The Person, the Pastor, and the Psychiatrist - St. John's Vancouver

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Preachers: Dr. Don Lewis, Dr. James Holmlund

[0:00] My name's Don Lewis. I teach church history at Regent College, and I'm going to begin by asking some questions of James to introduce him, because most of you don't know him. So, James, come here. Tell us where you're from and where you trained.

I'm originally from Saskatchewan, where God lives. And so I started training there, and I've trained at McGill and... Sorry?

I started training in Saskatchewan, and I've also done training at McGill and at Harvard. And you spent a number of years in the interior of BC. Can you tell us about that, where you were?

So, things that you don't actually need to know, but if you're in psychiatry, you should realize that there's community practice, and there's academic practice, and if you're really, really good, you get to practice at Homewood in Guelph.

And so I moved in 1993 to work with Merv Vincent, who was the executive director at Guelph. I don't know that that counts on my resume, but it was a wonderful thing to be one of three Christian psychiatrists working in the interior.

[1:22] Oh, this is... When you said Homewood, I thought you were talking about a home for... But it's actually a town in BC. No, it's a psychiatric hospital.

In BC? No, in Ontario. Oh, but you lived in the... I thought everybody knew this. You lived in the interior of BC. Tell us about that. Yeah, so when Merv retired from Homewood, he moved to Salmon Arm, and then he recruited me because he was lonely, and we worked there together for many, many years. It was great.

Sorry, excuse me, Don. Do you have your... Do you want me to give the mic right in his way? Right into the mic. Is that better? Good. Okay. We'll try to do that. Sorry about this.

James, how did you come to faith? Wow. Well, I was fortunate to be raised by my parents, who at the time were very active in the United Church Sunday School.

Then they kind of fell away from the faith and went into more like parachurch things like Boy Scouts.

[2:35] When Dad retired from that, I felt it was part of family integrity to uphold that mission. And when Emmanuel Baptist in Saskatoon was looking for a Cub Scout leader, that meant that I had to try and be it.

And that gave God the opportunity to get Jake Crooker, the pastor there, to try and try and try and try to meet with me, which he finally did.

And that was the beginning of that story. Now, I have to tell you, the best thing about James is the fact that he's married to Linda, who is over here on the far right, who is an extraordinarily gifted visual artist.

Just amazing. And that gift really has flourished since she's come to Regent and studied here. What do you do now? Currently, I try to keep up with Linda and support her by working as a consulting psychiatrist for Vancouver Coastal Health and Child and Youth and Addiction Psychiatry.

So what would your typical patient be like? There is no such thing as a typical patient. But the range, of course, will be children between the ages of 3 and 24.

[4:02] At my age, 24 is still childhood. And things like major depression, schizophrenia, crystal meth dependence, things like that.

Great. Thank you very much. As I said, I teach church history at Regent College. I grew up in a Christian home in Quebec.

And then after teaching in Montreal, came to Regent as a student about 40 years ago. Did a degree and then went to the UK for my doctoral work and then returned to teach. I've been on faculty for 36 years now, which makes me considerably older than all of my students.

Or virtually all of my students. The question you may be asking yourself, what is a church historian doing here talking on this topic? Somebody asked me last night, are you the person, the pastor, or the psychiatrist?

I only qualify for the first one, the person. But once upon a time, there were two men making soup at Regent.

[5:11] We have soup groups every Tuesday morning after chapel. And the students and faculty make soup. And I was being obedient, volunteering as a soup maker several years ago.

And as I was chopping carrots or celery or something, the person across the chopping board on the other side of the table from me was James, who was also a student at Regent at the time.

And as we were talking, he said to me, Don, I know that you know and spend a lot of time giving pastoral counsel to a number of men at Regent.

Regent, I want you to know that you in your pastoral role at Regent with these guys can actually be more helpful to them than I can be as a psychiatrist.

And I said, my goodness, why would you ever say that? And he said, well, I as a psychiatrist am limited by a number of factors. Firstly, I can only see people who are referred to me by a medical doctor.

[6:19] So there's a screening process. The only people who are really sent to talk to me about their issues are people who are already diagnosed with significant issues in their life. Secondly, I as a psychiatrist can only ask certain questions.

And there are only certain things I can do. You in your pastoral role can actually ask questions that I can ask. You can pray with the guys you're talking with and you can be more effective than I as a psychiatrist could be with them.

And I thought, wow, that's amazing. If someone in a pastoral relationship or a spiritual friendship can actually be more helpful to someone who is suffering than a psychiatrist, then we need to tell people that.

And James said, well, how are we going to do that? And I thought, hmm, maybe we should teach a course together. And we just came up with this course, The Person, whereby we look at what it means to be a person, what it means to be human from a Christian perspective, looking at the history of the church and scripture, what it means to be in a pastoral role, and then also where does a psychiatrist come in.

So psychiatrists are actually really the A-team of those who offer professional help to people who are dealing with serious mental health issues.

[7:41] I have a number of friends, close personal friends, who see psychiatrists regularly. They need someone with that sort of long-term training. One has to appreciate that psychiatrists are different from psychologists or counselors in that they are first trained as medical doctors.

So they do the whole gamut of medical school training, and then they specialize in psychiatric training. Most medical doctors get a few weeks of psychiatric training in their three years of medical school.

James has taught medical students that psychiatric rotation. But most GPs really have very limited experience in treating people with serious mental issues.

If what they really are trained at, the level that they're trained to, is that they can recognize that there's a significant issue that needs the help of the specialists. So psychiatrists are able to prescribe antipsychotic drugs in the way that other health care professionals aren't.

It's very hard, actually, to get an appointment to see a psychiatrist in British Columbia. Firstly, because there are not many of them, and those who are working are overworked, and often it takes several years to actually get an appointment, because we'll have a referral to see a psychiatrist in our system.

[9:08] Pastors are often intimidated by a mental illness, and feel that they're out of their depths in dealing with people with serious mental health issues, and feel they always have to defer to psychiatrists.

But if what James said to me, that a great deal of help can be offered by people who are not psychiatrists, then we felt that we had to do something about that. The course that we put together looks at the history of the Christian tradition in pastoral care.

It also looks at, well, we bring in a number of experts. Jim Packer has come in and spoken about the treatment of depression from a pastoral point of view. Some very helpful insights he's read.

A great deal of the Puritans who have a lot to say about depression. Dr. Edwin Hui is a medical doctor also on faculty at Regents who comes in and speaks about, particularly the issue of what it means to be human.

The other aspect of the course is to really look at the major forms of mental illness that every church is going to encounter.

[10:18] One quarter of adults during their lifetime will need a psychiatrist. One quarter. That's right across Canada, the whole population.

If you think one quarter needs to see a psychiatrist, very often that one quarter have spouses, they have children, they have parents who are going to be impacted by their mental illness.

And therefore, as much as the people who are going to be dealing with these issues are clearly the majority of people in our churches. The course, for me, has been tremendously helpful.

In fact, I don't think I would want to come out of Regent and go into pastoral ministry without having the basic knowledge that I've acquired from doing this course with James. What are some of the practical outcomes from tonight?

Well, the one takeaway that I want to just start off with is, firstly, that mental health issues are enormous in our culture.

[11:26] We've made that point already. But secondly, I want Christians to realize that they can be helpful to people who are suffering and to realize that this is not some scary subject.

These people are not, by and large, dangerous. If they are dangerous, they're more of a danger to themselves in terms of self-harm or suicide than posing a danger to the rest of society.

In fact, a number of movies have done a great deal of damage to people's thinking about mental illness. And that, in a sense, puts people off even talking about this.

So I think that events like tonight helps us to begin to bring out into the light this very important issue. An issue which is often obscured by other factors than popular movies.

One significant factor is cultural taboo, which is very much accentuated. There's a psychologist here in Vancouver, Ed Ng, who was a student at Regent about six years ago, has now got his PhD from Fuller and was practicing at UBC this past year.

[12:38] But Ed's doctoral work, his thesis which I read, really looks at the cultural taboo in Asian culture, particularly in Chinese culture, around the issue of mental illness.

This is not an issue that is going to be discussed in the Asian family, because if you're dealing with mental illness, this is something that is a tremendous problem in terms of a cultural taboo of being shameful.

And in an honor-shame society, this is highly problematic. And Ed is hoping, as a psychologist, to address that issue in his own practice. But there are also religious taboos.

A year ago, we did this talk, actually, at Christ City here in Vancouver, and the pastor, Brett Landry, said that his own upbringing, he had a strong background in a very charismatic church in Alberta, and he said when he hit the wall in terms of personal depression, his religious culture said to him, no, all you have to do is have more faith.

This is an issue which is your fault because you don't have enough faith. So you get into a shame and blame religious mentality that is associated with a number of Christian denominations.

[13:58] So this is another reason why I think bringing this topic into the open is so important. Thirdly, I think it's essential that we create a Christian community that normalizes therapy, whether it's by psychiatrists, by counselors, or psychologists.

We all need counsel at times, and we should greatly value the resources that are available for us in therapy.

It may be talk therapy, or it may involve a drug treatment in terms of dealing with issues. Many people are going to need both talk therapy and drug therapy.

One very simple takeaway for me is related to the issue of depression. I remember about a year ago, Phil Reiton, who some of you may know as the president of Wheaton College, a leading English scholar, a well-known evangelical leader in the U.S., spoke in the Wheaton College chapel about his own struggle with depression.

Really quite remarkable how open he was as a well-known public leader within evangelicals of America, talking about the fact that he has gone through periods of severe depression.

[15:16] I talked to James about that, and he said, yes, I saw that video, but there was one thing that he did not do, which was really a huge lesson to me. Phil Reiton did not say, what you should do if somebody like himself comes to you and says, I'm dealing with depression.

The first thing you do is say, have you been to a medical doctor? And why would you say that? Well, in a pastoral role, this person says they're depressed.

Well, perhaps they just lost their spouse, or there may be something that is contributing to the depression. It may be the cause of the depression, but you cannot assume that that's the case. The person may have a brain tumor, and the brain tumor is responsible for the depression they're in.

They may be diabetic, but not have been diagnosed as a diabetic, and the lack of insulin is causing depression. There are six or seven organic medical causes that a GP will say, oh, you're extremely depressed?

What about this? What about this? What about this? We're going to run these tests to rule out causes that may not immediately surface. So if you're a pastor, and somebody comes to you, or a friend, and they're depressed, and you say, oh, the reason for your depression is that you're living in sin, which may be a reason why you're so depressed, or the reason you are is because your mother died recently, whatever.

[16:43] That may be the cause. But you also may, by giving them that false leave, prevent them from getting the treatment they need to address issues that could kill them.

So we have to be very careful here in discerning, especially in what we are saying to people who are depressed, that we don't jump into conclusions.

People for the past 2,000 years in the Christian church have been dealing with issues of mental health. In the course we teach, we look particularly at the work of St. Augustine and his work, The Confessions, which is foundational to the modern sense of the self, the modern notion of the individual.

Some scholars would go as far as to argue that Augustine actually invents the modern self. We also look a great deal at Gregory the Great, who was Pope in the late 6th century, who wrote a work entitled On Pastoral Care, which was the handbook for priests in the Western church for 1,000 years.

It was translated very quickly into the major languages of Europe, and it was to the priests in the parish what the benedicting rule was to the life of the monk in the monastery.

[17:57] And Gregory the Great is a remarkable writer. He has a great discernment of personality disorders, of different personality types. In fact, there's an interesting article written by a man who was a professor of psychology at UBC, Roger Tweed, and he writes about the pastoral care work by Gregory the Great.

And he makes the case that the modern forms of therapy are all found there in Gregory the Great. I'll talk about the three forms of treatment today.

But his essential argument is that they're all found there in Gregory the Great because they're all ultimately found in scripture. I can give you the reference to that.

It's a very interesting article. Now, when we talk about psychotherapy in particular, people automatically go back to the father of modern psychiatry, Sigmund Freud.

His psychoanalytic approach, which dominated much of Western thinking up to around 1950, was quite different from Gregory the Great because Gregory the Great's primary insight was that no size fits all.

[19:13] Every person you speak to is unique, and there may be different approaches in counseling them or encouraging them or challenging them that need to be adapted to that unique person.

Freud's attitude was no. All forms of mental illness are related to powerful human drives, particularly the sexual drive and the development of children, and they are responsible for all the forms of mental illness that we see.

Now, Freud's approach was widely applauded, particularly in the United States. It was very expensive. It was elitist. One was encouraged to build a relationship with a psychiatrist.

It went on for years and cost vast amounts of money. Progress was expected to be slow. But this approach by Freud was largely discredited in the early 1970s.

Freud has said all these different illnesses are all related to the same cause. But in the early 1970s, pharmacologists began to say, oh, actually we can target this type of drug for this type of mental illness.

[20:20] So we can target manic depression, or what's sometimes referred to as bipolar disorder, with this range of drugs. Schizophrenia can be treated by a very different sort of drug because there are different things happening chemically in the brain that we have to address, or major depressive disorders, or even personality disorders can be addressed by different types of drugs, which leads people to think that Freud's one-size-fits-all doesn't work, which is now largely, his approach is largely discredited, and there are very few Freudian psychoanalysts anymore.

I just want to say something about the three approaches to psychological counseling. These are the three that I've argued are there in Gregory the Great and really inform the approaches to counseling today.

I simplified these down to head, heart, and hand. So just use that rubric as the three different approaches in modern counseling really are ones that focus on the head, those that focus on the heart, and those that focus on the hand.

Let me explain what I mean. First of all, the one that focuses upon the heart. It's usually called client-centered therapy. It was developed by the famous Carl Rogers.

Here's, to put it very basically, the therapist in this approach is really a facilitator and someone who guides the patient to see for themselves what their challenges are.

[21:53] Through self-awareness, they come to see where their core problems are and then figure out what changes they need to make. So the therapist is very non-directive.

At least they're not obviously directing the person. They're trying to help the person to come to see for themselves. The counselor is there to offer empathy, patience. The crucial importance of being a good listener is emphasized.

And certainly, if you're going to help anybody with emotional distress, you have to be a good listener. In many ways, this approach fits well with Christian insights. In pastoral counseling, you have to be careful not to interrupt people as they unpack things in their lives.

One also has to be careful not to project your own fears or problems onto the person and distort their reality. This is one approach which can be very helpful with many people.

So this emphasis upon the heart. The second approach is what I would describe as the approach of the hand. The hand in terms of behavior, what you do.

[22:59] And this is behavior modification theory. If the verse is focused on the heart, this is focused on what you do with your hands. The pastor or counselor focuses on encouraging good behavior because we are creatures of habit.

And the habits that we form can continue to shape how we live our lives and what we do. But the counselor here is to help the person become aware of good behavior.

The counselor praises good behavior, discourages bad behavior that needs to be avoided, helps old habits to be broken or redirected. This hand approach that needs to focus on behavior modification can be helpful with some people.

But those two approaches, the approach of the heart and the hand, are really dwarfed today by the third approach, which is the approach that focuses on the mind or the head.

That is what is called cognitive behavioral therapy. Now, cognition is thinking. So this therapy focuses on not the heart or behavior, but in the first instance, but rather focuses upon what the person is thinking.

[24:23] That is, what was going on in your head when you did that? Like what? Now, very obviously, we can act out of our emotions right away.

The thing with cognitive behavioral therapy is it doesn't deny that very often our first reaction is an emotional reaction. But, and I think this is very close to a central Christian insight, is that we are people who have the ability to think about our emotions, to think about our reactions, whether they're emotional reactions or patterns of behavior.

We are primarily thinking creatures. While we may respond emotionally, with our thinking we can critique these responses and reorient them so that we don't simply act on our emotional responses.

You heard the question, what were you thinking when you did that? Well, maybe you weren't thinking. And a therapist can help us to appreciate where we have suspended our thinking and are simply acting out of reactions.

For Christians, I think this is congruent with the New Testament. We want people to reorient their thinking in light of whom God says they are. We are, in Christ, new creations.

[25:34] We are adopted into the family of God. And that we need to think about how we respond. And, of course, the Psalms and meditating on Scripture is very important in this approach.

And I think you can see how this fits in with a Pauline approach very clearly. So about 80% of therapists today are practicing some form of cognitive behavioral therapy.

It really is the overwhelming sort of choice. Now, there are many different schools of psychotherapy, even within cognitive behavioral therapy, some emphasizing one aspect or another aspect of humanity.

It seems to me that both psychology and psychiatry are deeply indebted to the Christian view of what it means to be human. The famous political theorist at Oxford, who was in the college that I was a member of, Larry Seidentop, has written...

And Seidentop doesn't claim to be a Christian, but he's written a book recently entitled Inventing the Individual, the Origins of Western Liberalism. And he really, in many ways, echoing the insights of Carl Becker, an American historian writing way back in the 1930s in his work, The Heavenly City of the 18th Century Philosophers, that even the Enlightenment thinkers were far more indebted to Christian notions than they cared to admit.

[27:00] And really, they are, in many ways, presenting secularized forms of Christian insights. The whole caring profession really grows out of the Christian tradition.

Central to any sort of therapy is the whole issue of discernment. I remember when I was studying at Oxford, several of my undergraduate friends were medical students.

And one day they said, Oh, we've got this leading psychiatrist coming in from Broadmoor. Broadmoor. Broadmoor is the hospital for the criminally insane in south of London.

And this psychiatrist came in. And he was a Christian. And he said, in his talk, he said something I've never forgotten. He said that, you know, he said, pastors and psychiatrists have the same challenge in dealing with people.

As you talk with this person, you have to be trying to discern what tack you should take with them. He said, Jesus said, you know, come unto me all you who labor and are heavy laden and I will give you rest.

[28:08] A very comforting message. So with some people, and this would really be in concurrence with Gregory the Great, with some people you say, you need comfort. You need reassurance.

He said, but other people need to hear what Jesus says when he says, he would follow me, must give up everything and take up his cross and follow me.

A very bracing, challenging, not a comforting, but a challenging message. And he said, if you have somebody who needs to be challenged and you comfort them, what you do is reinforce them in the rut they're in.

If you have somebody who needs to be comforter and you challenge them, you will crush them. He said, the psychiatrist and the pastor both have the same dilemma.

When do you offer comfort? When do you offer challenge? And that discernment, I think, is actually crucial in our conversations with friends, with those who need help, those who need our encouragement.

[29:12] This is a great gift, I think, of a great psychiatrist or a great pastor. When do you challenge? When do you comfort? That gift of discernment is absolutely critical. Well, I've said enough, you really want to hear James.

So, James is going to come and talk to us about the medical side of all this. Well, speaking of the medical side, I imagine many of you are experiencing a paralysis of the lower limbs at this point.

So, if you want to stand up for 60 seconds and get circulation flowing again, that will be good. So, at this point, you may be wondering, out of all the psychiatrists there are, why you should listen to me.

The main reason is that Don likes me. The second main reason is that I'm very, very, very old. I'm so old that when Don wants insight into what it was like to live in Victorian times, he has to ask my younger sister because I'm much older than that.

Now, some of you are saying, hold on, it's true, you do look decrepit, but you're somewhere about 60, you can't fool us.

[30:42] So, thank you, thank you for making me feel young again, but also making this crucial point. As Don has pointed out, psychiatry is the youngest branch of the youngest science.

Medicine has been described as the youngest science. psychiatry, the youngest branch. Sixty years is about the time frame we're looking at.

I had the privilege of attending lectures from Heinz Lehman when I was in McGill. And the reason that matters is that he was the man who first brought medication to North America in 1954, chlorpromazine, the first antipsychotic that we had.

and in 1957 in Mipramine, the first tricyclic antidepressant. That's how recent all of this is. So, the developments that we've talked about are as young as I am.

All right. So, a great privilege to be here and to start where all good thinking begins as Don did with the encounter of man and God.

[32:00] And this verse is meant to get us thinking along those lines. As you know, there's a kind of a structure to the book of Psalms and some would argue that the last three Psalms, 147, 148, 149, represent a kind of summary or climax, 150, of course, being the climax of the climax.

And most of the Psalms, let's say 60%, are Psalms of lament. But these final hymns are hymns of praise and the transition Psalm 147, as Derek Kidner points out, bridges the gap between lament and praise by taking up the questions of Isaiah 40 and the questions of the book of Job and turning them into praise.

It's not a move that happens overnight. Significantly, says Kidner, the promises of Isaiah 40 were made to a homeless generation and are here reflected back in praise.

God heals the broken hearted and binds up their wounds. This is something that's easy to miss in our modern conception of medicine and psychiatry.

We're in the habit of saying, the doctor made me better or the psychiatrist helped me. But in our training, both as medical doctors and as psychiatrists, we know that our job is actually to create the conditions healing in which healing can occur.

[33:53] Your immune system, if you want to think of it reductionistically, is healing you while the medication is holding the bugs at bay.

And exactly as Don was explaining, the same kind of process happens with psychiatric medication and with psychotherapies. It isn't sufficient to just sit there and wait for something magical to happen.

Don's contention and mine is that God's kingdom includes psychiatry and pastoral care. Don made it sound like I was the one teaching him, but this is the book he was talking about.

This is the book of pastoral rule, the greatest book of psychiatry ever written. I would argue that if you read this and pay attention to it, it would be the next best thing to being a historian.

Because the beautiful thing about historians when it comes to mental health care is that you're used to listening and taking into account a whole range of factors, not just simple this caused that.

[35:13] There's a range of things that happened in the history of a person's life and they all need to be taken into account. Gregory is just fantastic in recognizing how to discern the individual differences.

the paradigm shift, which Don does so beautifully in the course, is to understand that the cure of souls, the care of the mind and body, is first and foremost a Christian responsibility.

It's what we were known for in the Roman times and subsequently, and as I say, this was the manual of pastoral care for a thousand years.

It's too bad that it's not more widely practiced. So, sorry, this is the book of pastoral rule. This is an English translation, so you'll get different titles depending on how they've translated it, but it's, yeah, it's just lovely.

Yeah, so to reclaim this enterprise as a fundamentally Christian enterprise under the heading of Psalm 147 is one of the things I'd like to turn around.

[36:36] It's not a medical paradigm so much as a human paradigm. If you can't be a historian and you want to help in mental health, the next best thing is to come from Saskatchewan, if you possibly can.

The reason is that in Saskatchewan it's almost impossible to think very much of yourself because you're so small compared to the landscape.

Also, it's almost impossible to avoid paying attention to the big picture because that's all there is in Saskatchewan. It's just big.

So, as Don was saying, mental health is a topic that's big and wide and deep because human nature is big and wide and deep. You know this, but maybe you don't think about it enough.

Eugene Peterson would say, suppose we got the six most brilliant men and women in the world and brought them here and then took any one of you by random selection and put you in a room with those six people.

[37:57] Individually and collectively, they could each spend the rest of their lives examining you, talking to you, and looking at you, and never come to the end of who you are.

That's how marvelous human beings are. Let's say one of these people is a physician, so she studies your body, not just bodies in general, but your body, learns how everything works together, how your knee joints work, how the antibodies work in your bloodstream, and with all the laboratory equipment in the world, all the time of a lifetime, she'd never get you completely figured out.

There is that much to learn, that much to know, that much to observe in a human body. Let's say the second person is a novelist, so he asks you a lot of questions, gets all the bits and pieces of experience that are embedded in your memory, all the thousands of details that you thought were unimportant or boring or that nobody would ever care to know.

Conflicts, resolutions, frustration, and joys. And out of all of that, the novelist would make a story that the rest of us would take up and read, stay up all night, be interested and thrilled by, and then he could go on and make another one and another one and another one.

He could write more stories and novels than Anthony Trollope and Charles Dickin put together, just out of your life. There's that much going on in a human life.

[39:40] There's that much material to give a good novelist to write any number of novels using the experiences that you've already had. The third person is an artist.

She looks at you, you've never been looked at that way before, you didn't know anyone could be that attentive, noticing so much. she'd look at you from every angle, in different light, seated, standing, nude, clothed, watching the texture, the curves, the angles, proportions, symmetries, asymmetries, and then render you into a sculpture or a painting, and you'd look at that, and although you'd been looking in the mirror all of your life, you would see beauty and meaning there that you'd never dreamt were there.

she didn't make it up. She saw it in you and rendered it in a way that others can see. Let's say the next person is a lover.

He's just very good at falling in love, does it a lot, and he falls in love with you. And in the experience of someone falling in love with you, all of a sudden, things start happening in you.

You have sensations, realizing, energies you never knew were in you. There's life aroused in you now. You want more life, more joy, intimacy.

[41:08] You never knew that kind of thing was there, and you never there when you were by yourself, when people were just looking at you, or staring, or giving you the time of day, or not giving you the time of day.

But suddenly the experience of love releases an awareness of depths, of a capacity for intimacy and relationship, that you never knew were there. The fifth member of our committee is a pastor.

He seems to be there with you, believing, praying, aware of the God action in your life, discerning the workings of grace in your experience, listening to you, sensing what's going on.

And he'd see both you and the image of God in you, and start making connections between them, so that you could see them. He'd see all the slight or obvious distortions of sin that were messing up your life, and then he'd point out the counter movements of grace that showed how each one of these sins or sin experiences was a foothold for something God could heal.

You never knew that before. You never knew all those things were going on in you, and endlessly, day after day after day.

[42:26] He'd find new ways in which you could get in on this whole world of the action and being of God. The sixth member of our committee is a psychologist.

She listens, reads between the lines, conscious of a whole reality that you're unaware of, the realities of the unconscious that are barely visible, hardly audible, but are no less real and actual.

most of what we experience feels chaotic, fragmented, disjointed. We don't see the patterns, we don't realize the connections, and she'd be able to show you that, show you all those things in your past and your unconscious that all fit together and made some coherence, help you understand yourself in a way that you hadn't before.

most of us experience ourselves through stereotypes that other people put on us.

They don't quite fit right, and we sense something's not quite right with them, but they are our parents, our teachers, and we respect them, so we figure they must be right. But then this person, this psychologist, this counselor, this pastoral care provider, who is trained and talented in bypassing the stereotypes and just seeing who you are, helps you realize the uniqueness of your life.

[43:57] There is nobody like you. Nobody ever thought the thoughts that you think, did what you do, puts it together just the way you do.

And now here's somebody who shows you all that endless unique creativity that is yours and yours only. Well, all I'm trying to do by setting you in the room imaginatively with these six people talking about the endless beauty, spirituality, intelligence, biology, drama, that's in each one of our lives.

They'll never run out of material, never run out of things to exclaim over, to write reports on, to put in journals. The human being is the most astonishing piece of protoplasm that this universe has ever seen.

Isn't it wonderful to be so wonderful? To wake up in the morning as a creature like this is an adventure far surpassing anything that a lion does in Africa, or a whale does in the Arctic, or a bird does in the spring migration.

But here's something even more astonishing. These marvelous creatures that are our cells are notoriously messed up, in trouble, and unhappy.

[45:21] If we're so good, why do we feel so bad? Why do we go around with these inferiority complexes? If we're more interesting than, say, the surface of Mars, or the petals of a rose, why are we so bored with ourselves, and with each other?

If we're so fearfully and wonderfully made, why do we spend so much money on deodorants, perfumes, cosmetics, razor blades, trying to make ourselves look and smell different?

If we're made in such a way that we can enter into this extraordinary and complex adventure that we call love, why do we experience so much hate, rejection, cruelty, and loneliness?

So, again, illustrating John's point, Eugene Peterson as a pastor, best pastoral care provider ever, next to Don. So, we've talked a little bit about how things that you already know, you're intricately and wonderfully made, you're multifaceted, there's a biology to you, there's a psychology to you, there's, there's, you unfold over time, there is relationality to you, and all of this is wrapped up, as Peterson would say, the world of salvation is larger than the world of creation.

You already know this, but we'll make it more explicit. You experience your identity in and through relationships, not just social relationships, as important as they are, but relationships to the natural world, your inner world changes when you see a sunset.

[47:16] To the interpersonal and intrapersonal worlds you already know about, and of course, your relationship with God transforms you.

life. As we progress through each of life's stages, it can be helpful to think in terms of the accomplishments that life brings to us in one way or another.

Things like basic trust, autonomy, initiative, industry, identity, intimacy, generativity, and ego integrity perspective on the whole shooting match.

And in this process, it seems as though God is trying to grow in us some virtues, for lack of a better word. Hope, self-control, purpose, confidence, fidelity, affiliation, the capacity to care, and wisdom.

So, whatever else is true of us as human beings, we're a work in progress. It's not something that can change overnight. And again, you already know this.

[48:50] Many of you have already been through many dangers, toils, and snares. And that wasn't necessarily enjoyable, but mainly, you learn something from it. Turning now more specifically, when you have the context of the human being inside the larger world of salvation, the large world of creation, then, and only then, can you narrow down and understand mental health in perspective.

there. So, as Don was pointing out, this is using, you'll see different numbers in different studies. This is using the numbers from the National Comorbidity Survey replication.

population. And so, it's just saying that 25% of the population will experience some mental illness within any one year. Another 25% will experience some mental illness during a lifetime.

And so, by these standards, half of the population will experience some diagnosable mental illness in their lifetime. Now, you may look at that and say, well, that's hard to believe.

if you don't believe it from your own personal experience, don't actually do this, but just when you're leaving, look at the people beside you. The reason you might not believe it is exactly again, as Don was pointing out, the range of pathology is very broad, from minimal impairment to severe impairment.

[50:23] So, just to clarify, in this study, 3% to 9% had severe impairment, 5% to 7% of the total population had moderate impairment, and 10% to 15% had mild impairment.

So, a different study, so slightly different numbers, but you can see the big circle is meant to represent the percentage of the population with mental or addictive disorders within any one year, approximately 25%, 28%.

And the smaller circle is the percentage of population receiving mental health services in any one year, approximately 15%.

Now, notice the narrowness of the overlap. What that means is that only 8% of people who have a diagnosable mental illness are receiving treatment.

treatment. The other 6%, 7% who are in treatment don't need treatment. That is a huge screening problem.

[51:34] Meanwhile, that leaves 20% of the whole population who actually has significant diagnosable mental illness receiving no treatment.

mental health services. Not that I feel strongly about this. So this just subdivides those figures a little bit more.

6% of the population receiving mental health services in any one year are receiving that service from specialty care. Another 5% are receiving that help through their general physicians.

another 4% are receiving that from you, the voluntary sector. Other human services. I don't expect you to be able to read this.

But these bars, the orange bars represent the prevalence of different specific conditions in any one year. And the blue bars represent the prevalence in a lifetime.

[52:45] time. So at the bottom, about 7% of people meet criteria for major depressive disorder in any one year. About 17% of people will experience a major depressive episode in their lifetime.

The other longest lifetime blue bar there is alcohol abuse. About 13% of the population in a lifetime. both 3% in any one year.

Just to illustrate. These are not rare conditions. A rare condition for purposes of comparison is pregnancy.

Pregnancy affects about effects, you know, like an illness. Pregnancy affects about 1% of the population at any one time. All of those conditions are more than 1%.

Right? Any one of those conditions. So, coming to terms with all of this, it's helpful to broaden your minds as you already have. There's this very large perspective on what it means to be human inside of God's grace.

[53:56] disease. And then it's also helpful not to narrow down, again, as Don was enormously helpful in pointing out, there's more going on in my office or in your pastor's study than disease.

But, of course, disease is an important thing. So, disease is a construct, a frame of reference that implies abnormal structure or function in the body. typically named by its cause.

So, cocaine induced mood disorder is such a thing. Or pneumococcal pneumonia, you know about. It's sometimes named by a pathology, so circadian rhythm sleep disorder.

Or glomerulonephritis is something that can happen to your kidneys. It can also, diseases can also be named by syndrome. Syndrome is just a cluster of symptoms.

symptoms. And so, we use names like schizophrenia or migraine. But it's better to think of the group of schizophrenias and the range of types of migraine rather than think that each of those is just one thing.

[55:09] It isn't a unitary thing. It's an umbrella. But there's more going on in your lives than diseases. There are also dimensional issues.

The concept of dimension has to do with a continuum rather than a category. So, this is the language of personality.

Yeah, so this is the language of personality and temperament.

Your differences viewed as a totality in comparison to other people in your group and age and stage. It's also, dimension is also the right way to think about attributes, traits, qualities, aptitudes.

Again, differences viewed separately within you. And again, as Don mentioned, the concept of behavior.

[56:13] Behavior means consciously or unconsciously goal-directed activity, which we typically talk about in terms of their consequences. So, migration is obviously a behavior. Addiction is obviously a behavior.

There's more to it than that, but it can be understood as a behavior. Eating disorders are behaviors. Delinquency is a behavior. This category, this concept, this framework, talks about abnormalities in the strength of the urge to drink or to do something, the mode of its expression or the nature of its object.

behavior becomes a focus of clinical concern when the individual or others suffer from its expression, especially when the behavior takes the form of a stereotyped craving that has a life of its own for a particular experience.

But again, as Don pointed out, and as Gregory is great at pointing out, our knowledge of diseases, attributes, and motivated behaviors doesn't enable us to know someone as a person.

Your individuality, expressed by your opinions and choices, your moods and your whims, your successes and failures, convictions and values, hopes and dreams, remains to confront our understanding as would-be helpers of you and demands still another perspective.

[57:48] Life story, history, this is why historians are such good counselors. Narrative is the language of self, roles, life stages, and intentions.

So, just again, just trying to equip you with frames of reference that I think will be helpful as you help others or understand yourself better. It's not just about disease, it's about dimensions, it's about behaviors, and it's about life story.

Each of our many dimensions manifests disorder differently. Yeah, so we typically associate disease with biology, dimensions and behaviors with psychology, dimensions and story with our unfolding over time, and behaviors and story make sense of some relational issues.

But there's this larger dimension, as Edwin Huy pointed out, of eschatology, the fact that the world of salvation is larger than the world of creation.

And so, as Don alluded to, it's certainly possible to have spiritual problems. It's helpful to put this in perspective in another sense.

[59:18] About 20% of children and adolescents have mental disorders, and of all mental disorders on earth, half of those began before the person was 14.

Wasn't diagnosed before 14, but began before 14. mental disorders and substance use disorders are the leading cause of disability worldwide.

When you combine those two categories, about 23% of all years lost to disability are caused by mental and substance disorder.

The World Health Organization category for this, the way you compare disability across time and across cultures is the DALI, the Disability Adjusted Life Year.

14% of Disability Adjusted Life Years, worldwide, this isn't just a North American problem, are lost to mental disorders.

[60:23] And that's unfortunate because these conditions are exceedingly treatable. Unfortunately, in our current system, only 3% of healthcare budgets goes towards conditions which are responsible for 14% of the disability.

Worldwide, about 800,000 people commit suicide every year. Suicide is the second leading cause of death in the 15 to 29 year old age range worldwide.

Again, following Don, as he pointed out, stigma and discrimination against patients and families prevent people from seeking mental health care. This is a 14 year old boy who's been chained to that bench for the last nine years.

So, last but not least, just trying to emphasize what we can understand. I love this verse because one of your members taught Greek.

The Greek for foolish is affrontes. It just means don't leave your frontal lobe behind. Don't be foolish, but understand what you can do, what God can enable you to do, which as Don pointed out is a lot.

[61:59] Yeah, so first things first, understand that the range of normal behavior is quite broad. Just because the person you're going to look at next to you as you leave seems odd to you doesn't mean they're disordered.

That could be a normal variant. but by the same token, it's helpful to have in your back pocket the signs and symptoms of the most common mental disorders.

In the same way that you understand the signs of a stroke or the signs of a heart attack, you must memorize the following phrase, SIG-E-CAPS, S-I-G-E-C-A-P-S.

A major depressive episode is an abnormally low mood for you most of the day, most of every day, for at least two weeks at a stretch and often much, much longer, together with four out of those eight SIG-E-CAP symptoms.

S is for diminished sleep, I is for interest diminished, G is for guilt, means low self-esteem, E is for low energy, C is for diminished concentration.

[63:23] In my office, when I ask anybody at all if their concentration is bad, they all say yes. You must not count that kind of a yes toward the diagnosis of major depression.

Instead, you need to ask for severity criteria. Is your concentration so bad that you could not follow a newspaper story or a television program? Say, oh, no, no, I can do that.

Fine. But if you can't, then that counts. A is for appetite, usually diminished but sometimes increased in about 10% with 5% weight loss, unintentional.

P is for psychomotor. That's your fancy word for the day. psychomotor is just how quickly the mind and hand are moving together. So slow speech is psychomotor retardation, whereas ringing of hands is psychomotor agitation, right?

Rough and ready ways of looking at that. And S, of course, is for suicidality. the approach to this, you will never ever put this idea in somebody's mind just to ask about it.

[64:36] And your approach is simply to say, have things gotten to the point, all the things you've told me about, have things gotten to the point where it sometimes feels as though life is no longer worth living?

If they say yes to that, then you say, have you thought of ways of harming yourself? If so, what? And if they say yes to that, the question is, have you tried to harm yourself?

So it's just a very gentle approach for giving people permission to talk about how that is. Anyway, major depression is SIGICAPS four out of those eight, together with sustained pervasive low mood for at least two weeks, not better explained by general medical conditions, as John pointed out, not better explained by normal bereavement.

There you go. Now, you know, like heart attack, stroke, and major depression. Never attribute illness to lack of faith.

There may be lack of faith, again, as John pointed out, but lack of faith doesn't cause illness. Mental illness is not contagious. It used to be contagious.

[65:49] It used to be that syphilis was the leading cause of mental illness, tertiary syphilis, but you're too young to know about that, so I won't tell you. So you can help people in many, many ways, and are already helping people in many ways, but just simple things.

That Dr. Packer, I wish he could have been at that talk, because it was the single most practical helping lecture ever given. you help someone when you help them see their doctor, counselor, pastor, therapist, take them to appointments, you encourage them to see those people, you make sure their practical needs are looked after.

If you're so depressed that you can't get out of bed, you are unlikely to cook for yourself or your family. That's where your church community is enormously helpful.

And what J.I. Packer did with his parishioners was take the time to talk with them, but also get them out.

Activation, and of course, Jim is not dragging them out of bed, but gently encouraging just the kind of walking that you can do.

[67:02] It just, it's amazing. Even a little sense of accomplishment can make a difference. And of course, being there is the greatest gift.

Yeah, so that's the world's shortest talk on mental health. That's the goal. Competent, compassionate, considerate care requires a community, preferably a church community.

So there. Thank you for your attention. Thank you. Thank you. Thank you. Thank you. Thank you. Thank you. Thank you. Thank you. Thank you. Thank you. Thank you. Thank you. Well, thank you very much.

Don and James. Now, I earlier gave you my cell phone number for you to text me some questions. So questions. I'm waiting. Maybe you have a question to anticipate answering Don or James.

Tell me one of the best questions that has been asked of you when you've given this lecture. One question that came up was what was James' view on marijuana as a form of medical treatment?

[68:23] Totally unfounded. There is there is simply no solid evidence base for the use of marijuana in preference to other treatment modalities in any condition.

Don't use marijuana. marijuana. I've got other questions. Okay, well, there was one thing that you did say last year in response to that question was that marijuana was 127 times more toxic than tobacco in terms of lung disease.

Yes. Don't quote me on that. But think about it. You know this already, right? Marijuana does not come from a single source of carefully filtered product.

It's exceedingly potent. It's smoked, for heaven's sakes. Do you enjoy inhaling smoke in your lungs? No. You go like this.

No, I don't. Every time you're at a campfire and you inhale smoke, you cough and gag and turn green. Why any sentient being would do this to their lungs defies explanation.

[69:46] A very good way of getting lung cancer. You have a pretty good explanation for why people would do that, though. Right? In terms of addictions. But anyway, I do have some questions here.

And one you can answer really quickly, which is when is the next time the course will be offered? And can you offer? How many does that apply to? Yes? I don't know.

You don't know. Okay. Yes. Well, call the college and ask them when's the next time you're going to offer that. That might be a helpful way, don't you think? Okay, here's another question.

Someone wanted you to repeat those eight, the four of eight for depression, clinical depression. So can you do that again, please? Sure. Right up here, like this.

Psychiatrists don't like yelling at people, so sorry about this. The eight are SIG E caps.

[70:44] This is a mnemonic that was created by a colleague of mine at Mass General named Kerry Gross, and he was just trying to help people understand the warning signs of depression.

S is for sleep, I is for interest, G is for guilt or low self esteem. If you Google SIG E caps, you'll get a full description of it.

It's SIG E caps is available on Google. S-I-G E-C-A-B-S. Right. If you just put that in your Google search, it'll bring up the full description.

Excellent. And it's four of eight, right? Four of eight. Four out of eight. So those of you who have already transitioned from DSM-3 to DSM-3R to DSM-4 to DSM-5, the way that they describe the very same condition is a little different, but it's still simpler to remember the four out of eight.

So here's another question. How do I help someone who's unwilling or resistant to seek professional help? Very good question.

[72:11] There's not a lot you can do because unless someone wants help, they're not going to receive help. Unless a counselor can establish a deep personal relationship, trusting relationship, people aren't going to be able to be helped.

But having said that, you can refer them to other people who've had similar issues, whether it's depression or bipolar or schizophrenia, who have been helped.

And you can say to them, let me introduce you to a friend who's had psychiatric help with a doctor and let them talk to you about what you're going through.

and I think building bridges that way is probably the best way to get somebody to actually get help if they're really resistant to it.

There may be religious reasons, there may be cultural reasons, et cetera, that are holding people back. But unless the person is willing to be helped, there's very little that a counselor of any sort can really do.

[73:21] I think the referral to somebody else who has gone through something similar is probably the best way to get over that hurdle. I wonder also if the Christian community is, maybe not a unique community, could be helpful or more helpful to that end.

because you have this cohesive community, right? And so it's not just one person who's trying to help. You've got options, alternatives, other people can collectively help the person.

Another question, do you think it's important for Christians to see Christian counselors slash psychologists slash psychiatrists? Yes, it's absolutely essential.

The same thing if you break your leg, you really want to have a Christian doctor set your leg. If you go to a dentist, make sure that they have signed a creedal statement that agrees with what you believe.

It's absolutely essential that you have somebody who agrees with, you know, it really doesn't matter whether they're a brilliant psychiatrist, have got all sorts of skills, you know, if they're a Christian, that's enough.

[74:31] I mean, that just proves how good they are. You really should only go to somebody who thoroughly agrees with you theologically. Nobody else who doesn't believe exactly what you believe can really help you.

That's very true with your dentist, your doctor, your insurance agent, your stockbroker. You know, they really, because they don't believe exactly what, they can't actually understand that you actually have bipolar disorder or schizophrenia or personality disorder.

You really have to go with Christian option. That's the only way to go. Absolutely. What can I add? Someone wants to add one thing.

Are you joking? I have a very good friend who's, well, I have a number of very good friends who have seen psychiatrists. Some of them are people you know.

And some of those psychiatrists have been Jewish. Some of them have been agnostic. some of them have been Christians. But just as if you go to somebody who doesn't hold exactly what you believe, they still may be competent in their area of expertise.

[75:47] So you want to ask, is this person competent and effective? They may be a Christian. They may be an absolutely dreadful psychiatrist. You want to ask the right sort of questions for the help that you need.

Now it isn't to say that being a Christian is going to be detrimental. But certainly there are many people around who are excellent at setting the bones and there are other people around who are excellent at diagnosing the chemical imbalance in your brain.

That may be the cause of mental health issues, one that's facing. I'm going to add a question to that as a moderator here. So what is it then that actually really makes for a good psychologist, psychiatrist, or therapist?

I mean, how do you differentiate? What makes that person really, really good? And sometimes that person may be good for one person but not good for another one. Okay, so in this day and age, we're fortunate to have things like Google and to also know about some reputable medical sites like the Mayo Clinic or WebMD or UpToDate.

So when you suspect that you have something more in the disease realm that might benefit from medication, it's a relatively simple matter for you to do your own homework and find out what the generally recommended treatments are.

[77:22] And so your way of checking out somebody's credentials would be to find out what sorts of things they would suggest first in terms of assessment and then in terms of treatment for conditions for which the treatments are well known.

That would be the simplest thing in the disease realm. In terms of psychotherapy, exactly as Don was saying, the important thing is being willing to be helped.

But as you were pointing out, James, exactly right, of course, what matters is the goodness of fit between you and the therapist. So studies have shown that successful outcome in psychotherapy has to do with you feeling comfortable with the therapist, but also you feeling that the therapist is competent, which is something that you only experience over time.

So I'm not suggesting that you have to give them a year, but over the course of even a very few weeks or sessions, you'll have a sense of whether they're talking nonsense or doing things which are consistent with the approaches to cognitive therapy and so on that you can study.

I often ask, or I often ask a lot of people to see counselors, and very often I will send them specific Christian counselors who I know, because part of their issues very often are spiritual issues that are affecting them.

[78:56] So certainly in terms of spiritual direction, I would be very careful about who I would send people to, but if it's a pure issue of medical diagnosis of schizophrenia or other major forms of mental illness, then I would...

So there are different categories. I certainly would recommend people to see counselors who are Christians for certain issues, but other issues, I don't think that the theological test or the spiritual test really applies.

So I think it's... And also I think what James is saying, there are certain counselors in the city who are particularly good in treating certain types of issues. So if somebody's asking me today, there are several counselors who are particularly known to me as excellent in treating people with post-traumatic stress disorder.

There are other counselors who are particularly good at family therapy, others who are good at abused women, others who are good at addictions, etc. So there are people who get reputations, well-deserved reputations, who are very effective in what they do, and very often it's really by word of mouth that you can get a sense, okay, if this is my issue, then this is the person I want to see.

So particularly when you're dealing with issues, they really touch on spiritual issues. Oh, and I should just mention that Catherine Gifford is an excellent therapist in many regards.

[80:27] Well, yeah, we've got endorsements to make. I've got a list of referrals, and Don has his, and some of the other staff do as well, so she's on mine. Just a question.

This is a practical one. Is it possible to get a copy of the PowerPoint presentation? What did you have in mind? I don't know. That's just the question, I think, what you presented, the content of it.

Maybe that person can come up and ask you later, how does that sound? Okay. Sorry, how well do you think someone with a mental illness could work in mental health?

Wild or ill? You can address that. Yeah, so if you know your history of psychology, you know that many great therapists had personal experience of many.

Perry Stack Sullivan, Carl Jung, Freud himself had some very interesting terms and twists. So, of course, when something is as prevalent as mental illness, having had the experience yourself doesn't preclude being able to help.

[81:55] But we were just talking, obviously, if you're in the midst of an episode, you need to know it yourself well enough to know that you're not well enough to help others. Another question.

I agree it's important for a person to have a medical exam when depressed. However, many GPs seem very quick to prescribe medications instead of talk therapy.

How do you advise people you're sending to their doctor? Yeah, so it helps to actually know your family doctor and to, you know, have a conversation.

If, as we've suggested, what you're there for is to rule out the general medical causes of depression, then that's the conversation you're having.

And it would be, I hope, a rare GP who says, no, well, never mind that. We're just going to try to run an antidepressant. So being clear yourself, what you're there for, to rule out the general medical causes of depression first, will be helpful.

[83:17] But, of course, the vast majority of psychotropic medication is prescribed by GPs. So if, at the end of an assessment process, the GP thinks that this may be the way to go, then, again, they shouldn't be just prescribing that.

They should be recommending that. And that's your opening for a conversation. Okay, why are you recommending that as opposed to this and so on? If there are no reasons behind it, that's a bad sign.

But if there are reasons, then it's worth finding out what those reasons are. This is a, they aren't all practical questions.

This one's pretty practical, which is what happens if a person isn't interested in getting better, getting healthier, but in relationship with a friend is making that friend feel guilty.

So this friend is actually afraid that the friend who needs help is actually going to potentially harm themselves. Close to your point. Understand that? Yeah.

[84:22] A friend who's not interested in getting better, but another friend who's interested in that person who's not interested in that. And in that relationship is making the helping friend feel guilty and concerned about cut off in that relationship.

So how do you stay in relationship with that person, though? It sounds like there's some manipulations going on. You've dealt with this as much as I have.

While you're thinking that through, maybe I can, maybe this might be helpful. It sounds to me like, I don't know how much you talked about this, I had to pop out for a second, but systems and anxiety and how they get transferred and bound.

And so maybe you could speak about something like having a non-anxious presence in systems like that, in systems that often aren't just between the relationships of two people, but include triangles.

Because often I think we do think that when we're in those caregiving relationships and we think of those relationships between being the care receiver and the caregiver. We often think that it's just a two-way relationship there, but there's more that's going on than that.

[85:47] Sorry to the person who asked that question. Hopefully that will actually end up being helpful. That's good. No, you just answered the question. I just answered the question. Okay, I hope that was helpful to the person who posed that question.

Let me go on to another one. We have 10 more questions, and we have negative 5 minutes.

If anyone does feel like they need to get up and walk out, feel free to. But you're welcome to stay too. We'll keep answering for, if you want to do it for another 10 minutes, we won't get through one question in one minute each, but I'll try to select a few out.

So, are there some conditions for which prescriptions of medication is the preferred treatment? And this question is a concern. As Christians, I think we are very hesitant to acknowledge the organic base for mental illness.

Yeah, I think that's very true, but part of that is from the theology, because we are relational beings, we are many aspects. One of those, we are chemical beings, and the chemicals in our brains can go astray or amiss, and the firing of those can be affected.

[87:12] So, yes, I think that's true. I think it is helpful to realize that one of the points that James made is that something like schizophrenia, which is a terrible condition, one of the most awful diagnoses you can get, but 50 years ago, we had no treatment for schizophrenia, none whatsoever.

Now, about a quarter of people who are diagnosed can live normal lives with targeted drug treatment and therapy. 25% we had no way of touching.

We still are, and then the other 50% are sort of between those. So, there is strong evidence that drug therapy can work very effectively with some people.

Not all, certainly with schizophrenia, but 25% of people living normal lives is far better than 0%, which was in the 1970s before these drugs were developed.

So, those who argue against the use of these sorts of drugs, you have to realize that these drugs are very effective for some people.

[88:22] Now, they do have side effects, et cetera, and they have to be, all those things have to be weighed, but the evidence medically, as I understand it, is overwhelmingly in favor of the use of drugs judiciously alongside talk therapy.

and they're, yeah. This one I can see would be really helpful for those of us when we're actually caring for someone.

I do want to resource you in this way. So, can you point to some signs that might illustrate someone struggling needs comfort or challenge? I hope I don't misinterpret this because I don't want to mess up your question.

I think it's a good one. I wonder if the question is at what point does this person need comfort and other signs of that, but at what point does this person need challenge? Well, I think most people need both at different times, and the spiritual gift is discerning when does that person need one and when does that person need the other.

That's the $64,000 question, I think, in terms of discernment. So, people need both at different times, and it's a matter of discernment in talking with a person as to how you move forward in your counseling.

[89:51] So, one of the things that sounds like it comes out of maybe some experience as well, are there any conditions that have low track records of successful treatments? One example is given here.

I'm thinking of hoarding as an example where I've heard of minimal results. But, you just mentioned schizophrenia, which had a low track writer, but what are some of the other ones maybe that are low?

Yeah, as Don and James have pointed out, there are a number of conditions that are famously difficult to treat. eating disorders springs to mind.

But, you see the problem. We've tried to make the point that these categories are spectrums. And so, to say to somebody, well, you have hoarding disorder and so it's unlikely that you'll be helped would be a bad thing to say.

because, of course, first of all, you're at a point where there hasn't even been an assessment of all of the factors that are maintained in behavior.

[91:06] So, it may be a treatment responsive hoarding disorder. And, and, and, until there's been a proper assessment and a trial of treatment, you simply don't know that.

But, but bear in mind, again, those of you who are gracious enough to point out how very, very young I am. The, the point of that is simply that we've, we've had less than 30 years to develop treatments and test them.

Right? So, don't, you know, stay tuned. Don't give up with the message there. When your child turns 25, where do you send them for, for help?

That's how the question is stated. Might require some interpretation. I've got an idea of it anyway. Go ahead and think. No, not where to send them, but where the questions coming from are going.

Oh, okay. Yeah, so the, the way the system was originally designed, um, your family doctor is meant to be a gatekeeper. And, and so if you're at a very early stage where you don't know whether the condition is in the disease category or dimension or behavior or life story, then, then the family doctor, uh, can assess and do some treatments, um, but would also be the one to, uh, make the appropriate referrals if, if that's necessary.

[92:37] If you've already done the kind of assessment, you know, the situations like Don runs into all the time and knows it's not a disease so much as, uh, something that's going to benefit from counseling again, exactly as these gentlemen have pointed out, there are, there are people who are known to be able to help at any age.

Let's pull up. Questions from one person. Are there trends in relationships today which are contributing to mental illness? If so, what encouragements do you have for us in being proactive in preventing mental illness?

Do you want to do the isolation? See, the truth is that Don is better than I am. He has more experience but he's so shy.

It's a problem. Okay, so I know you already know this. Vancouver is famous for the extent of the loneliness and social isolation in the lower mainland just compared to anywhere else in North America.

I know you understand from what we've tried to impart, we're not trying to draw a straight line from social isolation to developing schizophrenia but we're saying that social isolation is a grief itself and there are lots of things that you as a church community of course can do to address that.

[94:09] The other experience that Linda and I have had in traveling around North America for training when I went to Boston in the 80s it seemed to us compared to Saskatchewan which is the center of the universe and therefore normative that everybody in Boston was manic.

I mean they're just full of energy and they talk loudly in subways about anything to everyone so we had to adjust our threshold for diagnosing manic depression and then we went to Montreal and it seemed to us that everybody there was depressed they talked about nothing to anybody on the subway ever and were all very dour and quiet which was amazing to us because they have the world's best snow removal like what what's not to be happy about you come from Saskatchewan they remove the snow within six hours of it landing that's crazy anyway and so Vancouver the big thing here is entitlement anybody who's driven in Vancouver knows this right like yeah I don't it's good you're sitting down I don't know how to break this to you but yellow doesn't mean speed up when was the last time you saw somebody let you in on a merge or the thing we really notice again Saskatchewan normal keep that in mind go visit

Saskatchewan you'll know what normal is try walking down the street in Saskatchewan people will see you a mile away and move to the side in Vancouver people will walk into you as they're looking at their phone and it's your fault entitlement is a serious mental illness in Vancouver in my professional opinion and that's the DSM 3R is it or DSM 4 homelands personal pet homelands right okay homelands someone asked James' last name there you have it homelands can I just ask a question further to that though some mental illnesses cannot be prevented right right I mean some are biological chemical and so there's nothing that you can do right like heart disease in some cases right it's but some heart diseases can be prevented as well so helpful addition to that

I think there are other things we've been here for a long time talking about things that are contributing to mental illness the family breakdown is huge migration is huge there's a much higher incidence for instance of certain forms of mental illness in second generation migrants which we have a lot of in Vancouver drug use is huge in terms of exacerbating mental illness or even bringing on pushing people along a continuum through even soft drug use there's certainly I think a fair amount of evidence to that effect so there are things that people can do but I think most I think you would agree that most mental illness is either created by the experience growing up of abuse or being in strange families which a lot of us have or it's organic related but a lot of things that people suffer from are not things that they could have prevented unless it's something obvious in terms of drug use so again

I think the great so much of the shame of mental illness is people think I'm to blame well that's I think part of what we're trying to disabuse people of that most people suffering from mental illness didn't bring it on themselves they're the victims in part of the genetics mental illness often has a genetic component with some and then family drug environment if you live next to a gas manufacturing plant then there are things that can so there are all these things can affect mental illness but I think by and large the things that people do the most to contribute to it is their addictions that I'm rambling here but no that's good you want to say something about yeah we're always in danger of oversimplifying in an overview like this not that anything

[99:18] Don was saying was that per se but within the disease model something like attention deficit disorder is 80% of the variants is explained by genetics the remaining 20% has to do with exposure to things like second hand smoke in pregnancy and heavy metals and things like that something like panic disorder would be perhaps 60% heritable and major depression as we just talked about is thought to be maybe 40% heritable that's probably an assessment problem people aren't using secret caps when they're trying to separate out the part of that that has a biochemical basis so yeah okay it's it's 10-2 and I have one more question if I can okay and because I really want to help us grow in our mental health and awareness in light of our

Christian faith and Don just mentioned something in terms of a victim and blame and one of the things that I find is that with diagnoses that we can tend to take on the well we put on an identity based on our diagnosis and how do we differentiate from victim to I'm a child of God my true identity though this is what has happened to me and this is my behavior not to deny that because that is reality but the greater reality and maybe this was your point earlier James about creation and salvation redemption the story how do we how do we hold fast to who we really are in Christ and not apart from from those other identities or diagnosis but not to deny them either so another three hours there you go see call

Regent College and say offer that class again is that what your class is about yeah okay well thank you Don and James very much it was great to have you tonight everyone was really interesting let me just close my prayer thank God we give you thanks for who we are we know that we're fearfully and wonderfully made and you take great delight in us you've done for us what we can't do for ourselves through Jesus Christ but you also have ways and means in this community that we might grow into more of who you know that we already are so help us to receive the help that we need when we need that help us to give the help that we can when we're able and not try to be more for people than we can to be able when we need to refer and help and encourage to get the kind of help that is available that we're able to do that

God we give you thanks for your spirit that dwells richly in us and as we're growing in our own mental health and helping others in Jesus name we pray amen amen amen