Mental Well-Being, Neuroscience, and Religion

with Gillian K. Straine and Mark Harris, "Mental Well-Being, Neuroscience, and Religion: Contributions from the Science and Religion Forum"; Fraser Watts, "Theology and Science of Mental Health and Well-Being"; Lindsay Bruce and Sarah Lane Ritchie, "The Physicalized Mind and the Gut-Brain Axis: Taking Mental Health Out of Our Heads"; Jaime Wright, "In the Beginning: The Role of Myth in Relating Religion, Brain Science, and Mental Well-Being"; William L. Atkins, "Empirical Mindfulness: Traditional Chinese Medicine and Mental Health in the Science and Religion Dialogue"; and Ben Ryan, "The Church and Mental Health: Theological and Practical Responses."

THE CHURCH AND MENTAL HEALTH: THEOLOGICAL AND PRACTICAL RESPONSES

by Ben Ryan

Abstract.   Over the past few years, the number of Christian projects and charities working in the mental health sector in the United Kingdom has increased dramatically. At the same time, scientific and medical understandings of mental health have been advancing rapidly. These parallel trends beg a serious question: is the Christian Church's response to mental health authentically engaging with a changing scientific picture? Are theological questions like responsibility, sin, redemption, and reconciliation taking account of a changing landscape? This is not a theoretical question, but has major practical consequences for developing practical pastoral responses.

Keywords: Christianity; mental health; psychiatry; social action; well-being

Mental health is fast becoming a critical area of British public policy. Over the past two years, few issues (with the inevitable exception of Brexit—the political fallout from the United Kingdom's decision to leave the European Union) have commanded such attention as the promotion of mental health and well-being as a political issue.

The former UK Prime Minister David Cameron certainly maintained a significant interest in the area, making it a key commitment of the Department of Health, with several ministerial appointments and a promise (that would go as yet unfulfilled) to oversee "a revolution in mental health treatment" (Prime Minister's Office 2016). He also took seriously, at least

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for a while, measures of national happiness and well-being (these have been recorded by the Office for National Statistics since 2012). He took some flak (in terms of press coverage and mockery) for that decision, but it was in many ways quite a bold and interesting counter political cultural move to prioritize markers of performance that were not simply economic in nature. Over time, the importance placed by the government on that measure seemed to decline. That notwithstanding, the policy importance attached to mental health and well-being has continued to increase.

This interest among policy makers has led to my own organization, the United Kingdom religion and society think tank Theos, to engage in two separate research projects. Theos is a think tank which provides research, comment, and events analyzing religion and society, primarily in a British context. Our first intervention was a report called *Religion and Well-Being: Assessing the Evidence* (Spencer et al. 2016) which was a study of 139 academic studies into the relationship between "religion" and "well-being" (recognizing the significant breadth in the way both of those terms are understood and evaluated).

The second, which was published in 2017, was *Christianity and Mental Health: Theology, Activities, Potential* (Ryan 2017). This second project was a scoping study; it was not intended to be the final word on anything. It was instead designed to scope out the field of what British Christians are doing in response to mental health, so far as an initial study could identify, and to raise questions for future research.

This article draws out some of those questions and themes. First, it will tentatively point to the evidence of what is widely regarded as being anecdotally true—namely that, in the United Kingdom, Christians are increasing their involvement and producing more and more services, interventions, resources, and responses to mental health issues.

That development raises a number of questions, but this article will look at two in particular: First is how to measure the extent of the activity, and who has ownership of it? Second is how Christian is it? Or, to ask it another way, what is the particular Christian theological or value structure, if any, which underpins that work?

That in turn raises the specter of whether that latter issue matters: Does it matter whether or not there is an authentic Christian approach to the issue of mental health? The answer, I would suggest, is yes, but that conclusion is not necessarily widespread within the sector.

Finally, this article will conclude by exploring some particular theological and theoretical issues in forming a Christian response, both anthropological and explicitly theological, from which we might begin to form the building blocks of an authentically Christian response to mental health. Within the broader context of religion and science, this connects to wider debates about the use of spirituality and religion within medical science (e.g., Wood et al. 2016, and the work of Harold Koenig in the American context), and into

theological debate about the extent to which Christianity has adequately wrestled with the growing medical literature (e.g., Beer and Pocock 2006).

THE GROWTH OF CHRISTIAN ACTIVITY

Anecdotally, there seems to be a pretty broad consensus that a lot of Christian groups are springing up each year with a particular focus on mental health issues. Over the course of interviews conducted for the Theos project on mental health (Ryan 2017), this was regularly stated as the case by practitioners within the field. This ought not to be surprising—in fact, it merely mirrors the reality that society more broadly (and the Church within that) has shown a significant increase in interest in, and awareness of, mental health and the need for additional services over recent years.

Certainly, the public visibility of mental health is growing. It is no longer staggering, though it is still unusual, to see public figures—politicians, athletes, musicians, actors, and prominently over recent months the royal family, open up about their personal experiences of mental health. It does remain a curiosity that that trend is not nearly so widespread among religious leaders (though here too there are signs of change). That does not mean that all mental health issues are popularly well understood or recognized (by any means!), yet the growth of public understanding of some issues has increased dramatically. With that increased understanding comes a natural response. It is only when something is widely recognized as a problem (or at least as being important) that responses start to be formed. There is little money or volunteer resources to be found for issues that are not considered of public importance.

More contentious is the claim that not only public understanding but actual instances of mental illness have increased over recent years. This is the claim that something about the modern world particularly lends itself to poor mental health. Dozens of articles and studies have been produced in the past few years about how, for example, work-life balance (Guest 2002), or particular careers (Michalak 2015), or changing patterns of family life (Centre for Social Justice 2011), or countless other facets of modern life are linked to particular issues of poor mental health or well-being.

The validity of those various claims and reports are beyond the scope of this article, and it is at any rate a moot point as to whether the United Kingdom in 2017 is less conducive to good mental health then Britain in the 1930s, or at any other historical point. What does seem to be to be incontestable, however, is that diagnoses for many mental illnesses and disorders are on the rise (McManus et al. 2016). Whether the causes for that increase lie in the flaws of the modern world, or in our increased medical knowledge and willingness to make such diagnoses, either way mental health is becoming a growing concern of public health and policy.

The effect is that mental health is moving up the agenda of public issues in the United Kingdom, and with that comes increased attention from medical and social services, media and the public, and, of course, policy makers. Under such circumstances it is no surprise to see an increase in charities and third sector bodies (nongovernmental organizations and nonprofits) springing up to confront particular issues—particularly at a time when austerity economics has seen an increased role for the third sector in healthcare and social services. At the same time, since a large percentage of the UK population is Christian, and since the Church has a history of and, in so far as these trends can be detected, a growing contemporary involvement in, social action and providing welfare services (Spencer 2017), it is no surprise to see Christian groups increasing in this space.

Nevertheless, it is interesting to see the spread of activity in the sector. It is very difficult to accurately map everything that is going on for at least three reasons:

(1) The definition of mental health is contested. Differing definitions (and indeed projects and organizations), for example, may or may not include dementia as a mental health issue. Some might consider loneliness to be a mental health issue—where others might see it only as a causal factor of bad mental health. It is difficult to adequately group together clinical issues that would have a sufferer detained under a section of the Mental Health Act, with issues which are not treated medically. Since there is little consensus, it is difficult to map everything that is going on.

(2) A second issue is the extent to which it is possible to keep accurate records of such activity. For example, it has been demonstrated that people who regularly attend some sort of social activity better resist the effects of dementia (see among others Pargament et al. 2004; Koenig 2007; Spencer et al. 2016)—but few would consider it sensible to include every church service or bingo activity as a Christian intervention on mental health. Other research has demonstrated the positive effects associated with ceremonies that provide closure after the death of a loved one (Romanoff 2010)—but again counting all religious funerals would inflate the number of Christian mental health projects considerably, and beyond what most people would understand as a mental health intervention.

(3) So much of what is going on is grass roots level, small-scale work. Such work is notoriously difficult to track. In other research projects with the faith charity sector (Ryan 2016a), I have previously explored the difficulty of keeping track of volunteers, the exact hours they put in, and evaluating how effective that work is. Volunteers, staff, and indeed whole faith-based charities, have a tendency to come and

go—a particular volunteer or leader will get a project going, but when he or she retires or moves on the project may stop. This makes keeping accurate records notoriously difficult.

Given those difficulties, what the Theos research on mental health tried to do was to look at a series of particular mental health issues and identify what was going on in each case. As a base we used the list of mental health problems identified by the mental health charity Mind (Mind 2013), though some were added where existing categories failed to really encapsulate the issues being addressed by some Christian charities (e.g., projects looking specifically at clergy mental health).

What that exercise reveals is that, as would broadly be expected for largely volunteer-based programs, in social action projects a lot of the activity is focused at a "softer" end of the spectrum. Christian groups were producing a great number of "resources"—including awareness-raising campaigns, guides to dealing with particular issues, and how-to guides for churches.

Some particular mental health problems had greater provision than others. For example, a lot of work was being done on loneliness (some of it extremely innovative). This included a number of projects focused on the well-being of the elderly and other groups (e.g., refugees or the disabled) who, for a variety of reasons, were unable to fully participate in communities. These projects crossed a range of denominations. In one case, a small Catholic charity was operating a phone line staffed by volunteers who called local elderly residents simply to chat with them to help alleviate loneliness. The Cinnamon Network, which resources and funds churches to run a local social action network, has partnered with a Baptist charity called the Link Visiting Scheme to franchise a model for befriending that began in Berkshire and now works through nineteen churches and has more than four hundred beneficiaries.

Among the other areas which seemed to receive significant Christian attention was suicide; we found a significant number of projects and charities working on suicide prevention and supporting the friends and families of those who were suicidal. This included a growing number of groups concerned with clergy mental health—an issue which is only beginning to come fully to light. Perhaps most interestingly the secular Northern Irish suicide prevention charity Lighthouse was running a scheme called Flourish which worked with clergy on their mental health needs, with financial support from the Northern Irish government.

We also found a lot of work with children and teenagers. This has long historic roots and makes sense given that a very large number of mental health symptoms emerge in adolescence. Accordingly, it makes sense to focus attention on early identification and intervention. Ally that to the fact that Christian groups have always tended to invest a lot of time and energy into children and education (there are still a vast number of faith

schools, scouts clubs, and youth clubs) and it is little surprise to be seeing so much work in that area. Some of this work has been extremely innovative particularly around issues of self-esteem and body image in teenage girls, and in confronting bereavement in children.

Unsurprisingly the other, "harder," end of the spectrum—including clinical issues such as personality disorders, saw fewer Christian interventions. That is hardly surprising—it reflects the fact that some work in this area is primarily medical and the rest is increasingly left to civil society. The interesting feature here is that it was the sense of several interviewees that more and more extreme cases are being moved into the charity sector. For example, there was one interviewee who worked for a children's charity that worked very closely with the local council, social services, and the National Health Service (NHS) trust. All work with children was put into four tiers, with level 1 being the least serious, and level 4 being something highly serious requiring the immediate intervention of the police or social services. Throughout the 1990s, the charity only worked with category 1 cases, and the rest were referred to the council. In the 2000s, it moved to all level 1 and 2 cases. Now they deal with everyone level 3 and below, plus a small group of level 4 cases. This transition has been driven almost entirely by the underfunding of council services. In fact, it was proving impossible to get social workers even to assess possible level 4 cases, so overstretched were such social workers who were still employed. This trend of increasingly severe mental health issues being outsourced is one which looks set to continue, despite increasing government funding and demands.

So, to summarize the initial point—it appears that there is a real and significant growth in Christian responses to the issue of mental health. It is very difficult to map them precisely, but every indicator is of increased interest and spread, and it is likely that this is a trend which will have to continue to meet the demands of wider society.

CHALLENGES STEMMING FROM INCREASED CHRISTIAN INVOLVEMENT

All sorts of challenges are raised by this increased Christian involvement in the mental health sphere, many of them practical and political. For example—who's going to pay for it? Should faith-based charities and churches be bailing out the state at all? Who if anyone is responsible for inspections, training, and standards? There are also a range of questions around what impact looks like in this space—that is, how do we evaluate these bodies to determine who is doing a good and effective job? What measures need to be recorded and how reliable are the results likely to be?

Those practical questions are extremely important, but largely beyond the scope of this article. Instead, the issue for the rest of this piece is the question of whether there is anything distinctively Christian about these

projects. This a familiar question from a number of different projects commissioned by Theos and others on the faith charity sector (Bickley 2015; Ryan 2016a, b). There is a spectrum of "faith" that ranges through work done by churches, through work done by explicitly Christian charities with a strong and prominent Christian ethos, through to those with a fuzzier ethos and history—perhaps only a Christian inspiration, or just a historic link. For the latter consider something like the YMCAs, originally quite an explicitly Christian charitable organization, but where the vast majority of staff are now simply secular.

Aside from that issue, there is also a spectrum within charitable activity itself. A classic example here is the food bank. There is nothing distinctly Christian about the activity of a food bank. The ethos may be driven by a Christian motivation to serve the poor and be alongside people, but the work itself is not substantially different from any secular agency performing the same role in most cases. This contrasts with activities that are explicitly religious in nature—praying with people, taking communion, providing religious services, and the like. Both who is doing it and the work itself can, therefore, define something about whether the operation is Christian.

When we look at mental health initiatives there is plenty of evidence of Christians getting involved in providing something, as was explored above. The question is how Christian is the theory and practice behind what they're actually doing? Across the faith charity sector there is a perceived pressure on Christian ethos (Bickley 2015). There are several reasons behind this. One is an issue of Christianity's own making—namely, that there are not as many Christians as there used to be. So, for example, not so long ago a Catholic school in England would not employ any teacher who was not a Catholic. Now the rule is only applied to head teachers, and many schools are struggling to fulfill even that criterion. When the personnel who make up an organization changes from those who have a common (default) faith ethos, to a more plural space, it is inevitably harder to keep that ethos at the heart of the operation.

There are other factors, however. One is pressure from secular bodies. There are countless examples of charities softening their faith ethos because it was proving too difficult to get local government money or help. Accusations of being exclusivist, or of proselytizing (though the term is never actually defined), of perceptions of homophobia, sexism, and so on have led to many faith charities abandoning, or at least softening their public faith ethos. A number of local government agencies as a matter of policy will not work with organizations of a single faith. That same pressure also comes from funders. Charity funding is currently infamously stretched—local government money has fallen through the floor, and trusts and foundations have their own criteria, and we are witnessing an increased trend of resistance to those more explicitly religious operations (Ryan 2016b).

When it comes to mental health there are particular pressures in this regard. There is a perception among some that medicine/healthcare and religion are two arenas which ought to be entirely separate. That perception is one to which Christians have contributed in some sense. A lot of Christians have accepted this dualism of science/medicine as entirely separate from the spiritual. At its worst, the danger is an "overspiritualizing" of issues. A complaint from some in the medical profession was of Christian groups rejecting medical diagnosis and urging sufferers to pray harder, or see their problem as one of relationship with spiritual powers (Wood 2016). At its most extreme this is seen in the contentious issue of exorcisms. This is not to necessarily discount the possibility of demonic possession, or of a subject being spoken to by spiritual forces, or angels, but when the first step taken by churches is to reach for spiritual warfare there is a potential for serious harm.

That dualism exposes part of the issue about the question of how extensive the Christian content of this activity really is. The language of mental health is medical and scientific. Well-being, as a term, interestingly does not quite suffer from the same issue—because it has come to incorporate a softer and more spiritual set of elements, including mindfulness.

Mental health language is new; it has its own jargon and its own medical terminology; and little of it has much theological resonance or biblical basis. The sorts of terms used to describe particular medical illnesses have only been invented in the past few decades. So when Christians try to engage in this space there is a language problem. The words are foreign to the resources on which Christians (and indeed other faith groups) usually draw. There is a lack of a shared register by which issues can be discussed, analyzed, and processed.

This is part of what sits behind that problem of "overspiritualizing" mentioned above. Because the language is not familiar—and the usual sources for theological and Christian engagement seem to be in a different language—there is a tendency to reject or ignore the medical terminology and, sometimes even, diagnosis.

There are cultural issues here too. For example, you are disproportionately likely to be sectioned if you are from a West African or Caribbean immigrant background (Sainsbury Centre for Mental Health 2006). Plenty of possible factors have been suggested for that trend, including institutional racism, and the fact that migrants generally seem to be more susceptible to particular issues, perhaps as a result of upheaval and loneliness (refugees, of course, often have particularly traumatic pasts). Another factor which is often suggested is that members of that community are disproportionately likely to express what they are experiencing through a language of spiritual conflict. The same experience of inner turmoil might be expressed very differently by someone of a different background—but what seems to be the case is that when West Africans (particularly but exclusively those drawn

from Pentecostal religious backgrounds) phrase their experiences in those terms this tends to prompt a particularly strong reaction from the medical profession.

There is a known phenomenon, though anecdotally there is evidence that it seems to be shifting in recent years, that the psychiatric medical branch is among the most atheist and hostile to spirituality of any profession (De Beer 2000). The result of this is that when confronted with someone presenting themselves as having some sort of spiritual battle, often diagnosis is more severe than it might otherwise be had the same experience been differently expressed.

The problem, therefore, comes from two poles. One is a hard medical, clinical approach that can often prioritize quite a materialist, rationalist mindset (this is obviously a generalization—but it is the extreme expression of one pole), and the other is a faith mindset that views everything through a prism of spiritual conflict, in which mental health can be dismissed or devalued (again, this is not necessarily, or even likely to be, typical, but is the extreme pole).

Why Should the Christian Foundation Matter?

With all that in mind, the question of what motivates and theoretically underpins these Christian projects is an important question. Their value structures and language for what they are doing is significant in navigating between the two poles.

Are they simply secular service providers using mental health language—but done by Christians? For many that would seem to be a reasonably fair descriptor, and potentially a significant missed opportunity.

No doubt for many people working in this sector and elsewhere this will all seem like an irrelevance. If people are being helped then it should not really matter whether there is a cohesive theoretical underpinning to the work. On one level of course that makes sense. The need for someone to run a social action project and help dozens of people ought to outweigh any concerns that they spend hours of time in introspection working out the theoretical principles for why they're doing it.

But on another level it does matter that we have an authentic Christian language with which to talk about these issues. There are two big reasons for that.

The first is authenticity. There is a reason that service users seek out faith-based charities for help. There are, after all, secular charities and service providers. It is not simply a matter of having to go to faith charities because every other option is expended; on the contrary, many people's first port of call is to go to a religious group.

We know that clergy mental health is notoriously poor—but also the issues they are expected to confront are what one of our interviewees

described as "the thick end of the wedge"—people show up to parishes seeking help with very serious issues. They go to the faith bodies because it matters to them—they choose a faith body because it provides something important to them that other groups do not.

Now with that in mind, they are expecting help which comes with a faith ethos. They want to be helped in their own language. They are seeking something more than just secular medicine. There is always the danger mentioned above about overspiritualizing, but there is nonetheless a demand for an authentic Christian response which embraces mental health.

Second, the sector as a whole is moving towards embracing approaches to spirituality and the importance of spiritual care—so we are faced with a possible irony of a secularizing faith charity sector just as the secular healthcare world is waking up to the importance of spirituality.

This can be overstated of course, but there is new guidance on spiritual care in the NHS (NHS England 2015), and there are a number of interesting ongoing research projects concerning spirituality in healthcare settings. The work of the Spirituality and Psychiatry Special Interest Group (SPSIG) at the Royal College of Psychiatrists was widely praised by interviewees. If ever there was a time to be exploring this and embracing the spiritual side of health it might be now.

There is plenty to build on. The majority of studies (not all) show a link between high subjective religiosity and positive mental health—that is, if you are religious and you take it seriously that is correlated with better health (Spencer et al. 2016). And conversely, if you have low subjective religiosity you are more correlated with depression.

Likewise, many studies suggest a really positive link between involvement in collective religious activities and mental health. Among others one study showed that "frequent churchgoers were about half as likely to be depressed" (Koenig et al. 1997).

So there is evidence that religion and participation makes an impact—if it makes an impact then it is incumbent upon faith groups to work through some of the questions that that raises.

Working toward an Authentic Christian Approach

There are a number of possible elements on which we can draw to develop this distinctive Christian approach. The first is biblical—and is complicated by the fact that biblical approaches to mental health are hard to identify. The second is a Christian anthropology and is more promising as a starting point. The third is theological, looking at the three Rs—responsibility, redemption, and reconciliation, and raises the most difficult challenges for Christianity as it looks to the future in this space.

A Biblical Approach

Looking specifically at examples of mental health issues in the Bible is a difficult process. It may be the default source of theology for Christians, but the fact is that the language and terminology of medicine has moved so rapidly over the past few decades that there should not be much meaningful expectation of clear-cut mental health diagnosis in modern terms in ancient biblical texts.

The Bible does of course occasionally refer to what we might consider to be mental illness; we have to treat those sections with caution. For example, in Daniel 4 Nebuchadnezzar is described as having gone mad, and is driven away from his people and lives like an animal, eating grass. 1 Samuel contains details of the madness of Saul, who has "an evil spirit" come upon him, which causes him to irrationally despise David, and even to attempt to murder him (1 Samuel 18:10 NRSV); later he falls into a "prophetic frenzy" (1 Samuel 19:23 NRSV).

Both of these cases are talking about madness—but it is impossible at this distance to define what sort of mental health issue Nebuchadnezzar and Saul were suffering from. Nor do these accounts really help us much in terms of how we ought to approach mental health today. They do, however, illustrate that some sorts of mental illness were at least familiar in the Hebrew Bible.

A further set of contentious examples might be drawn from the demonic possession accounts in the New Testament—which some have taken to be examples of mental illness. In fact, this is by no means clear-cut, and the symptoms of those possessed in the New Testament do not necessarily match up well with what we know of mental illness.

Of greater interest for our purposes are those passages that seem to speak to mental illness in a way that can resonate powerfully with sufferers, since these might give us the building blocks for forming an authentic distinctive language for talking about these issues (Meynell 2018). For example, Psalm 88 is sometimes taken as a passage that speaks very closely to the experience of depression. The psalmist expresses feelings of being cut off and forgotten by God and then laments: "You have put me in the lowest pit, in the darkest depths. Your wrath lies heavily on me; you have overwhelmed me with all your waves. You have taken from me my closest friends and have made me repulsive to them. I am confined and cannot escape; my eyes are dim with grief" (Psalm 88: 6–9 NRSV); "From my youth I have suffered and been close to death; I have borne your terrors and am in despair. Your wrath has swept over me; your terrors have destroyed me. All day long they surround me like a flood; they have completely engulfed me. You have taken from me friend and neighbor – darkness is my closest friend" (Psalm 88:15-18 NRSV).

A number of other Psalms (e.g., 13, 42) also contain passages which speak of the psalmist's despair, hopelessness and feeling of isolation. This may provide a stronger basis for building a biblical answer to the question of mental health than the examples of madness given above, since the feelings expressed more closely mirror the experiences of many suffering with conditions including anxiety, depression, and isolation. The task of building a language with which to talk about mental health in Christian terms, an issue identified as critical by several interviewees, may be easier if we start from these personal expressions of suffering and isolation than from accounts of madness in others.

That might be a first step to forming a distinctive language.

An Anthropological Approach

Any Christian approach to mental health must answer a fundamental question about where the mind sits within our theory of human existence. Christianity has a distinctive focus on humans as both body and soul, with both being of critical importance. So in 1 Corinthians 6:19 Paul famously warns his audience not to sin against their body because the body is a "temple of the Holy Spirit" (1 Corinthians 6:19 NRSV). Christians are to glorify God with their bodies.

In the incarnation, God takes on the fullness of human bodily existence, including suffering and death. The resurrection is itself a physical and bodily event, as is made clear to Thomas, who is able to put his fingers where the nails had been in Jesus's hands, and his hand in Jesus's side (John 20:26-27). To this, many more examples could be added, but the point is that there is a significant focus on the physical as well as the spiritual element of human existence.

By contrast there is comparatively little biblical material on the place of the mind in Christian anthropology.

The Bible does in fact talk about the mind, though not perhaps in the same way as we might do today. In the Hebrew Bible, the word "heart" (*leb*, *lebab*), refers to the inner self, where decisions are made (e.g., 2 Chronicles 12:14), and where wisdom and understanding are located (1 Kings 3:12; Proverbs 16:23). Elsewhere the terms "spirit" (*ruah*) or "soul" (*nepes*) are used of the will or internal thought process (e.g., Daniel 5:20). The latter is significant in the famous passage from Deuteronomy to "You shall love the Lord your God with all your heart, and with all your soul, and with all your might" (Deuteronomy 6:5 NRSV) which combines *leb* and *nepes* in a single command.

The New Testament, and Paul in particular, talk more about the mind. The Greek word *nous* is used in a range of contexts, including talking about moral inclination, the means of understanding, and the means of determining action. Its associated noun *anoia* is used for a failure to understand,

often resulting in a distance from God. A different term *phroneo* is also used, for example, in Romans 8, in which the mind governed by spirit is opposed to the mind governed by the flesh.

This suggests that an integrated human existence demands a fuller appreciation of the mind. Just as Christians are called to make temples of their bodies so, too, a greater emphasis needs to be placed on the need to care for and cultivate the mind. This is all the more true given that, although we can talk of these things as separate in principle, in practice it is impossible to abstract one from the others. Poor physical health can cause mental symptoms, and vice versa. Poor health in either can hinder our ability to fully live out our humanity, and place limitations on our ability to be in right relationship with God.

A second aspect of Christian anthropology worth mentioning briefly in the context of mental health is that of relationality. Human beings are not atomized individuals but instead reach their fullness of being in relationship with God and other human beings. In this, the Trinity provides perhaps the most comprehensive model for Christian understandings of relationships. Just as each person of the Trinity (Father, Son, and Holy Spirit) cannot exist without relation to the other two in a single Godhead, so human beings too (made in the image of God) are essentially relational beings. The social consequences of this includes the idea of the tenet of Catholic social teaching which is the common good—only by working with others is the fulfillment of each individual accomplished.

Our ability to be in relationships can be strained by issues of mental health. This can be either because the issue itself creates difficulties—anxiety, for example, can make social interactions strained or even impossible—or because the nature of the issue is difficult to communicate. Those struggling with mental health issues can find it difficult to put their experiences into words (and can find that efforts to do so are inadequate or unhelpful) and those who have never experienced the mental health issue in question have no way of understanding or conceiving the experience of the other person.

Further to that, an issue identified in several of the interviews is that of stigma. Some mental health issues are poorly understood (like schizophrenia) and can provoke fear. Common experiences include people not wanting to bring up the subject of a mental health issue for fear of causing offense, saying the wrong thing or making the situation worse. All of this makes the task of forming relationships a potentially difficult one.

This raises a critical issue for the Church and the way it addresses mental health. Human beings are relational, and called to form relationships in order to be fully human and to develop what Catholic social teaching refers to as the "common good"; the sense in which all humans are interdependent for their development. The Catholic Bishops' Conference of England and Wales refers to the idea in terms of necessary interdependence: "Because we

are interdependent, the common good is more like a multiplication sum, where if any one number is zero then the total is always zero. If anyone is left out and deprived of what is essential, then the common good has been betrayed" (CBCEW 2010). Then there needs to be more thought put to the issue of what that means for people with mental health. How can we maximize the relationality of Christian mental health initiatives?

Theological Issues

Added to these are at least three additional theological issues. The first is the theme of *responsibility*, the second is the Christian understandings of *redemption* as they relate to mental health, and the third is the related idea of *reconciliation*.

Responsibility. The first of these is the challenge posed by particular mental health issues to our idea of responsibility. Christian teaching holds that all human beings are fallen and in need of redemption, and are deemed to be held responsible for their own failings. In Matthew 25:31-46, Jesus provides a vision of the final judgment, with people divided according to their actions, with the righteous enjoying eternal life, and the unrighteous eternal punishment. How do we reconcile that with an increasing body of scientific, medical, and indeed legal analysis that suggests that particular mental issues diminish the responsibility of individuals?

Psychosis impairs thoughts and emotions such that the sufferer experiences a loss of connection with external reality. Can such people be held responsible for what would otherwise be considered sinful behavior? Depression causes feelings of guilt and a distortion of reality such that some sufferers are incapable of believing that they can repent and be helped. How can this be squared with the demand on all people to repent of their sins? Some (by no means all) mental health conditions are the result of proven physical problems within the brain itself (either present from birth or developing later—often in adolescence). How does this square with our notions of what it is to be sinful?

An example of this issue in practice is the particular challenge of addiction (one of the few mental health issues which has some explicit biblical evidence). In Galatians 5:21, Paul declares that drunkenness is a sin which will prevent those who perpetuate it from entering the Kingdom of God and in 1 Corinthians 5:11 he tells his readers not to associate with any drunkards, or even to eat with them. Such injunctions seem fairly clearcut—being a drunk is sinful. Yet, we now know that addiction can cause changes in neural pathways in the brain. It is not a simple matter simply to stop drinking. This does not mean that alcoholism is acceptable, or that the actions of an alcoholic should simply be deemed to be entirely beyond their control, or even that alcoholics are not culpable to some degree in their condition. It, along with a number of other mental health issues,

does, however, call for a challenge to our conceptions of responsibility which will require future exploration.

Redemption. Here, the issue I want to raise is the long psychiatric debate over the extent to which particular conditions are treatable. In psychiatry there is the division of mental health between personality disorders and mental illness. The latter is an absence of health, the former in widely used medical terminology is a "deeply ingrained maladaptive pattern of behavior." This distinction matters because some psychiatrists hold that certain personality disorders are sufficiently serious and maladaptive as to be untreatable (Skeem et al. 2002).

For Christian practitioners in this field such a conclusion raises profound theological difficulties. First, what does it mean for repentance if someone is unable to conceive of right and wrong in any meaningful sense? Second, what does it mean for a Christian vision of redemption if some people have a disorder which leads to them committing evil acts, apparently without any ability to prevent them from doing so?

This is a serious issue, but despite that there are relatively few Christian initiatives in the sphere of severe personality disorders (outside of chaplaincy in prison and forensic settings). Nevertheless, in terms of ministering to those experiencing mental health issues, attention to the theology around treatability, and how it relates to redemption is something which could be developed further.

Reconciliation. Closely tied to responsibility and redemption is a third critical theological tenet, that of reconciliation. Reconciliation is one of the seven sacraments of the Catholic Church, with the idea being that through penance and confession Christians are reconciled with God and returned to right relationship rather than remaining in one which is divided by sin. Jesus's sacrifice and death is the ultimate reconciliation of humanity as a whole with God, as St Paul's second letter to the Corinthians makes clear: "All this is from God, who reconciled us to himself through Christ, and has given us the ministry of reconciliation; that is, in Christ God was reconciling the world to himself, not counting their trespasses against them, and entrusting the message of reconciliation to us. So we are ambassadors for Christ, since God is making his appeal through us; we entreat you on behalf of Christ, be reconciled to God" (2 Corinthians 5:18-20 NRSV).

That would suggest that reconciliation is primarily a matter of being individually reconciled to God. This is certainly important for many people experiencing mental health difficulties who struggle with their faith, and would like care paid to their spiritual needs as well as to medical treatment.

More broadly, there are several further aspects of reconciliation worth considering. The first is that one common theme to emerge from the interviews conducted for this scoping study was the importance of being able to accept a mental health problem and then learning how to live with it; one interviewee compared the experience to diabetes: "you have to learn

what you have and then how the medication and treatment affect you." This, in a sense, is a sort of *internal reconciliation* which may benefit from the spiritual assistance and pastoral care on the part of the Church.

There is also the broader question of reconciliation into the community. Many mental health issues isolate people from communities. Some, like anxiety, particular phobias, or low self-esteem prevent people from integrating themselves. Others, particularly at the more clinical end of the spectrum, such as personality disorders and psychosis, may lead to sufferers being actively detained under a section of the Mental Health Act or removed from society. Others carry stigma which makes it hard for people to (re-)integrate into society either after or before recovery.

This is a challenge to Christians, partly because of the relational nature of human beings which demands that we help people to build the common good by communicating with one another. Moreover, the healing ministry of Jesus reveals the importance of reintegration of people into the community once they are healed. The healing miracles of Jesus in the gospels reveal the power of God, and they heal those afflicted with a range of (generally physical) ailments. They also, however, fit into a wider message about reconciliation. Healing leprosy (Mark 1:40-45, Luke 17:11-19) is striking because lepers were not only sick, but social pariahs barred from integration into community. The hemorrhaging woman (Mark 5:21-43) was sick, but also deemed to be unclean, and therefore unable to be fully part of the community. It is notable that after healing the lepers, Jesus orders them to go and see the priest—since a priest as needed to declare someone fit to rejoin society.

How does the Church today help people with mental health issues integrate into society, either while they are suffering or after recovery? The evidence from the initial interviews was mixed. A number of schemes and programs have been developed which are designed to reduce stigma and find ways of including a more integrated community, but there were also concerns that this was a patchy process and that there was significant scope for improvement.

Each of these three themes—responsibility, redemption, and reconciliation—raises serious theological questions. Further research will be required to ascertain how churches, Christian mental health practitioners, people experiencing mental health issues, and medical professionals respectively view these issues and propose new models.

Conclusions

These discussions are not necessarily novel. Much of this has been debated for a long time—Carl Jung himself in the 1930s was concerned by issues of clergy who were "insufficiently equipped to cope with the urgent psychic needs of our age," and that it was "high time for the clergyman and the

psychotherapist to join forces to meet this great spiritual task" (Jung 2015, 5218). It is not that mental health has come out of nowhere to suddenly exist as something for the church to confront.

And yet it does seem to me that we are witnessing a situation at a crossroads. On the one hand, faith groups are more engaged than they have ever been in these areas—with a great multiplicity of services and charities springing up. And yet, at the same time, though activity is increasing it is not clear that it is yet cohesive, or that the Church has yet developed its own authentic way of engaging in this space. This is surely a critical task for the future. Mental health is one of the great societal issues; it demands a response which is both pastorally motivated and theologically grounded.

Getting this discussion into the bloodstream of activity that is springing up in ever more settings is the great challenge to meet.

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