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Counseling in the church : a proposed strategy for ministering to mental health needs in the church

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ABSTRACT

During the past several years there has been a growing concern for developing efforts to reduce mental health problems especially through primary prevention within the mental health establishment. However, the possible role of the church in preventive efforts has been largely ignored. Similarly, although there is considerable interest in counseling within the church, the church also has directed little concern toward the prevention of mental health problems. The church's mission is multifaceted, centering on loving submission to God and loving ministry to those about us. Meeting personal needs in a way which can minimize mental health problems clearly falls within the scope of this mission. A ministry strategy is proposed which encourages the church to concentrate on fulfilling its mission effectively. If effectively implemented, this strategy will also contribute to fostering mental health.

INTRODUCTION

During the past decade concern for holistic health has emerged as a growing trend on the national scene. Publication of reports showing that consistent practice of a handful of life-style habits increased physical health and life expectancy significantly sparked a dramatic growth in emphases on maintaining and enhancing health. To no small degree this movement has been enhanced by a well-justified recognition that one of the most effective ways to control rapidly growing health care costs was through maintaining positive health and wellness rather than through the treatment of recognized illness. Sadly, these constructive developments have almost completely bypassed mental health.

In a recent historical review of efforts to develop prevention approaches to mental health, Goldston (1986) reports,

> . . . some specific *continuing* and *unmet* needs merit high priority. Among the continuing needs I include (a) new knowledge derived from basic and applied research: (b) well-evaluated prevention service intervention models; (c) ongoing information dissemination on research in progress; and (d) additional prevention centers with the capabilities for preventive intervention research and investigations on issues of prevention service delivery, training, and knowledge transfer. (pp. 455–456; italics original)

PREVENTIVE CARE

Goldston goes on to call for "preventive trials" of specific interventions, for a focus on prevention of specific DSM III (American Psychiatric Association, 1980)

disorders along with a focus on fostering "quality of life," for consistent efforts to develop public awareness of and support for primary prevention, and for focus on *primary* prevention (i.e., preventing initial occurrence of mental disorders).

Goldston highlights the issue of developing public understanding of prevention as a key one, noting that recent epidemiologic data suggests that 19% or about 40–50 million Americans currently manifest symptoms of mental illness. He quotes George Albee, who notes that AIDS and genital herpes have gained tremendous public attention although they affect only a tiny fraction of the number of people affected by mental and emotional disorders.

In discussing his proposal for how to foster interest in prevention, Goldston suggests we need to practice "the principles of maximum participation" (p. 458). He goes on to outline a network of federal and state prevention efforts working together with researchers and mental health professionals at all levels, all working in coordination with the national citizens mental health movement. Notably absent is any proposed role for the church.

Almost simultaneous with Goldston's publication is an article by Long (1986) reporting on the work of the National Mental Health Association (NMHA) Commission on the Prevention of Mental-Emotional Disabilities. The Commission reported excitement about the possibilities of prevention and frustration in realizing preventive goals. The Commission noted that mental health does not receive an equitable allocation of resources, and that within mental health, prevention has been neglected. Especially considering the potential cost benefits, the modest sums allocated to prevention, compared with treatment, seem shortsighted. In summary,

> . . . the Commission found that (a) a substantial and rapidly expanding knowledge base exists to direct efforts in the prevention of mental-emotional disabilities; (b) the present application of that knowledge is creditable but far from sufficient, and (c) a prudent investment in prevention research and intervention over the next decade would dramatically lower the incidence of mental-emotional disabilities. (p. 826)

The Commision made specific recommendations for action to federal and state governments, the NMHA, and local agencies. However, "The Commission paid special attention to the roles of the schools, the workplace, and the media in the prevention of mental-emotional disabilities" (p. 828). It seems a striking oversight that again the role of the church is completely overlooked, both in the Commission's recommendations and in the composition of its forum of contributors.

Although the President's Commission on Mental Health's (1978) Task Panel on Community Support Systems included a brief section on the role of religious support systems in mental health, this inclusion stands out as an exception in the literature, which otherwise neglects the role of the church in mental health.

While the role of the church in mental health and mental health prevention has been almost completely ignored by the mental health community, a handful of professionals within the church have been calling for the church to become active in meeting the needs of its own, not only through the provision of counseling, but through prevention as well (e.g., Bufford & Johnston, 1982; Johnson, 1973; Uomoto, 1982). In particular, Bufford and Johnston argue that the church is ideally suited to exert a leadership role in promoting positive mental health and thus in primary prevention because of its vast pool of voluntary service workers, its commitment to a creedal system which offers meaning and purpose to the vicissitudes of life, and its emphasis on the development of a caring and supporting community.

In the material which follows we will discuss the role of the church as indicated by biblical mandates, the place of mental health concerns in the church in light of its

mission, and a proposed strategy for mental health prevention and intervention within the Church.

Concepts of Prevention

One of the problems of prevention in the field of mental health is the problem of definition. In his early work Caplan (1964) delineates three levels of prevention, primary, secondary and tertiary. **Primary prevention** is concerned with the initial occurrence of mental disabilities; it reduces the incidence of mental illness much like smallpox vaccination reduces the incidence of smallpox. **Secondary prevention** is concerned with early detection and treatment so that the severity and duration of the disease are minimized and recovery expedited, much as early detection and treatment reduce the harmful effects of cancer. **Tertiary prevention** focuses on rehabilitation and reintegration into the community to prevent relapse or chronic complications, in a fashion similar to the provision of an artificial leg and training in its use for an amputee.

The problem which Goldston identifies in current approaches to prevention in the mental health field is, at least in part, related to this multiplicity of levels of prevention and the tendency to refer to all as "prevention." Goldston reports that initial prevention efforts focused on *primary* prevention; however, more recent work does not clearly differentiate efforts to prevent initial occurrence from efforts to ameliorate severity and subsequent disability. It is thus possible for persons involved in traditional approaches to treatment to describe their work as prevention inasmuch as they are reducing the likelihood of prolonged and more severe problems. The result, Goldston laments, is that primary prevention, his principal concern, gets even less attention than the meagre prevention budgets might suggest.

MENTAL HEALTH AND THE CHURCH

The Mission of the Church

At first blush it may seem that there is little room in the mission of the church for concern for mental health prevention. However, before we draw such a conclusion, it seems important to ponder the mission of the church.

The mission of the church is multifaceted. In his discussion, Saucy (1972) suggests that the church has a mission (a) toward the kingdom of God to provoke Israel to jealousy so that she will seek God, to display God's grace and wisdom to the world through God's unfolding plan of salvation, and to prepare rulers for the kingdom; (b) toward the world to carry out the Great Commission of evangelization, thus reconciling man to God and man to his fellow man is the primary mission; (c) toward itself to edify leading to maturity and to purity; (d) toward God to offer thanksgiving and praise which redound to His glory.

Thiessen (1979) conceptualizes the mission of the church in a similar fashion, identifying six tasks for the church: to glorify God, to edify itself, to purify itself through personal and church discipline, to educate its constituency, to evangelize the world, and to promote all that is good. For Thiessen, glorifying God is an overarching task which seems to include each of the others.

To those areas identified by Saucy and Thiessen, W. R. Cook (personal communication, Sept. 12, 1986) adds one additional task, that of deeds of mercy and compassion toward the poor, needy, widowed and orphaned, ignorant and oppressed. Cook states, "A balanced view of the church's mission will give prominence to evangelism and edification but will not neglect social concern." Tillapaugh (1982) likewise affirms that the task of the church includes finding those in need and ministering to them. Tillapaugh suggests an approach which he terms "target

grouping." Target grouping involves identifying those groups within the community who share distinctive needs and developing a strategy of ministry to meet those needs and thus create the opportunity to evangelize.

An examination of the instructions of Jesus while he was involved in earthly ministry suggests three central themes, differing only slightly from those we have already examined. These include: (a) The "great commandments:" "The foremost is 'Hear, O Israel; The Lord our God is one Lord; and you shall love the Lord your God with all your heart, and with all your soul, and with all your mind, and with all your strength.' The second is this, 'You shall love your neighbor as yourself.' There is no other commandment greater than these" (Mk. 12:30–31, NASB); (b) The "new commandment" which Jesus gave to his disciples just before the crucifixion: "A new commandment I give to you, that you love one another, even as I have loved you, that you also love one another" (John 13:34); (c) The Great Commission: "Go therefore and make disciples of all the nations, baptizing them in the name of the Father and the Son and the Holy Spirit, teaching them to observe all that I commanded you" (Mt. 28:18–20). Taken together, these commandments begin with love of God and our fellowman, then move to manifestation of that love toward fellowbelivers, and then to all mankind; special emphasis is given to the evangelistic task.

Though many select one mission of the church to emphasize as the primary task, it seems inadequate to single one out in this manner. Rather, all the missions are intertwined. Promoting human welfare and good provides the opportunity for evangelization. Education in the ways of God is essential to ministry and service. The maintenance of a stable world order provides the context in which all of the tasks can be carried out. Finally, as noted above, all bring glory to God when done in His name as acts of loving obedience to His Lordship.

A first question to face in seeking to understand the commandment to love our neighbor is the question of who is my neighbor. Interestingly, this question was posed to Jesus immediately after he gave the command. In response, he told the parable of the Good Samaritan, then ended with the question, "Which of these three do you think proved to be a neighbor to the man who fell into the robbers' hands?" (Luke 10:36). As we explore the implications of loving our neighbor, it becomes more plausible that mental health is one dimension of such loving concern.

In giving the Israelites the law God promised "If you will . . . keep all his statutes, I will put none of the diseases on you which I have put on the Egyptians; for I, the Lord, am your healer" (Ex. 15:36; cp. Deut. 7:15). God also warned that if they did not heed his voice he would bring on them all the diseases of the Egyptians (Deut. 28:60). Jesus states this notion in a more positive fashion. He says, "I came that they might have life, and might have it abundantly" (John 10:10).

The diseases referred to in Deuteronomy include psychological disturbances such as despair, dread, and mental anguish (Deut. 28:66–67f). It seems likely that the abundant life includes the opposite qualities, especially in light of Jesus' teaching that he has come to bring peace rather than tribulation (John 14:1, 27; 16:33), and Paul's instruction that "the kingdom of God is not eating and drinking, but righteousness peace and joy in the Holy Spirit" (Rom. 14:17).

In a similar fashion, Paul contrasts the deeds of the flesh and the fruits of the Spirit (Eph. 5:13–23); this section begins with a reminder of Jesus' command to love our neighbor as ourselves (v. 14) and concludes with the instruction, "So then, while we have opportunity, let us do good to all men, and especially to those who are of the household of faith" (Eph. 6:10).

From these sections it becomes clear that loving our neighbor is not optional in the Christian life, and that the abundant life includes physical and psychological as

well as spiritual wellbeing. It is thus clear that the mission of the church extends to concern for the mental health of its members and the mental health of all people.

Mental Health Concerns in the Church

As we have seen, the mission of the church is multifaceted. Ministering to those in need, identifying target groups for ministry, is a part of that task. Although not the central focus of the mission of the church, ministry to the needy is at once obedient to God's direct command to do good to all, supportive of the central theme of bringing glory to God, and provides the opportunity for evangelism, the church's primary mission to the world. Thus, a healthy local church must surely consider such ministry.

Ministering to mental health needs in the form of prevention as well as through the care and treatment of those afflicted fits within the context of ministry to those in need. In America today the chronically mentally ill are our contemporary lepers. They are outcasts, unwanted and unwelcome in society. Few care to minister to their needs, desperate though they may be. In fact, it is common to find open resistance to plans to construct mental health facilities, halfway houses, and sheltered care homes in many communities. Sadly, many of the mentally ill are unwanted, shunted away from kith and kin because they are unpleasant or merely unwelcome. It is to minister to these outcasts that we call the church.

In addition to those who already manifest chronic mental illness, there is another, much vaster group which is also needy. These are the products of divorce, the single parent families, the lonely wives and husbands and the neglected, abused and battered children. These comprise the widows and orphans of our society. Many live out lives of quiet desperation and loneliness. These are recognized by public health demographers to be "at risk." The likelihood of major mental illness is many times higher among these individuals than for the population as a whole. To these also we call the church to minister.

A Practical Strategy

We have concluded that God's call to love our neighbor as ourselves includes concern for our neighbor's mental health and that the abundant life in Jesus Christ includes the absence of fear, dread, worry, and despair, together with the presence of love, joy and peace. Thus the prevention of mental disabilities and the amelioration of mental disease in the afflicted are a part of the mission of the church. Now we must confront the question of how the church is to go about fulfilling its mission in these areas.

The Church as an Army. Scripture uses many metaphors in seeking to help us understand the nature and function of the church in God's plan. One of those is the analogy to an army. This analogy may be helpful in conceptualizing a strategy for dealing with mental health issues in the church. The analogy of the church as an army is one with considerable biblical basis. Believers are urged to arm themselves (Eph. 6:10–17; Rom. 13:12; 2 Cor. 6:7), to fight a good fight (1Tim. 1:18; 6:12), to serve singlemindedly as good soldiers (2 Tim. 2:4). The Bible itself is likened to a two-edged sword (Heb. 4:12). We have an adversary who must be resisted at the cost of suffering so that we are not destroyed (1 Pet. 5:8–10).

A modern army has many branches: infantry, artillery, air corps, intelligence, police, doctrine and training, supply, transportation, construction, medical, and many others. The structure of an army is designed so that each branch carries out its own unique mission in support of the overall effort. When any branch fails in its mission the whole military effort suffers. The same is true in the Christian army.

The Christian church, the body of Christ, is in a continuing warfare against the forces of evil in this world. The ultimate victory is ours through Christ, but in this life the struggle continues.

There are a number of differences between a physical military force and the Christian army: the Christian army crosses cultures, but does not ignore cultural values. Christ calls "whosoever" on a number of occasions, and his recruiting slogan calls sinners, not the righteous, to repentance. Once an individual is enlisted in the Christian army, there is no provision for discharge and there are no approved dropouts. There is no age limit in the Christian army, no exterior uniform, no fixed "front lines:" the battle is all around us, and ambushes are common. Stresses wax and wane. In many ways the Christian army functions like a counterinsurgency force; there are no "front lines," the enemy is everywhere and uses unpredictable methods and strategies; his agents may even appear in Christian councils of war. Because of this, the casualties are numerous. The wear and tear of the battle is manifested in many ways.

Primary Prevention. In the military context group cohesion has been found to be one of the most important factors in prevention of psychological breakdown on the battlefield. Research on mental health consistently reveals two major factors associated with positive mental health: meaning and purpose in life and involvement in an effective social support system. Bufford and Johnston (1982) argue that a well-functioning Christian church is an ideal context in which these may be provided. The church, through its educational outreach, family life ministry, and shepherding groups, affords the small group cohesion and social support network that are important factors in mitigating the effects of stress on the individual.

A third factor which recent research suggests may be significant in reducing susceptibility to mental health problems is involvement in and commitment to religious belief and practice (Bufford, 1984; Ellison, 1983; Paloutzian & Ellison, 1982).

We have noted that concern for mental health is not the basic task of the church. How then can the church best conduct itself if it is to effectively contribute to mental well-being without neglecting its most important functions? In sum, our answer is that the church can best contribute to prevention of mental health problems by concentrating on doing well its primary tasks of evangelism, and edification and purification. If the local church, through instruction and example, teaches its people to love God and neighbor, encourages people in godly living, confronts sin, and stimulates to love and good deeds, it will have made a major, though unheralded, contribution to positive mental health.

Ways in which the local church can foster mental health in the process of carrying out basic tasks include: (a) teaching the whole counsel of God; (b) involving people in discipling—i.e., practical training in the living out of biblical teaching; (c) fostering small groups whose members minister to each other's needs in all aspects of life, including practical daily tasks, carrying the burdens of illness, grief and the like, sharing meals together, praying for each other, and so on; (d) reducing the experience of psychological stress through practical ministries to material and emotional needs—identifying and seeking to minister to those who are at risk, including the contemporary widows and orphans such as the divorced men and women, and "latch-key" children; (e) dealing prophetically and practically with the moral dimensions of life, including the institutionalization of evil in our culture. For purposes of preventing mental health problems this is a practical outworking of the instruction of 1 Cor. 12:26, "And if one member suffers, all the members suffer with it; if one member is honored, all the members rejoice with it."

The overarching context of the church as a caring and loving community forms the bedrock upon which preventive efforts can be built. Without the individual experiencing this care and love, any other interventions attempted will be resisted.

Secondary Prevention. The motto of the U.S. Army's medical corps is to conserve the fighting strength of the army. While the focus is primarily on function, it is

widely recognized that freedom from pain and suffering enables a soldier to function more effectively. In a similar fashion, the medical corps of the Christian army needs to be concerned with maintaining the effectiveness of each member. This includes relief of the pain and suffering, both physical and psychological, of those injured in spiritual warfare. Scripture clearly forewarns us that the spiritual battle will result in suffering and casualties (1 Pet. 5:8–10).

The medical corps of a modern army operates at several levels or echelons. The battlefield medic works alongside the combatants, providing emergency first aid on the battleground. At the battalion aid station intermediate care is provided and "triage" decisions are made regarding the nature, extent, and urgency of any additional care needed. Those able to do so are returned to the battle; others are evacuated either to a field hospital for further treatment with the expectation of early return to combat, or to a general hospital for more extended care. Studies indicate that treatment near the battle lines and the expectation of early return to service are associated with more rapid recovery from combat-induced psychiatric afflictions (Ingraham & Manning, 1980).

Research shows that early support and help in times of crisis is a key factor influencing severity and duration of mental disability. The pastor plays a key role at this point. First, many turn to the pastor by choice as the first source of aid. Further, the pastor is in a position to help the person make contacts with the most effective available help. At this point the pastor's role is not to provide all the needed care. Rather, the pastor needs to make certain that the individual seeking help makes contact with the appropriate caregivers. As Vander Goot (1983) and Visser (1983) note, there is no question that pastors are, and need to be, involved in personal counseling; however, overinvolvement interferes with other aspects of pastoral responsibilities. The danger is that "pastoral counseling is often paid for by the entire congregation on Sunday when the pastor's (sermon is ill-prepared)" (Visser, 1983; p. 18).

In the church the ministrations of the battlefield medic may be analogous to the comfort, encouragement, and exhortation of a fellow-believer. The Christian counselor in the local church may serve much like the battalion aid-station, providing crisis care, evaluation, and helping to decide regarding need for further assistance. Professional Christian counselors, psychologists, and psychiatrists provide a third level of service corresponding to the field hospital. Finally, psychiatric hospitalization, including acute and longterm care and follow-up correspond to the army's general hospital.

Other ways in which the church may be involved on the level of secondary prevention include helping the individual to find and secure professional aid. The church may provide financial assistance for those of its members who are unable to bear the costs of professional care. Perhaps most importantly, the church can continue to provide support, encouragement, esteem, love and practical ministry to the person during the period of mental health care. The process of therapy is often expedited in this way.

Secondary prevention can be fostered through educational efforts. The pastor can provide an example of safe vulnerability if he demonstrates the ability to acknowledge personal problems and to receive reproof and correction comfortably. Individual acknowledgement of problems can then occur, and help can be offered, probably initially through "counseling specialists" within the local church body, with referral for further evaluation and treatment as appropriate. Referrals and exchange of information up and down the echelon ladder is essential for the smooth functioning of this process.

Tertiary Prevention. In tertiary prevention, the church has a key role in fostering rehabilitation for those sick and suffering and restoration for those who have fallen

into sin and are in need of repentance and changed behavior. It can also offer a cup of cold water in the name of Christ to those needing both short and long term care. God calls us to love those who are, humanly speaking, unlovely. Too often those with chronic mental health problems are unloved and outcast from society. They are the "lepers" of our society. If we do not show them love, who will?

CONCLUSION

For too long, the pastoral staff, often a single individual in small churches, has labored under the need to be "a jack of all trades." In this situation, it is not uncommon for one percent of the congregation to take fifty percent of the staff member's time, often without satisfactory resolution of difficult problems and with resultant decreased service available to those not needing this kind of intense personal pastoral care.

Trained counselors, forming a coordinated multi-level network of care, can extend pastoral counseling care to all members of the church, while relieving the pastoral staff of often unbearable burdens in this area. The use of different echelons of counselors within the local church also recognizes differing abilities and spiritual gifts in the church body. Those with the gifts of exhortation, helps, and administration are fulfilled as they exercise their gifts, and those to whom they minister are edified through receiving their specialized ministry. Training and supervision in lay pastoral care and counseling are, therefore, needed for such ministry to occur effectively.

Counseling must not be elevated above other ministries of the church. Rather, it must be accorded its place within the body among the diverse gifts needed in any local assembly. Meeting people where they are in a practical way enables the church to build itself up in love so that it has the capability for effective witness and service outside the church as well as inside the church.

We are called to love God with our whole being and to love our neighbor as ourselves. We are called to comfort the afflicted with the comfort with which we ourselves are comforted. We are called to rejoice with those who rejoice and weep with those who weep. We are called to bring good news to the afflicted and to bind up the brokenhearted. We are told that true religion is to minister to widows and orphans in their affliction. If, as members of the body of Christ, we take seriously God's call in these areas, we will be about the task of preventing mental health problems. What will we do?

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