leaving the bodies behind, the king and his men returned to Ireland. The people of Geel buried the princess and her priest in a nearby cave.

Six hundred years later, early in the thirteenth century, excavation in and around the cave accidentally unearthed Dymphna's remains. Legend has it that several men and women suffering with madness in the area were miraculously healed upon the discovery of the grave. Word of these miraculous healings quickly spread throughout the region, and families began bringing their afflicted loved ones to pray at Dymphna's grave, with the hope that they might be healed too.

As more and more families made the pilgrimage to Geel for a miracle, the priests of nearby St. Maarten's Chapel built a shrine to hold Dymphna's relics. Dymphna was canonized by the church in 1247, and in 1349 a church honoring her was built in Geel. Within a short time, so many pilgrims were coming from across Europe to seek healing for the mentally ill that a small infirmary was built next to the church to help house them. While some did find healing, most did not. Many of the disappointed families used this opportunity to rid themselves of mentally ill relatives by leaving them at the church and returning home. It wasn't long before the sanctuary and infirmary were overflowing.

In desperation, the priests reached out to the townspeople for help. Out of charity and Christian piety, the people of Geel began taking the mentally ill into their own homes. Many of the afflicted would live out the remainder of their lives with these new families. Thus began a tradition of care that has continued for 700 years. In 1938, the community reached an all-time high when a total of 3,736 mentally ill "boarders" were placed with families in Geel. Today a modern psychiatric center sits on the site of the old infirmary next to the Church of St. Dymphna, and Geel families willing to take in a mentally ill individual have been incorporated into the modern mental health-care system. In 2019, 185 individuals were living as boarders in Geel.

If peasant farmers of the Middle Ages, empowered by their faith, could step into an impossible mental health crisis and transform tens of thousands of lives, how much more might believers do that today? The church still has a significant role in caring for those living with mental illness, and as this small Belgian town teaches us, compassion, grace, and love are powerful "treatments" it can use in such care.

## **MENTAL ILLNESS BY THE NUMBERS**

In the United States, one out of every five adults (48 million) will experience mental illness in a given year. Perhaps a more disturbing statistic is that almost 60 percent of adults diagnosed with a mental illness receive no treatment. Ethnic minorities access mental health care at even lower rates

than Caucasians (African-American, 30 percent; Hispanic, 27 percent; Asian, 18 percent; and Caucasian, 46 percent).<sup>2</sup>

Mental health problems also negatively impact the family and friends of the afflicted. An estimated 9 million individuals in the United States provide care for an adult with a mental illness annually. Those caregivers provide, on average, thirty-two hours of unpaid care per week. When surveyed, a vast majority of caregivers report that the situation causes them significant emotional distress, while just over half say that it has negatively impacted their own health. In addition, caring for a mentally ill loved one often results in significant financial problems for the family.<sup>3</sup>

## THE “SYSTEM”

Our present mental health-care system is badly broken. Unlike other areas of health care, mental health care lacks a continuum of care for those needing treatment. A continuum of care is an organized system of care that moves patients, over time, through a series of health services of varying intensity. Each step in the continuum up to hospitalization represents an increase in the intensity of the services or treatments provided. The hope is that earlier steps in the process will act as a filter, minimizing the number of people that need higher levels of care. Each step in the continuum following hospitalization represents a decrease in the intensity of care, with the goal being to effectively prepare people for a return home while reducing the chances of rehospitalization for the same problem.

The table below shows that the health-care system has a well-defined continuum of care compared to the mental health-care system, which has few levels of pre-acute care, a high frequency of emergency room visits and acute hospitalizations, and no post-acute care. This has resulted in a significantly higher thirty-day rehospitalization rate for mental disorders, such as depression, bipolar disorder, and schizophrenia, compared to conditions that are unrelated to mental health.<sup>4</sup>

To illustrate how differently physical and mental illnesses are treated by these systems of care, let's look at two examples based on actual clinical cases.

## COMPARING THE HEALTH-CARE AND MENTAL HEALTH-CARE SYSTEMS

Health-Care System	Mental Health-Care System	Phase of Care
Home Wellness/Fitness Center Pharmacy Urgent Care Primary Care Physician's Office Diagnostic Imaging Center Specialist Outpatient Procedure Center	Home Primary Care Physician's Office Mental Health-Care Provider	Pre-Acute
Emergency Room Hospitalization	Emergency Room Hospitalization	Acute
Skilled Nursing Facility Extended Care Facility Inpatient Rehabilitation Outpatient Rehabilitation Home Health Care/Hospice Home	Home	Post-Acute

Linda is a thirty-eight-year-old mother of three. She and her husband Ron have been married for ten years. For the last several days, Linda has been having indigestion and abdominal pain following meals. One morning, she stopped by the pharmacy to pick up some Pepto-Bismol after dropping her son off at kindergarten. Linda tried the over-the-counter treatment for two days, but it was ineffective. By the weekend, her symptoms included nausea, vomiting, and a low-grade fever. Ron, thinking she had a stomach bug, suggested Linda go to the local urgent-care facility. There she was given a prescription for antibiotics and an anti-nausea medication. Five days into the antibiotic treatment, her fever and vomiting were gone, but she was still

having daily abdominal pain and indigestion, so she made an appointment with her primary care physician (PCP). The PCP completed a physical exam and ordered blood work. The results of the blood work showed the presence of an infection and suggested she may have a gallstone, so the PCP ordered an abdominal ultrasound and prescribed another round of oral antibiotics. The outpatient ultrasound showed inflammation of the bile duct, a stone blocking the opening of the first part of the small intestine, and significant inflammation of the pancreas. Linda was diagnosed with gallstone pancreatitis and referred to a general surgeon. The general surgeon admitted her to the hospital for a round of intravenous antibiotics before removing the gallstone and gallbladder using an open surgical procedure. Linda was in the hospital five days before she was discharged. Because a more invasive open surgical procedure was used, the surgeon requested that she have home health care for two weeks following discharge.

Linda's health-care journey started with symptoms common to many medical problems: indigestion and abdominal pain. She entered the health-care system at the pharmacy but also engaged urgent care, her PCP, a diagnostic imaging center, a surgeon, a hospital, and home health care. Her symptoms were present for two days before she went to the pharmacy and seventeen days before she was hospitalized for surgery. In total, she received thirty-four days of care, plus a follow-up appointment two weeks later with the surgeon.

Now let's look at a mental health-care example.

Tonya is a thirty-two-year-old mother of two. She and her husband Jim have been married for six years. One day, Jim came home to find that his wife had bought all new living room furniture. He was surprised she would spend so much money without consulting him. Tonya had always been very careful with the family's money. While Jim's job allowed them to live comfortably, they didn't have extra cash

readily available for such an extravagant purchase without planned saving. The following day, Jim came home to find a new set of golf clubs waiting for him. He confronted Tonya about the purchases, but she said that buying things on credit was common and he should not worry about it. Tonya's spending only increased over the next two weeks. She charged both of their credit cards to the max and drained their savings. Nights were filled with Jim trying to explain to his wife the financial hole they were now in, but she seemed unconcerned. Jim also noticed that Tonya was sleeping very little and had become obsessed with keeping the "perfect" house.

Jim asked Tonya's parents to speak with her, but when they did, she again minimized the problem and said that having some debt was just the "American way." Jim also found out that the normally health conscious Tonya had started smoking. After another week of excessive spending and ever-increasing odd behavior, Jim made an appointment for him and Tonya to meet with their pastor. After listening to the couple's story, the pastor felt that the problem resulted from a lack of communication and Tonya's poor stewardship of God's financial resources. He suggested they meet with another couple in the church for marital guidance and begin attending a stewardship Bible study offered by the church. Jim and Tonya did meet with the other couple and began attending the Bible study, but things only got worse. Tonya was becoming more and more paranoid. She was absolutely convinced that Jim was having an affair with their neighbor, which caused an even greater strain on the couple's relationship. Then one afternoon Jim came home early to surprise Tonya. When she saw him, she screamed and ordered him out of the house. She ran to their bedroom, locked the door, and called 911 to report an intruder. When the police arrived, she said she did not know Jim and that he had broken into the house. After Jim proved to the police that he did indeed live there, an ambulance was called and Tonya was taken to a psychiatric hospital. She was diagnosed with bipolar disorder. After

four days she was discharged to her home with a phone number for a local psychiatrist. Jim called the next day to schedule an appointment for Tonya, but the receptionist said that “due to privacy laws” Tonya would need to make her own appointment. Two days later Jim was finally able to convince Tonya to call the psychiatrist’s office. She scheduled the first new-client appointment available, which was eight weeks away.

What few knew was that Tonya had suffered with significant depression at two different points during her life. The first time was when she was eighteen and went off to college. That semester, she spent most of her time in bed, failed two courses, and barely passed the others. Her parents thought it was because the high school-to-college transition had just been too difficult for a small-town girl like Tonya. By the spring semester, she returned to being her normal outgoing self.

Her second bout with depression had happened two years before, after the birth of her second child. Tonya had experienced what she assumed was the “baby blues.” Her family and friends assured her it was normal, and once again, she struggled through without any mental health care. Now thirty-two, Tonya entered the mental health-care system in crisis, although the onset of her mental illness had actually begun fourteen years earlier. In women diagnosed with bipolar disorder, the first episode is most often depression rather than mania. In total, she received four days of care and a referral to a local psychiatrist.

Presently, we do not have a true mental health-care “system” in this country; instead, we have a set of disjointed mental health resources that are often difficult, if not impossible, for struggling individuals or families to locate and engage. This is not to say that psychological and psychiatric treatments do not work. Research clearly demonstrates that when individuals diagnosed with mental health conditions receive proper treatment, the vast majority show clinical improvement.<sup>5</sup> The problem, however, is that most individuals diagnosed with a mental illness never receive any treatment.



## BARRIERS TO ACCESSING CARE

Once an individual or family attempts to engage the mental health-care system, they are confronted by obstacles that significantly hinder their ability to access services. The common barriers to accessing mental health care can be placed into three broad categories: availability, affordability, and acceptability.

**Availability.** There are simply not enough mental health-care providers to meet the growing demand for care. The U.S. Department of Health and Human Services estimates that a third of all U.S. residents (113 million) live in areas where there is a shortage of mental health professionals. Over half of U.S. counties have no practicing psychiatrist, while a third have no psychologist.<sup>6</sup> Access to care is also hindered by a serious shortage of psychiatric beds, of which fewer than one hundred thousand are available in the United States (general hospitals, 35,640; state psychiatric hospitals, 37,679; and private psychiatric hospitals, 22,020).<sup>7</sup> In other words, there are twenty-nine psychiatric beds for every one hundred thousand people! As a result of this lack, there are ten times more individuals with mental illness in our jails and prisons than in psychiatric hospitals. Our emergency rooms have become de facto psychiatric crisis clinics.<sup>8</sup> Finally, with providers and facilities being few and far between, transportation becomes a significant barrier to accessing care. In a recent survey of U.S. adults, almost half report that they or someone they know had to drive more than an hour round trip to get to their most recent mental health-care appointment.<sup>9</sup> For many, distance is a barrier that simply cannot be overcome.

**Affordability.** Cost is the primary reason that individuals report being unable to access mental health care.<sup>10</sup> Health insurance reimbursements to providers are far less generous for mental health conditions than for physical health issues, despite the Mental Health Parity and Addiction Equity Act signed into law by President George W. Bush in October 2008. Many health insurance policies don't even cover mental health care. This has caused many mental health providers to require payment directly from the patient rather than accept insurance. A recent study found that only

55 percent of psychiatrists accept private insurance or Medicare. Even fewer accept Medicaid (43 percent).<sup>11</sup> This same trend has occurred with psychologists, further limiting the mental health-care providers available to most patients.

**Acceptability.** Negative attitudes and beliefs toward people who suffer with mental illness are common.<sup>12</sup> In fact, social stigma is the second most common reason people report for not accessing mental health care. Myths—for example, that individuals with mental health problems are violent, lazy, or demon possessed—permeate our society. In a recent survey, a third of individuals with mental health problems reported worrying about others judging them, while a quarter said they had lied to avoid telling people they had sought mental health services in the past.<sup>13</sup>

## A DIVINE OPPORTUNITY

Research over the last seven decades has consistently demonstrated that individuals in psychological distress are more likely to seek assistance from a member of the clergy before looking for help from a PCP or psychiatrist.<sup>14</sup> This is especially true in minority groups.<sup>15</sup> Viewed through the eyes of faith, it is obvious that this is not an accident but rather a divine opportunity for the church to take the lead in caring for those afflicted by mental illness.

There appear to be three main reasons that people struggling with mental health seek the assistance of clergy before other professionals. The first is ease of access. In many communities, there is a church on every corner, and these churches generally do not charge for their services. Thus barriers related to transportation and finances are removed. Second, churches are healing communities called by God to care for those in need. That's why, historically, the counsel of a wise and godly pastor has been valued in times of distress. Finally, mental illness strikes at reason and emotion—the very heart of what it is to be human. This causes most to ask the bigger questions of life such as, “Who am I?” and “Do I have value?” These are questions for which only faith has answers.

Unfortunately, a majority of clergy report feeling inadequately trained to recognize the presence of mental illness in those they counsel.<sup>16</sup> This is not surprising, given that few seminaries in North America provide any formal mental health training for students, despite the fact that clergy are just as likely as psychiatrists to be sought out by those with serious mental illness.<sup>17</sup> As a result, fewer than 10 percent of distressed individuals seeking counseling from clergy are referred to mental health professionals.<sup>18</sup> In addition, few faith communities offer programs, services, or resources for congregants living with mental illness, even though a majority of these individuals and their families report that they desperately want their church to be more involved in their care.<sup>19</sup>

## PURPOSE OF THIS BOOK

The primary purpose of this book is to equip pastors, ministry staff, and lay ministers to better serve and support those suffering with mental illness who want assistance from the church. Many chapters contain a section with suggested Scripture verses and a related biblical story to assist you in ministering to individuals and families struggling with mental health problems. In addition, the book is grouped into four broad content areas, which can be called the four *Rs* of mental health ministry: Recognition, Referral, Relationship, and Restoration. The four *Rs* are described as follows:

1. **Recognition.** People seek the counsel of pastors for a variety of reasons, including marital discord, financial problems, and parenting issues, and it may not always be clear whether a problem stems from an underlying mental health condition. Recognizing the presence of a mental illness requires skills in psychological evaluation and assessment. While this may sound complicated, it only involves asking a simple set of standard questions that allow you to identify the person's level of psychological distress<sup>20</sup> and functioning as well as his or her suicidal risk.

2. **Referral.** Once you have recognized the presence of a mental health problem, it may be necessary to refer the individual to a mental health professional. The mental health-care system is complex and confusing, and few pastors have relationships with mental health-care providers beyond their local Christian counselor. To make a proper referral, you must understand the types of services that different mental health-care professionals provide. You must also build relationships with providers who are willing to collaborate with you and to promote a faith-affirming environment within their practice.
3. **Relationship.** Transformation and healing occur in supportive relationships. Unfortunately, due to stigma and misinformation, individuals living with mental illness are often isolated and alone. A supportive faith community cultivates life, while isolation brings frustration and fatigue. Actively working to break mental health–related stigma, educating your congregation, and building meaningful connections with hurting individuals and their families are important components of effective mental health ministry.
4. **Restoration.** Developing faith-based supportive services (e.g., support groups) and ministries within your church allows the individual or family seeking help to obtain some level of therapeutic care within the healing environment of the faith community itself, rather than always being sent away to get “fixed.” Much like those desperate families who traveled to Geel in the Middle Ages, God is drawing those suffering with mental illness to his church, and we must be prepared to receive them.