ASHLAND THEOLOGICAL SEMINARY

A RESOURCE: SPIRITUAL COMPANIONSHIP AND BIPOLAR DISORDER

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For Aunt Marie, Laura, Jessica, Brandon, and Taylor

In Memory of my Mom and Grandparents

God uses broken things.

It takes broken soil to produce a crop,

broken clouds to give rain,

broken grain to give bread,

broken bread to give strength.

It is the broken alabaster box that gives forth perfume.

It is Peter, weeping bitterly, who returns to greater power than ever.

Vance Havner

APPROVAL PAGE

Accepted by the faculty and the final demonstration examining committee of Ashland Theological Seminary, Ashland, Ohio, in partial fulfillment of the requirements for the Doctor of Ministry degree.

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ABSTRACT

The purpose of this project is to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The resource, *Spiritual Companionship and Bipolar Disorder*, establishes that pastoral caregivers are gateway people for those with bipolar disorder to receive appropriate care and models multi-disciplinary collaboration. The resource is evaluated by twelve experts using a questionnaire that includes both quantitative and qualitative questions. As a result, the resource is found to have a strong foundation and creative spiritual experientials. Insights give direction on how to improve the resource including format and cohesiveness.

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ACKNOWLEDGEMENTS

This project has taken me on a three-fold journey. Physically I have faced several health challenges and moved twice. Spiritually, I have encountered God in new ways, been healed in various ways, and had the privilege to have the support of several faith communities. This project has also challenged me cognitively. My research affirmed some ways of thinking, but it also persuaded me to change my perspective on other ways of thinking.

Mostly due to my geographical changes, my support team grew. I want to thank my Waco family for being the foundation of my support group. I was fortunate to live in an intentionally diverse Christian community when I started this endeavor. I will never forget The Ark and its many personalities who remain a part of me and informed my research and conclusions, especially Renee and Robin. Cindy Julian, thank you for being my greatest cheerleader and never doubting I could do this. Megan, Mandy, Gale, Rebecca, Lydia, and David, you ensured I had a safe place to land providing me with space to laugh and cry and doubt and hope. Anastasia, you took action and rallied the troops to make my way to San Antonio for my CPE Residency. Even though I was only in San Antonio a year, I found a family in a group of mutual friends. Heather, Lynn, Leigh, and Christina, you have never let me go, even though I moved on to Corpus Christi

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CHAPTER ONE

INTRODUCTION AND PROJECT OVERVIEW

Crazy. Psycho. Schizo. Insane. Deranged. Cray-cray. These are words used in everyday life. I admit that I still say some of them. They are words we use without thinking of the real meaning and what these words communicate. It is similar to the use of the word “retard.” There is a stigma attached to these words that demean people who genuinely do struggle with mental health challenges and disorders.

Over the past years, several celebrities have drawn attention to mental health. The death of actor and comedian Robin Williams prompted an onslaught of conversation concerning mental health, particularly on social media (Hoffner and Cohen 2017). For some, it was the first time to engage in the mental health conversation. For others, like me, there was a sigh of relief that finally, at least for a while, people were talking about mental health.

Even before Robin Williams, the Christian world was shocked by the death of Matthew Warren, youngest son of ministry team leaders of Saddleback Church Rick and Kay Warren (Boorstein 2014). As his parents openly shared about his death, Christians were asked to consider the relationship between faith and mental health.

Inside or outside the church, the statistics do not change. According to the National Alliance on Mental Illness, one in four Americans will face a mental health disorder or challenge (National Alliance on Mental Illness 2012). While I never expected to be included in these numbers, I am one in four. My project

began during the latter half of my recovery from a debilitating season of my mental health disorders.

Purpose Statement and Research Question

The purpose of this project was to create a resource that would better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The research question was: To what extent did this resource better equip pastoral caregivers to become spiritual companions for people with bipolar disorder?

Overview

The purpose of this project was to create a resource that would better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The assessment of the resource established that pastoral caregivers are gateway people for those with bipolar disorder to receive appropriate care and models multi-disciplinary collaboration. A model for holistic care was provided based on a biblical and theological framework for understanding mental health concerns and affirmed the role of scripture in mental health recovery. The resource demonstrated the importance of developing a secure identity in Christ for mental health recovery.

The resource provided an understanding of bipolar disorder including the emotional, physical, cognitive, and spiritual impact of bipolar disorder. The resource also demonstrated how bipolar disorder could interfere with one's connection with God, the church, and community. The impact of bipolar disorder can interfere with one engaging in spiritual exercises, but appropriate spiritual

exercises are offered in this resource that would assist the caregiver to position a care receiver to encounter Jesus. The manual provided further resources to assist pastoral caregivers in being better spiritual companions to people with bipolar disorder.

Foundations

The project was birthed from personal experience. The resource also has biblical, theological, and historical foundations. For the biblical foundation we look at the book of Ruth and the concepts of *hesed* (חֶסֶד lovingkindness (Zobel 1986, 44)) and *go'el* (גֹּאֵל "kinsman redeemer" (Strong, James. H1350)). The theological foundation shows how liberation theology offers a preview of redemption and salvation in the present moment. Historically, the church has followed the swing of a pendulum of being a source of shame or a source of healing for mental health challenges. The Friends Society took the lead as a role model of moral treatment and communal based recovery.

Personal Foundation

As a friend and pastoral caregiver, I have walked with people who suffer from mental health challenges and also with their family members. However, it was not until I experienced mental health challenges of my own that I became intimately aware of the issues and struggles those with mental health challenges and disorders face.

As a person of faith, I was deeply hurt and dumbfounded by the response of the church. I was fortunate to be introduced to Mental Health Grace Alliance, a Christ-centered nonprofit which provides support for individuals and their families

who struggle with mental health challenges and disorders, as well as training and education for the church. This organization saw me, not my disorder. They were Christ in the flesh extending God's *hesed*. Mental Health Grace Alliance offered community and restored a sense of purpose in my life. My recovery came through a holistic program including one-on-one consultation and support groups.

In my support group, I heard similar stories of how the church was no longer a safe place but a place of pain. Often we were told to "just get over it" or that we did not have enough faith. Some were even told they were demon possessed.

Understanding where God is in the midst of the chaos and trying to connect with him or others seems impossible. When we are in the depths of the battle, we cannot understand nor do we have the ability to see another perspective. They only know that the ones they have turned to cannot help them, but instead unintentionally may even hurt them.

My experience is that the church has every intention to help and not harm. When someone who has mental health difficulties seeks out the help of a pastoral caregiver, such as a pastoral figure, rabbi, imam, or the like, they are desperate. They do not understand what is happening, what they need, or what to do. They need someone to lead the way.

If a pastoral caregiver is not able to recognize what is happening or know what to do, then they offer either an empty cup or alternative solutions that unintentionally cause even more pain. It is critical for pastoral caregivers to be

informed and to educate themselves on how to walk with someone who has mental health challenges or disorders including bipolar disorder.

Biblical Foundation

A biblical story that shows God's *hesed* in the midst of suffering is the book of Ruth. Ruth's fidelity to Naomi demonstrates God's *hesed* (Sakenfeld 1985, 32). Throughout the story, though not mentioned directly, God is present and works in ways that seem mundane, yet which bring what one needs at the right time. The Lord sees Ruth and Naomi, he sees their situation, and he is present to them in their circumstances. In the end of the biblical narrative, the intimate act of the *kinsman redeemer* demonstrates God's desire to restore the relationship.

The death of Naomi's husband and two sons leaves her sons' widows, Ruth and Orpah, in a vulnerable position because a women's identity was determined by male relatives (Saunders 1998, 7). The women did not have the covering, protection, or provision of a male figure which left them without any rights or inheritance (Saunders 1998, 7). Naomi was a foreigner and did not have the provision of the Jewish custom and laws, which cares for widows (Saunders 1998, 7). The only hope for the daughters-in-law was to return to their fathers' homes to marry again and bear children.

Naomi heard "that the Lord had come to the aid of his people [in Israel] by providing food for them" (Ruth 1:6 NIV), so Naomi prepared to return home. (All scripture references will be from the New International Version unless otherwise noted). As faithful daughters-in-law, they showed respect to their mother-in-law in

setting out to return with her, but they must have known that they would not be accepted in Bethlehem (Sakenfeld 1999, 31). The story truly begins to unfold and reveal how God encounters His children whether rich or poor, Jew or Gentile, male or female, struggling with bipolar disorder or walking with someone with bipolar disorder.

As the women set out, Naomi released them to return to their families for there they will have a chance to remarry or at least have the covering of their family. After resisting, Orpah returned home, but Ruth was persistent and refused to turn back. One must ponder her motive. Was it out of loyalty to Naomi? Could it be that Ruth has witnessed something in the lives of her in-laws which compels her to seek out the truth? Regardless of her motives, Ruth most likely knew the difficulties which lied ahead of her due to cultural differences (Sakenfeld 1999, 31). When Naomi realized that Ruth was determined to go with her, she stopped urging her. (Ruth 1:16-18)

Ruth is risking her chances of marriage by leaving her culture and entering into a culture known to be unaccepting of Moabites. As one who has lived as a foreigner in another land, one may take on outward and some inward expressions of a different culture, but one will always be an outsider. Being a Moabite, Ruth faced the possibility of never being included in Naomi's community (Sakenfeld 1999, 32).

An aspect of God's character is revealed through Ruth's pledge of faithfulness to Naomi. God honors his promises such as the Abrahamic and Mosaic Covenants. Faithfulness to a covenant relationship is the heart of *hesed*

which is an act of pure grace. Robert Hubbard speaks about a "lifestyle of *hesed*" (Hubbard 1988, 73). Hubbard is referring to one who embodies and lives out the faithful covenant with another showing justice, mercy, compassion and forgiveness and loving-kindness without expecting anything in return (Hubbard 1988, 73). Caregivers are called to a lifestyle of *hesed* when they become spiritual companions to those with bipolar disorder. A spiritual companion is a conduit for someone to experience God's *hesed* as they walk alongside them in the midst of their life situation.

The *hesed* Ruth demonstrated to Naomi is returned to her through Boaz. After the recognition of the relationship between Ruth and Boaz, the process of redemption takes place. Boaz uses the law to restore life not only to Ruth but also for Naomi by providing an heir who would become part of the lineage of Christ (Matt 1:1-17).

This idea of God meeting his people in the mundane of every day and lavishing his *hesed* upon them is carried over into the New Testament. Jesus lived a "lifestyle of *hesed*" (Hubbard 1988, 73). We see this in the story of the woman who anoints Jesus' feet with her tears and perfumed ointment (Luke 7:36-50). As with Ruth, this woman is an outsider and is not welcome into the house of a Pharisee where Jesus was invited to dinner.

Many focus on the parable that Jesus tells the Pharisees, but it is the dialogue after the parable which demonstrates who pastoral caregivers are to those with bipolar disorder. Jesus asks the Pharisees a poignant question, "Do you see this woman?" For God is *El Roi*, the one who sees (Gen 16:13) his

daughter, not the sinner or mental health disorder, but the child he created who has been broken and wounded. As David Garland paraphrases the question, “Do you not recognize that this woman’s behavior is a sign of the one who has been forgiven many debts and is showing enormous love and gratitude?” (Garland 2011, 330). A forgiven child of God is who pastoral caregivers must see when they look into the eyes of those with bipolar disorder.

Jesus continues with a comparison of the Pharisee and the woman. While judging the woman who is unclean and unacceptable, the Pharisee is sure of his piety and purity. Jesus rebukes Simon, the Pharisee. Antoine Nachef states, “Jesus attacked not the life and actions of Simon, but his convictions and his relating to others” (Nachef 2004, 83). Jesus is forcing the Pharisee to evaluate how he sees the woman and the prejudices of his worldview (Nachef 2004, 85). Joel Green sees it as “an invitation to enlightenment, the consequence of which would be acceptance of both her (i.e., no longer- viewing her as a ‘sinner’ but as one who loves extravagantly) and of new behaviors modeled on those of this woman” (Green 1997, 312). As Green continues to point out, the woman’s actions were far beyond what was expected of Simon (Green 1997, 313).

The woman came with her sins already forgiven; therefore, her actions are prompted out of gratitude and love (Getty-Sullivan 2001, 105). Saunders suggests that she understood her relationship with her Savior and acted in accordance to it (Saunders 1998, 45-51). This unknown woman lavished her love on Jesus because of His great love, which flows from the Lord’s deep *hesed.* Jesus expressed *hesed* to the woman, reminding her, “Your sins are forgiven”

(Luke 7:48). “Your faith has saved you; go in peace” (Luke 7:50). In this act, Jesus affirms her identity as one who is forgiven and has new life restoring her place in the community (Green 1997, 314).

The relationship between Jesus and the woman challenges how we form our view of our relationship with ourselves, God and others and how we navigate through these relationships when we are in crisis (Nachef 2004, 85). In her chaos, the woman went to Jesus. In a similar way, people with bipolar disorder need a spiritual companion to walk with them through the chaos to a place of rest. Nachef says, “Encountering the Lord fulfilled the longings of her anxious heart” (Nachef 2004, 85). As a spiritual companion, a pastoral caregiver can position a care receiver to encounter the Lord in such a way.

Theological Foundation

In the 1960s, when Jürgen Moltmann published *Theology of Hope,* there was a global movement for liberation (Brown 2016). In the United States, the Civil Rights Movement and protests against the Vietnam War consumed everyday life. Europe was engulfed in student protests. Africa, Asia, and Latin America were all fighting for economic and political liberation. Moltmann explained these movements of liberation as an indication of people’s dissatisfaction in themselves and society, which compelled them to change their reality (Moltmann 2014, 23). *Theology of Hope* would go on to become the framework to what is now known as Liberation Theology.

In *The Living God,* Moltmann asked, “Why has Christian theology allowed this theme of hope to escape it? Are not God’s promises and human hopes the

scarlet thread running right through the prophets of the Old Testament and the apostles of the New?" (Moltmann 2014, 177). Quests to find meaning and hope in the Gospel lead to the development of the various liberation theologies.

Peter C. Phan boldly states, "Future historians of Christian theology will no doubt judge liberation theology to be the most influential movement of the twentieth century, possibly ever since the Reformation" (Phan 2000, 40). Gustavo Gutierrez, the father of Latin American Liberation theology, would answer, "The salvation of the whole man is centered upon Christ the Liberator" (Gutierrez 1973, 83). What makes liberation theology so influential?

Gutierrez began with the question, "What is the meaning of the struggle against an unjust society and the creation of a new humanity in light of the Word?" (Gutierrez 1973, 83). Liberation salvation looks more at the qualitative versus quantitative aspect of salvation. Salvation is not just about saving souls but more of the quality and abundant life that is found in Christ here and now.

The liberation of humanity and creation is part of the coming of the Kingdom of God. Dom Antonio Fragasso asserts, "The struggle for justice is also the struggle for the Kingdom of God" (Gutierrez 1973, 97). Liberation theology allows for the Kingdom of God to be experienced here and now through salvific holistic transformation. This salvific experience occurs through an encounter with Christ the Liberator within a communal context. If salvation is communal, then is sin communal as well?

Gutierrez looks beyond individual acts against each other to the institutions and systems created and sustained by oppressive communities

(Gutierrez 1973, 103). Oppressive communities dominate and enslave other communities based on things such as racism, sexism, socioeconomic class, religion, disability, etc. (Gutierrez 1973, 103). Liberation theology views the Kingdom of God as a process which grows through historical liberating moments (Gutierrez 1973, 104). Ultimately, salvation is realized in the "active participation to liberate humankind from everything that dehumanizes it and prevents it from living according to the will of the Father" (Gutierrez 1973, 174). How does it apply to the work of spiritual companionship with people with bipolar disorder?

Nancy Eiesland sets forth in *The Disabled God* a holistic and communal transformation of recognition, inclusion, and acceptance, which she calls the praxis of the "theology of accessibility" (Eiesland 1994, 20). This allows for those with disabilities to gain access to the "social-symbolic life of the church" and for the church to access the "social-symbolic lives of people with disabilities" (Eiesland 1994, 20). A theology of accessibility recognizes that a social construct exists that excludes anyone who is not able-bodied (Eiesland 1944, 24). It also rejects the stigma created by imposed terminology on persons of disabilities (Eiesland 1944, 27).

Eiesland uses the stories of persons of disability to highlight common themes. The first involves coming to grip with the knowledge that one's body demands contingencies. Secondly, the myth that disabled people are all spectacular "overcomers" and defy the limits of their disability denies them an alternative understanding of embodiment (Eiesland 1994, 31). Lastly, Eiesland brings to light the oppression against the bodies of people with disabilities. The

oppression stems from society's view of persons of disabilities bodies as being "flawed, dangerous, and dependent" (Eiesland 1994, 49).

In 1970, when *A Black Theology for Liberation* was first published, writer and theologian James Cone and the black church were asking, "what has the gospel of Jesus Christ to do with the black struggle for justice in the United States?" (Cone 1990, xi). Black theology is rooted in "nearly four hundred years of slavery and segregation in North America, both of which were enacted into law by government and openly defended as ordained of God by most white churches and their theologians" (Cone 1990, xi). The struggles outlined in Cone's work recognized the common pain of the oppressed.

This common pain for the oppressed is the denial of accessibility to the Gospel of Jesus Christ and the salvific liberation offered here and now with the coming of the Kingdom of God. A liberatory Christianity must reject the visions of disability as symptom of sin or as occasion for virtue (Eiesland 1994, 75).

For Eiesland, the risen Jesus shared in the humanity and vulnerability of embodiment (Eiesland 1994, 14). Jesus faces human limitations, helplessness, and humiliation as his body is mangled, stripped naked, and put on display (Eiesland 1994, 14). This is the concept of hope that Moltmann proposes in *Theology of Hope*.

Hope is based in reality. The reality is that God came and took on flesh, lived as the oppressed, was persecuted, tortured, and died. Gutierrez, Ruether, Cone, and Eiesland all looked at their context and were dissatisfied with their reality. Following the example of Christ the Liberator, they took action, working

out their faith in fear and trembling, knowing that salvation began now. Their theological beliefs can thus inform and empower the actions of communities of faith in response to the mental health needs of those they minister to.

Historical Foundation

Since its beginning, the Church has shown concern and given care to the sick, including those with mental health challenges and disorders. Rodney Stark makes this case in *The Rise of Christianity*. Christians, driven by the ethos of "*love one another"* and grounded in the belief that "God loves humanity," had "superior survival rates" due to their care for one another (Stark 1996, 86, 90). This care continued in the monastic movement. In the *City of God*, Augustine demonstrates empathy for the state of those with mental health challenges (Dillon 2013).

This sense of compassion eventually began to be lost. During the Middle Ages, there was a deadly shift in the view of those with mental health illnesses, particularly during the Inquisition (O'Connell 2001). During this time, the popular view of the church was that mental illness was caused by demon possession which led to widespread persecution, including burning and torturing those with mental health issues (Simpson 2013, 137). Yet, there was still hope. "The church did not abandon the mentally ill. The Rule of St. Benedict prescribed that the care of the sick is to be placed above and before every duty. In the Middle Ages, the mentally ill were cared for in monasteries along with the physically ill" (O'Connell 2001).

The Church opened the first psychiatric hospital in London in 1247 (Simpson 2013, 137). Unfortunately, it was handed over to the city and became the infamous Bedlam Hospital, which charged tourists to watch patients for entertainment (Simpson 2013, 137). The treatment of the mentally ill began to turn in a progressive direction when church leaders such as John Calvin and Martin Luther began to share their struggles with mental health (Simpson 2013, 137).

During the Enlightenment, “moral treatment” was introduced by Christian physician Philippe Pinel when he boldly unchained those imprisoned in a mental health facility in Paris in 1794 (O'Connell 2001). Pinel would not allow restraints, punishment, or other forms of harm. “Moral treatment” consisted of treating a patient with dignity, respect, and not inflicting harm (Simpson 2013, 137).

William Tuke, a Quaker, was prompted to action after the death of a friend in an asylum:

> In the year 1791, a lady, a member of the Society of Friends, was placed in the old York Asylum. Her friends, who resided at a distance, requested some of their acquaintance living in the city to pay her a visit. They accordingly went to the Asylum for this purpose, but their request was refused. (Bewley 2008, 1)

Tuke founded a private mental hospital called the Retreat at York. The Retreat was a model which supported and advanced the development of moral treatment. Tuke’s work had a lasting and far-reaching impact on the care of those with mental health challenges and disorders. The Retreat model was brought to Colonial America by the Friends Society. It was the Quakers who opened the Friends Hospital in Pennsylvania, which who also cared for those with mental

health challenges. In general, there was not any plan for chronic care, only episodic (Bewley 2008, 5).

In the wake of World War II, the Mennonite faith community found itself putting its faith into practice by choosing Civilian Public Service (CPS) rather than engaging in war. Becoming “disturbed with the de-personalization and frequent mistreatment of patients” in mental hospitals, Mennonite CPS workers “began discussing the possibility of developing several Mennonite-sponsored, small mental hospitals focusing on a ‘homelike atmosphere’ and ‘Christian care’” (Bender 2011, 45). Their faith-centered approach made a recognizable difference. First Lady Eleanor Roosevelt reflected on her encounter with a group of CPS workers at the Marlboro, New Jersey State Hospital in 1943, “They are a very fine group of young men, and bring a spiritual quality to their religion. In many ways, this is probably raising the standard of care given the patients” (Stoltzfus, 1943, 900).

A final look at the history of the church and mental health care moves to the twenty-first century, as faith-based non-profit groups have risen to minister to those in need of support. The Mental Health Grace Alliance and the ministry of Saddleback Church are noted as specific examples of programs that have come into existence because of personal interaction with family members in need of mental health care. The culmination of this historical review in current day brings us to contemporary practices in the mental health field.

Contemporary Foundation

If people challenged by mental illness struggle to find support within the church, as Simpson suggests (Simpson 2013) and my experience confirms, how can the church respond in a more helpful way? In this chapter, the conceptual framework of a community of *hesed* will be considered as a possible way forward for a faith-based response to mental health concerns. Concerns within the field of psychology regarding the integration of the role of counselor and spiritual companion are often raised, and so three perspectives will be explored in this manner: full integration, an exclusive non-integrative approach, and a cooperative model. The chapter will conclude with models that speak to both the need for a community of *hesed* and the role of psychology and spiritual companionship, and will consider what spiritual companionship can look like in the context of mental health concerns.

According to the National Institute on Mental Health, one in four Americans suffers from a mental health disorder (Simpson 2013, 33). This statistic does not change in the church. People in the church are suffering from the impact of mental health challenges and disorders.

Pastoral caregivers serve as common gateways for people with mental health difficulties to receive the proper help and support needed for recovery. “Nearly half (44.5%) of church leaders are approached two to five times per year for help in dealing with mental illness; 32.8% are approached more frequently, from six to more than twelve times per year” (Simpson 2013, 99). When mental health issues arise, “Family members and friends are often confused, frightened

and frustrated, not knowing how best to react or respond" (Yarhouse, Butman, and McRay 2005, 157), and so they often turn to clergy for support.

A person in the midst of a mental health-related episode finds it difficult to connect with others, including God. Psychologist Larry Crabb believes "that the root of all our personal and emotional difficulties is a lack of togetherness, a failure to connect that keeps us from receiving life and prevents the life in us from spilling over onto others" (Crabb 1997, 32). Connecting is not a simple thing, especially for someone with bipolar disorder. Many times it takes a person outside the immediate situation, such as a pastoral caregiver, to be the necessary companion who can provide that connecting point.

A key roadblock for those who have bipolar disorder is hopelessness. Those who suffer from bipolar disorder need the hope of Christ. Often, "spiritualizing mental illness translates to blaming sick people for their illness" (Simpson 2013, 107). Mental illness is a disease just like cancer, diabetes, or hypertension. With any disease comes the interaction of biology, psychology, and spirituality (Stanford 2008, 86). The hope of Christ does not mean in-depth Bible study or deep theological discussions. Instead, hope often resides in presence, a simple prayer, small successes, and a key verse to hold. Through holistic care, "God is the ultimate agent of healing" (Stanford 2008, 88). The pastoral caregiver's role in this case "is simply to offer encouragement and spiritual guidance" (Stanford 2008, 88). Terry Wardle uses the term spiritual companionship to describe this role. He defines it as a person "who provides encouragement and direction along the path to Christ" (Wardle 2004a, 29).

As pastoral caregivers provide spiritual companionship for a person with bipolar disorder, they become a conduit offering a connection to God. All believers need a spiritual companion whether formal or informal. A more formal form of spiritual companionship is spiritual direction. Gerald May describes the purpose and function of spiritual direction in the following way:

> In the spiritual life, we must make such discernments constantly, choosing our directions with care, consideration, and prayer. But because of our inherent personal blind spots and self-deception, and because of our vulnerability to deception from outside forces, it is necessary to have help. Thus the spiritual director aids us in finding our proper directions. (May 1992, 9)

Spiritual direction is not counseling or a type of therapy. Spiritual direction focuses on "prayer life, religious experiences, and sense of relationship to God" along with other spiritual challenges (May 1992, 15). The person will express thoughts and feelings and exhibit various moods and behaviors, but the focus of the spiritual direction should be redirected toward the impact and effect it has on the relationship between the person and God.

Psychologist Mark McMinn suggests, "In our sickness and pain, we grope for answers, for better understanding, for meaningful relationships. Our sickness leads us to God" (McMinn 2011, 20). In fact, May says, "it may be our finest hope" when we recognize our need for God and are compelled to seek out a pastoral caregiver (May 1992, 61).

McMinn sees the same developmental cycle in spiritual and psychological health. It is not a linear developmental but a continual spiral of consolation and desolation. A person is aware of her own need even if she is not able to articulate it. Through the process of recognition and acceptance of her neediness, the

person also grows in mindfulness and the reconciliation and healing of relationships (McMinn 2011, 50).

Greene-McCreight knows firsthand the role of a pastoral caregiver, but also the darkness of bipolar disorder. She sees the role of the spiritual companion as that of opening the doors and windows by speaking, meditating, and being with a person until they can do so on their own. It is not a dramatic grand opening, but, instead, curtain by curtain, blind by blind, shutter by shutter, allowing light in so that eventually the windows can be cracked, allowing in the refreshing wind of the Spirit to revive the captive (Greene-McCreight 2006, 116).

Greene-McCreight offers advice to pastoral caregivers journeying with those with bipolar disorder. First, offer but do not demand spiritual practices or spiritual exercises, such as extending the offer to pray, read Scripture, or take communion (Greene-McCreight 2006, 138). Second, become aware of the signs and symptoms of mental health challenges and disorders (Greene-McCreight 2006, 138). Last, know your professional role and purpose and work within this scope (Greene-McCreight 2006, 141). Pastoral caregivers who are not trained psychologists or psychiatrists need to have resources of referrals and should never try to make a diagnosis (Greene-McCreight 2006, 141). “Be consistent in your concern, prayer, and inquiries. Let them know that your friendship, or care as a clergyperson, is unconditional” (Greene-McCreight 2006, 143).

Spiritual companionship is one component of holistic recovery. Mental Health Grace Alliance sees an individual holistically as God made them, including physical, mental, spiritual, and relational dimensions (Padilla and

Stanford 2013a, 30-31). “A holistic approach to recovery relieves suffering, reveals Christ, and restores lives” (Padilla and Stanford 2013a, 30). Each component affects every dimension. Recovery for a person with bipolar disorder is possible when all dimensions are addressed. Greene-McCreight challenges pastoral caregivers to remember, “since mental illness can be a terminal disease, you may be helping to improve or even to save a life” (Greene-McCreight 2006, 143).

Context

In *Troubled Minds*, Amy Simpson shares her journey of growing up with a mother who had schizophrenia. She reflects on the painful truth of how the church remained “oblivious or a silent observer” throughout their family’s difficult journey (Simpson 2013, 28). Simpson also presents findings from surveys completed by pastors and looks at current clinical research and the current state of mental health care. She agrees with Marr that “stigma, shunning and shame” exponentiate the pain of mental health challenges and disorders for both the person with the disease and their family (Marr 2011, 122). Stigma leads to isolation and disconnection. Simpson’s research shows that “many reach out and are shocked to touch the church’s cold shoulder. Others fear the church’s rejection enough to hide their struggles and not risk exposure at all” (Simpson 2013, 16).

According to the National Institute on Mental Health, one in four Americans suffers from a mental health disorder (Simpson 2013, 33). Twenty percent of all adults will experience mood disorders, such as bipolar disorder, in

their lifetimes (Kessler 2005, 593-602). The likelihood of encountering a person or family member impacted by bipolar disorder in the church is high. Pastoral caregivers are often the number one gateway person for people receiving appropriate care.

The context of this project was rooted in my own inability to obtain sufficient and effective mental health care within my church context, both while on the mission field and upon my return to the United States. As my mental health began to improve, I became aware that my experience was not an isolated one, and that the broader church struggled to provide adequate training and support to its personnel who could serve as a gateway to appropriate care. As a result of my own experience and my observations, I created a resource to equip pastoral caregivers to become effective spiritual companions for people with bipolar disorder.

The evaluation of that resource became the basis of my doctoral work. The resource was sent to thirty people. The original recipients were chosen because of their experience working with people with bipolar disorder and their understanding of the disorder, including psychiatrists, psychologists, counselors, social workers, and support group leaders. The evaluators were also chosen because of their informal or formal biblical and theological training. I received twelve responses to my request to evaluate the resource.

Project Goals

The purpose of this project was to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar

disorder. The research question was: To what extent did this resource better equip pastoral caregivers to become spiritual companions for people with bipolar disorder? To this end, my project goals were:

1. The resource will establish that pastoral caregivers are gateway people for those with bipolar disorder in receiving appropriate care.
2. The resource will outline the biblical basis for a holistic approach to understanding mental health challenges and disorders.
3. The resource will outline the theological basis for a holistic approach to understanding mental health challenges and disorders.
4. The resource will identify how bipolar disorder impacts the lives of those who have bipolar disorder.
5. The resource will explain how bipolar disorder can interfere with one's connection with God.
6. The resource will provide appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus.
7. The resource will give other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their spiritual journey.

Design, Procedure, and Assessment

The purpose of this project was to create a resource that would better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. A handbook (resource) was written containing information to reach the project goals, and the project then reviewed the handbook's effectiveness as evaluated by a group of experienced mental health practitioners.

The handbook began with an introduction to establish that pastoral caregivers are gateway people for those with bipolar disorder in receiving appropriate care. Then a biblical and theological foundation was laid for a holistic

approach to understanding mental health challenges and disorders. From there bipolar disorder was defined and how bipolar disorder impacts the lives of those who suffer from the disease was explained. Building off this information, an explanation was given for how bipolar disorder can interfere with one's connection with God. The handbook then provided appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus. The resource ended by giving other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their journeys of recovery.

An assessment instrument was created with three qualitative and twenty-one quantitative questions. The resource and assessment tool was given to people with experience in working with people with bipolar disorder and who have an understanding of the disorder. The evaluators included psychiatrists, psychologists, counselors, social workers, and support group leaders. The assessment instrument and resource were sent via Survey Monkey to maintain confidentiality. Of the thirty who received the assessment instrument and resource, twelve responded. Each person reviewed the resource and evaluated it by completing the assessment instrument which addressed the specified goals.

Personal Goals

Imagine selling or giving away most of your possessions. Then pack two suitcases with what you think you will need to start a new life on the other side of the world. You leave your family, friends, and community of faith behind. You do this because of a calling you have sensed from God to be a light to the nations.

In many ways, it turns out to be all you hoped for – deep relationships and significant conversations, learning language and culture, being transformed and drawn closer to God.

You knew there were risks involved, but you are convinced they are worth it. Then your worst nightmare comes true. Your dream ends much sooner than you had hoped because you have lost your ability to cope and no longer have any resilience left. A quiet disease consumes you, and the wounds of your past along with the current occurrences leave you paralyzed without hope and a loss of any sense of purpose.

This is what happened to me. I felt that God had rejected me. I could not bear to read the Scripture. I did not have words to pray. Numerous experiences with fellow believers left me deeply wounded. Through my recovery, I have regained a sense of purpose. I have recently begun attending church again. The Scripture does not pose a threat as it did before. I understand prayer to be more than words. I am living into my identity in Christ. I move forward in the hope that I will continue to heal and grow.

To this end, my personal goals for this project were:

1. To continue a self-care plan to stay on the path of recovery.
2. To continue to develop as a differentiated leader as defined in my paper.
3. To address my wounds related to the Church to position me to be reconnected with the local church.

Definition of Terms

Agape (ἀγάπη) – In the New Testament, used to express the love of God or the way of life based on it (Günther and Link 1976, 538).

Bipolar Disorder – Bipolar disorder is a medical disorder which causes extreme shifts in mood, energy, and function (Stanford 2008, 75). There are various classifications of bipolar disorder. For a diagnosis of bipolar disorder, the patient must meet the criteria laid out in the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association. Bipolar disorder presents a combination of episodes of mania, depression, and hypomania (APA 2013, 65-92).

Go'el – גָּאַל "kinsman redeemer," one who advocates, restores, and redeems those closely related to him (Strong, James. H1350).

Hesed – חֶסֶד (Zobel 1986, 44) Acts of benevolence that one does out of kindness, not out of obligation (Eskenazi and Frymer-Kensky 2011, 58).

Mental Health Challenges and Disorders – In this project, the term mental health challenges and disorders encompasses all mental disorders, conditions, and symptoms identified by the American Psychiatric Association in the DSM.

Spiritual Companionship – The term spiritual companion as used in this project is a person "who provides encouragement and direction along the path to Christ" (Wardle 2004a, 29).

Plan of the Paper

The purpose of this project was to create a resource that would better equip pastoral caregivers to become spiritual companions for people with bipolar

disorder. The following chapters will provide biblical, historical, and theological foundations for this project (Chapter Two); a review of the contemporary literature (Chapter Three); a detailed description of the method, procedures, and design of the project (Chapter Four) with results (Chapter Five). The final chapter (Chapter Six) will provide a summary and reflection on the project goals, application to ministry, future study, and my personal goals.

Beginning with the Old Testament story of Ruth, God's character is demonstrated though others to be lovingkindness and redemptive. This is also seen in the New Testament when God becomes flesh in Jesus. Liberation theology echoes God's character seeking the Kingdom of God on earth. The Church has played a role in being Christ to those with mental health issues and challenges. This and more will lay the foundation in Chapter Two for the premise for the resource *Spiritual Companionship and Bipolar Disorder*.

CHAPTER TWO

BIBLICAL, THEOLOGICAL, AND HISTORICAL FOUNDATIONS

But Ruth replied,
"Don't urge me to leave you or to turn back from you.
Where you go, I will go, and where you stay, I will stay.
Your people will be my people and your God my God."
Ruth 1:16

Chapter Two gives a biblical, theological, and historical foundation to support the purpose of this project, which was to create a resource that would better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The biblical foundation looks at the role of *hesed* as seen in the book of Ruth, and in the person of Jesus as he interacted with the woman in Simon's house (Luke 7). In the theological section, a theology of hope is reviewed, particularly as it is explored in the context of liberation theology and specifically in a theology of accessibility. Since the role of a pastoral caregiver is to embody God's character and act as a conduit for the care receiver to experience God, the historical section explores how the church has responded to mental health needs to provide such an experience.

The cornerstone to the foundations lay in the Hebrew concept of *hesed* חֶסֶד(Zobel 1986, 44). Translated into English as "loving-kindness," *hesed* refers to the acts of benevolence that one does out of kindness, not out of obligation (Eskenazi and Frymer-Kensky 2011, 58). *Hesed* is more than a feeling, but an action demonstrated in a covenant relationship and includes justice, mercy, compassion, and forgiveness (Eskenazi and Frymer-Kensky 2011, 59). In this chapter, the reader will see how God relates to creation and humankind in *hesed*.

In turn, women and men demonstrate the same *hesed* in their relationships. Ultimately, *hesed* is expressed in Jesus, God in the flesh. These biblical stories challenge a pastoral caregiver to embrace the theology of *hesed* and establish a *hesed* based relationship with a care receiver. History shows that those with mental health disorders and challenges have not only been well cared for but found recovery when the church has embodied *hesed*.

Biblical Foundation

A biblical passage that shows God's *hesed* in the midst of suffering is the book of Ruth, as Ruth's fidelity to Naomi demonstrates God's *hesed*. Throughout the story, though not mentioned directly, God is present and works in ways that seem mundane and yet provides for the women at the appropriate time. The Lord sees Ruth and Naomi and is present in their situation, for He is *El Roi* (Hebrew for the God who sees) (Gen. 16:12-13). *El Roi* institutes the laws of kinsman redeemer that are documented in the Old Testament book of Leviticus (25:25). In doing so, God rescues and leads the women into a position of hope, salvation, and peace.

Jewish custom and laws provide for widows (Saunders 1998, 7) because the Jewish law is based on relationship. The first five of the Ten Commandments address humanity's relationship with God and the latter five address humanity's relationship with each other. Jesus states that the greatest commandment is to "Love the Lord God with all your heart, mind, soul, and strength" (Luke 10:27). This law is paired with "Love your neighbor as yourself" to derive the basis of all

the law and prophets (Luke 10:27). Long before the conception of Naomi and Ruth, God established laws to protect and provide for them.

In Leviticus 25: 23-25, the concept of the *go'el* or "kinsman redeemer" is addressed as one who advocates for, restores, and redeems those closely related to him. In Isaiah, God is Israel's kinsman redeemer (e.g., Is. 43:1-7). In Ruth's case, Boaz comes forth as the kinsman redeemer who is a demonstration of *hesed* (Sakenfeld 1985, 32).

In this story, it is Ruth who first unorthodoxly demonstrates the *hesed* character of God. She was a Moabite, a descendant of the incestuous daughters of Lot (Genesis 19). In the opening of Ruth, Elimelech and Naomi, devout Jews, move to Moab and allow their sons to marry Moabite women (Ruth 1:1-4). For faithful Israelites to forsake their homeland, God's gift to God's people, a life-threatening event would have had to occur. Such is the case for Elimelech and his family. The fact that they settled in Moab implies just how great this catastrophe must have been. "For centuries the Israelites had reviled this people as degenerate and, particularly, regarded Moabite women as agents of impurity and evil" (Donaldson 1999, 133). When Elimelech's sons break Jewish law by taking foreign wives, it is even more grievous that these wives are Moabites.

The death of Naomi's husband and two sons leaves her and her two daughters-in-law in a vulnerable position because in that time, male relatives determined a woman's identity (Saunders 1998, 7). The women no longer had the covering, protection, or provision of a male figure which left them without any rights or inheritance (Saunders 1998, 7). As a foreigner, Naomi did not have the

provision of Jewish customs and laws, which care for widows (Saunders 1998, 7). The only hope for the daughters-in-law was to return to their fathers' houses to marry again and bear children.

God desires to use people to demonstrate *hesed* to humanity as is illustrated in the book of Ruth. The Lord, *Jehovah-Jireh* (Hebrew for *the God who provides*), offers Naomi an opportunity to return home (Ruth 1:6-7). As obedient daughters-in-law, Ruth and Orpah show respect to their mother-in-law in setting out to go with her, even though they most likely knew that the people of Bethlehem would not accept them (Sakenfeld 1999, 31). At this point in the story, God begins to unfold and reveal how he embraces and welcomes God's children whether rich or poor, Jew or Gentile, male or female. Each encounter is unique and reveals something about God's nature and character.

As the women set out, Naomi releases her daughters-in-law to return to their families, for there they will have a chance to remarry or at least have the covering of their family. After resisting, Orpah returns home, but Ruth is persistent and refuses to turn back. One must ponder her motive. Is it out of loyalty to Naomi? Or could it be that Ruth has witnessed something in the lives of her in-laws which compels her to seek out this truth they possess? "Whatever Ruth's motives, she was presumably wise enough to know of the potential difficulties in the path she was setting for herself" (Sakenfeld 1999, 31).

Despite difficulties due to cultural differences, Ruth makes a powerful statement:

> But Ruth replied, “Don’t urge me to leave you or to turn back from you. Where you go, I will go, and where you stay, I will stay. Your people will be my people and your God my God. Where you die I will die, and there I will be buried. May the LORD deal with me, be it ever so severely if even death separates you and me.” When Naomi realized that Ruth was determined to go with her, she stopped urging her. (Ruth 1:16-18)

Ruth risks her chances of marriage by leaving her culture and entering into a culture known for its unwillingness to accept Moabites. As one who has lived as a foreigner in another land, Ruth knows she may take on outward and some inward expressions of a different culture, but she will always be an outsider. “Her ethnic identity stands as a barrier that must be hurdled in order to enable her full inclusion into the new community” (Sakenfeld 1999, 32). Being a Moabite, Ruth faces the possibility of never being included in Naomi’s community (Sakenfeld 1999, 32).

Ruth not only commits herself to Naomi’s land and people, but also to Naomi’s God. “In Jewish tradition, Ruth is remembered as the paradigmatic example of conversion” (Sakenfeld 1999, 32). She does not refer to her god(s), but to the LORD, *Adonai*, Yahweh Himself. She is not just committing her life to Naomi, but to I AM. It is I AM who Ruth acknowledges as the one she is accountable to if she breaks her promise. At this moment, Ruth abandons her identity rooted in her people, faith, and land, and exchanges it for a people, faith, and land that are foreign. This new land, people, and faith will most likely reject her. Still, Ruth has committed herself to this new path for her life until she dies.

Ruth’s pledge of faithfulness to Naomi reveals an aspect of God’s character. God is faithful to his promises and covenantal relationships. Faithfulness to a covenant relationship is the heart of *hesed* which is an act of

pure grace. God's loving-kindness or *hesed* counts faithfulness as righteousness (Wilch 2006, 35). Robert Hubbard speaks about a "lifestyle of *hesed*" which refers to one who embodies and lives out the faithful covenant with another showing justice, mercy, compassion and forgiveness and loving-kindness without expecting anything in return (Hubbard 1988, 73). Both Ruth and Boaz demonstrate a "lifestyle of hesed" as the story continues to unfold.

As is to be expected, Naomi's return captures the town's attention, especially since her Moabite daughter-in-law is with her. This recognition benefits them. One may not usually think of the law as God's provision, but it is in Naomi and Ruth's case. The story of Ruth demonstrates how God works through various means, and encounters us even in the most challenging situations.

As Naomi laments and asks to be called *Mara*, which means "*bitter*," she blames God for her hardships, stating, "the Almighty has made my life very bitter. I went away full, but the LORD has brought me back empty. Why call me Naomi? (meaning "*pleasant*") The LORD has afflicted me; the Almighty has brought misfortune upon me" (Ruth 1:20-21). Phyllis Trible notes that Naomi's journey actually drives the Ruth narrative: "Naomi's plight shapes the narrative and her plan brings it to resolution" (Trible 2009).

The narrative opens describing Naomi's bleak circumstances (Ruth 1: 1-22). When good news comes that she can return to her homeland, Naomi considers the daughters-in-law blessed, not herself (Ruth 1:8-9). This is confirmed when Naomi asks to be called *Mara* (Ruth 1:20-21). As Trible points out, Naomi continues to drive the story as she schemes a plan to have her

husband's lineage redeemed (Trible 2009). "From being the receiver of calamity, she has become the agent of change and challenge" (Trible 2009). In the end, Naomi names and recognizes God's role in providing a kinsman redeemer in Boaz (Ruth 2:20). We encounter God in the midst of our deepest heartaches and brokenness. In these moments, we turn to God for the answers that may not come. In the mystery and unanswerable questions, God meets us just as God does Ruth and Naomi.

Boaz begins by offering protection for Ruth by allowing her to glean in his fields. He also provides for Naomi and Ruth by ordering his men to allow Ruth to glean extra and for them to leave good wheat behind for her. He does this because of what Ruth has done for her mother-in-law (Ruth 1:8-12).

After the recognition of the relationship between Ruth and Boaz, the process of redemption takes place. Boaz uses the law to restore life not only to Ruth but also for Naomi. There was a guardian-redeemer in line in front of Boaz. He challenges him as required by law. At first, the guardian-redeemer is prepared to redeem Naomi until he realizes he must also redeem Ruth. Since the guardian-redeemer does not want the children of Ruth to endanger his personal estate, he therefore concedes to Boaz (Ruth 4:1-10). The *hesed* Ruth demonstrated to Naomi is returned to her through Boaz. After the recognition of the relationship between Ruth and Boaz, the process of redemption takes place. In the end, Boaz and Ruth become the parents of an heir who would become part of the lineage of Jesus Christ.

John Wilch says the story of Ruth “has the power as a theological vehicle to point its readers in unexpected directions, even transforming them” (Wilch 2006, 2). The book of Ruth demonstrates how God works through people (Wilch 2006, 53). Ruth, Naomi, and Boaz worked within their circumstances to take advantage of the opportunities God gave them to experience him (Wilch 2006, 35).

The story of Ruth is also a powerful demonstration of how God is the source of meeting the needs of God’s people, yet uses people as resources to address the needs. God does not come down and perform a miracle for Ruth and Naomi, but God does arrange events in God’s sovereignty and is active and present in the mundane circumstances of everyday life. "Thus Ruth is about the God who works through His people" (Wilch 2006, 53). Ruth, Naomi, and Boaz “did the best they could in the situations in which they found themselves, making use of the opportunities God made available to them as believers” (Wilch 2006, 35). Even today, God meets God’s people and transforms them.

The idea of God meeting God’s people in every day and pouring out God’s *hesed* upon them is also found in the New Testament as Jesus lived the lifestyle of *hesed* (Hubbard 1988, 73). “In the New Testament, however, ***agapaō*** and noun ***agapē*** have taken on a particular significance in that they are used to speak of the love of God or the way of life based on it” (Günther and Link 1986, 538). Ruth Anne Reese states that it is through the life, death, and resurrection of Jesus that *agape* is demonstrated (Reese 2006, 69). We see this in the story of

the woman who anoints Jesus' feet with her tears and anoints him with perfumed ointment (Luke 7:36-50).

As with Ruth, this woman is an outsider. The Pharisee did not welcome her into his house but did invite Jesus to dinner. The woman entered anyway and anointed the feet of Jesus with a mixture of her own tears mixed with perfume applied by her own hair (Luke 7: 36-38). The Pharisee questions the identity of Jesus as a prophet and his obedience to the law in regards to purity because Jesus allowed a woman with a bad reputation to touch him (Luke 7:39). For with the Pharisees, there was not any grace within the law. As demonstrated by Ruth, it is God's faithfulness to God's covenants which show God's *hesed* and honoring of faith that produces righteousness. For Stauffer, Jesus ushers in a "new and overflowing love which fills and directs life and action" beyond the covenant of *hesed* (Stauffer 1985, 8).

As the Luke 7 narrative unfolds, in rabbinic style, Jesus tells a story of a moneylender who had lent money to two people. One owed a small amount; the other a large amount. Neither of them had the ability to pay the money back, therefore the moneylender forgave their debts. Jesus asked, "Now which of them will love him more?" (Luke 7:41-42). The Pharisee can only answer, "The one who had the bigger debt forgiven" (Luke 7:43). Jesus affirms the answer.

Then comes a poignant question when Jesus asks, "Do you see this woman?" When *El Roi*, the God who sees (Gen 16:13), looks upon his daughter, he sees not the sinner, but the child he created who has been broken and wounded. As David Garland paraphrases the question, "Do you not recognize

that this woman's behavior is a sign of the one who has been forgiven many debts and is showing enormous love and gratitude?" (Garland 2011, 330).

Jesus continues with a comparison of the Pharisee and the woman. The Pharisee is sure of his piety and purity while judging the woman who is unclean and unacceptable. Jesus points out that the woman did what the Pharisee should have done. By custom, the Pharisee was to offer his guest a way to have their feet washed. The Pharisee had not done this simple act, but the woman went above and beyond, even using her own tears and hair. Jesus continues by mentioning that the Pharisee did not offer oil for his head, but the woman offered perfume for his feet. The Pharisee did not greet Jesus with a kiss, but the woman had continued to kiss Jesus feet as he spoke (Luke 7:44-47).

Antoine Nachef states, "Jesus attacked not the life and actions of Simon, but his convictions and his relating to others" (Nachef 2004, 83). "In a society where everybody turned their backs on her, this woman felt in the very depth of her heart an understanding Lord who did not judge her" (Nachef 2004, 85). Joel Green sees it as "an invitation to enlightenment, the consequence of which would be acceptance of both her (i.e., no longer viewing her as a "sinner" but as one who loves extravagantly) and of new behaviors modeled on those of this woman" (Green 1997, 312). As Green continues to point out, the woman's actions were far beyond Simon's expectations (Green 1997, 313).

The woman came with her sins already forgiven; therefore, her actions are prompted out of gratitude and love (Getty-Sullivan 2001, 105). Saunders suggests that she understood her relationship with her Savior and acted

accordingly (Saunders 1998, 45-51). Green reminds the reader, “Jesus is known as a friend of sinners” (Green 1997, 309). This unknown woman lavished her love on Jesus because of his great *agape* love, which flows from the Lord’s deep *hesed.* Jesus expressed *agape* to the woman, reminding her, “Your sins are forgiven” (Luke 7:48). “Your faith has saved you; go in peace” (Luke 7:50). In this act, Jesus affirms her identity as one who is forgiven and has new life, restoring her place in the community (Green 1997, 314). Sakenfeld ties Jesus’ actions back to *hesed* in that “one person is uniquely in a position to provide that needed help” (Sakenfeld 1999, 715). This echoes the role of kinsman redeemer, who usually has a close relationship with the recipient, and demonstrates that Jesus has positioned himself as the universal kinsman redeemer (Sakenfeld 1999, 715).

“The encounter between Jesus and the sinful woman warns against a false understanding of one’s relationship with oneself, God, and the world. The woman in this Gospel realized that her life was not in order, that she needed to do something about that” (Nachef 2004, 85). Nachef says, “Encountering the Lord fulfilled the longings of her anxious heart” (Nachef 2004, 85). It is the unfulfilled core longings that draw us to God. In these encounters, we will find our Savior, the one who comes to save and redeem what is his.

The dinner guests began to discuss, “Who is this who even forgives sins?” (Luke 7:49). Paul addressed this issue in Romans, asking, “Do you show contempt for the riches of his kindness, forbearance, and patience, not realizing that God’s kindness is intended to lead you to repentance?” (Rom 2:4). It is

God's *hesed* that leads to repentance and empowers. It is God's *hesed* that heals the brokenness and wounds of God's children and makes them whole. It is God's *hesed* that replaces lies and false beliefs with truth and acceptance. It is God's *hesed* that brings peace and comfort. God elevates *hesed* in Jesus as "*agape* often refers to a more unconditional, even self-sacrificial love" (Witherington 2003, 10).

The relationship between Jesus and the woman challenges how we form our view of our relationship with ourselves, God, and others, and how we navigate through these relationships when we are in crisis (Nachef 2004, 85). In her chaos, the woman went to Jesus. Nachef says, "Encountering the Lord fulfilled the longings of her anxious heart" (Nachef 2004, 85). God's covenantal love of *hesed* in the Old Testament is made complete in the *agape* of the incarnation of Jesus in the New Testament (Witherington 2003, 47). These scriptural accounts offer a foundation of *hesed*, a reassurance that as a spiritual companion, a pastoral caregiver can position a care receiver to encounter this extravagant covenantal and self-sacrificing love (Witherington 2003, 47).

Theological Foundation

This section will focus on a theology of hope, particularly as it is explored in the context of liberation theology and specifically in a theology of accessibility. When Jürgen Moltmann published *Theology of Hope* in the 1960s, there was a global movement for liberation (Brown 2016). In the United States, the Civil Rights Movement and protests against the Vietnam War were underway. Europe was engulfed in student protests. Countries in Africa, Asia, and Latin America were fighting for economic and political liberation (Moltmann 2015 23). Moltmann

explained these movements of liberation as an indication of people's dissatisfaction with themselves and society (Moltmann 2015, 23). *Theology of Hope* would go on to become the framework to what is now known as Liberation Theology.

Moltmann was influenced by Ernst Bloch's work, which was based on the Exodus story in the Hebrew Bible (Brown 2016). Moltmann added the life, death, and resurrection of Jesus as the promise of hope in the coming of the Kingdom of God (Brown 2016). In *The Living God,* Moltmann asked, "Why has Christian theology allowed this theme of hope to escape it? Are not God's promises and human hopes the scarlet thread running right through the prophets of the Old Testament and the apostles of the New?" (Moltmann 2015, 177). Quests to find meaning and hope in the Gospel within this context led to the development of the various liberation theologies.

Peter C. Phan states, "Future historians of Christian theology will no doubt judge liberation theology to be the most influential movement of the twentieth century, possibly ever since the Reformation" (Phan 2000, 40). Gustovo Gutierrez, the father of Latin American Liberation theology, would answer, "The salvation of the whole man is centered upon Christ the Liberator" (Gutierrez 1973, 83). What makes liberation theology so influential?

Gutierrez began with the question, "What is the meaning of the struggle against an unjust society and the creation of a new humanity in light of the Word?" (Gutierrez 1973, 83). Liberation salvation looks more at the qualitative versus quantitative aspect of salvation. Salvation is not just about saving souls,

as would have been the focus of earlier times, but more of the quality and abundant life that is found in Christ here and now. Gutierrez states, “Salvation – the communion of human beings with God and among themselves – is something which embraces all reality, transforms it, and leads it to its fullness in Christ” (Gutierrez 1973, 85). This places Christ at the center, transforming all of creation and making it possible for all humankind to reach fulfillment in every aspect of life.

The liberation of humanity and creation is part of the coming of the Kingdom of God. Dom Antonio Fragasso asserts, “The struggle for justice is also the struggle for the Kingdom of God” (Gutierrez 1973, 97). Liberation theology allows for the Kingdom of God to be experienced here and now through salvific, holistic transformation. This salvific experience occurs through an encounter with Christ the Liberator within a communal context. This leads to a further question: if salvation is communal, then is sin communal as well?

Gutierrez looks beyond individual acts against each other to the institutions and systems created and sustained by oppressive communities (Gutierrez 1973, 103). Oppressive communities dominate and enslave other communities based on racism, sexism, socioeconomic class, religion, disability, etc. (Gutierrez 1973, 103). Liberation theology views the Kingdom of God as a process which grows through historical liberating moments (Gutierrez 1973, 104). Gutierrez points out that these historical salvific liberations are not the end all but a pronouncement of the fullness of the Kingdom and salvation to come (Gutierrez 1973, 104).

Thus, the fullness of the Kingdom of God and full salvation is found in Christ the Liberator, who uses these moments to move humankind in closer relationship with God and each other (Gutierrez 1973, 174). Ultimately, salvation is realized in the “active participation to liberate humankind from everything that dehumanizes it and prevents it from living according to the will of the Father” (Gutierrez 1973, 174).

How does liberation theology apply to the work of spiritual companionship with people with bipolar disorder? In *The Disabled God,* Nancy Eiesland articulates a holistic and communal transformation of recognition, inclusion, and acceptance, which she calls the praxis of the “theology of accessibility” (Eiesland 1994, 20). This “theology of accessibility” allows for the disabled to access to the “social-symbolic life of the church” and the church to access the “social-symbolic lives of people with disabilities” (Eiesland 1994, 20). Theology of accessibility recognizes that a social construct exists that excludes anyone who is not able-bodied (Eiesland 1994, 24). It also rejects the stigma created by imposed terminology on persons of disabilities (Eiesland 1994, 27).

According to the World Health Organization, disabilities include any impairment of the body or bodily structure that limits a person’s activity, causing difficulty in doing tasks while also restricting participation and involvement in daily routine activities (Schaab 2015, 220). Mental health disorders and challenges are disabilities that impact people in different ways and in varying degrees. While Eiesland focuses mainly on physical disabilities, the concepts and principles she proposes relate to mental health disorders and challenges as well.

Eiesland uses the stories of persons with disabilities to highlight common themes. The first involves coming to grips with the knowledge that one's body demands contingencies. One cannot see the physical disability of mental illness, yet the symptoms of mental health disorders manifest themselves physically (Mayo Clinic 2011).

Secondly, viewing disabled persons as heroic overcomers focuses upon a few examples, while the majority struggle with their limitations (Eiesland 1994, 31). "Limits are real human facts" (Eiesland 1994, 47). Eiesland continues, "Embodying disability is not an extraordinary feat" but a natural process that provides a symbol for society to form a holistic understanding of physicality" (Eiesland 1994, 47-48). Every human being has limitations. Those with bipolar disorder experience cognitive, physical, emotional, and social limitations (Carsen 2012).

Lastly, Eiesland notes oppression against the bodies of the disabled. Oppression stems from society's view of the bodies of persons with disabilities as being "flawed, dangerous, and dependent" (Eiesland 1994, 49). Persons of disabilities also began a movement of liberation in the 1960s to become visible, eliminate restrictions, and end discrimination. The movement was helped by the great number of disabled veterans returning from war and an increased number of children facing various disabilities, especially from the recent polio outbreak (Eiesland 1994, 51). Proponents of the disability movement also found their voices within the Civil Rights Movement (Eiesland 1994, 55).

An additional theological perspective comes from studies within the Black church. In 1970, when *A Black Theology for Liberation* was first published, writer and theologian James Cone and the Black church were asking, “what has the gospel of Jesus Christ to do with the black struggle for justice in the United States?” (Cone 1990, xi). Black Theology is rooted in “nearly four hundred years of slavery and segregation in North America, both of which were enacted into law by government and openly defended as ordained of God by most white churches and their theologians” (Cone 1990, xi). It was not only racism and white supremacy, but “the failure of white religionists to relate the gospel of Jesus to the pain of the being black in a white racist society” (Cone 1990, 4). There is a common pain of the oppressed heard in these writings.

The Civil Rights Movement and the fight for women’s rights became prominent at the same time as the disability movement (Eiesland 1994, 56-57). As the disabled exposed the discrimination against race within their own community, they allied with the Civil Rights Movement. As women fought for their rights, issues of race and disability among women were noted (Eiesland 1994, 56-57). Concerns for civil rights, women, and persons with disabilities intersected, not just in the similarity of the battle, but also in theological ideas.

In Feminist Liberation Theology, society’s perception of women’s bodies was used to oppress women. Rosemary Radford Ruether spoke to this issue in *Sexism and God-Talk,* pointing out that the modern church still hangs onto the Greco-Roman idea of the female body representing the “evil lower nature” (Ruether 1993, 80-81). The idea that a woman’s body is unclean and a cause of

sexual temptation that leads men to Hell, is the impetus for the patriarchy's social domination and exploitation of women (Reuther 1993, 84). Miroslav Volf spoke for women when he acknowledged that when injustices are not overt, women are aliens in a male dominated world (Volf 1996, 184). The result is that the church has been deprived of understanding the full nature of God, both male and female. In doing so, church structures created barriers for women's accessibility to God (Reuther 1993, 53). In the same way, fully-abled theology "disables" not only those with disabilities but also those who are not disabled by distorting the true nature of God and humanity (Schaab 2015, 220).

For Eiesland, the Disabled God is not only Emmanuel, "God with us," but "God for us," who enables both a struggle for justice among people with disabilities and an end to estrangement from our own bodies (Eiesland 1994, 89). Jennie Weiss Block has pointed out that disabled people are just as much created in the image of God as are any able-bodied persons. Therefore, the image of God can be seen in all of humankind, not just the able-bodied (Block 2002, 12). To "reflect on disability is to reflect on the mystery of God's love and the great paradoxes of the Christian message" (Block 2002, 12).

Finally, as an oppressed group, there is a biblical mandate for inclusion of the marginalized (Micah 6:8, Matt 25:31-46, Galatians 3:28) (Block 2002, 12). Schaab notes that Block draws on Edward Schillebeeckx's description of "Jesus as host: a copious gift of God," whose gift is "the news of God's invitation to all – including and especially those officially regarded as outcasts" (Schaab 2015, 228). According to Block, the gift of Christ established a new order in which

"outsiders become insiders." (Schaab 2015, 228). If one feels excluded or demeaned by the Church's theology, then it begs the question, what is the *Good News* for women or persons with disabilities?

The common pain for the oppressed is the denial of accessibility to the Gospel of Jesus Christ and the salvific liberation offered here and now with the coming of the Kingdom of God. When living under oppression, one needs present hope, not only future hope. A folly of white male theology is glorifying suffering or identifying it with sin (Eiesland 1994, 75). A liberatory Christianity must reject the visions of disability as symptom of sin or as occasion for virtue (Eiesland 1994, 75).

Chris Marshall, in *Beyond Retribution*, sees the Cross as Jesus bearing our sin with us in solidarity and not as a substitution (Marshall 2001, 61). "God's justice is vindicated by overcoming oppressive powers, forgiving those who are guilty of collaboration with the enemy, and restoring covenant relationship to God" (Marshall 2001, 61). Therefore, Christ is the *Christus Victor* who "overcome(s) evil and the powers and principalities of evil" (Creegan and Pohl 2005, 157). Christ overcame the powers of death, but he did not escape the disability of the crucifixion.

> The Risen Jesus still bears the disfiguring and disabling scars of the Crucifixion. While many fail to recognize the disabling effects of the Crucifixion, the glorified body of the Risen Jesus remains marked even as his body transcends all social constructions of disabilities. (Iozzio 2009, 48)

For Eiesland, this risen Jesus shared in the humanity and vulnerability of embodiment (Eiesland 1994, 14). Jesus faces human limitations, helplessness,

and humiliation as his body is mangled, stripped naked, and put on display (Eiesland 1994, 14).

This is the concept of hope that Moltmann proposes in *Theology of Hope*, as hope is based in reality. The reality is that God came and took on flesh, lived as the oppressed, was persecuted, tortured, and died. Gutierrez, Ruether, Cone, and Eiesland all looked at their context and were dissatisfied with their reality. Following the example of Christ the Liberator, they took action, working out their faith in fear and trembling by acknowledging that salvation began now. In a similar understanding, people with bipolar disorder need hope now, not only in eternity. If persons with bipolar disorder do not have hope now, then they are likely to find a way to their eternal salvation.

Historical Foundation

Since its beginning, the church has shown concern and given care to the sick, including those with mental health challenges and disorders. Rodney Stark makes this case in *The Rise of Christianity*. Christians, driven by the ethos of "*love one another"* and grounded in the belief that "God loves humanity," had "superior survival rates" due to their care for one another (Stark 1996, 86, 90). When the church is imitating God and demonstrating God's *hesed*, those on the margins receive the care needed to recover.

The monastic movement of the early church Mothers and Fathers embraced and became one with the margins. In the *City of God*, Augustine demonstrates empathy for the state of those with mental health challenges:

> Crazy people say and do many incongruous things, things for the most part alien to their intentions and their characters, certainly contrary to their good intentions and characters; and when we think about their words and actions, or see them with our eyes, we can scarcely — or possibly we cannot at all — restrain our tears, if we consider their situation as it deserves to be considered. (Augustine)

During the Middle Ages, there was a deadly shift in the view of those with mental health illnesses, particularly during the Inquisition (O'Connell 2001). During this time, the popular view of the church was that mental illness was caused by demon possession which led to widespread persecution, including burning and torturing those with mental health issues (Simpson 2013, 137). There was still hope, however, for when society at large shunned those with mental illness, “the church did not abandon the mentally ill. The Rule of St. Benedict prescribed that the care of the sick is to be placed above and before every duty. In the Middle Ages, the mentally ill were cared for in monasteries along with the physically ill" (O'Connell 2001). The church went against the norm of society as it welcomed those who were marginalized, demonstrating God’s great *hesed*.

The church did not limit their care to the confines of the monasteries. The church engaged in developing holistic care for those who suffered from mental health issues by opening the first psychiatric hospital in London in 1247 (Simpson 2013, 137). Society at large interfered as the city took over the hospital, and it became the infamous Bedlam Hospital, which charged tourists to watch patients for entertainment (Simpson 2013, 137).

The treatment of the mentally ill began to turn in a progressive direction when church leaders such as John Calvin and Martin Luther began to share their

struggles with mental health, and the demonization of mental health challenges began to subside (Simpson 2013, 137). The most significant and profound difference made by the church happened during the Enlightenment. With the Enlightenment, “moral treatment” was introduced. “Moral treatment” was initiated by Christian physician Philippe Pinel when he boldly unchained those imprisoned in a mental health facility in Paris in 1794 (O’Connell 2001). Pinel would not allow restraints, punishment, or other forms of harm.

“Moral treatment” consisted of treating a patient with dignity and respect, and not inflicting harm (Simpson 2013, 137). “Moral treatment” can be understood as a form of *hesed*. Pinel did not see “crazy” people in the mental facility, but instead, his brothers and sisters made in the same image of God who deserved to know and experience the *hesed* of their Creator. Pinel was influenced by philosophers John Locke and Jean-Jacques Rousseau who wrote about the “essential worth and goodness of each human being” (Kent 2003, 61).

Quaker William Tuke was also prompted to action after the death of a friend in an asylum:

> In the year 1791, a lady, a member of the Society of Friends, was placed in the old York Asylum. Her friends, who resided at a distance, requested some of their acquaintance living in the city to pay her a visit. They accordingly went to the Asylum for this purpose, but their request was refused. (Bewley 2008, 1)

Tuke founded a private mental hospital called the Retreat at York. The Retreat was a model which supported and advanced the development of moral treatment. Tuke’s great-grandson, Daniel Hack Tuke, records the history of The Retreat at York and its unique characteristics. The Retreat could accommodate about thirty residents and included pastures for cows, a community garden, and

sufficient space for exercise (Tuke 1855, 507-512). The name alone “intended to convey the idea of what such an institution should be, namely a place in which the unhappy might obtain a refuge; a quiet haven in which the shattered bark might find the means of reparation, or of safety” (Tuke 1855, 507-512).

Tuke’s work had a lasting and far-reaching impact on the care of those with mental health challenges and disorders. The Retreat model was brought to Colonial America by the Friends Society as the Quakers opened the Friends Hospital in Pennsylvania, which also cared for those with mental health challenges (Kent 2003, 62). In general, there was not any plan for chronic care, only episodic. As the number grew of those who needed care, resources were strained, and the asylum era began in America (Kent 2003, 62).

Dorothea Dix also played a key role in introducing the moral treatment model to the United States. Dix learned about moral treatment when she visited England and met Tuke’s grandson Samuel and others. She was inspired to advocate for reform and began by visiting jails, almshouses, and asylums. Dix found mentally ill people held as prisoners like common criminals. She wrote about her visits in a pamphlet called “Memorial” and presented it to the Massachusetts legislation in 1842 (Kent 2003, 71). Her efforts resulted in an expansion of the Worcester Mental Hospital.

As the state hospital began to implement moral treatment, half the patients left within a year and did not need to return, and eighty to ninety percent of the patients experienced some level of recovery (Kent 2003, 74). Dix did not stop there but traveled from state to state petitioning state legislatures as she did in

Massachusetts. As a result, moral treatment facilities began to be established throughout several states. Dorothea Dix was driven by her faith which prompted her to ask, “How could Christians permit such cruelty and degradation in their communities?” (Kent 2003, 72). For example, one woman in an almshouse cried out to Dix on one of her visits:

> Why am I consigned to hell? Dark – dark! I used to pray – I used to read the Bible – I have done no crime in my heart; I had friends – why have all forsaken me? My God! My God! Why hast thou forsaken me?” (Gollaher 1995, 148)

Sadly, as the demand grew with a boom in population, the facilities could not afford to maintain the standard of moral care. With insufficient funds and untrained staff, the mental health facilities returned to the state of Bedlam by the end of the nineteenth century (Kent 2003, 75).

In the advent of World War II, the Mennonite faith community found itself putting its faith into practice by choosing Civilian Public Service (CPS) rather than engaging in war. Becoming “disturbed with the de-personalization and frequent mistreatment of patients” in mental hospitals, Mennonite CPS workers “began discussing the possibility of developing several Mennonite-sponsored, small mental hospitals focusing on a ‘homelike atmosphere’ and ‘Christian care’” (Bender 2011, 45). Their faith-centered approach made a recognizable difference. First Lady Eleanor Roosevelt reflected on her encounter with a group of CPS workers at the Marlboro, New Jersey State Hospital in 1943, “They are a very fine group of young men, and bring a spiritual quality to their religion. In many ways, this is probably raising the standard of care given the patients” (Stoltzfus 1943, 900).

The Mennonite CPS workers collaborated with other groups such as the Mental Hygiene Movement of CPS and were influenced by and contributed to the Mental Health Act of l946. Their engagement continued into the 1950s with the therapeutic community movement and the Community Mental Health Centers movement in the 1960s which resembled the moral treatment concept. The Mennonite CPS worker movement resulted in the creation of the Mennonite Central Committee (MCC), the Mennonite Mental Health Services (MMHS), and the creation of six Mennonite mental hospitals and centers (Bender 2011, 46). Mennonite CPS workers were asked to join the National Mental Health Foundation (NMHF), formerly the Mental Hygiene of CPS, which prepared legal briefs on state mental health laws, developed a model for mental health law, and published educational materials, including a series of eight dramatizations (Keeney 1971, 45).

Brook Lane was the first Mennonite mental hospital (Bender 2011, 50). The intent was to combine “the best of Mennonite culture, and competent psychiatric leadership would team up to be a creative force in the mental health field” (Bender 2011, 50). Brook Lane was the beginning of the Mennonite mental healthcare movement (Bender 2011, 50).

Brook Lane led to the concept of “therapeutic community.” Ebersole, an Anabaptist, noted three facets of the “therapeutic community.” First, “hierarchical characteristics are kept to a minimum” while maintaining healthy caregiver-care receiver boundaries (Ebersole 1961, 52). The community arrives at decisions by consensus, yet particular consideration is given to the advice of the expert

(Ebersole 1961, 52). Finally, there is an expectation of open and free-flowing communication (Ebersole 1961, 52). The underlying belief of the therapeutic community is “the assumption that the individual must be understood as a relational being and that man may not be understood in individualistic terms” (Ebersole, 1961, 52). For Ebersole, this was a picture of the covenant relationship God has with his people and the faith community had with one another (Bender 2011, 52).

The therapeutic community model can be linked to the principle of kinsman redeemer. Each person within the community offers redemption to another just as Ruth offered redemption to Naomi and Boaz to Ruth. Ultimately, as human beings created in the image of God, all God’s children have the opportunity to offer the *hesed* offered them by God. As we offer God’s *hesed*, we also become kinsman redeemers offering redemption to each other.

Historically, the church engaged the mental health community through personal connection from the early monasteries to moral treatment centers to therapeutic communities. The church, specifically the pastor, has become a gateway for people to receive holistic and appropriate care. Yet despite the church’s historical role in mental health care, there are only a handful of organizations that have been formed to carry the torch of Pinel, Tuke, Dix, and the Mennonites into the twenty-first century.

Today most Christ-centered community-based support organizations are non-profits and not affiliated with a specific church or denomination. In one example, Joe Padilla and Dr. Matthew Stanford founded the Mental Health Grace

Alliance (MHGA) through the experience of helping Joe's wife recover from a mental health crisis (Padilla and Stanford 2013d). Together, Padilla and Stanford created a "unique clinical, biblical and whole-health approach to reach recovery" (Padilla and Stanford 2013d). MHGA defines recovery as "a strength-based and a whole-health (holistic) process of change that focuses on self-management, community support, and rebuilding self-worth and a sense of purpose" (Padilla and Stanford 2013d). The stages of recovery include "distress, stability, function, and thriving in purpose" (Padilla and Stanford 2013d). The results of their treatments include a reduction of symptoms, reduction of frequency and intensity of episodes or cycles, and increased resiliency (Padilla and Stanford 2013d). MHGA focuses on one-on-one coaching, peer and family support groups, and education and empowering the local church.

Other ministries were also birthed through personal experience. Saddleback Church established the Mental Health and the Church Conference in response to the death of Pastor Rick and Kay Warren's son Matthew (Moges-Gerb, 2016). Their son committed suicide after struggling with mental health difficulties for many years. Ministries such as Pathways to Promise, Mental Health Chaplaincy, and Sanctuary Mental Health Ministries also grew out of personal experience. A common thread in all these ministries is the church responding to a need in their community. Salvation is brought as people of the church step in as kinsman redeemers for those who struggle with mental health difficulties and challenges. As history has shown, the most beneficial and effective care for mental health is within the community.

Mental health care changes to reflect the current view of mental health disorders and challenges. When society believed mental health issues were caused by the demonic, then mental health care was addressed solely through religious interventions. The pendulum then swings to the other extreme when society views mental health issues as only psychological. The solution is limited to therapy and medication. When the church has taken the initiative to lead in mental health care, which is founded in *hesed*, then a holistic, effective mental health plan can develop.

Having explored the biblical passages from Ruth and Luke, the theological concepts of hope and liberation, and the history of the church's role in mental health care, I now move to explore the idea that the crux of mental health stigma lies in how society or communities view mental health disorders and challenges. In a review of the current literature, most credible experts on mental health dismiss the idea of sin being the cause of mental health issues and disorders. There remains a conflict in how to treat mental health. In the next chapter, I will review the mainline practices of addressing mental health issues and disorders.

CHAPTER THREE

REVIEW OF LITERATURE

If people challenged by mental illness struggle to find support within the church, as Simpson suggests and my experience confirms, how can the church respond in a more helpful way? In this chapter, the conceptual framework of a community of *hesed* will be considered as a possible way forward for a faith-based response to mental health concerns. Within a community of *hesed*, the role of spiritual companion is significant to healing, yet how is that role understood? Concerns within the field of psychology regarding the integration of the role of counselor and spiritual companion are often raised, and so three perspectives will be explored in this manner: full integration, an exclusive non-integrative approach, and a cooperative model. The chapter will conclude with models that speak to both the need for a community of *hesed* and the role of psychology and spiritual companionship, and will consider what spiritual companionship can look like in the context of mental health concerns.

Community of *Hesed*

When the church lives out a lifestyle of *hesed*, it creates a safe environment for those who have bipolar disorder. The field of psychology confirms the need for communities of *hesed,* especially for those with bipolar disorder. Psychologist Larry Crabb boldly states,

> I have come to believe that the root of all our personal and emotional difficulties is a lack of togetherness; a failure to connect that keeps us from receiving life and prevents the life in us from spilling over onto others. I, therefore, believe that the surest route to overcoming problems and becoming the people we were meant to be is reconnecting with God and with our community. (Crabb 2005, 32)

Crabb comes to this conclusion after three decades as a Christian counselor and spiritual director. He bases this conclusion on the “deepest urge” of humankind to be in a relationship with God and others (Crabb 2005, 45). Crabb looks to a “healing community” to provide the environment needed to provide the connection. A “healing community” does not focus on fixing others or making people demonstrate “right” behavior, but “on releasing what’s good” in each other (Crabb 2005, 38).

Neuroscientist Matthew S. Stanford would agree partially with Crabb. Stanford points to sin as the reason for disconnection from God and community. Stanford makes a clear distinction between inherited sin and actual sin. Inherited sin is what Stanford calls our “sinful DNA” which inclines us to sin (Stanford 2010, 8). Inherited sin disconnects us from God as “it is out of a mind and body corrupted by original sin that actual sins come forth” (Stanford 2010, 8).

Stanford argues that inherited sin impacts us biologically and physiologically including aging, sickness, death, and cognitive differences (Stanford 2010, 11). “These cognitive differences have been linked to neurochemical, hormonal, and structural differences” (Stanford 2010, 11). Though, as Christians, we may have the “mind of Christ,” and those minds are “being renewed,” we still have a “significant amount of sinful baggage” (Stanford 2010, 23). “As a result of living separated from God, we have developed immoral desires, distorted drives, corrupt thought patterns, and sinful habits” (Stanford 2010, 23). Actual sin results when we act on those desires, drives, patterns, and habits.

According to Stanford, mental health disorders are one way inherited sin can corrupt the body and mind (Stanford 2010, 11). The disruption and disconnection caused by mental health issues can contribute to actual sin; therefore Stanford does see disconnection from God as the result of inherited sin. He affirms that this disconnection has impacted the brain. Reconnection is important to heal the brain, but Stanford supports the need for the community to be coupled with interventions such as medication and psychotherapy to heal a person (Stanford 2010, 23). This forces the question, "Where does this need for community originate?"

Stanford and Crabb both agree that humankind is created in the image of God. Stephen Seamands points out the significance of being created in the image of God is that God, himself, lives in the community of the Trinity. "We don't start with our human understanding of idealized relationships and project that onto God. Our starting point is the divine revelation of the triune relations, and that becomes a revelation to us of God's intention for human beings created in His image" (Seamands 2005, 38). Being created for community changes the concept of individual faith and the church. Seamands points out that our faith might be individual but exists only within the relationship of the church (Seamands 2005, 40).

Michael Downey articulates this in his statement about personhood,

> The human person is not an individual, not a self-contained being who at some stage in life chooses or elects to be in relationship with another and others. From the very first moment of existence, the infant is toward the other, ordinarily the mother or father, who is in turn toward and for the infant. From our origin, we are related to others. We are from others, by

> others, toward others, just as it is in God to exist in the relations of interpersonal love. (Downey 2000, 63)

Seamands summarizes this when he states, “In fact, you are only truly you in relationship to others” (Seamands 2005, 42).

Psychology supports the interpersonal Trinitarian relationship as described in attachment theory. Curt Thompson states that “attachment theory supports the supposition that there is no such thing as an individual brain, not even an individual neuron” (Thompson 2010, 109). Attachment theory explains the dynamic of human relationships through the needs of developmental stages. Each stage of development has a core need to be affirmed by a significant caregiver. Anne Halley identifies six basic core longings needed to form secure and healthy attachments: Love, Security, Understanding, Purpose, Significance, and Belonging (Halley 2009, 6). Humans cannot develop these core needs in isolation. They need another to attend to those individual growth-enhancing requirements lovingly. The key to such development towards healthy attachment is nurture.

Clarke and Dawson define nurture as “all the ways we offer positive recognition and stimulation. It includes giving love to ourselves and others” (Clarke and Dawson 1998, 21). They identify nurture as being necessary for people to develop and thrive (Clarke and Dawson 1998, 21). One can only be nurtured in community. In *Community 101*, Gilbert Bilezikian describes the need for attachment or connection as the “awful secret” of longing for intimacy with one whose love is safe to surrender and bare all oneself to in unforsaken trust (Bilezikian 1997, 15-16).

Wardle agrees that we are all longing for love and intimacy, but he identifies God as the source of love and intimacy (Wardle 2001, 21). From Wardle's perspective, "the heart of the Christian experience is the journey toward *His* intimate embrace" (Wardle 2001, 24). In this journey toward God, the role of a spiritual companion is to help and assist those suffering from bipolar disorder to connect with God. The transformational paradigm Wardle uses moves "learning to knowing," "knowledge to change," "principles to presence," "periods of time to moments in time," "reading Scripture to experiencing Scripture," "prayer to communion," and "working to waiting" (Wardle 2001, 28). This paradigm provides a way to address Bilezikian's "silent churning" which calls out to mutually know and be known, understand and to be understood, and to possess and be possessed by belonging unconditionally to all of creation (Bilezikian 1997, 15-16).

Bilezikian writes of "tormenting needs" (Bilezikian 1007, 15-16) that align with Halley's core longings. When these longings are not met through attachment development, Wardle likens them to "stolen treasures" and "lost dreams" (Wardle 2001, 43). This type of devastation can be caused by bipolar disorder. Those seeking help from caregivers are needing someone to facilitate the experiences to recover their "stolen treasures" and "lost dreams." Bilezikian captures this process in the context of community: "And now, whenever there is hope, our hope is for paradise regained, for human destiny remade in the redemptive restoration of community, the only certainty of oneness for here and for eternity (Bilezikian 1997, 15-16). A spiritual companion is the first connection to community.

In *Befriending the Stranger,* Jean Vanier explores how the marginalized actually create community. Vanier notes that most societies are structured like a pyramid of power with the rich and powerful at the top and the poor and marginalized at the bottom. He goes as far as to suggest that some people even fall outside the pyramid such as those with disabilities: “People with disabilities can be a paradox. Sometimes we are not quite sure who they are nor how to react to them” (Vanier 2001, 38). Vanier’s community of l’Arche has taught him and others a “secret” about people with disabilities. “People with disabilities are a sign, a presence of Jesus and a call to unity. The weak and the poor are for us a source of unity” (Vanier 2001, 38).

According to Vanier, the disunity caused by rejection and exclusion of people from our communities is actually an obstacle to faith and a barrier preventing us from experiencing the love of Christ. These obstacles and barriers are the “awful secret” Bilezikian refers to (Bilezikian 1997, 15-16). Vanier concludes that it is the weak and broken who make a community of *hesed* possible. The weak and broken makes our own “tormenting need,” that Bilezikian says is “churning inside,” visible and tangible. Bilezikian goes on to agree that the solace and healing for our grief is for closeness or connectedness found only in “the redemptive restoration of community, the only certainty of oneness for here and for eternity (Bilezikian 1997, 1).” Henri Nouwen shares: “No one person can fulfill all your needs. But the community can truly hold you. The community can let you experience the fact that beyond your anguish there are human hands that hold you and show you God’s faithful love” (Nouwen 2010, 7).

People with bipolar disorder need this type of safe community. According to J. LeBron McBride's definition, mental health issues and disorders are a form of trauma: "Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions and experiences" (McBride 1998, 12). Building a safe community begins with an initial encounter. A recent study conducted by LifeWay Research found that most people first turn to a pastoral caregiver when facing a mental health challenge or disorder (LifeWay Research 2014).

This kind of spiritual companionship can be described in a number of ways. In Margaret Silf's exploration of Ignatian spirituality, she identifies a good spiritual companion as someone who does not have it all together and knows they have not arrived (Silf 2004, 90). She states, "a wounded healer is the best healer; a blind guide is the best guide" (Silf 2004, 90). Gerald May says, "The essence of spiritual guidance or direction can be seen whenever one person helps another to see and respond to spiritual truth" (May 1992, 1). This relationship

> Involves a full acceptance of the physical and psychological nature of human beings and an informed, caring response to the manifestations of the nature. But it is also continually and consciously rooted in mystery and in an awareness of graced furtherance of the person's life in and towards God (May 1992, 31).

May agrees with Silf when she says "The most profound growth almost always happens in the darkness" (Silf 2004, 29). May calls our darkness "our finest hope" (May 1992, 61).

From the perspective of a Catholic priest, Nouwen captures his understanding of spiritual companionship through the concept of compassion:

> Compassion asks us to go where it hurts, to enter into the places of pain, to share in brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears. Compassion requires us to be weak with the weak, vulnerable with the vulnerable, and powerless with the powerless. Compassion means full immersion in the condition of being human. (Nouwen 2006, 3-4)

Despite the darkness, pain, and brokenness, May says we must be prepared to be "surprised by grace" (May 1992, 23). Spiritual companionship brings the darkness into the light of Christ and his transforming grace. How does one approach spiritual companionship with someone who has bipolar disorder? Must the spiritual companion be trained in psychology or be a licensed therapist? Does a person with bipolar disorder even need anything beyond community? Where does spiritual companionship intersect with psychology?

Psychology and Spiritual Direction

Mark McMinn addresses the main Christian counseling approaches to integrating spirituality into practice in his book, *Psychology, Theology, and Spirituality in Christian Counseling*. Counselor A views religion as a hindrance to overcoming mental health problems. This counselor encourages patients to lay religious views aside in order to cognitively and logically address symptoms of the patient's mental health disorder. Counselor A is likely to depend on Cognitive Behavior Therapy (CBT), which focuses on correcting unhealthy emotions, behaviors, and thoughts (McMinn 2011, 5). This model can be seen as an exclusive non-integrative approach.

In contrast, focusing on the emotions, behaviors, and thoughts goes against the formational counseling model offered by Terry Wardle. In fact, he asserts that focusing solely on emotions, behaviors, and thoughts will result in no longer-term change (Wardle 2001, 136). For Wardle, the core issue or "wound" must be addressed at some point, as his model begins with humanity being wounded (Wardle 2001, 136). These wounds lead us to believe lies which result in emotional upheaval (Wardle 2001, 136). In response, we try to kill the pain or fill what is missing with dysfunctional behavior (Wardle 2001, 136). Dysfunctional behaviors are what others would call sin. Ultimately, our life circumstances are a result of the consequences of our dysfunctional behaviors. Wardle does not discount the value of CBT but highly recommends CBT as one part of a holistic healing team (Wardle 2001, 21-22).

McMinn's Counselor B is open to consumers bringing up their religious beliefs in therapy. As McMinn states, "Religion can be discussed in therapy, but the power of change is found in the therapeutic relationship" (McMinn 2011, 3). This type of therapy is rooted in the idea of mental health issues stemming from what Crabb refers to as "connectedness." Crabb believes it is our lack of or inability to connect that causes our emotional, spiritual, and psychological troubles (Crabb 1997, 32). This can be considered a cooperative model.

Counselor C is the one who sees all issues being a result of sin. Matthew S. Stanford, who specializes in psychology and neuroscience, does not deny the role sin plays in mental illness but demonstrates how sin is not the cause of mental illness, so does not fully meet McMinn's criteria. Stanford conveys that

many Christians fear that psychological theory permits negative behavior caused by mental health disorders. Some Christians even see mental illness as a sin (Stanford 2008, 51). Thus, also an exclusive non-integrative approach.

In *The Biology of Sin*, Stanford looks at the fallen state of humanity. He does not point to Adam and Eve as the origin of sin but instead to the "adversary," Satan. Stanford refers to Martin Luther's response to the question, "By whom was sin brought into the world? Sin was brought into the world by the devil, who was once a holy angel but fell away from God, and by man, who of his own free will yielded to the temptation of the devil" (Stanford 2010, 5).

Stanford goes on to say that Adam and Eve became "co-conspirators" introducing original sin into creation (Stanford 2010, 6). Stanford acknowledges original sin as the "sinful DNA" that permeates creation (Stanford 2010, 8) including our biology which influences our physical and mental inclinations.

> Demons are involved at many levels of our existence, and it certainly is not necessary for demonic powers to purposefully cause a given mental illness in a person for us to be able to say that they were involved in the disorder. (Stanford 2008, 35)

Therefore, in a sense, original sin is humanity's first wound, a broken relationship or disconnection from God, self, and others.

The descriptions of Counselor A, B, and C as proposed by McMinn lend themselves to exploring a need for integration of the recovery process through holistic treatment. What type of integration is possible? McMinn suggests a full integration, which proves to be problematic to some. Psychiatrist and spiritual director Gerald May is adamant that counseling and spiritual direction are two distinct practices (May 1992, 15). Crabb believes that when Christians truly

connect intimately, God has provided the means for healing to occur (Crabb 1997, xiv).

McMinn sees the same developmental cycle in spiritual and psychological health. It is not a linear developmental but a continual spiral of consolation and desolation. A person is aware of her own need even if she is not able to articulate it. Through the process of recognition and acceptance of her neediness, the person also grows in mindfulness and the reconciliation and healing of relationships (McMinn 2011, 50). McMinn suggests, “in our sickness and pain, we grope for answers, for better understanding, for meaningful relationships. Our sickness leads us to God” (McMinn 2011, 20).

In *Grace of Mind, Grace of Spirit*, May makes the case that spiritual direction and formation are not counseling or types of therapy. Spiritual direction and formation focus on “prayer life, religious experiences, and sense of relationship to God” along with other spiritual challenges (May 1992, 15). The care receiver will express thoughts and feelings and exhibit various moods and behaviors, but the focus of the spiritual direction and formation should always be turned toward the impact and effect it has on the relationship between the person and God. This is the role of the caregiver or spiritual companion. A spiritual companion is a person “who provides encouragement and direction along the path to Christ” (Wardle 2004a, 29).

May identifies one danger to be “psychologizing the process of spiritual direction” (May 1992, 149). Many spiritual caregivers have been exposed to mental health disorders only through the news, television, and movies, which can

lead to misconceptions and misunderstanding of mental health disorders. Other caregivers know just enough to be concerned yet do not feel equipped to deal with people with mental health issues. Others may think they know enough to try and treat the mental health disorder as part of spiritual direction. May also recognizes that some spiritual directors have little to no knowledge of mental disorders or do not even believe mental health disorders exist. Ann Halley agrees with May that it is the responsibility of a caregiver to keep current on “concepts, data, verified biological, neurological, developmental understanding of human beings” (Halley 2009, 32).

May and Halley advise caregivers to focus on personality theory and diagnostic categories. Personality theories include developmental theories such as Maslow’s hierarchy of needs, Piaget's theory of cognitive development, Erikson's stages of psychosocial development, Kohlberg's stages of moral development, John Bolby’s attachment theory, and Fowler’s stages of faith development (Cherry 2019). Diagnostic categories are those set forth by the American Psychiatric Association in the *Diagnostic and Statistical Manual of Mental Disorders*. The categories are as follows: Neurodevelopmental Disorders, Psychotic Disorders, Mood Disorders, Anxiety Disorders, Dissociative Disorders, Somatic Disorders, Eating Disorders, Sleep Disorders, Impulse Control Disorders, and Personality Disorders (APA 2013, 1.3.1). A caregiver is not expected to have in-depth knowledge of all these disorders, but a working knowledge of signs and symptoms is needed in order to make appropriate referrals.

May points out that some care receivers come for spiritual direction when they actually need therapy. A caregiver must also discern if spiritual direction should be done concurrently. May makes it clear that the caregiver's role is not to diagnose. In holistic care, it is the role of a caregiver to make referrals, especially when there are concerns of the care receiver hurting themselves or others. This goes beyond suicide and homicide; May includes damage to relationships, loss of job, and dysfunctional behaviors outside the care receiver's normal behavior. As May points out, social and financial losses can lead to psychological and spiritual damage once a care receiver realizes what they have done. "As but one example, people with bipolar affective disorder can be thrust into ever-deepening depression with the realization of how much they have lost and squandered during manic episodes" (May 1992, 187).

Halley takes the discussion a step further and deeper into basic neuroscience. She says, "We cannot separate the development of the brain, emotions, and awareness of God" (Halley 2009, 4). Louis Cozolino describes the brain as "an organ of adaptation" (Cozolino 2002, XV). Cozolino presents the simplified model of the Triune Brain by Paul MacLean. Though neurology is not this simple, it creates a foundational model to build on. The Triune Brain includes the reptilian brain (core and responsible for homeostasis, protection, and survival of a person), paleomammalian brain (or limbic system controlling learning, memory, and emotion), and the neomammalian brain (higher level thought processes and integration) (Cozolino 2002, 8). Unlike MacLean, Cozolino reveals

that all areas of the brain are continuously adapting and are more integrated than previously thought. This is where neurology and attachment theory intersect.

The reptilian brain is fully functional when a child is born, but the paleomammalian brain is not. Attachments are made through the development of the paleomammalian brain. As Cozolino points at, this is “both good news and bad news” (Cozolino 2002, 8). “The early interpersonal environment may be imprinted in the human brain by shaping the child’s neural networks and establishing the biochemical setpoints for circuitry dedicated to memory, emotion, and attachment,” which becomes the “infrastructure for later developing intellectual skills, affect regulation, attachment, and the sense of self (Cozolino 2002, 9). The discussion about attachment theory, faith development, and psychosocial development are dependent on the well-being of the brain’s infrastructure; hence Halley’s statement about the responsibility of caregivers to be aware of the interaction between neuroscience and psychotherapy and how it relates to faith development.

> Emotional experience is not processed through language and logic. Therapies (spiritual experientials) dealing with disorders that are fundamentally emotional need to be able to reliably access sensory, motoric, and somatic experiences to engage them in a dyadic process of affect regulation and eventual transformation. This requires a bottom-up processing approach of experiential therapies, rather than the top-down approach of most cognitive and insight-focused therapies. (Focha 2003, 229)

Dr. Daniel Siegel draws these concepts together in his book, *Mindsight*. Siegel brings hope with his concept of Mindsight, “a kind of focused attention that allows us to see the internal workings of our own minds” (Siegel 2010, IX). Siegel uses

the framework of the triangle of well-being, which includes the brain, mind, and relationships. This reinforces the work of Crabb, Stanford, Erikson, Fowler, and Clarke and Dawson. Siegel affirms Clarke and Dawson's re-parenting with his understanding of neuroplasticity, or the "capacity for creating new neural connections and growing new neurons in response to experience" (Siegel 2010, 5).

For better visualization of this concept, Siegel uses the hand to show how the parts of the triune brain fit together physiologically (Siegel 2010, 14-15). The three major regions include the brainstem, limbic system, and the cortex. Looking at the hand, Siegel identifies the spinal cord as the wrist and the palm as the brainstem, which makes up the reptilian brain discussed by Coxolian (Siegel 2010, 15). When the thumb is folded into the palm; the thumb represents the limbic system or paleomammalian brain (Siegel 2010, 17-19). Wrapping the fingers around the thumb provides an image of the neomammalian brain or cortex (Siegel 2010, 19-20). Siegel takes this knowledge and integrates it with the developmental theories previously discussed.

How does this all come together? Just as Crabb and Stanford identify the need for connectedness and the interconnection between developmental theories, it is necessary to have a healthy connection between the three parts of the brain (Siegel 2010, 69-71). As Siegel presented in his Triangle of Well-Being, it takes the interconnection of the brain, mind, and relationships for a person to be holistically well (Siegel 2010, 71). Relational and mindful activities are used to facilitate these connections.

Siegel identifies two categories of integration: horizontal and vertical. Horizontal speaks to the familiar concept of right-brain and left-brain (Siegel 2010, 72-73). Siegel points out that information comes into our brains through the body via the brainstem, through the limbic system, and reaches the left side of the cortex (Siegel 2010, 72). More abstract concepts, feelings, nonverbal, and metaphorical images find their way to the right side of the brain (Siegel 2010, 72). The right brain is the source of emotion and psychosocial development. When a person is in the infancy stages of attachment-making, psychosocial development, and faith development, the right side of the brain is more developed (Siegel 2010, 72). The left side of the brain does not become more active until around three years of age. Siegel says we see this when children begin asking “Why? Why? Why?” (Siegel 2010, 108).

As humans, we all have had experiences. The facts and logical aspects of these experiences are routed to our left brain while the emotions and images are routed to the right brain (Siegel 2010, 107). Siegel and Hartzell refer to left-right brain integration as key to developing a secure attachment as an adult (Siegel and Hartzell 2003, 126). This is seen when a person can make sense of their story by relating the emotions and the facts of an experience coherently. Therefore, horizontal integration of the left and right brain is key to developing attachments, allowing one to experience Halley’s core longings which are foundational for the development of faith and psychosocial health.

Another form of integration that supports mental health recovery is vertical integration, which is top-down or bottom-up (Siegel 2010, 128). In horizontal

integration, we are combining elements of a story. Vertical integration interprets our “now” while comprehending logically what is going on and still able to feel emotion (Siegel 2010, 128). Siegel describes a top-down person as one who lives in their head and is disconnected from their body (Siegel 2010, 124). A bottom-up person lives in their body, reacting with flight-fight-freeze responses without being able to apply logic to the situation (Siegel 2010, 131). Healthy vertical integration relies on solid attachments built on having core longings met, thus allowing faith and psychosocial development. How does a spiritual companion support integration for a care receiver?

Experientials and spiritual exercises can promote integration. There are cognitive aspects connecting to emotions through tactical experiences. This is where everything comes together. The goal of a spiritual caregiver is to provide companionship and connection. Connection is developed by the application of personality theories. These theories can be hindered by disconnection which can be impacted from mental health issues. One must be cautious not to trigger a care receiver causing more harm than healing. Embracing the concept of *hesed* and *go’el*, while applying an understanding of psychology, allows one to be a true spiritual companion to those who suffer from bipolar disorder.

Models of Companionship

We have looked at the importance of connectedness, *hesed*, and the biblical and theological basis for it. Then we journeyed through the various developmental theories and their connection to neuroscience. Does anyone bring this all together? Reflecting on the desire for holistic healing and recovery to

happen in a community of *hesed*, one may ask, “Can it or does it even exist?” Are there current models and practices that provide a cooperative model? In fact, there are a number of models in place that share similar practices while networking and referring to each other as further resources.

The next section of this chapter will outline a number of faith-based organizations and congregations that put these concepts into practice. This integration can be seen in Mental Health Grace Alliance, The Samaritan Counseling Center of Texas, Saddleback Church’s Hope for Mental Health, Pathways to Promise, Sanctuary – Mental Health Ministries, and Mental Health Chaplaincy.

Mental Health Grace Alliance

The Mental Health Grace Alliance, now known as simply Grace Alliance, was a source of inspiration for my resource. Grace Alliance’s purpose statement is as follows:

> We strive to provide simple and innovative Christian mental health resources and programs for families and individuals experiencing mental health challenges and to equip the Body of Christ with active community support and leadership tools. (Padilla 2013c, About Us)

It was birthed out of the personal experience of co-founder, Joe Padilla and his wife’s battle with mental health issues. After serving as a licensed and ordained minister, both in the United States and abroad, Joe had to leave the ministry to care for his wife (Padilla 2018a, Video). After eight years of seeking professional and spiritual help, Joe teamed up with Dr. Matthew Stanford to develop a new process of holistic healing and mental health recovery (Padilla 2018a, Video). Dr. Stanford and Joe Padilla focused on addressing physical, mental, spiritual, and

relational needs in order to "relieve suffering, reveal Christ, and restore lives" (Padilla and Stanford 2013a, 3).

Grace Alliance has four specialized curriculums with over 160 groups in thirty states and seventeen countries including thousands of participants (Padilla 2013d, Home). Grace Alliance provides online and in-person training, a support network for facilitators, video series online of past training and webinars, articles, books, a blog, and further resources.

Grace Alliance applies neuroscience, spirituality, and developmental theories to support mental health recovery. Their model echoes attachment theory's "re-parenting" by addressing core longings lost with a mental health diagnosis. The four areas addressed in their recovery curriculum includes Relational, Physical, Mental, and Spiritual (Padilla 2013, Video). As one goes through the recovery process, Grace Alliance journeys with a person with bipolar disorder through Distress, Stability, Function, and Purpose (Padilla 2013a, Video). During the first stage, Distress, the goal is to develop hope through self-management and creating a support network including peer groups (Padilla 2013a, Video). As one becomes stable out of distress, then one works toward owning the recovery process and planning (Padilla 2013a, Video). The care receiver's strength and wellness are not tied to their diagnosis. Personal identity and worth are also separated from their problems (Padilla 2013a, Video). The end goal is to move from surviving to thriving. This is when a person is once again participating in the community as an equal partner while building a new, meaningful and satisfying life (Padilla 2013a, Video).

Samaritan Counseling Center

In comparison, The Samaritan Counseling Center of Texas, affiliated with Samaritan Institute, also identifies a holistic approach but their approaches differ from Grace Alliance. The Samaritan offers certified counselors who specialize in helping adults, young adults, adolescents, children, couples, parents and parenting, substance abuse and addiction, grief, trauma, and loss, clergy and congregational care, and spiritual direction. Unlike Grace Alliance, Samaritan offers one-on-one and group sessions of an Emotional Freedom Technique, mindfulness through the Hakomi Method (somatic experiential psychotherapeutic process), and Right Use of Power-Relational Ethic and Boundaries (Samaritan Counseling Center of East Texas 2018, Services). There is a stronger focus on children and families. Samaritan does promote and participate in the education of the church. This is done at a yearly conference held in Tyler, Texas to bring awareness to mental health, offer resources, and remove the stigma (Samaritan Counseling Center of East Texas 2018, Testimonials).

Hope for Mental Health

Saddleback Church in California has created a mental health ministry called Hope for Mental Health (H4MH). H4MH echoes the views of both Grace Alliance and The Samaritan but points to a more integrated large-scale model. “The Hope for Mental Health Ministry extends the radical friendship of Jesus by providing transforming love, support, and hope through the local church” (Warren 2018, Our Purpose). The heart of this ministry is based on The Hope Circle: you

are loved, you have a purpose, you belong, you have a choice, and you are needed (Warren 2018, Our Purpose).

Within Hope for Mental Health, there are thirty-seven support groups. The church states their goal to be “to provide a place of comfort, strength, support, and hope for people as they work through their personal struggles” (Warren 2018, Connect/Support Groups). The groups provide support in various areas, including military life, health issues, marriage, divorce, grief and loss, and specific mental health groups. These support groups point to a holistic understanding of healing. Though the issues seem unrelated to one another, all these issues produce stress and can cause anxiety or depression, or exacerbate a pre-existing mental health issue. Saddleback’s intention is to address each of these issues spirituality, mentally, and physically in the context of community.

A unique aspect of H4MH’s mental health ministry is the in-depth training offered in levels called Crawl, Walk, and Run (Warren 2018, Act/Start-Your-Own). H4MH’s desire is to transform churches into communities of *hesed*. The “Crawl” phase begins with the pastors speaking about mental illness from the pulpit in their sermons, having people with mental illness t share their testimony, surveying the congregation to see what they know about mental illness, having mental health professionals come and educate and raise awareness, opening up space for mental health support groups to meet at the church facilities, and providing meals for those experiencing mental health issues or crisis (Warren 2018, Act/Start-Your-Own).

This compares to the level at which Grace Alliance functions. When the church is ready to take it to the next level, “Walk,” a greater level of commitment is required in time and money. Care groups are created to support individuals or families with basic needs (Warren 2018, Act/Start-Your-Own). “Companions” are trained to support people with mental health issues whose symptoms, such as impulsive actions or speech, are triggered during the service (Warren 2018, Act/Start-Your-Own). A “walking” church has resources available and offers ongoing training. The church is able to match people who want to connect with others with similar mental health challenges.

In Saddleback’s model, the ultimate goal for churches is to get to the “Run” level. This is when the church becomes a model for other churches (Warren 2018, Act/Start-Your-Own). The church is then ready to step out into the community and network with mental health organizations. The church is capable of putting on mental health events and conferences like The Samaritan Counseling Center. Grace Alliance attends events like these as a mental health organization. The Samaritan functions in some areas of a “running” church such as community involvement and hosting conferences, but in general offers the same or similar resources as Grace Alliance but on a professionally licensed level versus volunteers. Saddleback has the advantage of networking and integrating all their resources together. They provide all the resources for a church to begin the journey of crawling, walking, and running (Warren 2018, Act/Start-Your-Own).

Pathways to Promise

Pathways to Promise is referred to by all the models and practices discussed in this chapter. They are located in St. Louis, Missouri, and their "aim is to train the church to be companions" (Pathways to Promise 2018, Home). The word "companion" highlights the essence of the purpose of my project. My resource is designed for individual clergy who are probably not connected or part of a network that provides training and resources for mental health. On the contrary, Pathways exists to provide connection for clergy.

On their website, it states, "Our site is intended for faith leaders, interested laity, people with mental illness and their families, friends, and supporters and mental health professionals interested in working with the faith community" (Pathways to Promise 2018, Home). Pathways has a vision similar to H4MH but on the level of Grace Alliance. It supports groups within the church as they work to reach out and serve those with mental illness and their family (Pathways to Promise 2018, Home). The focus is on the support groups like Grace Alliance, but Pathways can grow and expand the resources and skills of a group beyond support groups and education. Pathways empowers the church groups to do what Saddleback does like networking with mental health organizations and facilitating interfaith participation. Pathways provides the groups with resource materials, information, training and technical assistance at all levels to foster ministry, service, and advocacy on behalf of persons with mental illness and their families. Pathways acts in the capacity of Saddleback, yet the focus is on a group within a church instead of the church as a whole. Pathways to Promise offers a

link to Sanctuary – Mental Health Ministries based in Vancouver, British Columbia. Sanctuary is a Canadian version ministry similar to Grace Alliance.

Mental Health Chaplaincy

Mental Health Chaplaincy (MHC) in Seattle, WA, reflects a similar concept to Pathways. MHC exists through partnership. Though the previously mentioned models do work with other organizations, churches, and institutions, MHC stands out because they depend on their partners for their work, ministry, and existence (Mental Health Chaplaincy 2018, Mission/Presence).

Rev. Craig Rennebohm founded MHC in 1987 to provide companionship to those living in homelessness, mental illness, addictions, and trauma (Mental Health Chaplaincy 2018, Mission/Presence). MHC's core function is to train others to be companions through their Companionship Training. MHC identifies five components to companionship: hospitality, neighboring, side by side, listening, and accompaniment (Mental Health Chaplaincy 2018, Mission/Presence).

MHC flips the model from outside-in to inside-out. Research revealed that many models require the person with mental health issues to come to them. In contrast, MHC goes to the people. Hospitality does not necessarily mean the person comes to you; instead, space where you encounter one another becomes "a space that is sacred in the personal sense by creating free, friendly, and sacred space for the stranger" (Mental Health Chaplaincy 2018, Mission/Education). The experts on psychology and spiritual direction emphasize

boundaries. While MHC does not do away with boundaries, the relationship of a companion is less formal.

MHC defines being a neighbor as “sharing common time and space, beginning as human beings” (Mental Health Chaplaincy 2018, Mission/Education). The dynamic of the care receiver coming to the caregiver is dispelled as both become care receivers and caregivers. The chaplain background comes through the concept of side by side and clarifies what happens in the shared “common time and space” (Mental Health Chaplaincy 2018, Mission/Education). “The aim (of side by side) is not to fix things; it is simply to be together, to be present, a way of sharing the world together” (Mental Health Chaplaincy 2018, Mission/Education).

The concept of the ministry of presence embodies the essence of chaplaincy in general. As a companion, MHC trains people to look “at the world together, honoring each other’s unique gifts and perspectives” (Mental Health Chaplaincy 2018, Mission/Education). This is the calling of a chaplain, which is accomplished through the fourth component, listening. MHC encourages companions to “Listen carefully, in community and over time, to hear especially the language of the soul and the story of hope and wholeness in us each” (Mental Health Chaplaincy 2018, Mission/Education).

These four components come together to establish accompaniment. As MHC describes, “It is an act of faith, an outward sign of our belief that we are never alone” and “Accompany one another, both in practice and in spirit, on a healing journey so that, together, we experience recovery and grow toward

wellness” (Mental Health Chaplaincy 2018, Mission/Education). Whereas the other models of practice offer a place to come, MHC goes out and creates sacred space. MHC recognizes that the work of companionship is done together by partnering with denominations such as the United Church of Christ, Presbyterian, Episcopalian, United Methodist Church, Mennonites, etc. MHC also relies on Pathways to Promise and NAMI (Mental Health Chaplaincy 2018, Resources).

Throughout each of these models, one thing is the same – community. In the next section, stories of the church will emulate how this happens in ordinary time and not just theoretically.

Spiritual Companionship

According to the National Institute on Mental Health, one in four Americans suffers from a mental health disorder (Simpson 2013, 33). This statistic does not change in the church. People in the church are suffering from the impact of mental health challenges and disorders. Sadly, in the church, people often suffer in silence.

> The suffering of mental illness, whether for the afflicted or for their families, is typically marked by isolation. When people desperately need to experience the love and empathy of their fellow human beings and to know that their Creator has not abandoned them, many reach out and are shocked to touch the church’s cold shoulder. Others fear the church’s rejection enough to hide their struggles and not risk exposure at all. (Simpson 2013, 16)

Simpson points out that the government, lawmakers, insurance companies, and even Hollywood are taking note of the issue of mental health and they are taking steps to demystify and destigmatize mental health challenges and disorders,

while actively seeking solutions to fix the broken system of mental health care (Simpson 2013, 17). By and large, it appears that it is the church which is behind on this issue. This is due to lack of education, not lack of heart.

Pastoral caregivers are common gateways for people with mental health difficulties to receive the proper help and support needed for recovery. “Nearly half (44.5%) of church leaders are approached two to five times per year for help in dealing with mental illness; 32.8% are approached more frequently, from six to more than twelve times per year” (Simpson 2013, 99).

A key roadblock for those who have bipolar disorder is hopelessness, the hope of Christ that those who suffer from bipolar disorder need. This does not mean in-depth Bible study or deep theological discussions. In fact, “spiritualizing mental illness translates to blaming sick people for their illness” (Simpson 2013, 107). Mental illness is a disease just like cancer, diabetes, or hypertension. With any disease comes the interaction of biology, psychology, and spirituality (Stanford 2008, 86). Hope is found in presence, a simple prayer, small successes, and a key verse to hold. Through holistic care, “God is the ultimate agent of healing” (Stanford 2008, 88). The pastoral caregiver’s role in this care “is simply to offer encouragement and spiritual guidance” (Stanford 2008, 88).

> From a theological perspective, the most dangerous thing about mental illness is that it can lock us in ourselves, convincing us that we are indeed on our own, and completely on our own, isolated in our distress . . . Mental illness shuts all windows and doors to the soul so that we cannot speak, meditate, or do anything to the glory of God, or so it seems. (Greene-McCreight 2006, 116)

In her book, *Darkness in My Only Companion*, Greene-McCreight shares how she knows firsthand the role of a pastoral caregiver, but also the darkness of

bipolar disorder as one who suffers from bipolar disorder. She sees the role of the spiritual companion as one that opens the doors and windows by speaking, meditating, and being with a person until they can do so on their own. It is not a dramatic grand opening, but, instead, curtain by curtain, blind by the blind, shutter by shutter allowing light in so that eventually the windows can be cracked, allowing in the refreshing wind of the Spirit to revive the captive (Greene-McCreight 2006, 116).

Greene-McCreight offers advice to pastoral caregivers journeying with those with bipolar disorder. First, offer but do not demand spiritual practices or spiritual exercises such as extending the offer to pray, read Scripture, or take communion (Greene-McCreight 2006, 138). Second, become aware of the signs and symptoms of mental health challenges and disorders (Greene-McCreight 2006, 138). Last, know your professional role and purpose and work within this scope (Greene-McCreight 2006, 141). Pastoral caregivers who are not trained psychologists or psychiatrists need to have resources of referrals and should never try to make a diagnosis (Greene-McCreight 2006, 141). “Be consistent in your concern, prayer, and inquiries. Let them know that your friendship, or care as a clergyperson, is unconditional” (Greene-McCreight 2006, 143).

Spiritual companionship is one component of holistic recovery. Mental Health Grace Alliance sees an individual holistically as God made them, including physical, mental, spiritual, and relational dimensions (Padilla and Stanford 2013a, 30-31). “A holistic approach to recovery relieves suffering, reveals Christ, and restores lives” (Stanford and Padilla 2013a, 30). Each

component affects every dimension. Recovery for a person with bipolar disorder is made possible when all dimensions are addressed. Greene-McCreight challenges pastoral caregivers to remember: “Since mental illness can be a terminal disease, you may be helping to improve or even to save a life” (Greene-McCreight 2006, 143).

Simpson has not only researched the intersection of mental health with the church; she has lived it, as Simpson’s mother has schizophrenia. When her mother was first hospitalized, she wondered if she would lose her mother. The answer, “Yes, I did lose my mom – over and over again” (Simpson 2013, 22). In response to her illness, the Simpson family adopted three unspoken rules: “Don’t talk about it. Everything is fine. No one outside this family will understand” (Simpson 2013, 22).

Amy Simpson’s father was the pastor of their church, yet she describes the church as being “either oblivious or a silent observer” (Simpson 2013, 29). Simpson exhorts the church to fulfill its purpose of being the Body of Christ, a *hesed* community. “Unfortunately, in many churches, we are afraid of the dark. We have lost our courage and conviction that light can conquer darkness. The darkness has cast itself over the light, and suffering people are not safe” (Simpson 2013, 56). Simpson shares that people with mental health issues feel rejected by God because the church is not a safe place. Her experience validates the need for connection. It does not take an overwhelming gesture.

Simpson states that simple is better (Simpson 2013, 98). For her father, a couple befriending him and her mother made a significant difference. The

support of being in a small group helped her father as well. For Simpson and her siblings, it was a different story. She longed for the affection of a mother and dreamed of someone to help with dinner and keeping up the house. It would only take one person to step up and be a spiritual companion to Amy to make a difference (Simpson 2013, 98).

Sister Nancy Kehoe shares how she became a spiritual companion versus a clinician in *Wrestling with Our Inner Angels*:

> Because of their illness, the clients see themselves as wounded spirits, damaged goods, for the most part, neither religious nor spiritual. The constant struggle with their symptoms, feelings of rage, bitterness, resentment, and regret leads to a sense of self-hatred. For many, symptoms of their illness make attending a house of worship difficult. Though they may talk to God, they don't think this is praying because they aren't using scripted words. The benchmarks for the ways most people define themselves as religious or spiritual are missing from their lives. (Kehoe 2009, 37)

Kehoe goes on to share how she provides ritual, structure, and tangible worship options for her spirituality groups in local behavioral health institutions (Kehoe 2009, 37). For many, mental illness consumes their lives to the point of not being able to cope with their feelings, unable to express themselves coherently, and feel disconnected not only from people and God but their environment not being able to see color.

Kehoe uses brain integration activities that are creative and tactile to facilitate worship that do not require words but nurture connection (Kehoe 2009, 39). She encourages us "to have a curiosity about what is at the heart of a person" and nurture it (Kehoe 2009, 41). From her religious training, Kehoe reminds us of the root meaning of *religion,* which means "*to bind back*;"

specifically to bind us back to God. *Spiritual* comes from the concepts of *spirit* or *breath* referring to the *source of life* (Kehoe 2009, 51). A spiritual companion provides religious and spiritual experiences that facilitate connection with God.

These personal stories echo the need for a cooperative model which uses knowledge of psychology and mental health issues to inform spiritual companionship. Psychologist Sr. Kehoe affirms this in her story. She uses her knowledge to inform her time with clients in the spirituality group. Sr. Kehoe joins the members of the group on their journey, meeting them where they are and facilitating ways for them and herself to connect with God and each other. This approach is seen weaving in and through the organizations addressing mental health issues as described in the previous section. The psychiatrists and psychologist may not agree on the role of counselor and spiritual companion, but the need for a community of *hesed* is a thread that runs through their work, even when not named as such.

With a solid biblical, theological, historical foundation in place, as well as a review of the responses of the community of faith to the needs of those who struggle with mental health concerns, Chapter Four will now lay out the design, procedure, and assessment used to create and evaluate the resource project.

CHAPTER FOUR

DESIGN, PROCEDURE, AND ASSESSMENT

The purpose of this project was to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The project intended to answer the research question: To what extent does this resource better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The project goals were:

1. The resource will establish that pastoral caregivers are gateway people for those with bipolar disorder in receiving appropriate care.
2. The resource will outline the biblical basis for a holistic approach to understanding mental health challenges and disorders.
3. The resource will outline the theological basis for a holistic approach to understanding mental health challenges and disorders.
4. The resource will identify how bipolar disorder impacts the lives of those who have bipolar disorder.
5. The resource will explain how bipolar disorder can interfere with one's connection with God.
6. The resource will provide appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus.
7. The resource will give other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their spiritual journey.

The specific focus of this project was designed to establish that pastoral caregivers are gateway persons for those with bipolar disorder in receiving appropriate care. The resource outlined the biblical and theological basis for a holistic approach to understanding mental health challenges and disorders. An explanation was given for how bipolar disorder can interfere with one's connection with God. The handbook provided appropriate spiritual exercises to

equip pastoral caregivers to position care receivers to encounter Jesus. The resource offered other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their spiritual journey.

Context

What I learned through my own mental health crisis set the context for the birth of this resource. My recovery included a team of psychiatrists, psychologists, trauma specialists, a primary care doctor, medical specialists, mental health support groups, and a community of people who made the journey with me. In reviewing the entities that were helpful in my recovery, I did not place the church on that list. Through this journey, one thing remained clear: the church, particularly as represented by the clergy I was associated with, was not prepared to offer life-giving care to me, or to people with bipolar disorder. This included both those on the mission field as well as those I came in contact with upon my return to the United States.

Participants

The resource was evaluated by twelve people with experience in working with people with bipolar disorder and who have an understanding of the disorder. An initial list of thirty possible evaluators was made. The list contained people who I knew met at least three of four criterions: theological degree or training, background in psychology or counseling, involved in mental health support groups/recovery, and personal experience with bipolar disorder (self, family member, friend, client, and congregant). Because a handful of respondents and I

had a close connection, I wanted to insure anonymity, and I did not ask for any other demographic information.

I requested participation from six members of Mental Health Grace Alliance. One has theological training, experience in leading mental health support groups, and personal experience with bipolar disorder through family and clients. The second has a doctorate in behavioral neuroscience, has experience with mental health support groups, and personal connection through clients and friends. Another has theological education, experience leading mental health support groups, and personal connections through clients and friends. One was a graduate student at the time doing her thesis on seminaries and mental health education who had both theological and psychological training and experience in leading mental health support groups personally connecting her to bipolar disorder. The last two have experience leading mental health support groups, education background in psychology and human development, and both have personal connections through clients, friends or family. The first one did inform me that he completed the survey. I do not know if any of the others responded.

I drew from the Waco psychologist and counselor network for five more respondents. Most were psychologists but one was a licensed professional counselor. All of them had theological training on some level. Each of them serve clients with bipolar disorder. I know all of them lead small groups addressing different issues. The licensed professional counselor informed me she completed the assessment.

Six licensed social workers were chosen to complete the assessment. All of these social workers are unique because they all have training in psychology and theology and have personal connections to people with bipolar disorder.

I reached out to denominational ministries through the United Church of Christ, Mennonite, and Anabaptist Disabilities Network for feedback and other possible experts to evaluate the resource. From these organizations, I was referred to two other organizations. I was given a contact at the American Association of Pastoral Counselors who had experience with bipolar disorder, the leadership of mental health groups, and training in both psychology and theology. The other reference was a former pastoral counselor at a Christian mental health recovery center. She has her doctorate in pastoral counseling including psychotherapy. As a part of her role she led small groups and made connections with people who have bipolar disorder. I am unsure if any of these connections responded.

Through the Waco Chapter of the National Alliance on Mental Illness, I secured two other experts. Both have a Christian-based social work degree giving them both theological and psychological training. Both lead mental health groups and have personal connections to people with bipolar disorder.

Additional prospective respondents were colleagues in chaplaincy who have backgrounds in psychology. One has an ongoing practice and is a licensed professional counselor along with having theological education. He leads mental health groups and has personal connections to bipolar disorder. Another is a Clinical Pastoral Education Supervisor with a specialization in spiritual care in

mental health settings. As a chaplain, he has a theological education and has led mental health support groups. The third has a similar background but no longer actively practices. The final chaplain is a priest with theological training. He is also a trained psychologist and leads mental health support groups, giving him personal connections to people with bipolar disorder. The priest informed me he completed the survey.

My time in San Antonio connected me to three experts. One is the local Mental Health Grace Alliance coordinator who is also a licensed professional counselor, leads mental health groups, and has personal connections to bipolar disorder. The other two are a married couple who have their own private psychology practice. They also have theological training and experience in leading mental health groups. Through these avenues, they have personal connections with people with bipolar disorder.

I drew upon three additional possible respondents who were familiar with formational counseling. All three have theological and psychology training, lead mental health groups, and have personal experience with people with bipolar disorder.

In Corpus Christi, I became acquainted with a trained psychologist who had bipolar disorder. He had led mental health support groups and has some theology training. Another connection was a pastor who held a seminary degree and had taken courses to pursue counseling. This pastor led groups at the local mental health hospital and has congregants who have bipolar disorder. The first acquaintance mentioned completed the survey. As this review of potential

participants indicates, my knowledge of those asked to evaluate the resource met the criteria I had set for respondents.

Of the thirty who were invited to participate, twelve experts participated and completed the assessment. This group of people assessed if the resource accomplished the goals. Each person reviewed the resource and completed an evaluation, answering qualitative and quantitative questions related to the specified goals. Of this group, their responses indicated that seven have a theological degree or training; eight have a background in psychology or counseling; seven are involved in mental health support groups/recovery; and ten have personal experience with bipolar disorder (themselves, family member, friend, client, and/or congregant).

The criterion I set for my experts to relate to a minimum of three of the four categories came back with discrepancies in the criteria for some experts. Three participants selected all four descriptions; four participants identified with three of the four categories. Of those, three had theological training but did not have a background in psychology or counseling. The fourth had a psychology or counseling background but did not have any theological training. Three of the participants related to only two of the demographics, with all three having a personal connection to bipolar disorder. One had a theological background and the other psychological background. The third had experience in leading mental health support groups. Two participants identified themselves as only having a psychology or counseling background. Five of the participants only identified

themselves with only one or two categories. This indicates that the categories were not clear.

Procedure and Assessment

To complete the project, I created a resource for mental health professionals to evaluate. Using my own experience, integrating aspects learned from mental health support groups of the Mental Health Grace Alliance, the Doctorate of Ministry Formational Counseling Track, Clinical Pastoral Education Residency, and relying on my teaching background, I created a handbook that would better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. I titled the fifty-page resource *Spiritual Companionship and Bipolar Disorder*.

The guide begins with the Introduction, explaining why I created the resource. The first section, Mental Health and the Church, looks at mental health and the church including an overview of the state of mental health in the U.S., the history of mental health and the church, and how pastoral caregivers are gateway people for those with bipolar disorder to receive care. These themes were also addressed in Chapters Two and Three. The point is to highlight that mental health statistics on mental health in the U.S. includes the church. One in four people in our congregations will suffer from mental health challenges at some point in their life. Studies are shared that demonstrate that people turn first to clergy before seeking other professional help.

In the second section, Bipolar Disorder, I define bipolar disorder and how pastoral caregivers can respond. Essentially, bipolar disorder is a mood disorder.

Many know it by the name manic-depressive disorder. The disorder is characterized by the shifts of elation that last up to two weeks or more, then shifting to a depressive state for two weeks or more. Both extremes interfere with a person's ability to function in daily life. Guidelines are given in the section to help caregivers identify signs that might indicate a person has bipolar disorder or another mental health difficulty. Caregivers are encouraged not to diagnose or treat care receivers, but to refer them to a doctor. Pastoral caregivers do join the care receiver on the journey in ways expounded on in this section.

Then I look at the Biblical and Theological Perspectives by asking, "Where is God?" Mental health issues and disorders cannot be prayed away. Often church, prayer, and the Bible are triggers that can make a person move to religious extremes. When in an elated state, a person can become hyper-religious and can experience hallucinations and delusions of grandeur, causing harm to themselves or others. In a depressive state, it is possible for a person to blame themselves for the disorder and believe they are being punished for sin or lack of faith. Pastoral caregivers can offer alternative ways to encounter God.

The final section shares ten alternative ways to encounter God through experientials. Each experiential includes an objective, supply list, Scripture, opening, experience, and closing. The ten experientials include Mindfulness, Affirmation of Identity, Mosaic of Jesus, Sensory Labyrinth, Sounds of God, Tastes of God, Fragrance of God, Popsicle Sticks, and Chromatic. As an example, in the sensory labyrinth, the care receiver "walks" the labyrinth with their finger. Options of various textures are given to fill the pathway. The labyrinth

takes the care receiver on the journey of the Psalms. The spiritual companion guides them through the inward journey of desolation to find consolation. Once one has spent time in consolation, the care receiver then moves back out through the path of reclamation. Along this journey, the “I AM” statements of Jesus are used to help position the care receiver to encounter Christ. An Appendix at the end of the manual includes outlines and worksheets to be used with some of the experientials.

Further resources are listed at the end of the handbook. There are websites and organizations for additional support and study. A variety of books and journal articles are listed according to the topic. Books include those specifically addressing mental health and the church. Personal stories are offered from clergy and non-clergy. Further reading on bipolar disorder is also available. A section focuses on writings around the topic of theology and psychology. A list of books is given for further reading on spiritual companionship.

Once my resource was completed, I scanned the document creating a pdf file. The resource was emailed to a list of thirty participants in hopes of getting a minimum of ten responses. The email included a personal greeting, explanation of the project, link to the survey, an attachment of the resource, deadline date, and an expression of gratitude. Depending on my relationship with the expert, I personalized the email more. The template of the email can be found in the Appendix: Cover Letter.

The assessment instrument was created with both qualitative and quantitative questions. I created three quantitative questions per goal. The questions were worded as statements and evaluated on a Likert scale from one to seven. The experts identified the statements to be 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true. The quantitative questions I asked by goal can be found in the Appendix Two: Assessment Tool.

The qualitative questions were designed to create space for feedback not related to the quantitative questions, to give room for respondents to explain their reasoning for rating the statements, and to produce insights for improvements. The qualitative questions could also make note of cautions that needed to be taken on an experiential. I created the following three qualitative questions:

1. What are the strengths of the resource? Why?
2. What are the weaknesses of the resource? Why?
3. How can the resource be improved?

I created the assessment in Survey Monkey, which allowed it to be anonymous. Survey Monkey creates a link that can easily be inserted into an email and it is user-friendly for those responding. At the end of my survey I did ask the participants to check which of the following applied:

1. theological degree or training
2. background in psychology or counseling
3. involved in mental health support groups/recovery
4. have personal experience with bipolar disorder (self, family member, friend, client, congregant).

I felt it important that my respondents remained anonymous. Soliciting additional information concerning demographics would have easily led to me figuring out who the respondents were due to the various types of relationships I have with the respondents.

Twelve responses were received within a month. Chapter Five will report the results of the surveys. The findings will be evaluated based on the goals set for the resource.

CHAPTER FIVE

REPORTING THE RESULTS

This chapter will report the results of the expert evaluation of the resource. The outcomes are listed in order of prominence. The purpose of this project was to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The research question was: To what extent does this resource better equip pastoral caregivers to become spiritual companions for people with bipolar disorder?

Goal One: Pastoral Caregivers as Gateway People

The most prominent finding was: The resource will establish that pastoral caregivers are gateway people for those with bipolar disorder in receiving appropriate care. This goal received a rating of 5.97 based on three quantitative questions as follows: The resource establishes that pastoral caregivers are gateway people for those with bipolar disorder to receive appropriate care (#1). The resource models multi-disciplinary collaboration (#2). The resource provides a model for holistic care (#3). The participants used a Likert scale of one to seven on the Evaluation Questionnaire: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true.

Table 1. Goal Number 1 – Pastoral Caregivers as Gateway People

Question	Average	Respondents
1. The resource establishes that pastoral caregivers are gateway people for those with bipolar disorder to receive appropriate care.	6.17	N = 12
3. The resource provides a model for holistic care.	5.92	N = 12
2. The resource models multi-disciplinary collaboration.	5.83	N = 12
Composite Score	5.97	N = 12

Likert Scale: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true

Question #1 was most prominent of the three with the combined score of 6.17 from twelve respondents. Question #3 followed with a composite score of 5.92 from twelve respondents. Last was Question #2 with a composite score of 5.83 from twelve respondents. The experts thought it very true that the resource models multi-disciplinary collaboration and holistic care.

One respondent's comment identified incongruencies with the purpose of the resource and the need to model multi-disciplinary collaboration. This same respondent sees the resource as "an exercise tool to use" and should focus on "using the tool or model for individual pastoral care." Pinpointing a solution to resolve the incongruencies, the latter respondent commented, "Pastoral caregivers are informed, through this resource, about their role in dealing with those with mental illness and encouraged to compile a list of therapists, community helpers, and such. On the other hand, how they might integrate the experientials into their setting of being a 'gateway' for the individual is not

completely and clearly explained." The uncertainty is clarified in the qualitative questions concerning the resource's strengths and weaknesses.

While the experts understood that a pastoral caregiver is a gateway person, it was not clear how to translate that into personal contexts. An expert said, "This is a select ministry style that works with personality types that are deeply rewarded within this methodology." Concerns were raised about the need for a "live training" and more detailed information for those without any knowledge of mental health. A respondent pointed out more attention needs to be given on the "warnings" concerning "determining stability" and "boundaries." Another respondent questioned if pastoral caregivers would have access to the resources offered at the end of the project. The qualitative responses suggest that the resource establishes that pastoral caregivers are gateway people for those with bipolar disorder to receive appropriate care, but does not sufficiently explain how to apply it within the context of various ministry settings.

Goal Five: Bipolar Disorder and Connection with God

The second highest goal in prominence was: The resource will explain how bipolar disorder can interfere with one's connection with God. Overall, the goal received a score of 5.89 based on three quantitative statements as follows: The resource explains how bipolar disorder can interfere with one's connection with God (#13). The resource demonstrates how bipolar disorder can interfere with one's connection with the church community (#14). The resource shows how bipolar disorder can interfere with one engaging in spiritual exercises (#15). The participants used a Likert scale of one to seven to the Evaluation Questionnaire:

1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true.

Table 2. Goal Number 5 – Interference with Connection to God

Question	Average	Respondents
13. The resource explains how bipolar disorder can interfere with one's connection with God.	5.92	N = 12
14. The resource demonstrates how bipolar disorder can interfere with one's connection with the church community.	5.92	N = 12
15. The resource shows how bipolar disorder can interfere with one engaging in spiritual exercises.	5.83	N = 12
Composite Score	5.89	N = 12

Likert Scale: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true

Question #13 and #14 both had a score of 5.92 based on twelve respondents. Question #15 scored a little lower at 5.83 also based on twelve respondents. The respondents found all three questions to be closest to very true.

Qualitative responses suggested Goal 5 to be the strength of the resource. Three comments were made about how bipolar disorder impacts one's connection with God. In fact, one comment was made about each of the statements used to evaluate Goal 5. A respondent mentioned the understanding gained of how bipolar disorder impacts one's relationship with the church community (#14). This respondent also said the same about one's personal connection to God (#13). A second expert expressed "a major strength of the

resource (is) furthering the conversation on how mental health issues can complicate and/or undermine the spiritual journey." This would apply to Goal 5 in general. Qualitatively, Goal 5 is given more merit than Goal 1. With only a .08 quantitative difference, Goal 5 could have been met as well, if not better, than Goal 1.

Goal Seven: Further Resources

The next goal in prominence was: The resource will give other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their spiritual journey. Overall, Goal 7 received a score of 5.82 meaning the experts found it to be closest to very true. The following three questions evaluated this goal: The resource provides further resources to assist pastoral caregivers in being better spiritual companions to people with bipolar disorder (#19). The resource provides a variety of resources for pastoral caregivers (#20). The resources are readily accessible for those caring for persons with bipolar disorder (#21). The participants used a Likert scale of one to seven to the Evaluation Questionnaire: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true.

Table 3. Goal Number 7 – Further Resources

Question	Average	Respondents
19. The resource provides further resources to assist pastoral caregivers in being better spiritual companions to people with bipolar disorder.	6.08	N = 12
20. The resource provides a variety of resources for pastoral caregivers.	5.83	N = 12
21. The resources are readily accessible for those caring for persons with bipolar disorder.	5.55	N = 11
Composite Score	5.82	N = 12

Likert Scale: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true

Question 19 scored 6.08, giving it the highest prominence of the three questions. The experts found it very true that the resource provides further resources to support spiritual caregivers in being better spiritual companions to people with bipolar disorder. The experts found items #20 to be very true and #21 to be between moderately and very true.

The qualitative questions concerning the resource's strengths and weaknesses address why items #19 and #20 scored lower. Respondent #10 suggests that cross-referencing to the bibliography for further reading on subjects that cannot be reasonably covered in the resource should be provided to assist those who desire more information or need more understanding. This correlates with Respondent #3's request for more "readable books" for pastoral caregivers without any psychology background.

Goal Four: Impact of Bipolar Disorder

The next prominent goal was: The resource will identify how bipolar disorder impacts the lives of those who have bipolar disorder. The score for Goal 4 was 5.75. The three quantitative questions were: The resource shows the emotional impact of bipolar disorder (#10). The resource identifies the physical impact of bipolar disorder (#11). The resource demonstrates the cognitive impact of bipolar disorder (#12). Twelve respondents used a Likert scale from one to seven to show the goal to have been very true about the resource. The participants used a Likert scale of one to seven to the Evaluation Questionnaire: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true.

Table 4. Goal Number 4 – Impact of Bipolar Disorder

Question	Average	Respondents
12. The resource demonstrates the cognitive impact of bipolar disorder.	5.92	N = 12
10. The resource shows the emotional impact of bipolar disorder.	5.75	N = 12
11. The resource identifies the physical impact of bipolar disorder.	5.58	N = 12
Composite Score	5.75	N = 12

Likert Scale: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true

Question #12 rated highest of the three questions with an average of 5.92. Question #10 rated next with a 5.75. The lowest score of 5.58 was Question #11. This scoring places this goal closest to very true.

Qualitative responses suggest that Goal 4 might be less than very true. Four experts gave constructive criticism for Goal 4. The first expert requested that the medical definitions be used and then explained. This does not address the goal, but is asking for clarification on the actual definition of bipolar disorder. Respondent 3 states, “I really wanted to learn more about the inner experience of bipolar.”

Another expert felt the “gifts” of persons with bipolar were overlooked. This respondent also expressed concern over the use of the word “sin” in the context of mental health. These two opinions lend themselves more to Goals 2 and 3, the biblical and theological foundations. On the other hand, a respondent felt that more information was needed for “acting out” behaviors and the extent to which a person with uncontrolled bipolar disorder may go. Included in this, the expert asked for a deeper look at the emotional impact the “acting out” behaviors cause. This is the only statement that directly addressed Goal 4. The response demonstrates the understanding of how bipolar disorder impacts the lives of those who have bipolar disorder emotionally, physically, and cognitively. Goal 4 had to be addressed well enough for someone to respond with such a statement.

Goal Three: Theological Basis

Following next in prominence was goal three: The resource will outline the theological basis for a holistic approach to understanding mental health challenges and disorders. Overall the goal received a score of 5.55. Goal 3 was found to be between very true and moderately true based on three questions as follows: The resource outlines a theological framework for understanding mental

health concerns (#7). The resource provides a quality theological basis for holistic care (#8). The resource demonstrates the importance of developing a secure identity in Christ for mental health recovery (#9). The participants used a Likert scale of one to seven to the Evaluation Questionnaire: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true.

Table 5. Goal Number 3 – Theological Basis for Holistic Approach

Question	Average	Respondents
9. The resource demonstrates the importance of developing a secure identity in Christ for mental health recovery.	5.92	N = 11
7. The resource outlines a theological framework for understanding mental health concerns.	5.54	N = 11
8. The resource provides a quality theological basis for holistic care.	5.18	N = 12
Composite Score	5.55	N = 12

Likert Scale: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true

Item #9 had twelve respondents who gave item #9 a score of 5.92. Item #7 had eleven respondents who averaged a score of 5.54. Item #8 also only had eleven respondents who averaged a score of 5.18. This goal had the widest range of composite scores, from 5.92 to 5.18.

In the qualitative question concerning the weaknesses of the resource (#22 and #23), several participants made general statements about “wanting more,” “not going deep enough,” and concepts and connections being “not clear.”

One participant (#5) identified a specific strength stating, “Good valuable theological connection to sickness” in Question 22.

The lack of comments referring to Goal 3 in the qualitative questions coupled with the lower quantitative score clearly demonstrates why Goal 3 is ranked second to last. One expert called the theological basis as a “bold attempt” to integrate theology and the care of those with bipolar disorder. One expert appreciated the theological connection to sickness. Another acknowledges the issues for holistic care but not that a solution was provided. These two responses give evidence of a theological basis for mental health (#7) and a need for a holistic approach (#8). Both are not solid and need improvement. The identity of Christ is not mentioned at all (#8).

Goal Six: Spiritual Exercises

Second to last in prominence was: The resource will provide appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus. Goal 6 received a score of 5.53, in between very true and moderately true. This score was based on the following three quantitative questions: The resource provides appropriate spiritual exercises for people with bipolar disorder (#16). The spiritual exercises in the resource will assist the caregiver to position a care receiver to encounter Jesus (#17). The resource identifies characteristics for appropriate spiritual exercises (#18). The participants used a Likert scale of one to seven to the Evaluation Questionnaire: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true.

Table 6. Goal Number 6 – Spiritual Exercises

Question	Average	Respondents
16. The resource provides appropriate spiritual exercises for people with bipolar disorder.	5.58	N = 12
18. The resource identifies characteristics for appropriate spiritual exercises.	5.58	N = 12
17. The spiritual exercises in the resource will assist the caregiver to position a care receiver to encounter Jesus.	5.42	N = 12
Composite Score	5.53	N = 12

Likert Scale: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true

Item #16 and Item #18 both scored 5.58 while Item #17 received a score of 5.42. This goal was the most addressed goal in the qualitative questions. The comments are very specific in addressing the exercises and/or the format of the exercises. One expert suggested the resource appendix should be removed and appropriate documents be inserted with the relevant experiential. A critical note was made concerning an aspect of one of the experientials. A tapping technique was included in the Affirmation of Identity experiential (Appendix Two). An expert pointed out that this technique should be removed because of the high chance it might be a trigger for some participants, leading to them become unstable. The expert did state the experiential could still work as is without the tapping technique and the change has already been made.

Nine of the qualitative responses address Goal 6. The goal looked for appropriate spiritual exercises, assisting in positioning a care receiver, and characteristics of an appropriate resource. Two of them questioned the validity of

the spiritual exercises. The question was asked if experientials like this have been done before and proven to work.

A lack of understanding and framework for pastoral caregivers not familiar with spiritual exercises used in this resource is the second reason given for questioning the resource's value. It can be argued that this addresses Question 18: "The resource identifies characteristics for appropriate spiritual exercises". If the resource identified characteristics for appropriate spiritual exercises, then there would not be a question such as this.

Two responses addressed triggering potentials in the spiritual exercises. This addresses Question 16: "The resource provides appropriate spiritual exercises for people with bipolar disorder". This is what was anticipated when the open-ended questions were created. The experts were able to not only point out the potential triggers but also give reasons why and offer alternatives. This affirms that the spiritual exercises are clear enough for such feedback.

The remaining responses address the layout of the resource. This does not directly address Goal 6, but the more user-friendly the layout of the resource, the better equipped the pastoral caregivers are to position care receivers to encounter Jesus (#17).

Goal Two: Biblical Basis

The goal of least prominence was: The resource will outline the biblical basis for a holistic approach to understanding mental health challenges and disorders. Twelve respondents used a one to seven Likert scale for an average score of 5.42. This was based on the following three quantitative questions: The

resource outlines a biblical framework for understanding mental health concerns (#4). The resource provides a quality biblical basis for holistic care (#5). The resource affirms the role of scripture in mental health recovery (#6). The participants used a Likert scale of one to seven to the Evaluation Questionnaire: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true.

Table 7. Goal Number 2 – Biblical Basis

Question	Average	Respondents
4. The resource outlines a biblical framework for understanding mental health concerns.	5.42	N = 12
5. The resource provides a quality biblical basis for holistic care.	5.42	N = 12
6. The resource affirms the role of scripture in mental health recovery.	5.42	N = 12
Composite Score	5.42	N = 12

Likert Scale: 1) definitely not true, 2) mostly not true, 3) slightly not true, 4) unsure, 5) moderately true, 6) very true, and 7) definitely true

All three questions for this goal received a score of 5.42, moderately true. The participants made general statements in the qualitative questions about “wanting more,” “not going deep enough,” and concepts and connections being “not clear.”

Qualitative responses for Goal 2 are similar to Goal 3. Three responses were made in conjunction with the theological basis: “bold attempt,” underlying issues supporting the need for holistic approach, and the concerns about the use of the word “sin” while overlooking the “gifts” of people with bipolar disorder. The

exception is a respondent who found the biblical analysis for mental health and holistic support to be solid. Though Goal 3 rated 0.10 points higher than Goal 2, reflecting on the responses of the open-ended questions reveals that both are in need of improvement. Using both the quantitative and qualitative data, an action plan has been created to address the insights gained.

Qualitative Analysis

The twelve respondents were asked to respond to three open-ended questions. These questions were designed to elicit expert insight into the information presented in *Spiritual Companionship and Bipolar Disorder* based on their knowledge and experience with spiritual care and bipolar disorder, and also to gain feedback concerning the effectiveness of the spiritual exercises.

The respondents were asked to identify the strengths of the resource and elaborate on why these were strengths. Only eleven of the twelve respondents replied to this question. The second question asked about the weaknesses of the resource and why they were seen as such. Only ten of the twelve experts responded to this question. The last question asked the respondents how they would improve the resource. Again, only ten of the twelve experts responded.

The first question addressing the strengths of the resource had responses indicating the resource was practical, concrete, and a good baseline. Three participants referenced the thoroughness of information concerning bipolar disorder. Five comments were made about how clearly the resource demonstrated the pastoral caregiver as a gateway for those with bipolar disorder and the relevance of mental health issues in the church. Four experts said the

resource offers a holistic approach that is creative and interactive. Two respondents mentioned valuable theological connection to sickness. Another respondent said the resource displayed a good biblical analysis of mental health and holistic support. Four respondents found the resource furthering the conversation on how mental health issues can compromise or undermine the spiritual journey.

The second question asked the experts to consider the weaknesses of the resource. Six responses given were specific and critical, four responses were a one sentence reply, and two skipped the question altogether. Two mental health professionals recommended changes to two of the exercises with the concern of negative impact on a care receiver. Two respondents addressed the formatting of the spiritual exercises. One respondent requested more information about the extent of “acting out” that could be expected from a person with severe bipolar disorder.

Another respondent asked why the spiritual exercise such as those of Ignatius of Loyola or the mindfulness exercises of Thomas Keating were not included. Another respondent was concerned that the resource focused more on spiritual experientials then concrete information. This respondent pointed this weakness out in light of the necessity for establishing trust between a caregiver and care receiver. A respondent believed that this resource would require live training as the average pastor does not have any background in mental health issues or awareness. Another concern was for pastoral caregivers who did not

come from a faith tradition which use such experientials. Four of the respondents asked for better connections in pulling the resource together as a whole.

The third open-ended question asked how the resource can be improved. One mental health professional identified tapping as a potential trigger that could possibly make the care receiver unstable. The professional said the exercise could be done without the tapping. This same professional gave insight on how the various breathing exercises could be adjusted for the needs of the care receiver. Two respondents offered further resources to consider for my personal use in improving the resource and to add as further resources for caregivers. One responded and recommended to expand on the gifts people with bipolar disorder offer. This respondent struggled with the way sin was used in connotation to mental illness. Another respondent wanted more information on the extent of negative behaviors caregivers may encounter. This same expert asked for clarity on boundaries and more details on how to discern when a care receiver is ready to participate in experientials. Another respondent gave ways the resource could be better organized. The main focus was on the layout of the experiential instruction and tools needed for each exercise.

Based on the quantitative analysis of the twelve expert responses, I achieved my overall goal to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The average score of the twenty-one questions was 5.70. Based on a Likert scale of one to seven, there was an agreement among the experts that the resource

achieves the goals on a very true basis. Unfortunately, the outcome of the quantitative questions could be unreliable as the questions were not randomized.

Chapter Six will elaborate on the experts' specific feedback and how it relates to the quantitative results. As stated in Chapter Four, the criterion for the experts was not clearly understood due in part by not asking for more information concerning the experts' backgrounds in a desire to maintain anonymity. Reflecting on the outcomes will show the impact on improvements to be made to the resource and possibilities moving forward. A will reflection on my personal goals will also be included.

CHAPTER SIX

SUMMARY AND REFLECTION

The idea for this project came from my own story. I was serving in ministry in South Asia when I went into a manic episode but was not even aware of what was happening. My mania gave me the energy and determination to leave my house and accomplish goals. I also became angry and aggressive. I incurred a great deal of debt as the mania sent me on spending sprees. I spent over $2,000 on books during one manic episode that lasted about four days. I was aware that I was experiencing depression. Therefore, the mania was welcomed. Before my own experience, I had walked with people who suffer from mental health challenges and with their family members. Those experiences did not prepare me for my own intimate experience with the issues and struggles faced by those with mental health challenges and disorders.

As a person of faith, I was deeply hurt and dumbfounded by the response of the church. I was fortunate to be introduced to Mental Health Grace Alliance, a Christ-centered non-profit which provides support for those who struggle with mental health challenges and disorders and for their families, along with training and education for the church. This organization saw me, not my disorder. They were Christ in the flesh extending God's *hesed*. Mental Health Grace Alliance offered community and restored a sense of purpose in my life. My recovery was accomplished through a holistic program including one-on-one life coaching and support groups.

In my support group, I have heard similar stories of how the church was no longer a safe place but a place of pain. Often we are told to "just get over it" or

that we do not have enough faith. Some were even told they were demon possessed.

Understanding where God is in the midst of the chaos and trying to connect with him or others seems impossible. When people are in the depths of the battle, they cannot understand, nor have the ability, to see another perspective. They only know that the ones they have turned to cannot help them, but instead unintentionally may even hurt them.

My experience is that the church has every intention to help and not harm. When someone who has mental health difficulties seeks out the help of a pastoral caregiver, they are desperate. They do not understand what is happening, what they need, or what to do. They need someone to lead the way.

If a pastoral caregiver is not able to recognize what is happening or know what to do, then they offer either an empty cup or alternative solutions that unintentionally cause even more pain. It is critical for pastoral caregivers to be informed and to educate themselves on how to walk with someone who has mental health challenges or disorders, including bipolar disorder.

Throughout the previous chapters, I have presented the foundation for spiritual care for those with bipolar disorder and reported what contemporary authors are saying about it in relation to the church and experiencing God. Reflecting on the survey results presented in Chapter 5, Chapter 6 will address the project goals, how the information can be applied to ministry, my concerns for further study, and a reflection on my personal goals.

The purpose of this project was to create a resource that would better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The overall goal was to determine to what extent this resource better equipped pastoral caregivers to become spiritual companions for people with bipolar disorder. The overall results of this assessment indicated the resource better equips pastoral caregivers to be spiritual companions with bipolar disorder. The vast majority of the feedback indicated that the style and format were the resources' greatest weakness. A few respondents had specific feedback concerning content, including significant input into the spiritual exercises.

Project Goals

In reviewing the findings of this research, it must be noted that unfortunately, the outcome of the quantitative questions could be unreliable as the questions were not randomized. While the qualitative questions did not address the goals specifically, as noted in chapter five, some responses could be associated with the specific goals. Helpful information was gathered in the qualitative questions concerning the strengths, weakness, and how the resource can be improved. This feedback is invaluable in moving forward to make this resource more useful and accessible for pastoral caregivers.

The project goals were:

1. The resource will establish that pastoral caregivers are gateway people for those with bipolar disorder in receiving appropriate care.
2. The resource will outline the biblical basis for a holistic approach to understanding mental health challenges and disorders.
3. The resource will outline the theological basis for a holistic approach to understanding mental health challenges and disorders.

4. The resource will identify how bipolar disorder impacts the lives of those who have bipolar disorder.

5. The resource will explain how bipolar disorder can interfere with one's connection with God.

6. The resource will provide appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus.

7. The resource will give other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their spiritual journey.

On a seven point Likert scale, all the goals scored between 5 and 6. Respondents found all but one of the goals to be very true. Goal #1 with a 5.97 scored the highest, whereas the lowest was Goal #2 with 5.42. However, it is possible that had the questions been randomized, the scoring could have been altered.

Goal Number One
Pastoral Caregivers as Gateway People

The goal that scored the highest was: "The resource will establish that pastoral caregivers are gateway people for those with bipolar disorder in receiving appropriate care." The average score for the quantitative questions (5.97) was very true. The three questions were as follows: The resource establishes that pastoral caregivers are gateway people for those with bipolar disorder to receive appropriate care (#1). The resource models multi-disciplinary collaboration (#2). The resource provides a model for holistic care (#3). The extent to which the resource established pastoral caregivers as gateway people for those with bipolar disorder receiving appropriate care was found to be very true.

As Simpson's work notes as essential to understand (Simpson 2013, 99), the resource is clear about pastoral caregivers being gateway people. Upon reflection, questions 2 and 3 did not relate to the goal as specifically as they could have, yet provided information as to the resource's ability to model multi-disciplinary collaboration and holistic care. Still, the answer to question 1 clearly supports the premise of the goal. The qualitative comments suggested that the resource needs to go into more depth about what being a gateway person looks like in various contexts. This will need to include more background knowledge of mental health care models and bipolar disorder. A direct connection needs to be made between the model for holistic care and the application, pointing to a need to expand and bridge a gap between the content presented and the application.

Goal Number Five
Bipolar Disorder and Connection with God

The second highest goal was: "The resource will explain how bipolar disorder can interfere with one's connection with God." Overall, the goal received an average of 5.89 coming in as very true. The goal was measured by three quantitative statements as follows: The resource explains how bipolar disorder can interfere with one's connection with God (#13). The resource demonstrates how bipolar disorder can interfere with one's connection with the church community (#14). The resource shows how bipolar disorder can interfere with one engaging in spiritual exercises (#15). Based on a Likert scale of one to seven, the respondents found Goal 5 to be very true.

Once again, more detail would be helpful to strengthen this goal. Though the interference is clearly communicated, requests were made for a fuller picture

of the positive side of the goals as well as the negative side of disconnection. Adding anecdotes will strengthen this section by giving concrete contextual experiences. Offering how one with bipolar disorder connects with God, along with the interference bipolar disorder creates, brings a balanced pictured. When a person can see the comparison of how the connection is made versus not made, it clarifies the impact of bipolar disorder, as Kehoe's work of using creative and tactile to facilitate worship that did not require words but nurtured connection indicated (Kehoe 2009, 39).

Goal Number Seven
Further Resources

Goal 7 came in third with a score of 5.82. The goal stated: "The resource will give other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their spiritual journey." The goal was evaluated based on the following statements: The resource provides further resources to assist pastoral caregivers in being better spiritual companions to people with bipolar disorder (#19). The resource provides a variety of resources for pastoral caregivers (#20). The resources are readily accessible for those caring for persons with bipolar disorder (#21). The respondents found Goal 7 to be very true. Qualitative responses only mention Goal 7 once. The expert stated that the further resources were clearly presented.

In general, the additional resources are fairly comprehensive, which could be overwhelming. Instead of categorizing by subject or type of resource, the resources could be presented in reference to level of background knowledge. If a person does not have any background knowledge or experience, then a category

for beginners can be created versus a category for those who have a solid background and looking for more in-depth study. A summary of each resource and what it has to offer would also be beneficial. Overall, it appears as though Goal 7 received a lower rating because of accessibility, not thoroughness.

Goal Number Four
Impact of Bipolar Disorder

Next was Goal 4: “The resource will identify how bipolar disorder impacts the lives of those who have bipolar disorder.” The average for Goal 4 was 5.75. The three quantitative questions were: The resource shows the emotional impact of bipolar disorder (#10). The resource identifies the physical impact of bipolar disorder (#11). The resource demonstrates the cognitive impact of bipolar disorder (#12). The twelve respondents felt the goal to have been very true.

People with bipolar disorder are vulnerable in many ways like the widows Naomi, Ruth, and Orpah, as Saunders notes (Saunders 1998, 7). Often people with bipolar disorder are seen only for the unhealthy behaviors. Bipolar disorder can render a person unable to follow through with commitments or fulfill responsibilities because “behavioral or situational cues are misinterpreted or ignored” (Yarhouse, Butman, and McRay 2005, 157). Not understanding these cues can make it virtually impossible for one to make wise and informed decisions. This can lead to undesirable behaviors such as excessive spending, sexual promiscuity, substance abuse, or violence against self or others. Along with stigma and misconceptions, limited resources and bureaucracy, often prevent those with mental health challenges from getting proper care and support (Simpson 2013, 17).

Understanding the impact of bipolar disorder is key to understanding the interference in connection (Goal 5). Statements were made concerning the physical, emotional, and cognitive impact, but did not give details or examples. Once again, there is a need for more detail and less assumption of knowledge. Integrating Goals 4 and 5 by demonstrating how the physical, emotional, and cognitive impacts play into the interference with connection could strengthen this goal.

Goal Number Three
Theological Basis

Goal 3 came next: “The resource will outline the theological basis for a holistic approach to understanding mental health challenges and disorders. Overall the goal received an average mean of 5.55 from twelve experts. Goal 3 was found to be moderately to very true based on three questions as follows: The resource outlines a theological framework for understanding mental health concerns (#7). The resource provides a quality theological basis for holistic care (#8). The resource demonstrates the importance of developing a secure identity in Christ for mental health recovery (#9).

The theological basis did not score as well as the others due to the weaknesses of the previous goals. As mentioned before, the integration of the impact of bipolar disorder and the interference in connections would strengthen Goals 4 and 5. The impact and interferences of bipolar disorder highlight the theological basis for the resource, that of extending hope. Moltmann’s question echoes for all, but especially for those with mental health concerns: “Why has Christian theology allowed this theme of hope to escape it?” (Moltmann 2014,

177). Goal 4 specifies that all aspects of the person are impacted. And Goal 5 addresses how this holistic impact creates interferences with connection for people with bipolar disorder. The damage and pain impacts one's identity in Christ, the holistic self, and questions where God is in bipolar disorder. Moving forward, it may be helpful for the theological basis to include the concept of the imago Dei. Goal 4 and 5 demonstrate the damage and interference of bipolar disorder that hinders one from living out of the imago Dei, their identity in Christ. Goal 3 could be strengthened by an understanding of this concept.

Goal Number Six
Spiritual Exercises

Following in prominence was Goal 6: "The resource will provide appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus." Goal 6 received an average mean of 5.53. This score was based on the following statements: The resource provides appropriate spiritual exercises for people with bipolar disorder (#16). The spiritual exercises in the resource will assist the caregiver to position a care receiver to encounter Jesus (#17). The resource identifies characteristics for appropriate spiritual exercises (#18). Overall the respondents found the goal to be between moderately and very true.

The exercises were acceptable overall, appropriate for mental health clients as Greene-McCreight suggests (Greene-McCreight 2006, 138). According to some of the respondents, the formatting and presentation caused confusion. Restructuring the format to be more user-friendly is a must going forward with the resource. The style of the spiritual exercises is challenging. As a respondent

pointed out, the experiential dynamic can be uncomfortable for people who have not encountered such exercises. Going forward, a change in the style can be made to be more accessible for people of various backgrounds. The exercises came to be by merging elements from Mental Health Grace Alliance, personal counseling, and Formational Healing Prayer. Putting less emphasis on the formational healing prayer, or at least offering an alternative, would make the experientials more user-friendly.

Goal Number Two
Biblical Basis

The last goal was: “The resource will outline the biblical basis for a holistic approach to understanding mental health challenges and disorders.” The average score for Goal 2 was 5.42, based on the following statements: The resource outlines a biblical framework for understanding mental health concerns (#4). The resource provides a quality biblical basis for holistic care (#5). The resource affirms the role of scripture in mental health recovery (#6). The respondents found this goal to be moderately true.

In the resource, the role of Scripture is only seen as applied in the spiritual exercises. The biblical basis for holistic care is interlinked and relies on the theological basis. Actual passages from the Bible might give more credibility to reaching Goal 2. Matthew Stanford does this in his books *Grace for the Afflicted* and *The Biology of Sin* (Stanford 2008, Stanford, 2010). Using his examples as a model, an effective and clear biblical framework, the basis for holistic care, and an affirmation of the use of Scripture will be communicated. This will strengthen Goal 2 and also Goal 3, thus improving all the other goals.

Application

In my current ministry setting, there are three major applications that I want to pursue. The first is that I would like to use the responses to the open-ended questions and to the thematic questions to edit the material for publication. The assessment tool identified the greatest weakness as being that of style and format, suggesting that I will need an editor who is familiar with the topic to assist in a final shaping of the workbook. That editing will include changing the language to be more gender inclusive.

I will also make some changes in the spiritual exercises, removing the tapping from the identified exercises. I wrote “Earth, Air, Wind, Fire” as elements of grounding. It should read “Earth, Wind, Water, and Fire.” I will also consider creating worksheets for each exercise. I want to reformat the presentation of the spiritual exercises using the respondents’ suggestions concerning more scripting, bringing the activity sheets from the appendix and integrating them into the actual exercise.

The second major area of practical application for me is to determine how this work will assist me in being a better spiritual companion to others. Since this comes from a pastoral caregiver who has been on both sides, I believe my personal experience can strengthen my care of others.

A third possibility for me is to develop training modules that can be presented to clergy and other pastoral care workers, such as Stephen Ministers and others who walk alongside those with mental health concerns. Depending on a pastoral caregiver’s background, they may need training at various levels,

especially if the spiritual exercises are unfamiliar within their denominational traditions. This could be one-on-one training, internet-based training, or group training within the church or a community mental health center.

As for how this work can be applied in the church, I can see the handbook being used by pastoral caregivers who can commit to a long-term spiritual companionship with someone with bipolar disorder. With some adjustment, the materials could be used to raise awareness in a Sunday School class, a small group, or a seminar setting.

Further Study

Moving forward, I would like to reconstruct the resource with the recommendations given and improve the goals stated in the reflection. I would want to have a selected group of professionals to evaluate again. After the second evaluation, I would do a trial with a select group of pastoral caregivers including training, implementation, and debriefing.

Upon the success of this project, I would like to consider continuing with a series addressing major mental health disorders such as the following:

- Anxiety Disorders. (PTSD/GAD/Panic Disorder/ Social/Phobias) – PTSD separate
- OCD
- Bipolar Disorder
- Depressive Disorders
- Schizophrenia and Psychotic Disorders.
- Dissociative Disorders (DID)
- Eating disorders. (Anorexia/Bulimia/Binge)

As for others, I recommend researching what individual faith traditions are doing in the area of mental health. I encourage the investigation of the types of spiritual exercises for self and for care receivers in general. An additional topic

for research would be how the theologies of liberation can inform the treatment of mental health disorders for people of color.

More than anything, one must begin to reach out and connect with those working with people with bipolar disorder such as local psychiatrists, psychologists, and local behavioral health centers. A good place to start is attending a NAMI class. Begin the conversation about mental health with other ministers and in your congregation.

Personal Goals

As a doctoral student, I have had many demands on my life, and it has been a challenge to maintain margin. In preparation for the work on my dissertation, I created a life management plan to complete this process. The plan was based on Calvin Miller's concept (Miller, 2001) of our inward, upward, and outward journeys while maintaining margin emotionally, physically, financially, spiritually, and time-wise. My personal goals for this project were then derived from my life management plan.

My inward journey included the ongoing development of myself as a differentiated leader. A differentiated leader is secure in his or her identity in Christ, has a clear vision, understands vocation, is committed to a core set of values, is connected to the community, and demonstrates healthy boundaries. I outlined what these characteristics mean to me in a paper completed for one of my courses.

My inward journey also involved managing my emotional and mental health. To this end, I planned to continue to meet with my counselor on a weekly basis, take my medication, attend support groups, and see my psychiatrist as

needed. My physical health impacts my emotional and mental health; therefore, I planned on focusing on eating healthier and exercising. As a part of my life plan for my Ark community, I worked with the case manager on how best to live within a budget and on how to make wise financial decisions.

For my upward journey, I planned to engage Scripture through non-study methods to experience God's Word in my life. I also planned to engage in spiritual exercises and other forms of prayer to establish the discipline of prayer in my life. I planned to continue to meet with my spiritual director as well as my Ark accountability partner.

As far as my outward journey is concerned, I wanted to address my wounds related to the Church to position myself to be reconnected with the local church.

To this end, my personal goals for this project were:

1. Continue self-care plan to stay on the path of recovery.
2. Continue to develop as a differentiated leader as defined in my paper.
3. Address my wounds related to the Church to position me to be reconnected with the local church.

Goal Number One
Self-Care Plan to Recovery

The purpose of this goal was to continue my self-care plan to stay on the path of recovery. This included my inward, outward, and upward journey while respecting my margins.

When I created my self-care plan, I had not intended to move twice. When I moved from Waco to San Antonio, I was able to continue counseling but not weekly. Since moving to Corpus Christi, I have seen my counselor as needed. I

was able to search out and find a psychiatrist before my moves so that there would not be any interruptions. My medication has been well maintained.

I was not able to attend my usual mental health support group while in San Antonio or now in Corpus Christi. I was able to continue my eating disorder support group in San Antonio. I have not attended any support groups since moving to Corpus Christi. It has impacted my eating disorder significantly as I used food to cope with my mom's journey through cancer and eventual death.

While in San Antonio, I received multiple new diagnoses and added more specialists to my list of doctors as well as more medications. I was able to establish new patient appointments with new doctors in Corpus Christi, so there was not any interruption of care. During the time of new health diagnosis, I began slipping back into my destructive food disorder habits. I have been on a roller-coaster ever since. The financial counseling and advice I sought in Waco helped me establish a plan to pay off my debt. It is working and continues to work.

Goal Number Two
Differentiated Leader

The purpose of this goal was to continue to develop as a differentiated leader as defined in a paper written during my course work. A differentiated leader is secure in his or her identity in Christ, has a clear vision, understands vocation, is committed to a core set of values, is connected to the community, and demonstrates healthy boundaries.

In my paper on differentiated leadership, I defined my identity in Christ as knowing and experiencing that I am loved, chosen, and empowered by God. A differentiated leader understands that others, life circumstances, who she thinks

she should be, fears, even gifts and talents are not who she is. In fact, a differentiated leader embraces the fact that nothing external or internal defines her. Her vitality is rooted in a secure identity in Christ. The differentiated leader's true-self is found in Christ and God's vision for her.

I have made significant progress in this area. I moved to San Antonio to do my Clinical Pastoral Education (CPE) residency. CPE took me on a journey that led to me being able to embrace who I am in Christ. Being confident in God's love for me has allowed me to face rejection without diminishing my self-worth. Knowing I am chosen by God has empowered me to take risks without fear of failure. In the end, I was able to bring my whole self into the interview process for a staff chaplain position. I was able to identify and join a church that had space for me at the table and did not desire for me to conform to a mold.

In the paper on being a differentiated leader, I defined my vision in this statement:

> As a minister of the Gospel, I am called to serve the global Church. My passion is to walk with people on their journey of faith providing pastoral care as we discern our God-given identity, vision, and purpose in the Kingdom of God. My gift of teaching will allow me to help others through discipleship and spiritual formation. My desire is to provide leadership development in hopes of a "spontaneous expansion of the indigenous church."

My life journey transformed me and prepared me to live out my vision. My vision provides real and possible answers to unique situations. Vision provides me with direction and empowerment, along with facilitating the process. Because my identity is secure in Christ, my vision will inspire, empower, and be a catalyst for personal growth and development. It will require being intentional and committed

to self-care in all areas of my life. Vision gives the means to articulate my ministry. It is a key component of my life narrative.

As my journey continues, moving away from India and into chaplaincy, my vision has changed to meet the new unique situations and provide real and possible answers. I know that my new and changing vision is on point because it aligns with my vocation. Being able to be open to my vision being changed demonstrates how I have become more differentiated. Previously, my vision is what I held onto as the permanent defining piece of my life and personhood. Now I understand that my vision can change but will always be within the realm of my vocation.

As a differentiated leader, I defined my vocation as the “voice within,” calling me to be the person I was born to be, to fulfill the original selfhood given me at birth by God. Vocation is the narrator of my life story. God may give me various visions for different seasons of my life. He does have an ongoing vision for who he is transforming me to be and this is the fruit of my vocation. My vocation is God calling me to himself and finding my place in the grand narrative. Nothing can prevent me from engaging in my vocation except for myself.

My understanding of my vocation, of my purpose of existence, has become louder as I have become more differentiated. Marianne Williamson stated, “Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness that most frightens us. We ask ourselves, who am I to be brilliant, gorgeous, talented, and fabulous?” William continues by questioning, “Actually, who are we not to be?”

(Williamson 1992, 190-191). Her answer simply states that as a child of God, we are created to be shiny and brilliant and display our fabulous God-given talents. God is transforming me to reflect his glory. When I allow myself to be fully me, then I permit others to do the same.

As part of being a differentiated leader, I defined my values as non-negotiables. My non-negotiables include Sabbath, inclusivity, communion, Spirit-filled, Christocentric, and margin (space to allow healthy rest and growth in all areas of my life). These still have not changed, and I have been able to keep them central to my decision-making process.

I envision a tree. The roots are our identity which gives us life and vitality. The trunk is our vocation which is the source of our voice. The branches are our vision bursting forth in victory allowing us to climb. The fruit and greenery are the beauty of being connected. Boundaries are the care and pruning that must be in place to maintain the health of the tree. This is what I need to cultivate to be a differentiated leader.

My roots are strong and have grown deeper through this process. My trunk has gained circumference and becomes more solid. My branches continue to grow, and new branches have sprouted. The greenery comes easy and is lush and full. The fruit has not yet blossomed in this season. It will in due time as it has in past seasons. I continue to care for the tree, adjusting to its needs in different seasons.

Goal Number Three
Reconnecting with the Church

The purpose of this goal was to address my wounds related to the Church to position myself to be reconnected with the local church. I have made the journey from being a Southern Baptist to Cooperative Baptist to non-denominational to Vineyard, and have planted myself in the United Church of Christ. Throughout the journey, I was looking for a place to belong. I was not a differentiated person. I was looking for the church to define who I was in Christ, what my vision and vocation should be, what community looked like and meant, and to define my values. As I began to heal and become more differentiated as a person, the journey changed focus to being about me embracing who I am and in what community can I be my full differentiated self while making space for others. Being more differentiated allowed me to be reconnected to the local church. My wounds were based on my identity being in the church and not Christ.

Concluding Thoughts

I entered the Doctor of Ministry program more for myself than for academic purposes. I needed answers. I never intended to write a resource, but was encouraged by a few of my professors to do so. What I discovered is that I needed the resource I created. Since it is the project least recommended, I took the challenge, unsure if I would be able to finish. I am one who can see the big picture but gets frustrated with the details. Writing this resource helped me take a vision and walk it through to fruition. I have never thought I was a good writer. Now I know I am a good writer. Knowing that I can be detail focused and follow

through to completion opens up possibilities for my future. Being confident in my writing allows me to know I can make this resource into a series.

My findings from the assessment encourage me that this is a much-needed resource and people would benefit from it. My respondents pointed out that content and style was the greatest need for improvement. Respondents stated a firm foundation was established. They suggested expounding on various core concepts such as the pastoral caregiver's role, further details about bipolar disorder with examples, and making the experientials more user-friendly for people of various denominational backgrounds. Some respondents felt the sections on history and biblical and theological foundations were not necessary. Any pertinent information in these sections could easily be incorporated into the other sections. There is a future for publication for this resource.

The process validates a caregiver's need for the resource, which will provide caregivers with a tool that will allow them to be better spiritual companions to people with bipolar disorder. This resource will keep others from experiencing the pain I went through due to the ignorance of the church. I am inspired to improve the resource and publish it. I also hope to create further resources. *Spiritual Companionship and Bipolar Disorder* equips us to embody the *hesed* of God and be a conduit connecting those who suffer from bipolar disorder with the ultimate *go'el,* Jesus Christ.

APPENDIX 1

PROJECT PROPOSAL

ASHLAND THEOLOGICAL SEMINARY

SPIRITUAL COMPANIONS FOR THOSE WITH BIPOLAR DISORDER

A PAPER SUBMITTED TO
THE FACULTY OF ASHLAND THEOLOGICAL SEMINARY
ASHLAND THEOLOGICAL SEMINARY
IN CANDIDACY FOR THE DEGREE OF DOCTOR OF MINISTRY

BY
CHRISTY JEAN WOOD

ASHLAND, OHIO
APRIL 12, 2014

Purpose Statement

The purpose of this project is to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. To what extent does this resource better equip pastoral caregivers to become spiritual companions for people with bipolar disorder?

Overview

The focus of this project is to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The project intends to answer the question to what extent does this resource better equip pastoral caregivers to become spiritual companions for people with bipolar disorder.

The specific focus of this project is to establish that pastoral caregivers are gateway persons for those with bipolar disorder in receiving appropriate care. The resource will outline the biblical and theological basis for a holistic approach to understanding mental health challenges and disorders. It will explain how bipolar disorder can interfere with one's connection with God and provide appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus. The resource will give other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their spiritual journey.

The resource will be evaluated by people with experience in working with people with bipolar disorder and who have an understanding of the disorder. The evaluators include psychiatrists, psychologists, counselors, social workers, and

support group leaders. This group of people will assess if the resource accomplishes the goals. Each person will review the resource and complete an evaluation eliciting qualitative and quantitative questions related to the specified goals.

Foundations

God sees his children and lavishes his *hesed* upon them. Translated into English as “loving-kindness,” hesed refers to the acts of benevolence that one does out of kindness, not out of obligation (Eskenazi and Frymer-Kensky 2011, 58). *Hesed* is more than a feeling, but an action demonstrated in a covenant relationship and includes justice, mercy, compassion, and forgiveness (Eskenazi and Frymer-Kensky 2011, 59). God desires to restore the covenant relationship that has been broken by sin. One way he does this is through the body of Christ. Pastoral caregivers are frontline people who are sought out when someone is in crisis. It is critical that the pastoral caregiver be prepared to be present, attuned, and empathetic. Care receivers need to be positioned so that they know God sees them in their distress and experience his *hesed* poured out upon them restoring life and relationships.

Personal Foundations

As a friend and pastoral caregiver, I have walked with people who suffer from mental health challenges and with their family members. However, it was not until I experienced mental health challenges that I became intimately aware of the issues and struggles those with mental health challenges and disorders face.

As a person of faith, I was deeply hurt and dumbfounded by the response of the church. I was fortunate to be introduced to Mental Health Grace Alliance, a Christ-centered nonprofit which provides support for those who struggle with mental health challenges and disorders and for their families, along with training and education for the church. This organization saw me, not my disorder. They were Christ in the flesh extending God's *hesed*. Mental Health Grace Alliance offered community and restored a sense of purpose in my life. This was accomplished through a holistic program including one-on-one consultation and support groups.

In my support group, I have heard similar stories of how the church was no longer a safe place but a place of pain. Often we are told to "just get over it" or that we do not have enough faith. Some have even been told they were demon possessed.

One cannot pull up their bootstraps when they are paralyzed by a disease. Understanding where God is in the midst of the chaos and trying to connect with him or others seems impossible. When one is in the depths of the battle, they cannot understand nor have the ability to see another perspective. They only know that the ones they have turned to cannot help them, but instead unintentionally may even hurt them.

My experience is that the church has every intention to help and not harm. When someone who has mental health difficulties seeks out the help of a pastoral caregiver, they are desperate. They do not understand what is happening, what they need, or what to do. They need someone to lead the way.

If a pastoral caregiver is not able to recognize what is happening or know what to do, then they offer either an empty cup or alternative solutions that unintentionally cause even more pain. It is critical for pastoral caregivers to be informed and to educate themselves on how to walk with someone who has mental health challenges or disorder including bipolar disorder.

Biblical Foundations

A biblical story that shows God's *hesed* in the midst of suffering is the book of Ruth. Ruth's fidelity to Naomi demonstrates God's *hesed*. Throughout the story, though not mentioned directly, God shows up and works in ways that seem mundane yet which bring what is needed at the right time. The Lord sees Ruth and Naomi, he sees their situation, and he is present to them in their circumstances. In the end, the intimate act of the kinsman redeemer demonstrates God's desire to restore the relationship.

Ruth as one who demonstrates the character of God is quite unorthodox. Ruth was a Moabite, a descendant of the incestuous daughters of Lot (Genesis 19). "For centuries the Israelites had reviled this people as degenerate and, particularly, regarded Moabite women as agents of impurity and evil" (Donaldson 1999, 133). Ruth carried a stigma placed on her by society much like people with bipolar disorder.

The death of Naomi's husband and two sons leaves her and her two daughters-in-law in a vulnerable position because a women's identity was determined by male relatives (Saunders 1998, 7). The women did not have the covering, protection, or provision of a male figure which left them without any

rights or inheritance (Saunders 1998, 7). Naomi was a foreigner and did not have the provision of the Jewish custom and laws, which cares for widows (Saunders 1998, 7). The only hope for the daughters-in-law was to return to their fathers' homes to marry again and bear children. People with bipolar disorder are vulnerable in many ways like these widows. Whereas Jewish custom and laws provided for widows (Saunders 1998, 7), often limited resources, bureaucracy, stigma, and misconceptions prevent those with mental health challenges from getting proper care and support (Simpson 2013, 17).

Naomi heard "that the LORD had come to the aid of his people (in Israel) by providing food for them" (Ruth 1:6). Naomi prepared to return home. As faithful daughters-in-law, they showed respect to their mother-in-law in setting out to return with her, but they must have known that they would not be accepted in Bethlehem (Sakenfeld 1999, 31). This is when the story truly begins to unfold and reveal how God encounters His children whether rich or poor, Jew or Gentile, male or female, struggling with bipolar disorder or walking with someone with bipolar disorder.

As the women set out, Naomi released them to return to their families for there they will have a chance to remarry or at least have the covering of their family. After resisting, Orpah returned home, but Ruth was persistent and refused to turn back. One must ponder her motive. Was it out of loyalty to Naomi? Could it be that Ruth has witnessed something in the lives of her in-laws which compels her to seek out the truth? Regardless of her motives, Ruth most

likely knew the difficulties which lied ahead of her due to cultural differences (Sakenfeld 1999, 31). Ruth makes a powerful statement,

> But Ruth replied, “Don’t urge me to leave you or to turn back from you. Where you go, I will go, and where you stay, I will stay. Your people will be my people and your God my God. Where you die I will die, and there I will be buried. May the LORD deal with me, be it ever so severely if even death separates you and me.” When Naomi realized that Ruth was determined to go with her, she stopped urging her. (Ruth 1:16-18)

Ruth is risking her chances of marriage by leaving her culture and entering into a culture known to be unaccepting of Moabites. As one who has lived as a foreigner in another land, one may take on outward and some inward expressions of a different culture, but one will always be an outsider. Being a Moabite, Ruth faced the possibility of never being included in Naomi’s community (Sakenfeld 1999, 32).

People with mental health challenges and disorders, like bipolar disorder, often feel their illness stands as a barrier preventing them from becoming integrated into the church. Ruth personifies what it takes to walk with someone with bipolar disorder. One must consider what is involved in riding the roller coaster of bipolar disorder. It has steep climbs and sudden drops. It can plunge into darkness and emerge into chaos. It is a ride that never ends. Ruth most likely understood the cost and committed to staying with Naomi despite the obstacles she would face. Ruth knew Naomi needed a companion to survive just as those with bipolar disorder cannot thrive again without a companion by their side.

An aspect of God’s character is revealed through Ruth’s pledge of faithfulness to Naomi. God honors his promises such as the Abrahamic and

Mosaic Covenants. Faithfulness to a covenant relationship is the heart of *hesed* which is an act of pure grace. Robert Hubbard speaks about a "lifestyle of *hesed*" (Hubbard 1988, 73). Hubbard is referring to one who embodies and lives out the faithful covenant with another showing justice, mercy, compassion and forgiveness and loving-kindness without expecting anything in return (Hubbard 1988, 73). Caregivers are called to a lifestyle of *hesed* when they become spiritual companions to those with bipolar disorder. A spiritual companion is a conduit for someone to experience God's *hesed* as they walk alongside them in the midst of their life situation.

The *hesed* Ruth demonstrated to Naomi is returned to her through Boaz. After the recognition of the relationship between Ruth and Boaz, the process of redemption takes place. Boaz uses the law to restore life not only to Ruth but also for Naomi by providing an heir who would become part of the lineage of Christ.

A spiritual companion can position someone to experience God as the kinsman redeemer. John Wilch says the story of Ruth "has the power as a theological vehicle to point its readers in unexpected directions, even transforming them" (Wilch 2006, 2). The book of Ruth demonstrates how God works through people (Wilch 2006, 53). Ruth, Naomi, and Boaz worked within their circumstances to take advantage of the opportunities God gave them to experience him (Wilch 2006, 35). Pastoral caregivers can help those with bipolar disorder experience God in the midst of their daily struggle to establish a new normal.

This idea of God meeting his people in the mundane of every day and lavishing his *hesed* upon them is carried over into the New Testament. Jesus lived a "lifestyle of *hesed*" (Hubbard 1988, 73). We see this in the story of the woman who anoints Jesus' feet with her tears and perfumed ointment (Luke 36-50). As with Ruth, this woman is an outsider. She is not welcomed into the house of a Pharisee where Jesus has been invited to dinner.

Many focus on the parable that Jesus tells the Pharisees, but it is the dialogue after the parable which demonstrates who pastoral caregivers are to those with bipolar disorder. Jesus asks the Pharisees a poignant question, "Do you see this woman?" For God is *El Roi*, the one who sees (Genesis 16:13) his daughter, not the sinner or mental health disorder, but the child he created who has been broken and wounded. As David Garland paraphrases the question, "Do you not recognize that this woman's behavior is a sign of the one who has been forgiven many debts and is showing enormous love and gratitude?" (Garland 2011, 330). This is who pastoral caregivers must see when they look into the eyes of those with bipolar disorder.

Jesus continues with a comparison of the Pharisee and the woman. While judging the woman who is unclean and unacceptable, the Pharisee is sure of his piety and purity. Jesus rebukes Simon, the Pharisee. Antoine Nachef states, "Jesus attacked not the life and actions of Simon, but his convictions and his relating to others" (Nachef 2004, 83). Jesus is forcing the Pharisee to evaluate how he sees the woman and the prejudices of his worldview (Nachef 2004, 85). Joel Green sees it as "an invitation to enlightenment, the consequence of which

would be acceptance of both her (i.e., no longer- viewing her as a 'sinner' but as one who loves extravagantly) and of new behaviors modeled on those of this woman" (Green 1997, 312). As Green continues to point out, the woman's actions were far beyond what was even expected of Simon (Green 1997, 313).

The woman came with her sins already forgiven; therefore, her actions are prompted out of gratitude and love (Getty-Sullivan 2001, 105). Saunders suggests that she understood her relationship with her Savior and acted in accordance to it (Saunders 1998, 45-51). This unknown woman lavished her love on Jesus because of His great love, which flows from the Lord's deep *hesed.* Jesus expressed *hesed* to the woman, reminding her, "Your sins are forgiven" (Luke 7:48). "Your faith has saved you; go in peace" (Luke 7:50). In this act, Jesus affirms her identity as one who is forgiven and has new life restoring her place in the community (Green 1997, 314).

The relationship between Jesus and the woman challenge how we form our view of our relationship with ourselves, God and others and how we navigate through these relationships when we are in crisis (Nachef 2004, 85). In her chaos, the woman went to Jesus. People with bipolar disorder need a spiritual companion to walk with them through the chaos to a place of rest. Nachef says, "Encountering the Lord fulfilled the longings of her anxious heart" (Nachef 2004, 85). As a spiritual companion, a pastoral caregiver has the ability to position a care receiver to encounter the Lord in such a way.

Theological Foundations

The transforming power in these two biblical stories and throughout the Bible is God. Theology is the overarching word we give for speaking about God.

Every doctrine comes from the Doctrine of God (Erickson 1998, 13). Millard Erickson states, “The doctrine of God, is in many ways, the first and most basic element of Christian belief” (Erickson 1998, 13). Just as God is the genesis of life, he is also the beginning of theology. Erickson continues by acknowledging that revelation cannot even exist without God since it is the revelation of God and by God (Erickson 1998, 14).

Talking about God comes from the unanswered questions of the Biblical narrative (Kärkkäinen 2004, 9). From the various writings of the Scripture, how are we to understand and know who God is? Thus begins the doctrine of God. The doctrine of God does not start in the New Testament but in the beginning when He created humanity who could reflect and contemplate on their Creator (Erickson 1998, 14). Kärkkäinen reminds us that we must hold the tension that “God is the theme of the Old Testament” while acknowledging that “no doctrine of God per se is found in the Bible” (Kärkkäinen 2004, 16).

We know people through the demonstration of their character. This is true also with God. To know God’s unchanging character, we turn to the Scripture, but we also rely on our experience. Stevens identifies *hesed* as an essential characteristic of God that expresses “the depth of God’s passion for God’s people” (Stevens 2010, 152). She describes three aspects of *hesed*. The first is what is usually expressed in English as loving-kindness, mercy, faithful love, and favor (Stevens 2010, 152-153). These emotions are directed from God to his children. The second aspect is a covenant relationship. This relationship is one of loyalty, constancy, and everlasting love (Stevens 2010, 154). The last aspect

is God's faithful and good deeds. In summary, *hesed* is a word that grows out of the committed covenant relationship that demonstrates favor toward the partner (Stevens 2010, 154).

The characteristic of *hesed* is critical for a person with bipolar disorder to experience during their recovery. Often those who suffer from mental health challenges and difficulties feel the opposite of God. They feel abandoned, punished, and unworthy. It is *hesed* demonstrated through a pastoral caregiver that can help a person with bipolar disorder know that God's *hesed* has not left them.

"In Hebraic religion, God is known by what God does. What God does is remembered and recollected as history---the history of God's encounter with humanity. In these encounters, God is remembered as having a definable, discernible character by those whom God has met" (Odem 1987, 40). Names have great importance in the Jewish culture (Odem 1987, 40). Throughout the Old Testament God is called by various names identifying his multi-faceted being (Odem 1987, 40).

The first name used for God is *Elohim*, most commonly translated as Lord. The name *Elohim* conveys a creator in which the creation can relate (Kärkkäinen 2004, 19). In its plural form, *Elohim*, "is an intensive plural suggesting that this God embodies all the deity there is" (Kärkkäinen 2004, 19). The common word for god, *El*, is used for a god among many and commonly used to express the characteristics of the God and how he relates to his creation (Kärkkäinen 2004, 19).

As God personally encountered his people, a new aspect or attribute was revealed forming a foundation for the Doctrine of God. After Hagar fled from Sarai, she refers to God as El Roi, “the God that sees me,” for he demonstrated his personal attention to her situation (Genesis 16:12-13). When a pastoral caregiver can look a person suffering from bipolar disorder in the eye and see them and not the disorder, the person knows they are seen by God at that moment.

It is God that makes things right and provides for his people. He is our kinsman redeemer. When his children suffer, he is the one who does what is necessary to make sure we are not denied our rights as children of God. Redemption is an act prompted by relationship. “To be a person is to be made in the image of God: that is the heart of the matter. If God is a communion of persons inseparably related, then…it is in our relatedness to others that our being human consists” (Gunton 1991, 116). Being a spiritual companion to someone with bipolar disorder is an act of redemption. It is the first step to grafting the person back into the community. In the case of a pastoral caregiver, that community is the church, the Body of Christ. It is in the community and through relationships that we experience God’s *hesed* and know that he is *El Roi*, the one who sees us and our situation.

Historical Foundations

Since its beginning, the church has shown concern and given care to the sick including those with mental health challenges and disorders. Rodney Stark makes this case in *The Rise of Christianity*. Christians, driven by the ethos of

"*love one another"* and grounded in the belief that "God loves humanity," had "superior survival rates" due to their care for one another (Stark 1996, 86 & 90).

This care continued in the monastic movement. In the *City of God*, Augustine demonstrates empathy for the state of those with mental health challenges,

> Crazy people say and do many incongruous things, things for the most part alien to their intentions and their characters, certainly contrary to their good intentions and characters; and when we think about their words and actions, or see them with our eyes, we can scarcely — or possibly we cannot at all — restrain our tears, if we consider their situation as it deserves to be considered. (Augustine)

This sense of compassion eventually began to be lost. During the Middle Ages, there was a deadly shift in the view of those with mental health illnesses, particularly during the Inquisition (O'Connell 2001). During this time, the popular view of the church was that mental illness was caused by demon possession which led to widespread persecution, including burning and torturing those with mental health issues (Simpson 2013, 137). Not all was lost. "The church did not abandon the mentally ill. The Rule of St. Benedict prescribed that the care of the sick is to be placed above and before every duty. In the Middle Ages, the mentally ill were cared for in monasteries along with the physically ill" (O'Connell 2001).

The church opened the first psychiatric hospital in London in 1247 (Simpson 2013, 137). Unfortunately, it was handed over to the city and became the infamous Bedlam Hospital, which charged tourist to come to watch patients for entertainment (Simpson 2013, 137). The treatment of the mentally ill began to turn in a progressive direction when church leaders such as John Calvin and

Martin Luther began to share their own struggles with mental health, and this view began to subside (Simpson 2013, 137).

With the Enlightenment “moral treatment” was introduced. This was initiated by Christian physician Philippe Pinel when he boldly unchained those imprisoned in a mental health facility in Paris in 1794 (O'Connell 2001). Pinel would not allow restraints, punishment, or other forms of harm. “Moral treatment” consisted of treating a patient with dignity, respect, and not inflicting harm (Simpson 2013, 137).

Quaker, William Tuke was prompted to action after the death of a friend in an asylum:

> In the year 1791, a lady, a member of the Society of Friends, was placed in the old York Asylum. Her friends, who resided at a distance, requested some of their acquaintance living in the city to pay her a visit. They accordingly went to the Asylum for this purpose, but their request was refused. (Bewley 2008, 1)

Tuke founded a private mental hospital called the Retreat at York. The Retreat was a model which supported and advanced the development of moral treatment. Tuke’s great-grandson, Daniel Hack Tuke, records the history of The Retreat at York and its unique characteristics. The Retreat could accommodate about thirty residents and included pastures for cows, a community garden, and sufficient space for exercise (Tuke 1855, 507-512). The name alone “intended to convey the idea of what such an institution should be, namely a place in which the unhappy might obtain a refuge; a quiet haven in which the shattered bark might find the means of reparation, or of safety” (Tuke 1855, 507-512).

Tuke’s work had a lasting and far-reaching impact on the care of those with mental health challenges and disorders. The Retreat model was brought to

Colonial America by the Friends Society. It was the Quakers who opened the Friends Hospital in Pennsylvania, which who also cared for those with mental health challenges. In general, there was not any plan for chronic care, only episodic.

In the wake of World War II, the Mennonite faith community found itself putting its faith into practice by choosing Civilian Public Service (CPS) rather than engaging in war. Becoming “disturbed with the de-personalization and frequent mistreatment of patients” in mental hospitals, Mennonite CPS workers “began discussing the possibility of developing several Mennonite-sponsored, small mental hospitals focusing on a ‘homelike atmosphere’ and ‘Christian care’” (Bender 2011, 45). Their faith-centered approach made a recognizable difference. First Lady Eleanor Roosevelt reflected on her encounter with a group of CPS workers at the Marboro, New Jersey State Hospital in 1943, “They are a very fine group of young men, and bring a spiritual quality to their religion. In many ways, this is probably raising the standard of care given the patients” (Stoltzfus, 1943, 900).

The Mennonite CPS workers collaborated with other groups such as the Mental Hygiene Movement of CPS and were influenced by and contributed to the Mental Health Act of l946. Their engagement continued into the 1950’s with the therapeutic community movement and the Community Mental Health Centers movement in the 1960’s. This resulted in the creation of the Mennonite Central Committee (MCC), the Mennonite Mental Health Services (MMHS), and the creation of six Mennonite mental hospitals and centers (Bender 2011, 46).

Mennonite CPS workers were asked to join the National Mental Health Foundation (NMHF), formerly the Mental Hygiene of CPS, which prepared legal briefs on state mental health laws, developed a model for mental health law, and published educational materials, including a series of eight dramatizations (Keeney, 1971).

Brook Lane was the first Mennonite mental hospital (Bender 2011, 50). The intent was to combine “the best of Mennonite culture, and competent psychiatric leadership would team up to be a creative force in the mental health field” (Bender 2011, 50). Brook Lane was the beginning of the Mennonite mental health care movement (Bender 2011, 50).

This led to the concept of “therapeutic community.” Ebersole, an Anabaptist, noted three facets of the “therapeutic community.” First, “hierarchical characteristics are kept to a minimum” while maintaining healthy caregiver-care receiver boundaries (Ebersole 1961). The community arrives at decisions by consensus “yet, particular consideration is given to the advice of the expert (Ebersole 1961). Finally, there is an expectation of “open and free-flowing communication” (Ebersole, 1961). The underlying belief of the “therapeutic community” is “the assumption that the individual must be understood as a relational being and that man may not be understood in individualistic terms”(Ebersole, 1961). For Ebersole, this was a picture of the covenant relationship God has with his people and the faith community had with one another (Bender 2011, 52).

Contemporary Foundations

In this section, I will demonstrate the need for pastoral caregivers to be knowledgeable and equipped to engage in the lives of those who suffer from bipolar disorder. Then I will look at how mental health challenges impact the lives of those with bipolar disorder, particularly their relationship with God. I will end by showing how spiritual companionship can be used to strengthen and help provide a better recovery plan for those with bipolar disorder.

According to the National Institute on Mental Health, one in four Americans suffer from a mental health disorder (Simpson 2013, 33). This statistic does not change in the church. People in the church are suffering from the impact of mental health challenges and disorders. Sadly, in the church, people often suffer in silence.

> The suffering of mental illness, whether for the afflicted or for their families, is typically marked by isolation. When people desperately need to experience the love and empathy of their fellow human beings and to know that their Creator has not abandoned them, many reach out and are shocked to touch the church's cold shoulder. Others fear the church's rejection enough to hide their struggles and not risk exposure at all. (Simpson 2013, 16)

Amy Simpson points out that the government, lawmakers, insurance companies, and even Hollywood is taking note of the issue of mental health and they are taking steps to demystify and destigmatize mental health challenges and disorders while actively seeking solutions to fix the broken system of mental health care (Simpson 2013, 17). By in large, it is the church which is behind on this issue. This is due to lack of education, not lack of heart.

Pastoral caregivers are common gateways for people with mental health difficulties to receive the proper help and support needed for recovery. “Nearly half (44.5%) of church leaders are approached two to five times per year for help in dealing with mental illness; 32.8% are approached more frequently, from six to more than twelve times per year” (Simpson 2013, 99).

What is mental illness? The National Alliance on Mental Illness (NAMI) defines it as “medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning” (NAMI 2012). Mental illness is a holistic disease impacting the entire person and their whole life. Bipolar disorder is a mental disorder which impacts the regulation of mood. It is a disease of extremes. A person can be in the depths of depression and be unable to get out of bed or in a manic episode and be unable to sleep. Bipolar disorder makes a person unpleasant to be around due to their extreme emotions and unpredictable behavior. “Family members and friends are often confused, frightened and frustrated, not knowing how best to react or respond” (Yarhouse, Butman, and McRay 2005, 157).

According to Dr. Matthew Stanford, each individual experiences their own unique combination of symptoms that can change with severity over time (Stanford 2008, 75). Common symptoms include sad, anxious, or “empty” moods lasting longer than two weeks; feelings of hopelessness, guilt, worthlessness, or helplessness; loss of interest in things previously enjoyed; fatigue or lack of energy; difficulty concentrating and remembering; insomnia or excessive sleeping; change in appetite and eating habits; suicidal thoughts; restlessness

and irritability; and physical symptoms which do not respond to treatment (Stanford 2008, 75-76).

Bipolar disorder can render a person unable to follow through with commitments or fulfill responsibilities because “behavioral or situational cues are misinterpreted or ignored” (Yarhouse, Butman, and McRay 2005, 157). This makes it virtually impossible for one to make wise and informed decisions. This can lead to undesirable behaviors such as excessive spending, sexual promiscuity, substance abuse, or violence against self or others.

A person in the midst of an episode finds it difficult to connect with others, including God. Psychologist Larry Crabb believes “that the root of all our personal and emotional difficulties is a lack of togetherness, a failure to connect that keeps us from receiving life and prevents the life in us from spilling over onto others” (Crabb 1997, 32). Connecting is not a simple thing, especially for someone with bipolar disorder. Many times it takes a person outside the immediate situation, such as a pastoral caregiver, to be the necessary companion who can provide that connecting point.

A key roadblock for those who suffer from bipolar disorder is hopelessness. It is the hope of Christ that those who suffer from bipolar disorder need. This does not mean in-depth Bible study or deep theological discussions. In fact, “spiritualizing mental illness translates to blaming sick people for their illness” (Simpson 2013, 107). Mental illness is a disease just like cancer, diabetes, or hypertension. With any disease comes the interaction of biology, psychology, and spirituality (Stanford 2008, 86). Hope is found in presence, a

simple prayer, small successes, and a key verse to hold. Through holistic care, "God is the ultimate agent of healing" (Stanford 2008, 88). The pastoral caregiver's role in this care "is simply to offer encouragement and spiritual guidance" (Stanford 2008, 88).

As a pastoral caregiver provides spiritual companionship for a person with bipolar disorder, they become a conduit offering a connection to God. All believers need a spiritual companion whether formal or informal. A more formal form of spiritual companionship is spiritual direction. Gerald May describes the purpose and function of spiritual direction in the following way:

> In the spiritual life, we must make such discernments constantly, choosing our directions with care, consideration, and prayer. But because of our inherent personal blind spots and self-deceptions, and because of our vulnerability to deception from outside forces, it is necessary to have help. Thus the spiritual director aids us in finding our proper directions. (May 1992, 9)

Spiritual direction is not counseling or a type of therapy. Spiritual direction focuses on "prayer life, religious experiences, and sense of relationship to God" along with other spiritual challenges (May 1992, 15). The person will express thoughts and feelings and exhibit various moods and behaviors, but the focus of the spiritual direction should always be turned toward the impact and effect it has on the relationship between the person and God. A spiritual companion is a person "who provides encouragement and direction along the path to Christ" (Wardle 2004a, 29).

Psychologist Mark McMinn suggests "in our sickness and pain, we grope for answers, for better understanding, for meaningful relationships. Our sickness leads us to God" (McMinn 2011, 20). In fact, May says "it may be our finest hope"

(May 1992, 61). This begins with a recognition of need, which has brought a person struggling with bipolar disorder to a pastoral caregiver.

McMinn sees the same developmental cycle in spiritual and psychological health. It is not a linear developmental but a continual spiral of consolation and desolation. A person is aware of her own need even if they are not able to articulate it. Through the process of recognition and acceptance of her neediness, the person also grows in mindfulness and the reconciliation and healing of relationships (McMinn 2011, 50).

"From a theological perspective, the most dangerous thing about mental illness is that it can lock us in ourselves, convincing us that we are indeed on our own, and completely on our own, isolated in our distress…Mental illness shuts all windows and doors to the soul so that we cannot speak, meditate, or do anything to the glory of God, or so it seems" (Greene-McCreight 2006, 116). Greene-McCreight knows firsthand the role of a pastoral caregiver, but also the darkness of bipolar disorder. She sees the role of the spiritual companion as to open the doors and windows by speaking, meditating, and being with a person until they are able to do so on their own. It is not a dramatic grand opening, but, instead, curtain by curtain, blind by blind, shutter by shutter allowing light in so that eventually the windows can be cracked, allowing in the refreshing wind of the Spirit to revive the captive.

Greene-McCreight offers advice to pastoral caregivers journeying with those with bipolar disorder. First, offer but do not demand spiritual practices or spiritual exercises such as extending the offer to pray, read Scripture, or take

communion (Greene-McCreight 2006, 138). Second, become aware of the signs and symptoms of mental health challenges and disorders (Greene-McCreight 2006, 138). Last, know your professional role and purpose and work within this scope (Greene-McCreight 2006, 141). Pastoral caregivers who are not trained psychologists or psychiatrists need to have resources of referrals and should never try to make a diagnosis (Greene-McCreight 2006, 141). “Be consistent in your concern, prayer, and inquiries. Let them know that your friendship, or care as a clergyperson, is unconditional” (Greene-McCreight 2006, 143).

Spiritual companionship is one component of holistic recovery. Mental Health Grace Alliance sees an individual holistically as God made them, including physical, mental, spiritual, and relational dimensions (Padilla and Stanford 2013a, 30-31). “A holistic approach to recovery relieves suffering, reveals Christ, and restores lives” (Padilla and Stanford 2013a, 30). Each component affects every dimension. Recovery for a person with bipolar disorder is made possible when all dimensions are addressed. As Greene-McCreight demands for pastoral caregivers to remember, “since mental illness can be a terminal disease, you may be helping to improve or even to save a life” (Greene-McCreight 2006, 143).

Context

The project will be completed in Waco, Texas. This is where I returned after living overseas for three and a half years. I was experiencing severe mental health symptoms and did not know what to do or what I needed. In the midst of my pain, I could not understand the reactions of others. Looking back I know that much of what was said and done was undertaken with good intentions. The lack

of knowledge of mental health left many people in my life unable to help in life-giving ways.

In *Troubled Minds*, Amy Simpson shares her personal journey of growing up with a mother who suffered from schizophrenia. She reflects on the painful truth of how the church remained "oblivious or a silent observer" throughout their family's difficult journey (Simpson 2013, 28). Simpson also presents findings from surveys completed by pastors and looks at current clinical research and the current state of mental health care. She agrees with Marr that "stigma, shunning and shame" exponentiate the pain of mental health challenges and disorders for both the person with the disease and their family (Marr 2011, 122). This leads to isolation and disconnection. Simpson's research shows that "many reach out and are shocked to touch the church's cold shoulder. Others fear the church's rejection enough to hide their struggles and not risk exposure at all. (Simpson 2013, 16)

Education is a key to being able to walk with someone through their recovery. It also requires a decision to jump into the pit with them. This is not an easy decision. Thankfully I had a handful of people who jumped in with both feet. Most of them learned about mental health along the way. It was those who already possessed the knowledge that had the power to position me to reconnect with God and community; find purpose, and thrive again.

According to the National Institute on Mental Health, one in four Americans suffer from a mental health disorder (Simpson 2013, 33). Twenty percent of all adults will experience mood disorders, such as bipolar disorder, in

their lifetimes (Kessler 2005, 593-602). The likelihood of encountering a person or family member impacted by bipolar disorder in the church is likely. Pastoral caregivers are often the number one gateway person for people receiving appropriate care. This resource is being created to better equip pastoral caregivers to become spiritual companions for people with bipolar disorder.

The resource will be evaluated by people with experience in working with people with bipolar disorder and who have an understanding of the disorder including psychiatrists, psychologist, counselors, social workers, and support group leaders.

Significant Terms

Bipolar Disorder- Bipolar disorder is a medical disorder which causes extreme shifts in mood, energy, and function (Stanford 2008, 75). There are various classifications of bipolar disorder. For a diagnosis of bipolar disorder, the patient must meet the criteria laid out in the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association. Bipolar disorder presents a combination of episodes of mania, depression, and/or hypomania (APA 2013, 65-92).

Connectedness- This term is used as defined by Larry Crabb in his book, Connecting. He defines connectedness as “Releasing the power of God through our lives into the hearts and souls of others requires that we both understand and enter into a kind of relating that only the gospel makes possible” (Crabb 2004, 5).

Hesed- Translated from Hebrew into English as “loving-kindness,” *hesed* refers to the acts of benevolence that one does out of kindness, not out of obligation (Eskenazi and Frymer-Kensky 2011, 58). *Hesed* is more than a feeling, but an action demonstrated in a covenant relationship and includes justice, mercy, compassion, and forgiveness (Eskenazi and Frymer-Kensky 2011, 59).

Major Depressive Episode- As defined by the American Psychiatric Association, a major depressive episode presents at least five or more symptoms as outlined in the DSM including either a “depressed mood” or “loss of interest

and pleasure" for at least two weeks causing interruption in daily functioning and not caused by another medical condition or medication (APA 2013, 67-68).

Mania- Mania is an extremely elevated mood characterized by a lack of need for sleep, excess energy, irritability, impaired judgment, impulsivity, and grandiose ideas (Stanford 2008, 75).

Manic Episode- As defined by the American Psychiatric Association, a manic episode includes an elevated mood that lasts at least one week and includes at least three or more additional characteristics outlined in the DSM causing an interruption in daily functioning and not caused by another medical condition or medication (APA 2013, 65-66).

Mental Health Challenges and Disorders- In this proposal, mental health challenges and disorders encompasses all mental disorders, conditions, and symptoms identified by the American Psychiatric Association in the DSM.

Mood Disorder- Mood disorders are conditions which impact the regulation of moods (Stanford 2008, 74).

Moral Treatment- Moral Treatment consists of treating a patient with dignity, respect while not inflicting harm (Simpson 2013, 137).

Spiritual Companionship– The term spiritual companion as used in this proposal is a person "who provides encouragement and direction along the path to Christ" (Wardle 2004a, 29).

Spiritual Direction– As for this proposal, spiritual direction is a more formal form of spiritual companionship with defined time and focus.

Project Goals

The purpose of this project is to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. To what extent does this resource better equip pastoral caregivers to become spiritual companions for people with bipolar disorder? To this end, my project goals for this project are:

1. The resource will establish that pastoral caregivers are gateway people for those with bipolar disorder in receiving appropriate care.

2. The resource will outline the biblical basis for a holistic approach to understanding mental health challenges and disorders.

3. The resource will outline the theological basis for a holistic approach to understanding mental health challenges and disorders.

4. The resource will identify how bipolar disorder impacts the lives of those who have bipolar disorder.

5. The resource will explain how bipolar disorder can interfere with one's connection with God.

6. The resource will provide appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus.

7. The resource will give other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their spiritual journey.

Design, Procedure, and Assessment

The purpose of this project is to create a resource that will better equip pastoral caregivers to become spiritual companions for people with bipolar disorder. The resource will be a handbook containing information to reach the project goals.

The handbook will begin with an introduction to establish that pastoral caregivers are gateway people for those with bipolar disorder in receiving appropriate care. Then a biblical and theological foundation will be laid for a holistic approach to understanding mental health challenges and disorders. From there bipolar disorder will be defined and how bipolar disorder impacts the lives of those who suffer from the disease. Building off this information, an explanation will be given for how bipolar disorder can interfere with one's connection with

God. The handbook will then provide appropriate spiritual exercises to equip pastoral caregivers in positioning care receivers with bipolar disorder to encounter Jesus. The resource will end by giving other resources to further assist pastoral caregivers in helping care receivers with bipolar disorder on their journeys of recovery.

An assessment instrument will be created with both qualitative and quantitative questions. The resource and assessment tool will be given to people with experience in working with people with bipolar disorder and who have an understanding of the disorder. The evaluators include psychiatrists, psychologists, counselors, social workers, and support group leaders. Each person will review the resource and evaluate it by completing the assessment instrument which addresses the specified goals.

Personal Goals

Imagine selling or giving away most of your possessions. Then pack two suitcases with what you think you will need to start a new life on the other side of the world. You leave your family, friends, and community of faith behind. You do this because of a “calling” you have sensed from God to be a light to the nations. In many ways, it turns out to be all you hoped for---deep relationships and significant conversations, learning language and culture, being transformed and drawn closer to God.

You knew there were risks involved, but you are convinced they are worth it. Then your worst nightmare comes true. Your dream ends much sooner than you had hoped because you have lost your ability to cope and no longer have

any resilience left. A quiet disease consumes you and the wounds of your past along with the current occurrences leaves you paralyzed without hope and a loss of any sense of purpose.

This is what happened to me. I felt that God had rejected me. I could not bear to read the Scripture. I did not have words to pray. Numerous experiences with fellow believers left me licking my wounds. Through my recovery, I have regained a sense of purpose. I have recently begun attending church again. The Scripture does not pose a threat of landmines as it did before. I understand prayer to be more than words. I am living into my identity in Christ. I move forward in the hope that I will continue to heal and grow.

To this end, my personal goals for this project are:

1. Engage scripture through non-study methods in order to experience God's word in my life.
2. Engage in spiritual exercises and other forms of prayer in order to establish the discipline of prayer in my life.
3. Continue self-care plan in order to stay on the path of recovery.
4. Continue to develop as a differentiated leader as defined in my paper.
5. Address my wounds related to the Church in order to position myself to be reconnected with the local church.

Calendar

April 2014	Submit Proposal
May 2014	DM 919 Writing Seminar for Dissertation
May 2014	Proposal Accepted and Assessment Tool Approved
June 2014	Write Chapter 1 of Resource
July 2014	Write Chapters 2 & 3 of Resource
August 2014	Write Chapters 4 & 5 of Resource
September 2014	Complete Resource and send to be evaluated
October 2014	First Draft of Chapter 2
November 2014	First Draft of Chapter 3
December 2014	Evaluations due
January 2015	First Draft of Chapter 4
February 2015	First Draft of Chapter 5
March 2015	First Draft of Chapter 6
June 2015	First Draft of Chapter 1
July 2015	Final Draft of Dissertation
September 2015	Submit Dissertation
October 2015	Defend Dissertation
December 2015	Graduation
May 2016	Commencement

Core Team

Advisor: Dr. Karen Taylor, DMin

Field Consultant: Dr. Lauri Rogers, Psy.D. Psychologist at Baylor University Counseling Center

Resource People:

Matt Stanford, Ph.D. - Professor of psychology, neuroscience, and biomedical studies at Baylor University. Executive Director and Co-founder of Mental Health Grace Alliance.

Carrie Arroyo, LCSW - full-time lecturer at Baylor University School of Social Work

Beth Kilpatrick, MSW/MDiv – lecturer at Baylor University of Social Work

Amy Everett, MDiv/MSW - Community and Care Pastor, DaySpring Baptist Church, Waco, TX

Sharon Rollins, MS, LPC, EMDR certified

Josh Warren, MD – Psychiatrist

Rev. Wesley M. Eades, Ph.D., LPC, and LMFT

Joe Padilla, CEO, and Founder of Mental Health Grace Alliance

Jenna Hoff, MDiv, Managing Director of Mental Health Grace Alliance

Support Team

Beth Kilpatrick, friend

Megan Monnich, friend

Dale and Miranda Peacock, friends

David and Lydia Tate, friends

Rebecca Edwards, friend

Cindy Julian, friend, life group member, church member, accountability partner

Brandy Powers, friend, and editor

Elizabeth Murrell, friend, and editor

Grace and Hope Group, support groups

Ark Community, the intentional Christian community in which I live

Life Group, members of my church I meet with weekly

In general, this group will provide a support system of encouragement and prayer. Within the group, certain individuals will play more specific roles. Beth Kilpatrick will be a sounding board and give feedback on my writing. Brandy Powers and Elizabeth Murrell will act as editors. The others will provide fellowship, meals, and other practical needs.

I will be communicating through email with those who are not in the area but will meet individually with those who are in my area. I will keep all members up-to-date with prayer concerns and my progress through usual means of communication and interaction. Beth, Lydia, and my editors will hold me accountable to my calendar.

Life Management Plan

As a doctoral student, I have many demands on my life. It is a challenge to maintain margin. I have created a life management plan in order to complete this process successfully. The plan looks at my inward, upward, and outward journey while incorporating maintaining margin emotionally, physically, financially, spiritually, and with time. My personal goals are derived from my life management plan.

My inward journey includes the ongoing development of myself as a differentiated leader. A differentiated leader is secure in their identity in Christ,

has a clear vision, understands their vocation, is committed to a core set of values, is connected to the community, and demonstrates healthy boundaries. I have outlined what these characteristics mean to me in a paper completed for one of my courses.

My inward journey also involves managing my emotional and mental health. To this end, I will continue to meet with my counselor on a weekly basis, take my medication, attend support groups, and see my psychiatrist as needed. My physical health impacts my emotional and mental health; therefore, I will be focusing on eating healthier and exercising. As a part of my life plan for my Ark community, I will be working with the case manager on how best to live within a budget and on how to make wise financial decisions.

For my upward journey, I will engage scripture through non-study methods in order to experience God's word in my life. I will also engage in spiritual exercises and other forms of prayer in order to establish the discipline of prayer in my life. I will continue to meet with my spiritual director as well as my Ark accountability partner.

As far as my outward journey is concerned, I will address my wounds related to the Church in order to position myself to be reconnected with the local church.

Resources

Mental Health Grace Alliance

Formational Counseling Seminars

Personal Spiritual Direction

The Gathering on Mental Health and the Church, Saddleback Church, Lake Forest, CA. March 28, 2014.http://mentalhealthandthechurch.com

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APPENDIX 2

RESOURCE ASSESSMENT TOOL AND COVER LETTER

Dear Jane Doe,

I am currently a candidate for a DMin in Formational Counseling at Ashland Theological Seminary. For my project, I have created a resource for pastoral caregivers to be better spiritual companions for people with bipolar disorder. I am sending a preview of the resource along with a link to a survey to people I have identified as having a mutual understanding of spiritual formation/direction and bipolar disorder.

I would appreciate if you would take the time to preview the resource and complete the survey by clicking on the link below. The survey is anonymous.

Many thanks!
Chaplain CJ Wood, MDiv

Spiritual Companionship Survey

1. The resource establishes that pastoral caregivers are gateway people for those with bipolar disorder to receive appropriate care.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

2. The resource models multi-disciplinary collaboration.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

3. The resource provides a model for holistic care.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

4. The resource outlines a biblical framework for understanding mental health concerns.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

5. The resource provides a quality biblical basis for holistic care.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

6. The resource affirms the role of scripture in mental health recovery.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

7. The resource outlines a theological framework for understanding mental health concerns.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

8. The resource provides a quality theological basis for holistic care.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

9. The resource demonstrates the importance of developing a secure identity in Christ for mental health recovery.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

10. The resource shows the emotional impact of bipolar disorder.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

11. The resource identifies the physical impact of bipolar disorder.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

12. The resource demonstrates the cognitive impact of bipolar disorder.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

13. The resource explains how bipolar disorder can interfere with ones connection with God.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

14. The resource demonstrates how bipolar disorder can interfere with ones connection with the church community.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

15. The resource shows how bipolar disorder can interfere with one engaging in spiritual exercises.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

16. The resource provides appropriate spiritual exercises for people with bipolar disorder.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

17. The spiritual exercises in the resource will assist the caregiver to position a care receiver to encounter Jesus.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

18. The resource identifies characteristics for appropriate spiritual exercises.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

19. The resource provides further resources to assist pastoral caregivers in being better spiritual companions to people with bipolar disorder.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

20. The resource provides a variety of resources for pastoral caregivers

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

21. The resources are readily accessible for those caring for persons with bipolar disorder.

1	2	3	4	5	6	7
Definitely Not True	Mostly Not True	Slightly Not True	Unsure	Moderately True	Very True	Definitely True

22. What are the strengths of the resource? Why?

23. What are the weaknesses of the resource? Why?

24. How can the resource be improved?

25. Check all that apply

- ☐ I have a theological degree or theological training
- ☐ I have a background in psychology and/or counseling
- ☐ I am involved in mental health support groups/recovery
- ☐ I have personal experience with bipolar disorder (self, family member, friend, client, congregant)
- ☐ Other (please specify)

APPENDIX 3

RESOURCE

Below are excerpts from the resource, *Spiritual Companionship and Bipolar Disorder*. Included are a portion of each section and one spiritual experiential.

Introduction

Over the past years, several celebrities have drawn attention to mental health. The death of actor and comedian Robin Williams prompted an onslaught of conversation concerning mental health, particularly on social media. For some, it was the first time to engage in the mental health conversation. For others, like me, there was a sigh of relief that finally, at least for a while, people were talking about mental health.

Even before Robin Williams, the Christian world was shocked by the death of Matthew Warren, youngest son of ministry team leaders of Saddleback Church Rick and Kay Warren. Christians were asked to consider the relationship between faith and mental health.

The purpose of this resource is to equip pastoral caregivers better to become spiritual companions for people with bipolar disorder. The resource establishes that pastoral caregivers are gateway people for those with bipolar disorder to receive appropriate care and models multi-disciplinary collaboration. A model for holistic care is provided based on a biblical and theological framework for understanding mental health concerns and affirms the role of scripture in mental health recovery. The resource demonstrates the importance of developing a secure identity in Christ for mental health recovery.

The resource provides an understanding of bipolar disorder including the emotional, physical, cognitive, and spiritual impact of bipolar disorder. The resource demonstrates how bipolar disorder can interfere with one's connection with God, the church, and community. The impact of bipolar disorder can interfere with one engaging in spiritual exercises, but appropriate spiritual exercises are offered in this resource that will assist the caregiver to position a care receiver to encounter Jesus. The resource provides further resources to assist pastoral caregivers in being better spiritual companions to people with bipolar disorder.

The State of Mental Health

Crazy. Psycho. Schizo. Insane. Deranged. Cray-Cray. These are words used in everyday life. I admit that I still say some of them. They are words we use without thinking of the real meaning and what these words communicate. It is similar to the word retard. There is a stigma attached to these words that demean people who truly do struggle with mental health challenges and disorders

The reality is one in four Americans will face mental health challenges each year. That is approximately 61.5 million people. The National Alliance on Mental Illness (NAMI) defines a mental illness as “medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning.” Mental health challenges and disorders encompass a vast spectrum of disorders, conditions, and symptoms as identified by the American Psychiatric Association in the Diagnostic Statistical Manual of Mental Health Disorders (DSM-V). These include but are not limited to depression, eating disorders, anxiety disorders, post-traumatic stress disorder (PTSD), schizophrenia and schizoaffective disorders, bipolar disorder, borderline personality disorders, obsessive compulsive disorders, attention deficit disorders, autism spectrum disorder, etc.

Mental illness costs Americans approximately $193.2 billion in lost wages. Mood disorders such as depression are the third leading cause of hospitalization for adults between 18 and 45. The average onset of mental illness is between 15 and 20 years old, but it can take up to a decade before receiving treatment.

Anyone can develop a mental health challenge or disorder. It is an illness. The brain is a remarkable and complex organ. There is a lot we do not understand about how it works. Neuroscientists are discovering more and more with the breakthrough of new technology. Brain scans can now show how the activity in a brain changes when one is depressed and when they are not. It is a dysfunction, misfiring or chemical imbalance that causes mental health challenges and disorders.

Some people are more vulnerable to developing a mental health disorder. Biology plays a role as with any disease. There are genetic influences. There are also social factors that contribute to the development of mental health challenges and disorders. Every human being has basic needs such as love, security, the need to feel significant and understood and have a sense of belonging. During the early stages of development, children's brains are changed by either receiving or not receiving these innate desires. If a child

experiences trauma, abuse, neglect, lives in poverty or has more stress than can be processed appropriately, it can increase a person's chance of developing a mental health disorder. A child's temperament can contribute as well. As adults, when we face trauma or stress, our level of vulnerability and development established even before birth can make us more likely to develop a mental health issue or disorder. The reality is the statistics do not change within the walls of the church.

Mental Health and the Church

Since its beginning, the church has shown concern and given care to the sick including those with mental health challenges and disorders. Rodney Stark makes this case in *The Rise of Christianity*. Christians, driven by the ethos of "*love one another"* and grounded in the belief that "God loves humanity," had "superior survival rates" due to their care for one another.

Pastoral Caregivers as Gateway People

A recent study conducted by LifeWay Research found that most people first turn to a pastoral caregiver when facing a mental health challenge or disorder. The reluctance of pastoral caregivers to engage is understandable considering they are not mental health professionals. There are limitations and appropriate boundaries that pastoral caregivers need to acknowledge and maintain.

Pastoral caregivers lead the way in changing the attitude of the church. A majority of those who suffer from bipolar disorder and their families want to hear from their church leaders speaking openly about mental health issues. Pastoral caregivers are the ones who establish a safe environment for those with mental health issues and disorders and their families.

What is Bipolar Disorder?

Bipolar disorder is a mental disorder which impacts the regulation of mood. It is a disease of extremes. A person can be in the depths of depression and be unable to get out of bed or in a manic episode and be unable to sleep. Bipolar disorder makes a person unpleasant to be around due to their extreme emotions and unpredictable behavior. This leaves friends and family members confused and wondering how to respond.

According to Dr. Matthew Stanford, in *Grace for the Afflicted*, each individual experiences their unique combination of symptoms that occur in cycles and can change over time in severity. Common symptoms include sad, anxious, or "empty" moods lasting longer than two weeks; feelings of hopelessness, guilt,

worthlessness, or helplessness; loss of interest in things previously enjoyed; fatigue or lack of energy; difficulty concentrating and remembering; insomnia or excessive sleeping; change in appetite and eating habits; suicidal thoughts; restlessness and irritability; and physical symptoms which do not respond to treatment.

How do I respond?

We need a comprehensive approach for a holistic disease. A spiritual companion is only one person of a multidisciplinary team. A multidisciplinary team of doctors, psychiatrist, psychologist, counselors, other professionals, and pastoral caregivers know their boundaries and limitations. The primary role of a spiritual guide is to be present, validate, affirm, and make referrals.

Where's God?

God is holistic. God meticulously created the universe, the earth, the sky, the seas, various creatures, and man. All aspects of creation are God's masterpiece and beloved handiwork. Just as the whole earth and everything in it will one day be restored, we are being transformed holistically – mentally, emotionally, spiritually and physically.

Experientials

Spiritual experientials are opportunities for spiritual companions to help care receivers listen and hear God. The spiritual companion provides structure, safety, and creative ways to engage with God using the imagination. The spiritual exercises in this resource are designed to help develop brain integration. Brain integration helps the care receiver to connect reality and their feelings.

Precautions

Each person will respond differently to exercises. There is not an expected response for any of these exercises. The care receiver is in control at all times. They have the right to decide to participate, stop at any time, and set boundaries. Explain the experiential in detail before beginning. Then the caregiver should continue to remind the care receiver what is about to happen as they move through the exercise. The participant should feel safe and free to ask questions. It is the role of the caregiver to be attuned, present, attentive to things other than words such as body language, tone and inflection of voice, posture, etc. Remember you are a conduit for the Holy Spirit. You are helping the care receiver in the listening process on this journey of spiritual renewal.

Affirmation of Identity

Objective: We are loved, chosen, and empowered as a child of God.

Supplies: Use list of affirmations in the appendix

Scripture:
Psalm 139 (NIV)
(may choose to read only a portion or use it as the opening/closing prayer)

Romans 12:2 (NIV)

Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing and perfect will.

Philippians 4:8 (NIV)

Finally, brothers and sisters, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things.

Experiential

Open: Start with prayer and a breathing exercise.

Experience

Read through the affirmation list while taking turns. Then have the care receiver listen to the caregiver read the affirmations personalized with the care receiver's name. Do this again but have the care receiver repeat the personalized statements. Finish by having the care receiver read on their own the affirmations one more time using personal pronouns.

Closing

Identify one statement that feels the truest. Have the care receiver choose an item from the supply box such as a rock, feather, piece of cloth, etc. that will be a tangible reminder for them to meditate on the affirmation. The care receiver may also want to create something either with paper, sticks, coloring with different mediums, etc. If the care receiver gets stuck, prepare suggestions that might reflect the affirmation. Have the care receiver take the object home as a reminder of the affirmation. If you choose, the reading of the affirmations can be recorded and the care receiver can listen to it at home.

Affirmations

I am loved by God unconditionally (Jeremiah 31:3)

I am chosen and accepted by God (Ephesians 1:4)

I am empowered by God through his Spirit (Acts 1:8)

I am God's workmanship, his masterpiece (Ephesians 2:10)

I am a new creation in Christ (2 Corinthians 5:17)

I am redeemed and forgiven (Ephesians 1:7-8)

I am God's temple, his dwelling place 1 Corinthians 6:19)

I have the mind of Christ (Romans 12:1-2)

I am made complete in Christ (Colossians 2:9-10)

I am righteous in God's sight (Romans 3:21-24)

God delights in me (Psalm 18:19)

I am fully known by God (Psalm 139)

I am God's child (Galatians 3:26-29)

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