

MENTAL HEALTH AND THE CHURCH: A PASTORAL CARE STRUCTURE THAT ASSISTS INDIVIDUALS, FAMILIES, AND CONGREGATIONS AFFECTED BY MENTAL HEALTH CONCERNS

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A large inner-city New Zealand church was faced with a unique challenge in 2008. A number of attendees were complaining about the lack of pastoral care that they were receiving and as a result they were grumbling about the church leaders and/or leaving the church. While this criticism may not be uncommon in other churches, there were clear reasons for the unrest in this case. The church had mushroomed from a congregation of around thirty parishioners in 2004 to approximately 1200 attendees in 2008. In the light of this exponential growth, the existing staff—gifted as they were—had understandably battled to keep up with the care expectations and requirements of the church parishioners.

In response to this situation the church leadership created a pastoral care position. I was the fortunate person to secure this role.² Part of my brief was to develop and implement a pastoral care strategy for the wider church. At the time of this commission, I thought that there would be numerous pastoral care models available for me to emulate, but I was wrong. I was unable to locate a single church pastoral care plan.

To create the pastoral care plan (and as I will explain below the mental health reading of it) I utilised James D. Whitehead and Evelyn Eaton Whitehead's model and method for theological reflection.³ The *model* builds on relevant information from three important sources that inform pastoral decisions—namely, those of Christian tradition, the community of faith's experience, and the resources of the surrounding culture. It is no easy task to attend judiciously to the data that can be mined from these rich sources. One reason for this is that researchers need to recognize the uniqueness and depth of each source, yet at the same time comprehend how the sources overlap and inform each other. A further reason is that Christian tradition needs to take the preeminent position in authentic pastoral care.⁴ Peterson puts it this way: Pastoral caregivers must distinguish between the biblical foundations of pastoral work, which are non-negotiable, and pastoral superstructures, which change as they evolve.⁵ Pastoral superstructures equate to the programs and/or actions that caregivers implement in their own contexts. Whitehead and Whitehead's *method* describes *how* to gather and then apply relevant information to the given pastoral situation. This entails *attending* to the available data drawn from the sources identified above; generating *assertions* from this

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² I led the church's pastoral care and counselling department from November 2008 through to January 2016. The role comprised 50% of my working life, as I also lectured at Carey Baptist College throughout this time.

³ James D. Whitehead and Evelyn Eaton Whitehead, *Method in Ministry: Theological Reflection and Christian Ministry*. Rev. ed. (Lanham, MD: Sheed and Ward, 1995).

⁴ Whitehead and Whitehead, *Method in Ministry*, 10–22.

⁵ Eugene H. Peterson, *Five Smooth Stones for Pastoral Work* (Grand Rapids, MI: Eerdmans, 1992), 11.

information to clarify and expand one's insight; and then *deciding* upon and implementing an appropriate pastoral strategy.⁶

Pastoral care has a long and rich Christian tradition. Mills argues that every genuine definition of pastoral care has at its core "a way of understanding our relatedness to God and the ingredients or acts which may serve to enhance or detract from that relatedness."⁷ Viewed in this light, pastoral care is rightly seen as an expression of God's love. Caregivers ought to keep this in mind as they think about and offer care to everyone, especially the marginalized and misunderstood.

The traditional term for pastoral care is the Latin phrase *cura animarum*, which means the care of souls.⁸ Whilst "*cura* is most commonly translated 'care', it actually contains the idea of both care and cure." Thus, *care* points "to actions designed to support the well-being of something or someone" and *cure* relates "to actions designed to restore well-being that has been lost."⁹ *Anima* is "the most common Latin translation of the Hebrew *nephesh* ('breath') and the Greek *psyche* ('soul')."¹⁰ Traditionally, the Christian church has embraced both meanings of *cura*,¹¹ but this is not always the case in the context of mental health scenarios today.

In their seminal study of the history of pastoral care, Clebsch and Jaekle argue that pastoral care "consists of helping acts, done by representative Christian persons, directed toward the healing, sustaining, guiding, and reconciling of troubled persons, whose troubles arise in the context of ultimate meanings and concerns."¹² I want to mention four notable components of this definition.

First, pastoral care involves helping acts and accordingly has a pragmatic focus. It grounds religion in present-day realities and specializes in the ordinary. Pastoral care is ministry-in-mufti, which requires involvement and a sleeves-rolled-up, hands-on mentality.¹³ This means that when a parishioner becomes depressed the church needs to get involved and help. Pastoral care is not a spectator's sport.

Second, pastoral care is carried out by representative Christian persons. These people are recognized as trusted caregivers by their churches; they may or may not be ordained clergy. What matters is that caregivers bring the compassion and wisdom of Christian tradition to the situations they encounter.¹⁴ Interestingly, Stone expands the group of representative Christian persons to the "total Christian community."¹⁵ Given the demands of some mental health situations and the size of some congregations, one can readily endorse Stone's stance.

⁶ Whitehead and Whitehead, *Method in Ministry*, 22.

⁷ Liston O. Mills, "Pastoral Care: History, Traditions, and Definitions," in *Dictionary of Pastoral Care and Counseling*, eds., Rodney J. Hunter, Nancy J. Ramsay, H. Newton Malony, Liston O. Mills, and John Patton. Enl. ed. (Nashville, TN: Abingdon Press, 2005), 836–44, 837.

⁸ Albert L. Meiburg, "Care of Souls," in *Dictionary of Pastoral Care and Counseling*, eds., Hunter et.al, 122.

⁹ Gary W. Moon and David G. Benner, "Spiritual Direction and Christian Soul Care," in *Spiritual Direction and the Care of Souls: A Guide to Christian Approaches and Practices*, eds., Gary W. Moon and David G. Benner (Downers Grove, IL: InterVarsity Press, 2004), 11–28, 11.

¹⁰ Meiburg, *Care of Souls*, 122.

¹¹ Moon and Benner, *Spiritual Direction and Christian Soul Care*, 11.

¹² William Clebsch and Charles Jaekle, *Pastoral Care in Historical Perspective* (New York: Prentice Hall, 1964), 4.

¹³ Peterson, *Five Smooth Stones for Pastoral Work*, 1.

¹⁴ Clebsch and Jaekle, *Pastoral Care in Historical Perspective*, 4.

¹⁵ Howard W. Stone, *The Caring Church: A Guide for Lay Pastoral Care* (Minneapolis: Fortress Press, 1992), 14.

Third, pastoral care is “directed toward the healing, sustaining, guiding, and reconciling of troubled persons.”¹⁶ Accordingly, care for such persons might involve (a) healing that restores them to greater wholeness; (b) sustaining whereby struggling persons and their families are resourced to endure or transcend their circumstances; (c) guiding where the hurting are assisted to make prudent choices; and (d) reconciling wherein fractured interpersonal and transcendent relationships are re-established.¹⁷ It is interesting to observe that an implicit message of these four tasks is the priority of problem-solving in pastoral care.¹⁸ While few would disagree with this emphasis, it needs to be remembered that not all mental health “problems” can be resolved.

A fourth point that can be drawn from Clebsch and Jaekle’s definition of pastoral care is that people’s troubles need to be *meaningful*. For Clebsch and Jaekle, this means that authentic pastoral care only takes place when individuals’ existential concerns are being addressed and when the recipients of care acknowledge that the care is being given by representative Christian persons.¹⁹ The extension of this logic means, for example, that a secular organization can offer care, but not call it pastoral care, because their care does not have overt Christian overtones. It also needs to be acknowledged that caregivers oriented towards practical works may feel constrained by the specificity of Clebsch and Jaekle’s condition.

Clinebell provides a more expansive definition of pastoral care. He defines it as “the broad, inclusive ministry of healing and growth within a congregation and its community, through the life cycle.”²⁰ Inherent in this definition and the liberation-growth model that it represents are a number of important themes. For instance, Clinebell argues that the “overarching goal of all pastoral care and counselling (and of all ministry) is to liberate, empower, and nurture wholeness centred in Spirit.”²¹ Thus, while spiritual and ethical guidance lies at the core of pastoral care, caregivers ought to keep in focus a holistic view of pastoral care that facilitates growth in every area of life.

This comprehensive view of pastoral care provides space for churches to offer a wide variety of care to individuals, families, and communities affected by mental health concerns. Maslow (1943/2013) makes a related argument. He contends that people cannot achieve satisfactory levels of self-actualization and wholeness if their physiological (e.g., food and shelter), safety (e.g., security and stability), and relational (e.g., love and friendship) needs are not met.²² Following this logic, the reach of effective pastoral care must first address people’s basic physiological, safety, and relational needs.

An alternative way of describing pastoral care is to say it involves fence-like and ambulance-like roles. Fence-like and/or empowering ministries can be viewed as strategies that prevent people from getting hurt. An example of this might be educating people about the connections between methamphetamine use and

¹⁶ Clebsch and Jaekle, *Pastoral Care in Historical Perspective*, 1.

¹⁷ Clebsch and Jaekle, *Pastoral Care in Historical Perspective*, 8–9.

¹⁸ Emmanuel Y. Lartey, *In Living Colour: An Intercultural Approach to Pastoral Care and Counseling*, 2nd ed. (London: Jessica Kingsley, 2003), 21–22.

¹⁹ Clebsch and Jaekle, *Pastoral Care in Historical Perspective*, 4.

²⁰ Howard Clinebell, *Basic Types of Pastoral Care and Counseling: Resources for the Ministry of Healing and Growth*. Rev. and enl. (Nashville: Abingdon Press, 1984), 26.

²¹ Clinebell, *Basic Types of Pastoral Care and Counseling*, 26.

²² Abraham H. Maslow, *A Theory of Human Motivation* (Mansfield, CT: Martino Publishing, 1943/2013), 2–9.

psychotic episodes.²³ Ambulance-like and/or reparative actions can be understood as ministries that offer care to persons who have fallen off a cliff and are badly hurt or wounded. In keeping with the example above, these actions may include supporting people as they recover from psychotic incidents and/or visiting them in hospital. In the light of this breadth and complexity, pastoral caregivers clearly need to be both thoughtful and prayerful as they consider how best to provide care.

Whitehead and Whitehead assert that the second source that researchers need to consult to enhance their theological reflections is their own faith communities.²⁴ Culbertson concurs and advises that before the church can respond to people's needs effectively, it must first hear and understand their stories.²⁵ This advice motivated me to spend considerable time listening to two groups of people from within the church community as I continued to gather data to craft a pastoral care plan. The first cluster comprised the individuals and couples who came to me for pastoral counselling. Many of these persons were grappling with mental health challenges. What most of them wanted was firstly to be cured and freed from their maladies *and* secondly to be heard, known, accepted, and connected with other people. The second group consisted of approximately fifteen persons who the church's priests had identified as individuals who contributed significantly to the church and whose insights might prove to be beneficial to my project. This proved to be the case. One person, for example, suggested that the church should offer mid-week educational evenings on mental health themes. Another talked of her concern about the pressures the priests face in their roles.

The third source that Whitehead and Whitehead encourage researchers to examine in search of relevant data is that of their own surrounding cultures. The Whiteheads recommend three ways of doing this.²⁶ The first posture requires Christian tradition to challenge inappropriate cultural norms. For instance, where some organizations and individuals label persons with mental health concerns as "units", "consumers", "service-users", or "*the schizophrenic*", to list but a few examples, churches ought to confer dignity on these people and name them as image-bearers of God, for this is who they truly are.

I recall a stark lesson I had in this "school" several years ago. Karen, who was struggling with hysteria and anxiety, said to me in the middle of a pastoral counselling session, "Do you know what the problem with you is and for that matter some others in this church?"²⁷ I indicated I did not. She continued, "You relate to me as if I'm a project to be fixed rather than a person. I'm a person you know!" She was correct. I had nowhere to hide. After a lengthy silence, I simply said "I'm so sorry". Fortunately, I learnt my lesson and Karen gave me another chance.

²³ Research reveals that tolerance to methamphetamine develops quickly, which means people need ever-increasing doses to achieve the same effects. This in turn increases the risks of experiencing methamphetamine psychoses. See New Zealand Drug Foundation, "Methamphetamine", <https://drugfoundation.org.nz/methamphetamine> (accessed 14.10.16).

²⁴ Whitehead and Whitehead, *Method in Ministry*, 10–22.

²⁵ Philip L. Culbertson, "The Things We Do! Nurturing the Authority of Men in Ministry", in *The Spirituality of Men: Sixteen Christians Write about their Faith* (ed. Philip L. Culbertson; Minneapolis: Fortress Press, 2002), 221–43.

²⁶ Whitehead and Whitehead, *Method in Ministry*, 10–22.

²⁷ Pseudonyms have been employed for everyone cited in this article. Each person had freely given me their permission to use their stories, so long as I preserved their anonymity. To do this, I have altered some details in their accounts that might have identified them. Quotation marks are used to delineate their direct quotes.

Whitehead and Whitehead's second posture spotlights that religious communities need to examine themselves in the light of the developments within their local cultures.²⁸ Thus, churchgoers who harbour prejudicial attitudes towards individuals grappling with mental health concerns would benefit from examining their thinking and learning from support groups who are fully accepting of these persons. The third posture accentuates that the church should use the resources of culture to pursue their own missions. Consequently, caregivers ought to heed the salient insights offered by psychiatrists, mental health workers, therapists, and other experts outside of their immediate church circles and regardless of their religious orientation.

Having listened to the voices of Christian tradition, the community of faith's experience, and the resources of the culture in accordance with Whitehead and Whitehead's paradigm, the next stage of developing the pastoral care plan was to conflate the themes and insights into a draft plan. What emerged from this time-consuming yet valuable process was a 21-point generic pastoral care model,²⁹ which I presented to the church's priests for feedback and critique. Upon studying the plan, the priests thanked me and encouraged me to implement the different points. With the wonderful assistance of my skilled colleagues and many of the gifted caregivers from within the church community, I spent a large amount of the ensuing years instigating the points. The Whiteheads name this implementation work the decision making phase in which researchers move from insight into action.³⁰

During this exciting work it became clear to me that I needed to create a specific mental health reading of the pastoral care plan. This was because my ongoing investigation into what constitutes effective pastoral care and my pastoral counselling work revealed that a large number of parishioners were struggling with depression, anxiety, and a range of other mental health related concerns.

In connection with this work, I also studied many helpful definitions of mental health that intersected with this project. I was particularly attracted to Aist's definition, which states:

Mental health is a condition of well-being in relation to self and others characterized by such qualities as (a) positive self-acceptance, (b) accurate perception of others and the world, (c) stability and appropriateness in mood, (d) balance and purposiveness in behaviour, (e) dependable sense of identity and values, (f) adaptability to one's environment, (g) ability to engage in productive work and fulfilling love, and (h) commitment to a source of devotion beyond oneself. As such, mental health is an active process, not merely the absence of illness. Nor are its characteristics optimally present at all times; at best they represent general norms within which there is considerable variation. The term "mental health" also connotes rehabilitation of the mentally ill, prevention of mental and emotional disorders, and efforts to promote social-environmental conditions in which individuals can function according to their highest mental and physical potentials.

²⁸ Whitehead and Whitehead, *Method in Ministry*, 10–22.

²⁹ The generic pastoral care plan can be viewed in the May, 2016 edition of the *Pacific Journal of Baptist Research*. Permission was obtained from the Journal's editors to replicate portions of my article in order to set the scene for the mental health principles and points outlined below.

³⁰ Whitehead and Whitehead, *Method in Ministry*, 10–22.

Mental illness refers to a variety of enduring or recurrent disturbances in patterns of an individual's thinking, mood or behavior that are typically associated with painful distress and/or impairment of social, occupational or leisure functioning. Severity of symptoms may range from mild annoyance to extreme discomfort, from little or no violation of conventional norms to floridly deviant behaviors, and from minor distortions of reality to significant impairment in reality testing. The concept of "illness" is important in order to distinguish the condition from social deviance or moral corruption and to assure a response by society of diagnosis, treatment and follow-up in light of known and suspected causes.

Taken together, mental health and illness implies a continuum between gross pathology and psychological perfection, with most people most of the time occupying a broad mid-range between the two extremes. Everyone experiences transient thought disturbances, periods of depression, unexplained fears, and outbursts of unjustifiable behaviour; it is when these "symptoms" persist and interfere significantly with one's daily living, either without apparent precipitating cause or as an exaggerated response to untoward events, that one may infer some type of mental illness."³¹

By conflating the insights outlined above with the uniqueness of the mental health context, I arrived at the following mental health reading of my pastoral care plan.

THE MENTAL HEALTH PASTORAL CARE PLAN

1. Caring for the priests and their families: While the 21 points are not supposed to portray a level of importance or priority, Point One does underscore the fact that the health of a church depends to some degree on the mental wellbeing of its leaders. This can be explained both positively and negatively. A positive interpretation suggests, for example, that if leaders truly believe that "God stands – he is foundational and dependable; God stoops – he kneels to our level and meets us where we are; God stays – he sticks with us through hard times and good, sharing his life with us in grace and peace,"³² they will talk about and embody these principles as they serve persons grappling with mental health concerns. Similarly, these beliefs, attitudes, and actions will assist leaders to carry hope for the hurting until the hurting can (perhaps one day) carry hope for themselves. Given that present-day hope and not just eschatological hope is life-giving for all people, it is not difficult to imagine how the trickledown effect of leaders embracing Peterson's bedrock points could positively shape church communities and assist struggling parishioners.

Conversely, if leaders' object relations, egos, shadows, and wounds are unhealthy and unexamined, the leaders *will* detrimentally affect people in their congregations. This is because the intrapsychic is

³¹ Clark S. Aist, "Mental Health and Illness," in *Dictionary of Pastoral Care and Counseling*, eds., Hunter et.al, 711–14, 711.

³² Eugene H. Peterson, *A Long Obedience in the Same Direction: Discipleship in an Instant Society*. Rev. ed. (Downers Grove, IL: InterVarsity Press, 2000), 191–92.

outworked interpersonally,³³ the “ego takes everything personally,”³⁴ “what we resist persists,”³⁵ and our wounds act like magnets.³⁶ Examples are limitless. If a church member were to critique a pastor’s sermon and the pastor is controlled by an internal object authority figure, the pastor will be unable to distinguish between the church member’s words and the object authority figure’s words. As a result, the pastor will project his or her inner world onto the church member, the parishioner may be flayed, labelled an enemy, and treated accordingly. The pastor, in turn, will be judged by some of the parishioners who learn of the situation, and there will be an escalation of damage; unless, a helpful intervention occurs.

Put differently, Symington asserts that many pastors over-spiritualise matters and are psychologically blind. They are unable to see their own actions and omissions, and they cannot grasp that they have no emotional meanings attached to their psychic realities.³⁷ This sightlessness helps to explain how these leaders can freely dispense advice to hurting people that is completely devoid of empathy (e.g., “Why don’t you just get over your depression?” “The problem is in your imagination.” “Where’s your faith?”). What psychologically blind leaders need is a psychological awakening rather than a theological one. This usually only comes—if it ever comes—via personal crises and/or exposure to external realities that are greater than a leader’s present reality such as a revelation of the pain that she or he has caused others.³⁸ In keeping with this logic, it is critical that leaders pay attention to their own mental health in order to avoid hurting persons unnecessarily. To do this effectively will require the assistance of skilled others.

In the light of these points and the unique relational, spiritual, and financial pressures that church leaders commonly experience, the care offered to them will need to be shaped in an idiosyncratic fashion. Caution is also required concerning *who* provides the care, as complex relationships need to be managed ethically. Examples of complex or dual relationships include leaders counselling people, who have power over their employment, and leaders seeking counsel from persons from within their own congregations.³⁹

The care offered to our church leaders included pastoral care team members contacting the priests and their spouses on a regular basis to see if they had any specific practical needs or prayer requests in the given season. Care for leaders should also come from their external supervisors. The importance of supervision cannot be overstated here. Supervision offers a structure to protect the leaders and their flocks, instil accountability, monitor the leaders’ mental health, and helps to prevent burnout. It also provides a forum where ministers can be encouraged, receive input, further their development, examine themselves and their performance, and be reminded of the requirements and practices of their governing bodies.⁴⁰ The

³³ Philip L. Culbertson, *Caring for God’s People: Counseling and Christian Wholeness* (Minneapolis: Fortress Press, 2000), 26–28.

³⁴ Eckhart Tolle, *A New Earth: Create a Better Life* (London: Penguin, 2016), 68.

³⁵ Debbie Ford, “The Shadow Process” http://www.soulfulliving.com/the_shadow_process.htm (accessed 14.10.16).

³⁶ David J. Riddell, Personal Correspondence, (13.08.08).

³⁷ Neville Symington, *The Blind Man Sees: Freud’s Awakening and Other Essays* (London: Karnac, 2004), 8–10.

³⁸ Symington, *The Blind Man Sees*, 10.

³⁹ Philip Culbertson, “Managing Complex Relationships in Pastoral and Church-based Counselling,” in *Ethics in Practice: A Guide for Counsellors*, eds., Kathie Crocket, Margaret Agee, and Sue Cornforth (Wellington: Dunmore Publishing, 2011), 136–39.

⁴⁰ David J. Riddell, *Living Wisdom: Life and Counselling Skills Level 1 and 2* (Nelson: David Riddell, 2010), 2.12.

priests' spouses are also encouraged to attend regular spiritual direction and/or counselling sessions, as they too are highly valued members of the community, and their welfare affects their partners' ministry and the church.

2. *Caring for the church staff:* The wellbeing of church employees also affects the health of the parishioners. As with the priests and their spouses, one of the challenges that this exceptional group of people face is that they are prone to work too hard. Accordingly, staff may need help to say no, set boundaries, avoid rescuing, and balance their own life-sustaining activities with the irregular rhythms of congregants' needs. Two separate supervisors have helped me in this regard. One said, "You can only give some people one hand." By this he meant if I were to give certain individuals battling with mental health (or other) concerns all of my resources I could be pulled into an abyss from which I would be unable to return. In such circumstances I was advised to keep one hand anchored to God, key relationships, and/or life-giving activities, so that I would be able to serve on my own terms and sustain my caregiving over time. Similarly, another supervisor once asked me, "Do you know why the fourth commandment exists?" I hesitated. She said, "It's there to stop manic rescuers like you and me thinking we can save the world." This exhortation requires no interpretation.

Church workers may also need assistance to process the transference they invariably experience, as being the recipient of unrecognized transference is particularly troubling. Transference involves the involuntary and usually unconscious displacement of people's objects, reactions, and needs that relate to significant individuals from their pasts onto persons (or God) in the present.⁴¹ In other words, transference involves people redirecting their past feelings for one individual onto another person they are presently with; thus, in effect, transference is "an error in time."⁴² An example of transference is where a new church attendee, who has had a poor experience with a children's worker in an earlier church, starts to criticize publicly the children's worker at the new church before she or he has had any opportunity to get to know the children's worker and/or observe what the person actually does. The methods for supporting church staff to process issues like these and thereby maintain accurate perceptions of themselves and others, which are indicators of good mental health,⁴³ are similar to those described above for the priests and their spouses.

3. *Providing pastoral care training for the staff:* Training the church's staff team comprises a key component of the Mental Health care strategy. Not only does it add impetus to the trickledown effect whereby church employees embody their learning and pass on their new insights to the lay members of their teams (see below) and others, but it also serves to build a mutually agreed upon foundation that shapes the wider church.

Such training ought to be shaped around each church's setting. In our context this involved us receiving input on the topic of suicide from a counsellor who had extensive experience with depressed individuals who had attempted to suicide. At a fence-like level, we were encouraged to strive to connect all

⁴¹ Jan Grant and Jim Crawley, *Transference and Projection: Mirrors to the Self* (Maidenhead: Open University Press, 2002), 3–4.

⁴² John Patton, *Pastoral Counseling: A Ministry of the Church* (Nashville: Abingdon, 1983), 171.

⁴³ Aist, *Mental Health and Illness*, 711–14.

people into relationship orientated groups, because being known and experiencing life-giving friendships mitigates the likelihood of suicide. We were also introduced to a number of suicide myths such as when depression lifts the suicide risk is over whereas the sad reality is that a mood lift may indicate that a decision to suicide has taken place. And we were encouraged to talk openly about the concept of suicide with individuals, whom we rightly or wrongly deemed susceptible to taking their own lives. At an ambulance level of care, we were reminded of the necessity to remain present to individuals who had attempted to take their own lives *and* to their loved ones. This is because one person's choices always impact the people close to them. It is noteworthy that many staff members found these discussions on the topics of suicide and mental health particularly helpful, as these concepts are often cloaked in silence and ignorance.

4. *Staff building lay teams and training team members:* Given the magnitude of the pastoral care and mental health needs in the church, as well as the giftedness of so many church members in these areas, it was decided to build a pastoral care lay team that could respond to some of the parishioners' needs. The team comprised just over fifty known and trusted people from within the congregation who delight to care for others. At the discretion of the church's pastoral care staff, group emails were sent to the team in which specific opportunities of service were outlined briefly (e.g., "a woman out West is unwell and would appreciate a visit and prayer"). There was no obligation for team members to reply, but consistently one or more did. The first person to reply was then given additional information (e.g., "Mrs Smith has had an anxiety attack") and if that team member was willing to proceed she or he visited Mrs Smith. Successful as this strategy has proven to be in our context, it needs to be noted that it might not work in cultures where people expect and want only their ministers to visit them.

One of the training possibilities offered to members of the lay team has been to invite the group to meet with the church's pastoral care staff a few times a year, so that the team members can share their concerns, be heard, be thanked, and receive input. Two core values that are repeatedly talked about in these settings are the healing power of listening to other people's stories and the effectiveness of pastoral presence.⁴⁴ An exciting out-working of these achievable foci is that the recipients of this care not only feel cared for, but also on occasions have experienced some remarkable breakthroughs and cures (see below). In this way, the practices of pastoral presence and listening embody both the care and cure aspects of soul care.⁴⁵

The following account underscores this claim. Mary texted me from the acute ward of a psychiatric hospital. She had been admitted due to an experience of grandiose euphoria, which purportedly was evidence of her manic-depressive illness. Mary requested regular visitors who would be willing to listen to her and pray with her. Three members of the pastoral care team visited her separately each week. Four weeks later Mary e-mailed me from her apartment and said, "The women who visited me have helped me to recover more quickly than I ever have before. Their listening and prayers were wonderful." Eighteen months later she wrote again: "I wanted you to know that I have enjoyed the best run of health that I have

⁴⁴ Gabriel Fackre, "Presence, Ministry of," in *Dictionary of Pastoral Care and Counseling*, eds., Hunter et.al, 950–51, 950.

⁴⁵ See Moon and Benner, *Spiritual Direction and Christian Soul Care*, 11.

ever experienced. I have continued to meet weekly with one of the woman you connected me with and she has by now heard my whole story. I now visit two separate friends each week who have mental illnesses simply to listen to them. I think listening is spelt l-o-v-e.”

5. *Empowering the coordinator of pastoral care:* It is important to keep key church tasks in focus. As the coordinator of pastoral care I was authorized to ensure that the ethos of pastoral care was kept at the forefront of the church’s life and that the pastoral care ministry of the church ran as efficiently as possible. This involved amongst other tasks building relationships with professionals (e.g., psychiatrists and therapists), who we could refer people struggling with mental health concerns onto to receive additional support when our resources and skill-sets were exhausted. On these occasions we would try to arrange for a member of the pastoral care lay team to accompany these persons to their appointments to provide support, mitigate stress, and be an objective third-party to talk with post-meeting. In reflecting now on this simple practice of connecting people, I am reminded that some remarkable long-standing friendships have been birthed this way. This is encouraging, as being in relationships is an important marker of mental wellbeing.⁴⁶

6. *Developing a Geographical Care Network:* Since the church is situated in the inner city and many of its parishioners are separated by large distances, we decided to establish a number of care pods based around geographical locations in order to improve the quality of our pastoral care. The role of the pod leaders, who were known and trusted church members, was to touch base with and offer care to the church attendees who live in their areas and have expressed a desire to be part of the system.

Interestingly, when this part of the larger plan was in its nascent stage of development a pod leader said to me “I don’t know how to express care to a woman in our pod who tells me she has a borderline personality disorder; in fact, I don’t even know what that is!” One of our responses was to encourage the pod leader to view her care offering as resembling a spoke in a bike’s wheel. This way, the leader’s care offering could be construed as being one of many necessary support structures (spokes) that enables the woman to travel more smoothly through life. As it turned out, the spoke image liberated the leader to get involved and provide care via the delivery of fresh batches of scones and prayer. The spoke analogy also became emblematic for much of our caregiving across the church. A longer-term response was to facilitate an evening in which a psychiatrist talked about borderline personality disorder and presented different care options.

7. *Caring for the 99:* The shepherd who sought after the lost sheep in Matthew 18:12-14 was also clearly interested in the other 99 sheep. Too frequently, the silent majority in churches (i.e., the 99) such as the spouses, family members, and friends of people struggling with psychological concerns are overlooked and inadequately cared for. This omission is tantamount to a tragedy, especially given the overwhelming nature of some caregivers’ tasks.

Accordingly, effectual pastoral care strategies need to incorporate mechanisms that enable care to everyone connected with individuals who have mental health concerns. Intentionality is key here. For us,

⁴⁶ See Aist, *Mental Health and Illness*, 711–14.

this involved keeping a secured file of every person we knew who fitted into these categories and ensuring that we contacted them regularly to offer palpable and discreet care. Our contact hopefully communicated to persons who often feel invisible that they matter and are not alone. It also afforded us numerous opportunities to roll up our sleeves and help in practical ways.⁴⁷

8. *Developing a Welcoming and Caring Church Ethos:* A number of individuals whom I know that live with daily mental health concerns have informed me that they find it extremely difficult to attend church. One reason for this is that they feel either too welcomed or totally ignored when they arrive at church. The first posture reeks of falsity, suffocation, and threat. The second endorses their feelings of unworthiness and loneliness. Whilst some of these people's perceptions undoubtedly stem from within themselves, it is imperative that welcoming teams are cognisant of these issues, as well as of the fact that it takes a great deal of courage for some individuals to attend church. The effect of this awareness may well be the difference between an individual joining a church community or not.

9. *Developing a safe church environment:* Another reason why some individuals battling with mental health issues find it difficult to attend church is that they experience churches as being unsafe. This is not surprising. When service leaders make first-time visitors stand up mid-service, when preachers pressure parishioners to talk or pray with the people sitting next to them, when sermon illustrations identify congregants and break confidentiality, when ministry leaders compel everyone to file to the front of the church to take communion, when persons who tremor or cry are told they are possessed by demonic spirits, safety is compromised. What is needed, therefore, is that preachers and leaders are educated about these concerns, so that they might language activities more carefully, cease unsafe practices, and not assume that everyone thinks as they do. Additionally, it can be very helpful to facilitate safe forums in which persons contending with mental health challenges can share their experiences with church leaders.

A conversation I had some time ago helped me to realise that our desire to become a safe community was more than mere rhetoric. Helen, whom I had never met before, came up to me after a church service and said, "My psychiatrist told me that this church is a safe place and that I should introduce myself to you because the church and you will look after me." Inspirational words of this nature have helped us to walk with Helen as she has oscillated between seasons of impairment of function and profound altruistic service for others. They also motivated us to continue to care.

10. *Prioritizing prayer:* We believe that a key component of the renaissance that the church has experienced in recent years can be attributed to the church's burgeoning prayer life. At our last count, there were more than twenty distinct prayer ministries in the church.⁴⁸ One of these is named "Z prayer". Whenever individuals tussling with mental health challenges felt they needed prayer support, they were invited to text a single letter such as "Z" to a pastoral care team member. No explanation needed to accompany the text. The recipient of the text knew that it meant that the sender needed immediate prayer

⁴⁷ See Peterson, *Five Smooth Stones for Pastoral Work*, 1.

⁴⁸ Angelika Halstead and Philip Halstead, "Prayer at St. Paul's: Symphonising Many Voices," in *Journeying into Prayer: People and their Pathways*, ed. Neil Darragh (Auckland: Accent Publications, 2012), 169–75, 170.

and accordingly prayed and replied along the lines of “Thank you. I’m praying.” Many individuals have benefited from this expression of care.

Another initiative was to establish a church prayer-line that was emailed weekly to over 100 parishioners who had committed to pray. To access this prayer support, individuals were invited to send in their prayer requests to the pastoral care team who collated them and sent out the emails. Some people chose to remain anonymous (e.g., “A man in our congregation is feeling low at present and has asked for prayer support.”) whilst others wanted to be named (e.g., John Smith has had two panic attacks this month; please pray that they will cease and for his full recovery.”) Each person who requested prayer was also followed up by someone from the church’s pastoral care team. Numerous persons have testified to being comforted by these expressions of prayer and care. (See Point 12 for further discussion of prayer.)

11. Overt offers of care: To build the ethos of pastoral care across the church and demystify mental health topics we decided to offer care overtly to the parishioners on a regular basis. This happened through targeted courses, preachers encouraging people to make contact with the church’s pastoral care department to arrange one-on-one pastoral counselling sessions, and testimonies that normalised mental health challenges and the need of support. Intriguingly, the pastoral care team has never been stretched beyond its capacity to care for the persons who have requested assistance. Perhaps this reflects that it takes time to change a culture.

12. Pastoral counselling: Many individuals, couples, and families affected by mental health issues gratefully took hold of the free pastoral counselling offered by the church. Although every situation is unique, it is interesting to note that a number of overlapping themes repeatedly surfaced in this context. This reality affords counsellors the opportunity to upskill in these areas.

One example spotlights the notion of prayer. Many people who contend with mental health struggles understandably long for liberty and given the emphasis on healing prayer in the Christian tradition they logically seek relief and healing via prayer. The problem is, however, that healing or cure from mental illnesses in our experience rarely occurs instantly; in fact, it may not eventuate at all. This means that pastoral counsellors will often end up providing care and exploring topics like disappointment, theodicy, and how to build life-giving support structures around people.

Similarly, most people struggle at times to hear God’s voice, determine God’s will, and feel God’s presence. Sadly, these challenges seem to be magnified for many individuals battling with mental health trials. Stephen, for instance, had only been attending the church for a brief season when he announced that God had told him to leave his wife, teenage children, and job for a year in order to go overseas to serve as a missionary. His wife, children, and doctor thought that Stephen was making a mistake, but Stephen was determined to “obey” God. In instances like these, pastoral counsellors need to show respect and tread very cautiously. They also need to nurture people’s faiths and help them make decisions that are based on sound principles to avoid tragedies. This balancing act is not straightforward.

Counselees also frequently wanted to talk about the use of medication. Some individuals testified that God has saved them from the depths of their depression via medication; others swore that their prescribed medication had made their depression and lives far worse and accordingly wished they had never heeded

their doctors' advice to take medication; and still others did not know if they should commence a course of medication. Given this diversity and the fact that I am not qualified to speak with any authority on such matters, I tended to (a) explore alternative and/or additional strategies to help with depression such as the benefits of exercise, self-care, serving others, and/or processing anger; (b) identify some of the known benefits, side effects, and risks of taking medication and coming off it too quickly;⁴⁹ and (c) point persons to experts and offer to accompany them to these meetings. Although these strategies are not always appreciated by people who wish to be told what to do, they do feel ethical since they provide people with information that assists them to make informed choices.

13. Needs assessments: To offer the best pastoral care possible we habitually sought to assess the needs of the parishioners. This was done in a variety of ways such as noting what topics people raised in pastoral counselling and seeing how congregants responded to sermons. At a basic level, needs assessments are used to find out what persons know and are able to do, and what they need to know and do. This knowledge, in turn, assisted us to respond in ways that help people bridge these gaps.⁵⁰ For instance, members of the pastoral care team attended professional development courses in mental health care in order to upskill and provide more effective pastoral counselling.

14. Teaching pastoral care: When we identified that a number of congregants (and therefore families) were grappling with issues like anxiety and depression we hosted educational evenings on the topics and ran a number of related process groups. Teaching on these topics is very helpful, as it generates insight, promotes positive change, and brings comfort. To provide effectual input we regularly enlisted the aid of experts and asked parishioners to share their personal testimonies of living with the given issue. This approach worked well with two highlights being Ros Broome's input on how correct breathing can greatly help with anxiety⁵¹ and Patte Randal running two of her renowned *Re-recovery* groups for persons grappling with "enduring symptoms of psychosis and other extreme states."⁵²

15. Developing emergency care strategies: Emergencies and crises are common features of everyday life, but perhaps even more so in the context of mental health. At such times, people need to experience care; if they do not, further damage may eventuate and resentment towards the church and God can easily mount. Accordingly, we instigated a pastoral care emergency phone and email service that anyone could access at any time. The staff who fielded these cries for help received training in crisis management and were provided with the contact details of emergency providers such as *Community Mental Health*. While steps like these denote progress, it needs to be acknowledged that emergency care is oftentimes very difficult due to the nature of certain crises and people's different expectations concerning the levels of care that should be provided. This calls for diplomacy and wisdom from the caregivers.

⁴⁹ See for example Peter R. Breggin and David Cohen, *Your Drug may be Your Problem: How and Why to stop taking Psychiatric Medication*. Rev. ed. (Philadelphia, PA: De Capo Press, 2007).

⁵⁰ Kathleen Graves, "A Framework of Course Development Processes," in *Teachers as Course Developers*, ed. Kathleen Graves (New York: Cambridge University Press, 1996), 12–38, 12–13.

⁵¹ Ros Broome, *Rest: A Science and an Art* (Auckland: Creo Design, 2014).

⁵² Patte Randal, Malcolm W. Stewart, Deborah Proverbs, Debra Lampshire, Janette Symes, and Helen Hamer, "The Re-recovery Model: An Integrative Developmental Stress-Vulnerability-Strengths Approach to Mental Health," *Psychosis* 1:2 (2009): 122–33, 122.

16. *Developing a Discipleship Track:* Whilst we deemed it is important for churchgoers to take part in discipleship programs, we knew that these programs needed to be contextually shaped. Persons struggling with mental health concerns in our experience are often best served by first taking part in courses that build principles of mental and emotional health into their lives. It seems that when this supportive scaffolding is in place more traditional discipleship methods such as in depth bible studies are more productive. As the case study below reveals, remarkable progress has been achieved by this means.

17. *Visitation:* Most people appreciate pastoral caregivers offering to visit them in their homes, work places, favourite cafes, and/or when they are in hospital or other institutions. This approach has a rich tradition in pastoral care whereby luminaries like Richard Baxter would visit up to sixteen families per week from his parish. With this experience, Baxter claimed that visiting people effected a richer return in regards to their spiritual growth than did his preaching.⁵³ Our experience echoes this and as a result one member of the pastoral care team proactively initiates one visit per week to an individual or family contending with mental health worries.

18. *Connecting parishioners to circles of care:* A primary place for pastoral care to be practiced in churches is in their small groups. It is amidst the regular encounters that take place in these settings that people are most likely to share their stories; experience healing, sustaining, guiding, and reconciling;⁵⁴ develop meaningful friendships; and find true belonging. Accordingly, we attempted to connect every willing person who had a mental health concern to an existing small group that was open to receiving new members. Sadly, this worthy endeavour has only met with moderate success as some individuals in the existing groups proved to be unwelcoming and some individuals entering the groups lacked the required social skills that would have aided their successful inductions. In situations like these, we have tried to commence new groups that are based on common interests (e.g., a passion for fishing) or health commonalities (e.g., persons contending with fear and anxiety). We have also connected individuals to external skill-based groups such as a *Dialectical Behaviour Therapy* group in a local counselling clinic.

19. *Supporting church small group leaders:* Given the multiple benefits of small groups and the breadth of people's needs that often only emerge when they have become secure in safe and loving environments,⁵⁵ it is essential that small group leaders are adequately trained and supported. In our context this involved building relationships with each leader and shaping the support in accordance with the leader's context and desires. For example, some leaders asked for resources, others requested regular two-way communication to discuss complex interpersonal group dynamics, and still others solicited prayer support.

20. *Building pastoral care resources:* The efficacy of pastoral care is heightened when helpful resources are known and readily available. This involves building a database of experts we can consult and stockpiling key

⁵³ Richard Baxter, *The Reformed Pastor* (London: The Banner of Truth Trust, 1656/2007), 34.

⁵⁴ Clebsch and Jaekle, *Pastoral Care in Historical Perspective*, 4.

⁵⁵ Henri J. M. Nouwen, *The Inner Voice of Love: A Journey through Anguish to Freedom* (New York: Doubleday, 1996), xiii–xiv.

books such as Johnstone's renowned book on depression called *I had a Black Dog*.⁵⁶ It also entailed disseminating this knowledge to the people who needed it.

21. *Developing a church debrief policy*: People leave churches for a variety of reasons and persons with impulse control issues are particularly prone to leaving churches suddenly. One person, for example, informed me at the end of a service that he will not be returning to the church, as a priest had insulted him by not returning his smile. A helpful pastoral response to people's departures can be to touch base with these individuals, enquire if there is anything that the church needs to know or seek forgiveness for, and/or offer to bless them as they transition into the next season of their lives. This approach demonstrates care. It also helps persons to attend to unfinished business and bring closure. It may even motivate some individuals to return to the church.

EVIDENCE OF SUCCESS

Extensive anecdotal evidence and scores of encouraging emails point to the success of the church's Mental Health strategy. Numerous parishioners and families have been able to access help via the plan and as a result have experienced greater levels of connection with God, others, themselves, their own mental wellbeing, and life. These positive outcomes have inspired some of these individuals to extend care to others. And over the years an ever-swelling number of churches have approached us for assistance and advice. We interpret all of these results as markers of success.

George Attwood, a psychotherapist, recalls a sad tale of encountering a young man who had been diagnosed as manic-depressive and believed that "all is one." Fifteen years later, Attwood came across the same man and learned that he was doing poorly. His treatment had "included multiple hospitalizations, extensive electroconvulsive therapy, and an ever-varying succession of antipsychotic drugs."⁵⁷ Reflecting on this man's journey, Attwood pointedly asks, "I wonder what the outcome might have been if someone instead had been able to sit down with him—for a day, or a year, or a decade—and discuss what it meant that all is one. Is it not possible that good things might have emerged from such conversations?"⁵⁸

We know that "good things" can transpire when people take the time to listen and talk with persons affected by mental health concerns. When this happens, care is shared, friendships blossom, and cure might transpire. Many of the points in the Mental Health strategy are designed to facilitate such life-giving conversations and connections. Mary's story in Point 4 and Helen's in Point 9 clearly reflect this.

These encouraging stories remind me of Richard's narrative. When Richard first met with a member of the pastoral care team he said he was desperate not to be hospitalised again for his schizophrenia. Perhaps because of this, he allowed us to connect him to a small group in the church who wholeheartedly welcomed him. A co-leader of the group offered to meet with Richard fortnightly and by now these two men have

⁵⁶ Matthew Johnstone, *I had a Black Dog: His Name was Depression* (Sydney: Pan MacMillan, 2005).

⁵⁷ George E. Atwood, "Credo and Reflections," *Psychoanalytic Dialogues: The International Journal of Relational Perspectives* 25:2 (2015): 137–52, 141.

⁵⁸ Atwood, "Credo and Reflections," 141.

been meeting to share their stories for over five years. As a result, Richard learned to take his medication regularly, got married, became a father, and commenced work as a professional caregiver. Richard attributes much of his success to the care of his friend—the small group’s co-leader—and the church.

David Riddell argues that since our minds determine our perception of reality they need to be properly trained to acknowledge and adapt “to reality as it proves itself to be.”⁵⁹ To facilitate this process, to help persons make their minds their friends, Riddell identified 12 building blocks for mental and emotional health that he believes everyone ought to engage with. Given their utility, we tried to help a few individuals struggling with mental health concerns establish these principles in their lives as an expression of our discipleship initiative (see Point 16 above). To date, the results have been extremely positive. To illustrate this I offer here a summary of my 11-month journey through Riddell’s points with Cody, who presented with classic symptoms of depression:

a) Accepting responsibility for the outcomes of your own choices: For Cody, this involved accepting culpability for his attitudes and actions that had contributed to the fractured relationships he experiences. Where he had previously lived in denial and viewed himself as a victim, he learned to own that he had pushed loved ones away *and* that they have treated him appallingly on occasions. This more balanced view helped him to change his disposition, which, in turn, has created space for him to engage again with some of his estranged family members.

b) Accepting correction from those who know better than you: Cody readily accepted that he ought to heed the good advice of wise people, but he did not know how to determine who was wise or what advice was good! We therefore made a list of all the advice he could recall receiving (e.g., his mother exhorted him to get to bed at a reasonable hour). We then discussed the validity of each piece of advice and brainstormed possible applications. By this process, Cody eventually chose to build three life-giving structures into his life that have proven to be most helpful. (Numerous other good ideas were identified via this exercise, but we felt that setting too many new goals in this season was unwise.)

c) Accepting short-term pain for long-term gain: This concept proved to be Cody’s greatest challenge of the 12. He found it extremely difficult to consider that his feelings might not always be accurate barometers of reality. He was so used to going to bed when he deemed that an activity was pointless and/or remaining in bed when he felt listless that the very thought of challenging these feelings was an anathema to him. To confront these feelings would also be to concede that he had contributed to his present situation. Progress was made when Cody agreed to persevere with tasks for 15 minutes beyond his initial feelings of aimlessness or tiredness. Predictably, when he reached the 15-minute mark he sometimes felt invigorated and able to carry on.

d) Having realistic expectations for yourself and others: Riddell explains that people with poor mental and emotional health frequently have expectations that are either too high or low.⁶⁰ Cody tended to be at the perfectionistic end of the expectation spectrum for his friends and the lackadaisical end for himself. He

⁵⁹ Riddell, *Living Wisdom*, 1.12.

⁶⁰ Riddell, *Living Wisdom*, 1.12.

rigidly held to the belief that authentic friends should contact him, yet he did not see any need to step towards them. Baab's insightful assertion that friendship is a verb helped Cody to soften his stance on this point and as a result he set a goal of inviting a friend to coffee once per week.⁶¹ This equates to a positive step towards mental health, as it reflects an ability to love; though, of course, it does not hide the fact that Cody still needs to investigate many other expectations that he continues to carry.

e) Accepting your past: By the time Cody explored this principle our connection was strong. This presumably helped him to acknowledge freely that he had hurt many people as well as himself via his negligence and acerbic words. Consequently, Cody was willing to do the hard work of seeking and receiving forgiveness, as well as learning from his mistakes. As a result, he found greater internal peace.

f) Balancing your head and heart: The purpose of equalising one's head and heart is to help people make wise decisions, as opposed to ones that are exclusively based on either their own thinking or their feelings. Cody's propensity to dismiss all new ideas instantly and his struggles to overcome his feelings as depicted in Point C hint of the amount of learning Cody needed to do in this regard. One encouraging new principle that he came up with was not to say no to any new opportunity for 24 hours; this step helped him to become less rigid and more flexible.

g) Balancing your needs and wants with others' needs and wants: Cody needed assistance to respect other people's personal space, free-wills, and right to say no; he also required coaching regarding how to speak the truth in love and negotiate.⁶² Our regular conversations on these themes seemed to help him develop these social skills.

h) Developing wise trust: Riddell contends that an essential element of mental and emotional health is the ability to discern who is and is not trustworthy.⁶³ Trust needs to be earned; it must not be naively granted. Like so many people contending with depressive symptoms, Cody had largely concluded that no one including himself was trustworthy. Our starting point here was to help Cody to fulfil his promises and by doing so become more trustworthy.

i) Having a sense of progress via worthwhile goals: Cody seemed to have no goals when I first met him. This was sad, as goals invite progress and progress engenders hope of a future. Stated differently, Cody's lack of progress depleted him of emotional energy and created an obstacle to his mental wellbeing. The first goal that Cody came up with was to read for 15 minutes per day. Should Cody consistently meet this worthwhile yet stretching goal it is expected that he will one day be motivated to add additional goals.

j) Having an internalised sense of Belonging and Security: Since Cody lacked a sense of belonging and security, he frequently strove to control others in order to experience these qualities. Naturally, his effort to control frequently backfired and served to push people further away from him. I therefore encouraged Cody to build his connection with God via daily bible reading and re-establish his relationship with his alienated son.

k) Having an internalised sense of Worth and Value: Riddell argues that if we allow others to confer worth and value on us, we will live with the fear that they may one day withdraw their favour and as a result render

⁶¹ Lynne M. Baab, *Friending: Real Relationships in a Virtual World* (Downers Grove, IL: IVP Books, 2011), 18.

⁶² Riddell, *Living Wisdom*, 1.12A.

⁶³ Riddell, *Living Wisdom*, 1.12A.

us devoid of significance. Hence, Riddell encourages persons to individuate, become centred, and find their worth and value in themselves and God.⁶⁴ Cody liked this idea and linked it to his quest to draw closer to God. He also began to write down, consider, and then incinerate any harmful words that people spoke over him.

l) Properly caring for our bodies: Cody struggled with the realisation that his poor physical health was at least partially due to his own long-term neglect of his need for adequate rest, exercise, and healthy food. Albeit with some cajoling, Cody began to address this situation by allowing me to introduce him to a mindfulness exercise that helped him to register what his body was telling him. He also began to eat a healthy breakfast each day instead of skipping breakfast as was his pattern.

By the end of Cody's and my 11-month journey through Riddell's principles, which we trialled as an extension of our discipleship initiative, Cody claimed that he was a different man. His doctor had weaned Cody off all medication; he had a spring in his step; and he was talking about a number of meaningful future goals that he wished to pursue. A further point that we find particularly exciting about Riddell's model is that virtually any caregiver can lead others through it, so long as they have the time and inclination to do so.

SUMMARY

Olthuis claims that people "cannot flourish long without the nourishment that comes from an affirming and loving connection with another person."⁶⁵ Pastoral caregivers concur and add that authentic human flourishing – regardless of the present or future mental states of individuals – is also dependent on persons being connected with God and having their basic needs met. The Mental Health Pastoral Care Plan depicted here reveals many ways of helping persons to experience these bedrock principles first hand.

It is hoped that numerous caregivers will take up the challenge of this study to find the most effective way to serve, love, and journey with persons contending with mental health concerns in their own churches and communities. There are many ways that this could be achieved. For instance, pastoral caregivers could employ Whitehead and Whitehead's paradigm, adapt the Mental Health strategy presented here, and/or conduct their own needs assessments. A primary goal of these endeavours is to locate mental health concerns and everyone associated with them where they truly belong—namely, in the centre of caring churches and communities.

⁶⁴ Riddell, *Living Wisdom*, 1.12A.

⁶⁵ James H. Olthuis, *The Beautiful Risk: A New Psychology of Loving and Being Loved* (Grand Rapids, MI: Zondervan, 2001), 105.