What Is Medical About Mental Illness?

I. A Growing Controversy with the Publication of the DSM 5.

A. What part of it is real illness?

B. The controversy is between psychologist and psychiatrists.

C. Counselees sincerely believe that they have a disease which holds their behavior captive. They come with the labels such as PTSD, OCD, ADHD, SAD, BPD, ADD, and others. What is fact in all of this and what is theory?

D. Biblical views of illness (Luke 8:41-48, Mark 5:25-34). There are some problems medicine cannot deal with.

E. The sick need a physician (Mark 2:17).

F. Our current standards of care may not help (John 5:1-9).

II. What is the definition of disease? What is mental illness, medical illness?

A. Medical illness. Dictionary: a pathological change in the body. Must be objective. "…a disorder of structure or function…that produces specific signs or symptoms that affects a specific location and is not simply a direct result of physical injury."

B. Virchow, the father of modern pathology.

C. Mental illness: "A health condition that changes a person's thinking, feelings, or behavior and that causes the person distress and difficulty in functioning." – NIH/NIMH

D. The Surgeon General -- Mental illness is difficult to diagnose because there is not pathological change in the body.

E. Sometimes physicians cannot give objective evidence for a real disease. Migraine vs. diabetes.

III. Medical ailments with emotional, behavior, and thinking struggles.

A. Obstructive sleep apnea, sleep deprivation.

B. Cushings disorder.

C. Lupus.

D. Porphyria.

E. Hepatic encephalopathy.

F. Hypo/hyperthyroidism.

G. Schizophrenia.

H. Polypharmacy.

IV. The List! What is the difference:

A. PTSD. Real struggles with worry and fear. No pathology. Overlaps with traumatic brain injury. The Bible can give great comfort.

B. ADD/ADHD. No conclusive pathology. MRI studies are flawed.
- Use the scriptures. Warning: not every child labeled ADHD is well.
- Look for another neurological disease or disorder. Being different is not disease.

C. OCD. PET scanning is interesting. Use the scriptures.
- Always be gracious and patient.

D. Depression. Normal and disordered sadness.

E. BPD 1. No pathology, but leave room for questions. You cannot counsel people who are out of touch with reality. The Scriptures offer great help when they are back in reality.

F. BPD 2 and all variants. No pathology, use the Bible.

V. What is true?

A. What are you going to believe: theory or truth? (Psalm 19:2-11, John 17:17)

B. How do I parse my way through this?

C. Never call sin a disease!

D. Never call anything sin the Bible does not clearly identify as sin.

E. Always look for pathology if you are going to label something a disease.

VI. How to be helpful in the middle of the controversy. (1 Thessalonians 5:14-15)

A. Admonish the unruly. Those without a goal.

B. Encourage the fainthearted. The normally sad.

C. Help the weak. Those who struggle with physical disadvantage.

D. Be patient with all.

E. Do not zing back!

F. Seek good for others in and out of the body of Christ!

The Sufficiency of Scripture and Medicine Integration

Introduction: How do Biblical counseling and modern medicine mix?

"The sufficiency of scripture is not anti-medicine or anti-doctor; it is pro-Bible."
Dr. Bob Smith

I. Ground rules set by Scripture. Mark 5

A. The Gerasenes Demoniac. (verses 1-20)

1. He was not medically ill!
2. Today he would be identified as schizophrenic.
3. The Incarnate Word was superior and sufficient.

B. A dying child and a suffering patient. (verses 21-43)

1 Medicine was failing the child.
2. Medicine had failed the suffering woman.
3. Jesus was the superior and sufficient answer for the woman.
4. The Incarnate Word was the superior and sufficient answer for the girl.
5. No matter what the medical problem, if Jesus is there and so chooses, He will be sufficient and superior to whatever medicine can do.

C. What use are doctors?

1. Healing starts in chapter 1 of Mark's gospel.
2. The sick need a physician! Mark 2:14-17
3. Jesus did not always choose to heal the sick. John 11.
4. Jesus did not heal Paul. 2 Corinthians 12:7-10
5. When God chooses not to act, we need physicians.

D. An important note: If Jesus is superior and sufficient, is His Word?

1. Our Lord is completely identified with His Word and the Word is completely identified with Him. John 1:1-18.

2. Jesus is the Truth. John 14:5-7.

3. Jesus is the Truth and the Word is Truth! John 17:17.

4. In the same way, when Jesus chose to be sufficient and superior in medicine, the Word He gave us will be sufficient and superior when it speaks about issues in medicine.

II. How should Biblical counseling and medicine mix?

A. Definitions:

1. Sufficiency. 2 Peter 1:1.

a. Sufficiency is, according to the Westminster Confession, “the whole counsel of God concerning all things necessary for His own glory, man’s salvation, faith, and life, is either expressly set down in Scripture, or by good and necessary consequence may be deduced from Scripture.” (*A Theology of Biblical Counseling*, Lambert, page 42.)

b. “Christians sometime say that Scripture is sufficient for religion, or preaching, or theology, but not for such things as auto repairs, plumbing…and dentistry…That is to miss an important point. Certainly Scripture contains more specific information relevant to theology than dentistry. But sufficiency in the present context is not sufficiency of specific information, but sufficiency of divine words. Scripture contains divine words sufficient for all of life. It has the words the plumber needs, and all the divine words that the theologian needs. So, it is just as sufficient for plumbing as it is for theology. And in that sense, it is sufficient for science and ethics as well.” John Frame.

c. “The Bible tells a doctor all he needs to know in order to be a godly physician.” Dr. Bob Smith

2. Integration.

    a. The act of combining into a whole. Often reflects the idea that the two entities being integrated are equal. Particularly true for integrative Christian counseling.

    b. This should not be integration as much as it is finding out where medicine fits in with the Scripture.

3. Medicine. The practice of medicine involves the diagnosis, treatment, or correction of human conditions physical or mental by any means, methods, devices or instruments.

B. Medicine and Biblical counseling should complement each other.

1. Benjamin Rush, MD.
2. Strep throat and Pica.
3. OCD.
4. Depression.

Good Mood Bad Mood: Hope in Depression

Part One. Depression – what is it and how do we treat it?

1. First, a definition: What does medical science call depression?
   a. DSM5 criteria. Making diagnoses with rating scales.
   b. Understanding the suffering. Psalm 13, 42.

2. Knowing history keeps us from making the same mistakes.
   a. Depression rates stable until around 1960.
   b. Depression redefined in 1980. Exception for cause is changed in DSM 3.
   c. Prozac introduced 1987.
   d. Diagnosis of depression increased by 300% from 1987 – 1997.
   e. Antidepressant use doubles from 1995 – 2005.
   f. The chemical imbalance.

3. Who is affected?

4. After we diagnose, how do we treat?
   a. Medication.
   b. Psychotherapy, CBT, counseling.
   c. Christian liberty, medicine, and Romans 14.

5. What if they are wrong? What if they are right? Humility in uncertain waters.

6. Normal vs. disordered sadness.

7. Medicine and the sufficient Scriptures.

8. Sadness as a Biblical model in depression. 2 Corinthians 7.

9. Hope in a person. John 11.

10. Hope in grace: Hannah. 1 Samuel 1,2.

Part Two - How we can help.

1. Listen and let them talk. Remember Jesus, Martha, and Mary.

2. Understand. Asking good questions helps

3. Take them to the sufficient Savior. Psalm 23, 42.

4. Help them make the connection between the events, thinking, behavior, and emotion. John 11, John 13:17, Nehemiah 1, 2:1-2, Genesis 4:1-5.

5. Finding hope in the sufficient Word to respond to normal sadness and medical problems. 1 Corinthians 10:13, Philippians 4:13, Romans 8:31-35.

6. Changing thinking. Moving our thinking to:
   a. Truth! Philippians 4:8.
   b. Gratitude. Ephesian 5:18-21.
   c. Gospel. Preach it to ourselves. Romans 8:1.

7. Changing motive. 2 Corinthians 5:9, Matthew 22:37-39.
   - Moving from loss recovery to worship.

8. Changing actions. John 14:21, John 13, Philippians 4:9, Luke 9:23.
   - Work, exercise, Christian service.

9. Dealing with fear, anger, worry, guilt, grieving.

Good Mood Bad Mood: Bipolar Disorder

Introduction: Bipolar Disorder started the Journey.

I. Surge in Diagnosis since 1980.
   A. Epidemic?
   B. Changing criteria?
   C. Root of the problem is in diagnosis and treatment of depression.
   D. Similar subjective criteria method used to diagnose BPD as is in depression.
   E. Criteria for BPD 1 (old Manic Depression):
      1. Period of more than 1 week of improved mood.
      2. Irritable, inflated sense of self-esteem with decreased need for sleep.
      3. Easily distracted with a pressing need to get things done.
      4. Spending money they do not have. Disastrous sexual or moral choices.
      5. Mania is followed by depression. Diagnosis of depression required for BPD1.
   F. Tom's story fits.

II. Moving from Manic Depression to Bipolar Disorder.
   A. Starts with the Birth of Modern Medicine.
      1. William Perkin in 1900, discovery of purple dye.
      2. Paul Ehrlich used it to stain tissue samples.
         a. "It should be possible to find artificial substances which are really curative for certain diseases, not merely palliatives acting favorably on one or another symptom."
         b. Ehrlich found that nearly half of the patients at the Charite mental hospital (asylum) in Berlin had an infectious disease that caused their insanity.
         c. Truth is never an enemy in the pursuit of understanding and curing disease.

3. Freud turned psychiatry away from the kind of pathology-based medicine of Ehrlich and towards theory based explanations

B. Psychiatry was in disarray by 1950. Out of it came the drive to standardize psychiatric terms and descriptions of disease.
   1. Diagnostic Statistical Manual of Mental Disorders first published in 1950 tried to bring order.
   2. In the 3rd revision of the DSM in 1980, bipolar disorder was added in the place of manic depression.
   3. Prozac was launched in January 1988.

C. Bipolar disorder categories.
   1. BPD1, the old manic depression.
   2. BPD2.
   3. Cyclothymia.
   4. BPD caused by substance abuse or medication induced.
   5. BPD due to another medical condition.
   6. BPD, other specified bipolar disorder and related disease (was bipolar disorder not otherwise specified).

D. With the DSM3, came a couple of important changes in the diagnosis of BPD:
   1. You no longer had to have a week long episode of mania requiring hospitalization.
   2. The criteria for BPD2 is less restricted.
      a. Presence of one or more major depressive episodes.
      b. Presence (or history) of a least one hypomanic episode.
      c. There never has been a manic episode or mixed episode.
      d. Symptoms are not better accounted for by other disorder.

e. The symptoms cause significant clinical distress or social impairment in social, occupational or other areas of function.

3. The key difference is between mania and hypomania, which makes it much less difficult to apply the diagnosis.
    a. A distinct period of persistently elevated, expansive, or irritable mood, lasting at least 4 days, that is clearly different from the usual non-depressed mood.
    b. During the period of mood disturbance, 3 or 4 of the following symptoms have persisted (4 if only irritable) and have been present to a significant degree.
        1. Inflated self-esteem or grandiosity.
        2. Decreased need for sleep. (feels rested after 3 or 4 hours)
        3. More talkative than usual or feels pressure to keep talking.
        4. Flight of ideas or subjective experience that thoughts are racing.
        5. Distractibility
        6. Increase in goal directed activity (social, work, school, sexually) or psychomotor agitation.
        7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (buying sprees, sexual indiscretion, or foolish business investments).

E. Represents change in function level, observed by others.

F. Not severe enough to cause marked impairment in social or occupational functioning and does not have psychotic features.
    1. This is the important dividing line.

2. “Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (medication, ECT, light therapy) should not count toward a diagnosis of bipolar II disorder.
3. The problem is that most people labeled with depression are on antidepressant medication when labeled with BPD2.

    “Instead of treating a new disease, we may simply be treating the side effects of a drug used to treat an old one.”

III. How can we help? Example: the case of the struggling young mother.

A. “The solution is the same as it always has been in medicine. We need to make a better diagnosis based on the most solid factual evidence we can get.”

1. It starts by recognizing that the diagnosis of bipolar disorder is just as confused today as is the diagnosis of depression. The labels offer us no pathological certainty or validation.
2. As disordered/normal sadness is the key to understanding depression, so mania/hypomania is the dividing line in BPD.
3. In the absence of mania, the bipolar 2 label has no more validity than the label of depression in the absence of disordered sadness.
4. The first important thing to do is to deal with normal sadness/grieving due to loss.
5. All of the aspects of Biblical counseling come to bear on this issue and the problems that grow from it. Sadness, sorrow, loss, anger, fear, worry, bitterness, self-orientation, idolatry, grace, hope, confidence, repentance, faith, sanctification, salvation, or perseverance, are all areas that will need to be explored.
6. Responsibility for behavior. Example: Dr. Welch’s patient.

"(the) scriptures tell us that our sin comes out of our own hearts and that mania could not cause him to sin." Ed Welch, CCEF Conference, Lecture Fall 2011.

B. Medication

1. BPD1: If patient has had 2 or more episodes of mania, it is likely to be in their best interest to continue the best and most tolerable medication that controls their symptoms.
2. BPD2: The benefit of medication in these cases is subject to question.
3. In either case, the use of medication is not a primary issue in Biblical counseling!
4. Primary goal of Biblical counseling starts in 2 Corinthians 5:9:

   "I want to glorify God with my life more than I want to breathe!"
5. The greatest benefit to those with mood disorders is to be found in discerning between normal and disorder sadness due to loss and then dealing with them biblically.