

Supporting Families Living with Mental Illness

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Though gray and rainy, the day I graduated college was bright with possibilities. My friends and I smiled in our bright blue caps and gowns, our tassels blowing in the wind as we posed for pictures and looked toward what we were sure was a bright future. Because of the rain, colorful umbrellas bobbed like party balloons through a crowd of family, friends, and faculty, boosting the festive atmosphere.

No more school, I kept realizing. I really had done it. No more tests, grades, papers, or homework. I had earned my college degree, and I was ready to do something with it. I had a job lined up; I was a newlywed; I was already settled in the apartment my husband and I had moved into after our wedding a few months earlier. The future felt like a wide-open door to a promising new land.

My husband was with me that day, and he cheered me on as I had cheered for him at his graduation ceremony two years earlier. My best friends were there, most of them also graduating and making their own plans. My parents had driven five hundred miles to see me walk across the stage, to celebrate with us, and to show their pride in another college graduate in the family. In spite of the rain, we all smiled and enjoyed the celebration.

But beneath my smile that day, I was troubled. I tried to ignore it, but I couldn't overlook the familiar faraway look I saw in my mother's eyes, the stiff and half-unaware look on her face. Although I had spent my teenage years trying, I had never been able to escape the emotional devastation that came with seeing that expression on my mom's face. I knew what it meant. I suspected that sometime soon, perhaps very soon, we would lose her again.

I was right.

The next morning, after a night out to celebrate with friends, my husband and I got out of bed, planning to spend some time with my parents before they left our apartment for home. Instead of well-rested guests, we found Dad hovering over Mom, trying to rouse her. She lay where she had slept, awake but catatonic. Again.

After about an hour of gentle and persistent work, she began responding to our insistence that she engage with reality. We walked her through the basics: *Open your eyes. Move your arms. Move your legs. Sit up.* Slowly, step by step, she revived and eventually shuffled her way to the car. My parents drove home, and a day or two later Dad called to say Mom was back in the hospital. We weren't surprised, but we grieved as we had so many times before—and as we would do many times again.

Once again my mom's schizophrenia had stolen the precious person who had gently cared for me when I was sick, held me when I was sad, and taught me about Jesus. Year after year, her symptoms came in cycles and waves, and this new wave crashed right over a happy new stage in my life. Flush with the joy of getting married, graduating from college, and landing my first career job—a successful process of leaving home—I realized I couldn't really leave the heartache and grief that came with repeatedly losing my mother to delusions, paranoia, and other symptoms of serious mental illness.

Mom's illness began before I was born, but it wasn't until I was fourteen that it turned our lives upside down. That was the year Mom had a psychotic episode that was impossible to hide; she lost all connection with reality and was incapacitated. Our family had been through a period of extraordinary stress—a major move, unemployment, culture shock, financial hardship, marital strain, the first high-school graduation, and the conflict inherent in three teenage girls sharing a small bedroom. Mom's fragile mental health made her unable to navigate all this stress, and her disorder grew increasingly severe until she lost the ability to discern and understand reality. Although we needed years to really understand what had happened, life would never be the same after this time.

Mom was hospitalized multiple times through my high-school years, and each time she came home with bottles of pills that helped control most of her symptoms but made her miserable with side effects. She sat on the couch, staring into space. Eventually she would start to feel better and shuffle around the house, doing what she could to care for her family. And when she started feeling well enough, eventually she decided

she didn't need to take those pills anymore. So the cycle would repeat itself, and we learned to live without her. When she was home, we cared for her and let her care for us the best she could, because some kind of normalcy was important to all of us. But we couldn't really afford the luxury of needing her—so we didn't.

Neither did we feel we had the luxury of finding sympathy or support in the people around us. We knew we weren't supposed to talk about mental illness. No one else ever did, except to joke or dismiss people. We got the message that we were alone, worthy of shame, and supposed to pretend everything was fine and somehow keep it all under control. So that's what we tried to do. Even at church. For the most part, our church seemed content with this arrangement. They were quiet too.

I had spent my whole life deeply involved in churches, and I had never heard a sermon that mentioned mental illness. No one had addressed it in Sunday school or youth group, and I had the distinct impression the church was afraid of the questions I needed to ask—questions about what was happening to Mom, why my “good Christian family” was suffering, and why God didn't fix it.

As time marched forward, my family kept coping in the best way we knew how. Decade after decade, we walked with Mom through some of the worst that severe mental illness can visit on a person: delusions, paranoia, religious confusion, panic, hospital after hospital, homelessness, criminal conviction, prison. And so often, like so many families, our family was left out of the loop of information, out of the circle of care, floundering as we tried to figure out how to help Mom, how to deal with our own overwhelming emotions, and how to carry on with our lives at the same time.

Like most churches, ours was full of well-intentioned people who let fear, misunderstanding, and stigma keep them from ministering to a suffering family. Unfortunately, in that sense our story is not unique. But we do not have to keep making this mistake. We can start by recognizing that behind every person with mental illness is a family that has been impacted—perhaps even devastated—by that illness. The effects of mental illness go far beyond the individual.

In this article, I argue that supporting families who live with mental illness is a job for everyone in the church. I demonstrate the effects of mental illness on families, consider why the church is uniquely positioned to help, and offer ideas for specific ways we can offer support.

Families in Crisis

Mental illness is extremely hard on families. For starters, individuals with mental illness live with difficult symptoms. They may be overwhelmed by depression, anxiety, fear or even terror, compulsions that control their lives, voices or visual hallucinations that redefine reality, thoughts of suicide, or an inability to cope with everyday life. These symptoms are hard to live with—and not only for those who have them. They also make life difficult for people who love those suffering from mental illness.

But there's more trouble that affects families. They can be thrown into crisis, even with a relatively short-term and mild mental illness. The person with the illness necessarily tends to monopolize the family's resources, may be incapable of earning a living, may seem selfish and demanding at times, and may appear unmotivated or unwilling to do anything productive. The person may behave erratically; a small number become violent. These struggles can be extremely difficult for loved ones to live with them and even for family members who do not share a living space with them. Mental illness causes financial burdens and hardships. Families may be hit by lost workdays, unemployment, expensive medications, hospitalizations, residential care, or alternative schooling. These financial demands can bankrupt a family.

Many people who haven't had to experience it don't realize our mental health care system is badly broken and hard to navigate, for both individuals and families. It can be hard to access care: we have a shortage of mental health professionals, especially psychiatrists. What is a person to do when he or she needs an adjustment in medication and the psychiatrist is booked for the next six weeks? Many people try to wait it out, and they suffer for it, as does the rest of our society. Others turn to alcohol or illegal drugs to self-medicate and relieve their symptoms, a strategy that always backfires. Others go to emergency rooms, where some find the care they need and many more do not. In 1955, there was one bed in a psychiatric ward for every three hundred Americans; today there is one for every three thousand Americans.¹

As with other forms of health care, the mental health care system places the burden for managing care solely on the person with the illness, though that person may or may not be able to shoulder this burden.

1. National Sheriffs' Association and Treatment Advocacy Center, "More Mentally Ill Persons Are in Jails and Prisons than in Hospitals: A Survey of the States," (May 2010), 1, http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

Unless the person with the illness takes the initiative to sign paperwork granting loved ones access, family members and friends are outside the circle of care. Often they are left with no understanding of the disorder affecting the person they love or the best ways they can offer support and facilitate healing.

Doctors can be reluctant to offer solid diagnoses because they fear their patients will be stigmatized and insurance companies will discriminate in following through with benefits. Lack of clear diagnoses and treatment plans leaves patients and their loved ones floundering, not equipped to manage symptoms or pursue health. Insurance companies sometimes actively pressure doctors and hospitals to shorten treatment for psychiatric patients or deny necessary coverage altogether.² These short hospitalizations focus on stabilization, not on setting people up for long-term success. The average length of a hospital stay for psychiatric care in the United States is about seven days.³ The average length of time required for psychiatric medications to work is two to six weeks. People are routinely released from inpatient care with no idea whether their treatments will work, and they are immediately transferred to the care of new doctors, new therapists, and new peer groups with whom they must start from the beginning in forming relationships. When a hospital discharge takes place, again the focus is on the patient; families are not routinely educated or offered support. It is no surprise, then, that up to 13 percent of psychiatric patients find themselves re-admitted shortly after leaving the hospital;⁴ they lack the necessary support systems to make a successful transition and work toward greater health.

When people do not receive the care they need—and only about 50 percent of people with severe mental illness do receive treatment⁵—the consequences can be serious for individuals, families, and society as a whole. People with serious, untreated mental illness are at high risk for homelessness. Determining demographics of the homeless population is

2. Scott Pelley, “Denied,” CBS News (December 14, 2014), <http://www.cbsnews.com/news/mental-illness-health-care-insurance-60-minutes>.

3. “Mental Health,” Centers for Disease Control and Prevention, <http://www.cdc.gov/nchs/fastats/mental.htm>.

4. S.N. Vigod, P.A. Kurdyak, C.L. Dennis, T. Leszcz, V.H. Taylor, D.M. Blumberger, D.P. Seitz, “Transitional Interventions to Reduce Early Psychiatric Readmissions in Adults: Systematic Review,” *The British Journal of Psychiatry* (March 2013), <http://www.ncbi.nlm.nih.gov/pubmed/23457182>.

5. “About 50 Percent of Individuals with Severe Psychiatric Disorders (3.5 Million People) Are Receiving No Treatment,” Mental Illness Policy Org, <http://mentalillnesspolicy.org/consequences/percentage-mentally-ill-untreated.html>.

difficult for obvious reasons. Most reliable sources report that about 40 percent of homeless people have some kind of mental health problem and that 20 to 25 percent have a serious mental illness. This compares to just 6 percent of the general population affected by mental illness.⁶

Because only law enforcement officers and judges possess the power to force the receipt of care (and even their power is limited to intervention in specific situations), police officers, often ill-equipped, have become front-line mental health workers by default. And because our communities are not equipped or committed to offer the care people need before they reach the point where our criminal justice system intervenes, that very system has become the largest and most effective response to mental illness our society offers. Tragically, the three largest mental health providers in the United States are Cook County Jail in Chicago, Los Angeles County Jail, and Rikers Island in New York City.⁷

The Department of Justice estimates that more than half of U.S. inmates have symptoms of serious mental illness, ranging from 45 percent of inmates in federal prisons to 56 percent in state prisons and 64 percent in local jails.⁸ Almost three-quarters of female inmates have a mental disorder. More than three times as many mentally ill people are housed in prisons and jails than in hospitals, and while incarcerated they are regularly preyed upon and injured by other inmates. Some 40 percent of people with serious mental illnesses have been arrested at some point in their lives.⁹ For some people, breaking the law is the only way to get the help they need.

When our society refuses to pay directly for mental health care, we pay indirectly, both economically and socially, far more than offering appropriate, widely accessible care. The cost of allowing incarceration to serve as an alternative to community-based care is staggering. A ninety-day

6. These statistics are taken from a number of sources; however, a nice summary can be found at “Facts and Figures: The Homeless,” PBS (June 2009), <http://www.pbs.org/now/shows/526/homeless-facts.html>.

7. Michael Arceneaux, “Why Are the Three Largest Mental Health Providers Jails?” *NewsOne* (October 24, 2013), <http://newsone.com/2744141/prisons-mental-health-providers>. See also the *New York Times* article, “Rikers: Where Mental Illness Meets Brutality in Jail,” July 14, 2014, <http://www.nytimes.com/2014/07/14/nyregion/rikers-study-finds-prisoners-injured-by-employees.html>

8. Doris J. James and Lauren E. Glaze, “Mental Health Problems of Prison and Jail Inmates,” *Bureau of Justice Statistics Special Report* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, 2006)

9. Nicholas Kristof, “Inside a Mental Hospital Called Jail,” *New York Times* (February 8, 2014), <http://www.nytimes.com/2014/02/09/opinion/sunday/inside-a-mental-hospital-called-jail.html>.

incarceration of one person costs roughly the same amount (\$30,000) as an entire year of subsidized housing, disability income, and outpatient mental health services.¹⁰ Untreated mental illness costs the U.S. economy more than one hundred billion dollars each year.¹¹ Moreover, the human cost is incalculable: lives lost to suicide, people locked up for choices they would not have made when healthy, and the societal consequences of self-medication with drugs and alcohol.

Individuals and families affected by mental illness need help and support. They routinely find themselves on their own in the dark, unsure of how to get the help they need. Many often find themselves in crisis, and when they do reach out for help, they run into stigma and fear that alienate others from getting involved. Many people believe there is nothing churches can do to help. They are wrong.

The Church's Role

Whether they know it or not, churches are on the front lines of mental health care. A 2003 study by the National Institute of Mental Health found that 25 percent of people who sought help for mental illness first went to clergy.¹² This is a ministry opportunity the church cannot afford to ignore. Unfortunately, many church leaders are ill-equipped to help those suffering from mental illness get the care they need.

Churches leaders are not in an easy position. Many feel they are in over their heads. Like most people, clergy have a limited understanding of mental illness. They regularly interact with people who have mental-health problems but who fail to mention or simply deny those problems because they are afraid of stigma or silenced by their own shame. Church leaders wonder how to deal with people in their congregations who behave inappropriately or those who consume all their time yet still demand more. Pastors try to minister to people who are spiritually confused because of thought disorders and symptoms of other mental health problems. Although regularly faced with these challenges, most

10. Liz Szabo, "Cost of Not Caring: Nowhere to Go," *USA Today*, <http://www.usatoday.com/story/news/nation/2014/05/12/mental-health-system-crisis/7746535>.

11. "What Is Mental Illness: Mental Illness Facts," National Alliance on Mental Illness, available at http://www.nami.org/template.cfm?section=about_mental_illness.

12. Philip S. Wang, Patricia A. Berglund, and Ronald C. Kessler, "Patterns and Correlates of Contacting Clergy for Mental Disorders in the United States," Health Research and Education Trust, 2003, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360908>.

church leaders do not realize that they are first responders for mental health problems. From this position on the front lines, pastors and congregations can provide people with mental illness with friendship, love, and hope in Christ. Are they?

In 2010 I conducted a survey among five hundred readers of *Leadership Journal* and other publications for church leaders published by Christianity Today. I asked about their experiences with mental illness among members of their congregations, in their families, and personally. I also asked what their churches believe about mental illness, how they treat people with mental illness, how frequently they mention mental illness in sermons, and other revealing questions about this sensitive topic. I published the results of this survey in *Troubled Minds: Mental Illness in the Church's Mission*.¹³ My 2014 survey update yielded few changes.

Among the five hundred church leaders who responded to my 2010 survey, 98 percent indicated they had seen some type of mental illness in their congregation. Nearly half (44.5 percent) said they are approached two to five times per year for help in dealing with mental illness. Almost 33 percent (32.8) are approached more frequently, from six to more than twelve times per year. Twenty-nine percent said that on average mental illness is never mentioned in sermons at their church, 20 percent said mental illness is mentioned once a year, and 29.4 percent said two to three times per year. It is important to place this statistic within the context of another. Mental illness affects 20 to 25 percent of the adult population of the United States in any given year,¹⁴ and over the course of a lifetime, nearly 50 percent of us will experience a mental health problem.¹⁵ People who are suffering often come to the church first. Yet this kind of hardship is barely mentioned in our pulpits.

The gaps do not end there. Only 56 percent of church leaders said they have reached out and ministered to the family of someone with mental illness within their congregation. And although 80 percent of church leaders said they believe mental illness is “a real, treatable, and manageable illness caused by genetic, biological, or environmental fac-

13. Amy Simpson, *Troubled Minds: Mental Illness and the Church's Mission* (Downers Grove, IL: InterVarsity, 2013).

14. Various sources report statistics in this range. See Victoria Bekiempis “Nearly 1 in 5 Americans Suffers from Mental Illness Each Year,” *Newsweek* (February 28, 2014), <http://www.newsweek.com/nearly-1-5-americans-suffer-mental-illness-each-year-230608>, and “Mental Illness: Facts and Numbers,” National Alliance on Mental Illness, http://www.nami.org/factsheets/mentalillness_factsheet.pdf.

15. “Data on Behavioral Health in the United States,” American Psychological Association, <http://www.apa.org/helpcenter/data-behavioral-health.aspx>.

tors,” only 12.5 percent said mental illness is openly discussed in a healthy way in their church.

For church leaders, part of the problem may be a feeling of incompetence, just as it is for many of us when we think of mental illness. In my survey 53 percent of respondents indicated they feel “somewhat equipped” to minister to people suffering from mental illness. Only 27 percent felt “competent” or “confident,” and 3 percent considered themselves “expert.” Sixteen percent felt “not equipped at all” to minister to people with mental illness. My study revealed that, in general, church leaders who themselves have suffered from some type of mental illness feel more competent to minister to others who are suffering. Church leaders’ own experiences seemed to affect their responses in other ways as well. For example, church leaders who had suffered from mental illness were less likely to feel that their church discusses mental illness openly and in a healthy way (9.5 percent). Among those who had not suffered, 16 percent believed mental illness was openly talked about in a healthy way in their church.

Some Christian traditions mistrust psychiatric medicine. Believing all ailments can and should be handled within the church, some pastors discourage people from receiving the treatment they need. On the other hand, many church leaders assume that addressing mental health is the task of mental-health professionals exclusively. While it is often wise to refer a congregant to counseling or other treatment outside the church, the church should avoid the misconception that having made the referral their job is done. Even after those suffering from mental illness have received needed mental-health care, there is a distinct role to be played by the church. The front lines are populated with well-meaning people who often lack the confidence and tools they need. But we must respond. Helping people affected by mental illness is part of the church’s mission and calling. This is true not only for church leaders, but also for every Christian. We are responsible for our response to people in need.

We All Can Help

The good news is there is plenty of opportunity to help and improve support for families affected by mental illness. In most churches, one small step can make a big difference. And it is not necessarily up to the pastor to do the work. The most passionate, most well-equipped people for this kind of ministry are those who have their own story to offer—a story of living with mental illness, a story of loving someone through this

struggle. Some are called to do something requiring a big investment. Others simply are required to love others in small ways. Here are some ways, big and small, that we in the church can help families affected by mental illness.

1. Start by humbly acknowledging your own problems. Whether or not you have your own struggle with mental health, we are all flawed and scarred. We all have parts of ourselves that do not work as they were designed to work. Those who truly are effective in ministering to those impacted with mental illness are the ones who are aware of their own weakness.

2. What does your church teach about suffering, explicitly or implicitly? Be sure your church is teaching clearly that we should not expect a pain-free life on this earth. Christian theology teaches that our world is an imperfect place, polluted by our rebellion against God. Our bodies are affected by sickness and decay. There is no reason for us to believe that people who believe in God, go to church, repent of their sin, and follow Jesus are immune to the trouble that is part of the human experience on this earth. A prevalent assumption in our culture is that life should be easy and “happy.” Many Christians adopt this idea within their theology, and churches must actively correct it.

3. Recognize the person before you see the illness. Sometimes people with mental illness feel as if others see them as walking problems. But they are people like the rest of us. Make eye contact, smile, say hello. Don't pretend they're not there, and don't allow irrational fear to overwhelm you. So often our first reaction to mental illness is fear. If someone is dangerous to self or others, call the police. Otherwise, your fear probably is irrational. Try to look past it and recognize the real person in front of you, with the same human needs you have.

4. Be a friend. We often believe we are not qualified to help people struggling with mental illness if we are not qualified to treat their disorder. We do not have this same reaction when people are suffering from other types of illness. Most of us can't treat cancer, but we know we can offer friendship and practical support to people who have cancer. Most of us can't set broken bones, but we don't keep our distance from people who have them. You may not be qualified to treat mental illness, but everyone is qualified to be a friend. Do what you would do for other suffering people. You already know how to respond when someone needs help because of illness, injury, or family crisis. You bring meals, give rides, take them to the doctor, ask how they're doing, help them with expenses,

and visit them in the hospital. You can offer this same practical help to families affected by mental health crises.

5. **Encourage open talk about mental illness** in sermons, classes, Bible studies, and public prayers. In most churches, this step alone has the potential to transform the culture of the church, keep people plugged into the community, keep hearts open to God, and even save lives. One of the great tragedies of the stigma that surrounds mental illness is that it keeps people silent about their struggles when they desperately need to connect with others who will understand. Although mental illness is about as common in the United States as diabetes, cancer, heart disease, HIV, and AIDS combined,¹⁶ this silence means many people feel desperately alone and marginalized by their experience. Talking about struggles with mental illness normalizes them. And talking about them in the context of the church, informed by Christian theology and the gracious love of Christ, can transform them.

6. **Refer people to counselors, support groups, and other types of care.** Make sure your church builds a network of local professionals, creates a list of contact information, and makes it freely available to everyone. Include resources for people with illness and their families. It can be difficult and overwhelming for them to find appropriate help, especially in a time of immediate crisis. This is a hugely helpful resource churches can provide.

7. **Don't abandon people** once you've connected them to professional mental health care. Your job is not over, and a mental health professional will not provide what you can provide. Through God's grace, refuse to be fearful or put off by families in crisis. Assure them of God's love and that God has not abandoned them (Romans 8:35–38).

8. **Start or advocate for a support group or ministry** within your church or community. Perhaps this is a ministry you can start in partnership with other churches. Perhaps someone in your church already has the necessary expertise for this. In *Troubled Minds: Mental Illness and the Church's Mission*, I profiled four churches that have thriving ministries to people affected by mental illness.¹⁷ None of these ministries was started or is led by a pastor; all four are led by someone who lives well with mental illness or has an immediate family member whose life was changed by a struggle with mental health. This does not have to be one more job for the pastor!

16. Simpson, *Troubled Minds*, 37.

17. Simpson, *Troubled Minds*, 166–79.

Improving the response to mental illness is not just a job for mental health professionals. In fact, we are all on the front lines in this fight. All of us are called to help people with mental illness and their families. Those who have mental illness must speak up about what they need. And people like me, who have watched loved ones suffer, must advocate for them.

Conclusion: Support Makes a Difference

A couple of years ago I received a package from my mom. Inside were special outfits she had sewn for my kids. They were custom-made to my children's specifications, and they were beautifully and lovingly crafted. There was a long stretch of years leading up to that time when I would not have believed Mom would ever have the capacity to do such a project, but by the grace of God she had surprised me. She was stabilized on the medication she needed, making healthy choices for herself, and doing kind things for her grandchildren. She was the person we knew her to be and had missed for many years. She was functioning well.

Then, after three years of relative stability and health, a few months after I had released a book that included painful portions of my family's story, Mom once again stopped taking the full strength of medication she needed and lost touch with reality. My family was in crisis again. But something was different this time, and we discovered the power of having our story known. Because we had told our story, we had people praying for us and helping us, and we knew where we could go for support. We had had conversations with one another and done individual work that made us a healthier family. And this made a huge difference. Because of that, we were able to handle the crisis quickly. Within a few weeks Mom was living in a safe place and getting the care she needed, and a few months later she was psychologically stable.

Mom's schizophrenia isn't gone. I can't say she will never have another psychotic episode, but I can say she is a picture of the hope all people with mental illness can have. Modern medicine offers great hope for treatment, and loving, consistent friendships are the best context for encouraging people to get and maintain needed treatment. For the family, having support makes all the difference. And even more powerful, no one is ever beyond the reach of God's love, grace, and redemption. Both now and in eternity, the church has a message of hope that people affected by mental illness need.

A passage from *Troubled Minds* speaks to this kind of hope and its

source: “We are all in this together, and we all have hope in the current redemptive work of Christ and the future and eternal fulfillment of his promise of life without the burden of sin.”¹⁸ I can’t emphasize redemption enough. For we can offer hope based in medical and psychological treatments, loving relationships, the good things in life, and all the reasons we have for living well in the here and now. Yet ultimately this kind of hope pales in comparison to the hope we find in looking toward our eternal future and the coming redemption. We find hope 2 Corinthians 4:17–18 (NLT) speaks of this hope: “Our present troubles are small and won’t last very long. Yet they produce for us a glory that vastly outweighs them and will last forever! So we don’t look at the troubles we can see now; rather, we fix our gaze on things that cannot be seen. For the things we see now will soon be gone, but the things we cannot see will last forever.”

But God’s grace doesn’t stop there. God lovingly shows us glimpses of what is coming our way. He refuses to leave us as we are, never giving up on us. He takes the ugliest parts of life and uses them to grow something beautiful. We have hope now not only because of what is coming but also because of Jesus’s present work in and through us. It’s the work of redemption. Sometimes it simply serves to heal what was broken. Sometimes it brings us a new understanding as we walk through suffering. Sometimes it sets us free from prisons we never could have left on our own. As I wrote in *Troubled Minds*,

What’s remarkable about this life is not that we have pain, that we suffer, that life gets so ugly we can’t even look at it. The remarkable thing is that we have anything but suffering. That there is a large supply of goodness in this world. That despite our best efforts at self-destruction, grace still shines on us and the sun rises. That we are surrounded by beauty. That we know how to laugh. That we can laugh and cry at the same time. And—most remarkable—that our suffering and pain themselves become the media for some of God’s most beautiful work. It’s called redemption, and we overlook it every day.¹⁹

Let us join in this work of redemption. Let us be the instruments God uses to do beautiful work in and through people with mental illness.

18. *Ibid.*, 200.

19. *Ibid.*, 201.

We are the church, and it is our responsibility to do something—all of us. We can all start simply by extending grace to each other and taking some risks in relationship. This is the best way for us to participate in the beautiful redemptive work God is constantly doing in our world. And ultimately, the true hope we can offer lies in that redemption.

I conclude this article as I did *Troubled Minds*, with a blessing for the body of Christ, the representative of his love and compassion on earth:

A BLESSING FOR THE CHURCH

There is hope! Let us, the church, proclaim that hope in what we say and do.

May your heart be open.

May you understand your own suffering as an opportunity to witness God's redemption.

May you see the suffering within your church and outside your walls and respond with sacrificial compassion.

May God's redemptive work cause the struggles of people in your church to blossom into loving ministry toward the suffering.

May you invest what God has given you in things that will last forever.²⁰

“Three things will last forever—faith, hope, and love—and the greatest of these is love” (1 Corinthians 13:13, NLT).

20. Ibid., 210.