Preaching and Mental Illness

Bonnie L. Cook, MAS
Executive Director
Mental Health America of Kentucky

O. Wesley Allen, Jr.
Lois Craddock Perkins Professor of Homiletics
Perkins School of Theology, Southern Methodist University

Congregations too often hear little or nothing from their preachers about mental illness; or, worse, they hear things concerning mental illness that do more harm than good. One in four people in our population struggle with mental illness; 25% of a congregation must strive to live with an illness that creates stigma in our society. The percentage of those affected by mental illness rises exponentially when we include the parents, significant others, children, friends and co-workers of those who have a mental illness. We are in denial if we imagine the statistics in the general population are not represented as well in our congregations. If preaching is to be relevant to the full depth of the human condition as experienced in our day, sermons must deal with mental illness and mental health.

Here are some **HOMILETICAL GOALS** for discussing mental illness in the pulpit:

1. **Offer Pastoral Care.** The pulpit is the location from which pastors can offer the most pastoral care to the most people at one time. Harry Emerson Fosdick established an approach to preaching analogous to group counseling that was influential throughout much of the twentieth century. The preacher should address individuals "felt needs." There is something of value in this for addressing mental illness in the pulpit. G. Lee Ramsey, Jr., in his book, *Care-full Preaching: From Sermon to Caring Community* (2000), however, presents a homiletical approach that shapes a community that offers pastoral care to one another instead of placing the weight all on the pastor. People struggling with mental illnesses and their loved ones need communities that will love them and help bear their burden.
2. **Raise awareness.** Many people are unaware of how widespread mental illnesses are or of how different mental illnesses affect individuals, families, work environments, and congregations. An educational element, therefore, must be part of preaching on mental illness. Recovery is possible.

3. **Normalize mental illness.** There is a stigma surrounding mental illness in the general population which is often even stronger in religious communities. This is due to the fact that in the past many have viewed mental illness as a moral or spiritual failing instead of a bio-chemical condition. It is viewed as a sign of weakness in a way that other physical ailments are not. Or worse, mental illness is another is something feared as if the person were possessed by a demon. Preachers must talk and help the congregation talk about mental illness and its symptoms and causes in the same way we talk about other illnesses.
4. **A Place of Help.** Most ministerial staff are not trained to treat mental illness and should not feel the responsibility of doing so. Nevertheless, sermons on mental illness should help congregants know that they can turn to church leaders to be directed toward and accompanied on the journey to receiving the professional care they need. This means the church needs to be ready when people call the office seeking help in dealing with mental illness to refer them to professionals such as psychiatrists or psychologists and/or to groups such as Mental Health America. Naming in the pulpit that the church can help people make these connections will invite them to trust you and will help overcome their fear of seeking help on their own.
5. **Call for Action.** While sermons addressing mental illness mays may invite a response of seeking help and support from those who suffer from mental illness or are caregivers for those with mental illness, they should also call for action from the wider congregation as a whole. On the one hand, the community of faith should become involved in and establish ministries focused on the care of those in their midst who wrestle with various forms of mental illness. On the other hand, the congregation should come to see the treatment of those with mental illness in society as a social justice issue. The congregation should advocate for those who are marginalized and receive subpar care in relation to their illness.

Below are some **HOMILETICAL STRATEGIES** for achieving the above goals in relation to addressing mental illness:

1. Homiletics often focuses on the individual sermon, but preachers who want to shape a congregational conversation around mental illness and want to offer care to those struggling with mental illness must take a **cumulative approach** to their preaching ministry. (See O. Wesley Allen, Jr., *The Homiletic of All Believers* (2005) 58ff.) Much of the power in preaching, as in teaching, lies in repetition. Preachers cannot preach on mental illness once or even in a single sermon series and expect much to change in the congregation.
2. Part of a cumulative homiletic dealing with mental illness should involve **education** about mental illness. Many people have ill-conceived notions about the causes and types of mental illness. Preachers should make references to different type of mental illness in different sermons to resist the temptation to reduce people with mental illnesses to a stereotype while at the same time using some language in this different references to help hearers intuitively make connections to the larger issues revolving around mental illness. They should also model a proper use of vocabulary

related to mental illness. One of the most important things preachers can do is avoid using derogatory terms related to mental illness in the pulpit and speak out against them. Even in humor, calling anyone "nuts," "psycho," or "crazy" in a sermon is hurtful to any hearer struggling with mental illness.

3. In a cumulative homiletical approach to mental illness, it is important to note that the sermon as a whole need not be about mental illness to bring the topic into the sermon. One of the best ways to normalize mental illness is to use people struggling with mental illness in **illustrations in sermons** about a wide variety of topics. Preachers should use such people sometimes as those in need of our care and sometimes as positive role models. Remember, while mental illness can be a significant determining factor in one's life, no one's life is reducible to their mental illness. This is why it is better to speak of a person with schizophrenia than a schizophrenic person. It is important to add that any time preachers consider using a story from the life of someone with a mental illness, they must make sure they have permission to do so. Even then it is best practice to not use the person's real name. Pastors need to protect the confidentiality of any who come to them for help, especially those most vulnerable to stigma and stereotype while making clear to hearers that if they come seeking help the pastor will offer them protection as well. A rule of thumb is that preachers should not objectify anyone for the sake of a good sermon illustration.

4. Another element of a cumulative homiletical approach to mental illness involves the question of **the point of identification** when raising issues related to mental illness in a sermon. Good preachers, like good writers and story-tellers, know you always have to be intentional about the location at which you invite hearers to identify with a character or issue in a sermon. In some sermons, the focus should be on individuals who struggle with mental illness. In others, the perspective on mental illness should come from those individuals and families who love and care for those who are ill. In still others, the congregation as a whole should identify with communities struggling to advocate for those who suffer from and are marginalized due to mental illness. Trying to incorporate all such points of identification in a single sermon will weaken them. It is better to choose different ones at different times.

5. Normalizing mental illness for many congregations will require some significant work in **deconstructing bad theology** related to mental illness. Much theology of the past has participated in the syndrome of "blaming the victim" for being mentally ill, thus victimizing the person a second time. For example, preachers who exhort those with mental illness to persevere and the like send an underlying message that they should be able to handle their condition and leave them feeling guilty for being sick. Even more importantly, preachers should be explicit in naming that God does not judge persons for being mentally ill and neither should communities of faith. Consider the case of suicide. For centuries, religious communions have claimed that God condemns those who kill themselves to eternal condemnation for not appreciating appropriately God's most precious gift of life. But with modern advancements in the understanding of the bio-chemical state that leads one to such a depressed state that a person views nothingness as better than living, we can surely recognize that God could only feel compassion for a person suffering so.

6. Often **spiritual drought** accompanies mental illness. Preachers need to address this need while explicitly rejecting a cause-and-effect scenario in which the person thinks if they were more spiritual, more holy, closer to God, etc., their mental illness would go away.
7. Part of educating congregations about mental illness may require the use of statistics such as the one cited at the opening of this document. But such details should be kept to a minimum. As in good writing, in good sermons we do better to **show more than tell**. Show the congregation persons with mental illness (instead of telling them about mental illness in the abstract) and they will *feel* a point of identification leading them to seek help themselves, a desire to help such people, or a drive to change the way society approaches mental illness.

Finally, to implement the cumulative homiletic approach described above, here are some types of **BIBLICAL TEXTS** that when preached on invite the inclusion of a discussion of mental illness in the sermon:

1. Texts which include elements of **lament**, especially psalms of individual lament, express a level of anguish to which many persons with mental illness can relate. These texts model and give permission for the suffering to cry out to God asking Why? and How long? when people of faith often consider such questions to be unfaithful.
2. Scholars recognize that most of the narratives of the Hebrew Bible were put in their final form and many of the prophets prophesied in relation to the **exile** of Israel/Judah into Babylon in the sixth century BCE. Exile can be a powerful metaphor for those with mental illness as they feel deprived of potential and satisfaction and are marginalized as "abnormal" by society. They often feel like foreigners in a strange land. In drawing such a metaphorical connection between exile and mental illness, preachers must avoid relating any of the prophetic claims that the people were to blame for their exile due to disobedience and instead draw the connection between God's continued care for those in exile.
3. **Healing stories** are scattered throughout the narrative of the Bible, especially the Gospels. Preaching these stories in a modern context to people struggling with physical, psychological and spiritual suffering has much potential. Preachers must resist the temptation to emphasize the supernatural character of the healing as well as the fact that the healing is often dependent on the sick person's "faith." Stressing these elements of the stories can lead to persons with mental illness again feeling they are at fault for being depressed, bi-polar, schizophrenic, and the like. If they just had enough faith, God would zap them and make them all better. Moreover, for some people with mental illness there may be no cure in terms of completely overcoming the illness so much as a hope of being able to manage a chronic condition they will have for the rest of their lives. Healing stories invite, on the other hand, a view of God and God's agents as caring for the ill.

4. A major ethical theme throughout the Bible is **the community's care for the dispossessed**. Calls to care for the widow, orphan, sick, imprisoned, poor, and such certainly includes those with mental illness.
5. There are expression in the **wisdom literature** that draw on practical wisdom about aspects of life which in our day we would relate to mental illness. For example, a sermon on Proverbs 18:14 ("The human spirit will endure sickness; but a broken spirit—who can bear?") would offer preachers a great opportunity to show the Bible recognizes the depth that psychological pain can reach.
6. Throughout the Bible, there are **characters who exhibit signs of mental illness**, even if the language of mental illness would not have been used in the ancient world. By naming these characters and their situations with empathy and understanding instead of judgment, preachers will be able to model an approach to mental illness today. A few examples of such biblical characters are:
    - Hannah's depression in relation to being barren (1 Sam 1)
    - King Saul's depression in his later years (1 Sam 16)
    - The prophet Elijah's desire to die when fleeing persecution (1 Kings 19)
    - The demon possessed in the Gospels
    - Jesus praying in anxiety, fear and sadness in the garden (Lk 22:39-44)
    - The Apostle Paul exhibits at times neurosis or depression (e.g., throughout 2 Cor) (See Frederick Buechner in *Peculiar Treasures*.)