

Article

# Preaching Wholeness: Attending to Mental Health in Preaching Ministries

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**Abstract:** “Wilt thou be made whole?” This is a question posed by Jesus in the Gospels. Wholeness for Jesus means being in right relationship with God and in right relationship with other human beings. Wholeness can also be defined as completeness or well-being. This essay argues that preaching ministries committed to addressing the total well-being of all of God’s people must include sermons about mental health. As evidence of the need, the author cites statistics from the National Institutes of Health (NIH) that at least one in four people in the United States is affected by mental illness directly or indirectly during their lifetime. Then, to equip preachers to address mental health concerns, the author: addresses the causes of mental health stigma both in and beyond the pulpit; shares theological and hermeneutical approaches and concerns of disability proposed by the theologians Nancy Eiesland and John Swinton and homiletician Kathy Black; and provides resources for preachers to use in their preaching.

**Keywords:** mental health; mental illness; disability theology; preaching wholeness

## 1. Introduction

The Greek adjective *hygies* in the New Testament means whole, healthy, sound, complete, or characterized by well-being. In New Testament narratives, when people with physical and mental afflictions came to Jesus, he made them whole (Matt 12:13, Mark 5:34, John 5:6, Luke 5:31, etc.), meaning he restored them to right relationship with God and the community by forgiving their sins in addition to curing their diseases or healing their afflictions. The wholeness that Jesus enabled people to experience was not only about helping people achieve some sort of physical or mental health. Rather, it was about mending broken relationships and restoring a general sense of well-being. Before being made whole, those with physical and mental afflictions were marginalized or forced to live outside of their communities. After their encounters with Jesus, they were able to return to full communion. Therefore, preaching wholeness means developing sermons that help people achieve a general sense of well-being or be restored to right/good relationships with God, other people, the environment, and all of God’s creations (Carlson and Chase-Ziolek 2006).

The underlying premise of this paper is that God wants all of God’s people to be whole. Mental health is one aspect of human existence that impacts human wholeness. As a result, the prevalence of mental illness and the stigma and discrimination experienced by those impacted by mental illness (both inside and outside of the church) mandate that mental illness and mental health be addressed at the pulpit. Statistics and data from the National Institutes of Health (NIH) and the World Health Organization (WHO), along with information about mental health stigma, will provide evidence of a need to address mental health from the pulpit. The work of theologians and one homiletician will be engaged to develop a concise mental health hermeneutic. Though a more comprehensive hermeneutic is warranted to meet the tremendous existing needs, the parameters of this article are limited to the breadth of the hermeneutic being offered here.

Having asserted that mental health is essential to the overall well-being of all people (Organ 2017, p. 13), we begin by defining the terms “mental health” and “mental illness”,



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sharing the breadth and scope of mental illness and offering some reasons for the existence of mental health stigma (inside and outside the church).

## 2. Overview of Mental Health Issues and Challenges

Mental health and mental illness are two very different states of being. The World Health Organization defines mental health comprehensively:

“Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.” (World Health Organization 2023)

In addition to noting how crucial mental health well-being is to essential human functioning, the WHO’s definition declares that mental health is a basic human right. This means that every human being has the right to live in a world with the social, economic, and political infrastructure to support their mental health well-being. The National Institutes of Health defines mental illness this way: “Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses can be associated with distress and/or problems functioning in social, work or family activities” (American Psychiatric Association 2023).

With regards to the scope of mental illness, the National Institutes of Health contends that at least one in four people in the United States is affected by mental illness directly or indirectly during their lifetimes (National Library of Medicine 2007). Statistics about the impact of mental illness include the following:

- According to recent estimates, approximately 20 percent of Americans, or about one in five people over the age of 18, suffer from a diagnosable mental disorder in a given year.
- Mental illnesses are the cause of four of the ten leading causes of disability, including major depression, bipolar disorder, schizophrenia, and obsessive–compulsive disorder.
- Approximately three percent of the world’s population have more than one mental illness at a time.
- Approximately five percent of adults are affected by severe mental illnesses (such as severe forms of depression, panic disorder, and obsessive–compulsive disorder) that preclude them from being able to function effectively in society.
- Approximately 20 percent of medical appointments are related to anxiety disorders such as panic attacks.
- Eight million people suffer from depression each year.
- Two million Americans have schizophrenia disorders, and 300,000 new cases are diagnosed each year (National Library of Medicine 2007).

Mental illnesses are caused by genetic, environmental, and social factors (National Library of Medicine 2007). Disorders such as autism, attention deficit hyperactivity disorder (ADHD), bipolar disorder, major depression, and schizophrenia can be genetic. In a study conducted in 2013 in which the potential for genetic roots was discovered, scientists found genetic glitches that may lead to more effective treatments for mental illnesses (National Institutes of Health 2013). Having relatives with mental illness does not necessarily mean those related to them will have the illness as well. However, it does increase one’s risk of mental illness.

While some mental illnesses can be genetic, others can be caused by the environments in which we live (National Library of Medicine 2021). Some environmental factors include environmental pathogens, environmental destruction, and environmental form (National Library of Medicine 2021). Pathogens are parasites that have the ability to attack, live in,

and reproduce in human bodies. The novel coronavirus is an example of an environmental pathogen that has impacted the mental health of millions of people around the world.

Environmental destruction can be experienced in many different forms, including catastrophic and traumatic events such as hurricanes, tornadoes, floods, earthquakes, and fires. These types of events happen quickly but can radically change the life trajectories of those affected through the sudden loss of loved ones, property, and/or physical health. These events cause psychological distress, depression, and anxiety.

The term “environmental form” refers to the built, social, cultural, and political environment in which people live. Environmental form includes the social conditions created by public policies such as redlining, racial discrimination, and the systematic denial of goods and services to particular populations. For example, during the COVID-19 pandemic, the housing and income instability experienced by many communities led to a prevalence of mental health conditions such as depression and anxiety ([National Library of Medicine 2021](#)).

Genetic, environmental, and social factors often converge to create poor mental health outcomes. For example, growing up in poor urban environments doubles the risk of developing Alzheimer’s disease and other dementias, depression, and anxiety ([National Library of Medicine 2021](#)).

There are more than two hundred types of mental health disorders, including:

- Anxiety disorders
- Attention deficit/hyperactivity disorder (ADHD)
- Autism spectrum disorder
- Depression, bipolar disorder, and other mood disorders
- Disruptive behavior disorders, such as oppositional defiant disorder and conduct disorder
- Eating disorders
- Obsessive–compulsive disorder (OCD)
- Personality disorders, including borderline personality disorder and antisocial personality disorder
- Post-traumatic stress disorder (PTSD)
- Schizophrenia and other psychotic disorders
- Substance use disorders, including drug addiction and alcohol use disorder ([Cleveland Clinic 2024](#))

The prevalence of mental illness, which impacts people who are members of Christian communities as well as those who are not, creates a need for the topic to be addressed at the pulpit. Despite the fact that scientists and mental health professionals have identified many of the genetic, environmental, and social factors that can contribute to mental illness, those with mental illness often experience social stigma ([Wright 2020](#), p. 530).

### 2.1. Societal Stigma

According to the American Psychological Association, stigma, as it relates to mental health, is defined as prejudice against people with mental illnesses ([Weber and Boland 2023](#)). Mental health stigma has three manifestations: public stigma, self-stigma, and institutional stigma. Public stigma relates to the negative attitudes and biases people have about mental illness. Self-stigma is defined as negative attitudes people internalize about mental illness. Institutional stigma refers to systemic laws, structures, and policies of the government and other organizations that discriminate against people with mental illness.

Some prejudice against people with mental health illnesses stems from a lack of understanding and fear ([Borenstein 2020](#)). In Greco-Roman society, a stigma was a physical brand used to mark people as slaves or criminals. For hundreds of years, people who suffered from illnesses such as depression, schizophrenia, anxiety, and autism were treated like criminals. In some cultures, people with mental illnesses were believed to be possessed by demons and were burned at the stake, institutionalized in mental institutions, or chained to their beds ([Rossler 2016](#)).

Today, mental health continues to be stigmatized in many different societies and cultures. In her book *Troubled Minds*, Amy Simpson highlights the many manifestations of mental health stigma that are regularly employed in the media. For example, people with mental illness are portrayed in movies such as “Psycho,” “Strange Brew,” “The Shining,” and “Fatal Attraction” as terrorists or made fun of to generate cheap laughs (Simpson 2013, p. 144). In ordinary conversation, the terms “crazy” and “psycho” are used to characterize behavior that is perceived as abnormal or that may tend towards violence or disruption (p. 145).

However, over the past few years, including during the COVID-19 pandemic in 2020, public awareness of the need for mental health care has increased. Having celebrities such as Simone Biles, Mariah Carey, and Kristen Bell publicly share their mental health struggles has gone a long way toward helping mitigate the stigma of mental health.

Internationally renowned gymnast Simone Biles was lauded by some and criticized by others when she withdrew from the women’s team’s gymnastic final in the 2020 Tokyo Olympic Games, citing concerns about her mental health (Ramsay et al. 2020). Biles has won seven Olympic medals, four of them gold. While performing her Amanar vault, a challenging dismount involving a back handspring and two and a half twists, Biles landed awkwardly. The crowd gasped when they witnessed her uncharacteristically inexperienced landing. After withdrawing, Biles told reporters, “I have to focus on my mental health and not jeopardize my health and well-being” (Ramsay et al. 2020). She went on to say, “It just sucks when you’re fighting with your own head.” Gymnastics is a demanding physical sport, and being mentally unhealthy can put a gymnast’s physical health in jeopardy. Years before the Tokyo Olympics, Biles publicly discussed her ongoing struggles with anxiety and panic attacks (Williams 2021).

Singer Mariah Carey has sold more than 200 million records and achieved eighteen Billboard number-one hits. She was diagnosed with bipolar disorder in 2001 (Cagle 2018). However, she remained silent about her diagnosis for many years due to her fear of being exposed. By sharing her story publicly, she hopes that she can help destigmatize mental health so it can be publicly discussed and so people will not be ashamed to seek the help they need. She also wanted to remove from herself, and others, the burden of maintaining silence or keeping their mental health challenges secret (Cagle 2018).

Kristen Bell, star of the television shows “Veronica Mars” and “The Good Place,” started taking medication for anxiety and depression when she was a student at New York University’s Tisch School of the Arts (Scipioni 2021). Even after achieving a level of success as an actress, she remained silent about her struggles because of the stigma. However, in 2016, she decided to use her status as a celebrity to help those with mental struggles realize that they do have value and worth. She contends that it is important for people to separate the feelings they have while experiencing mental illness from their identities as human beings (Scipioni 2021). The breadth and depth of who they are as people transcends their mental health diagnosis.

However, though some progress has been made, much more work needs to be done to counter the stigma of mental illness. Some of that work needs to be done within Christian faith communities.

## 2.2. Mental Health Stigma in the Church

People of faith sometimes bring their lack of understanding and fear of people with mental illness with them into the church. Unfortunately, most do not receive any teachings or preaching to inspire them to reconsider their thinking on the matter (Lehmann et al. 2021, p. 2).

Mental health stigma within the church can be exacerbated or caused by contextually unsound approaches to biblical interpretation. Even in the twenty-first century, some preachers teach their people to ignore medical science and medical advances. Rather, they teach that the only way God heals is through miraculous intervention, and that the cause of all disease and illness is sin. For example, prosperity preachers such as Bill Winston teach

their followers that Jesus is able and willing to heal everyone of all sickness and disease (Mumford 2012, p. 85). Therefore, true Christians, those who have real faith in God, should never suffer from sickness and disease. Followers of Christ have only to ask and believe to receive healing. This doctrine is the result of a literalist interpretation that assumes that because Jesus healed everyone that he encountered in the Gospels who demonstrated belief in his healing abilities, God, through the person and work of Jesus Christ, will always miraculously heal all people for all time who demonstrate similarly strong faith.

In some congregations, people with mental illnesses are likened to the Gerasene man possessed by demons in the Gospels (Mark 5:1–20; Luke 8:26–39; cf. Matt 8:28–34). In this text, a man who is possessed by demons spends his days and nights howling and injuring himself with stones. No one knows what to do with him. He continually breaks chains that are put upon him by those who try to restrain him. However, when he has an encounter with Jesus, his destiny changes. At once, Jesus determines the man to be possessed by an unclean spirit. Jesus commands the unclean spirit to leave the man at once. The man is immediately restored to his “right mind.” Fear of people who are not in their “right mind” has been pervasive in communities from antiquity to today. Whereas people in the first century labeled this man as “demon-possessed,” mental health professionals today are able to diagnose people exhibiting similar symptoms and to prescribe therapies and medicine to help them live productive lives. To categorize all people with mental illnesses as people who are out of control and who can potentially do harm to others or themselves is misinformed.

In many of the healing stories of the Bible, such as the healing of a paralyzed man (Matt 9:2–8; Mark 2:1–12; Luke 5:17–26), Jesus heals those with physical afflictions by also forgiving their sins. In this particular text, Jesus encounters a man who is paralyzed being carried on a stretcher. In this case, Jesus perceives that the people transporting the man have strong faith. Jesus tells the man, “Take heart, son. Your sins are forgiven.” The scribes, who are witnessing this encounter, immediately accuse Jesus of blasphemy because only God has the power to forgive sins. In response, Jesus upheld his commitment to forgiveness by asking, “Which is easier to say, ‘Your sins are forgiven’ or ‘Stand up and walk’?” The conflation of these two statements would seem to suggest that for Jesus, physical affliction is related to sin. Reading other biblical texts such as John 9:3 refutes this contention. In this text, when Jesus encounters a man who has been blind from birth, the disciples ask whether it was the man born blind or his parents who had sinned and thus caused his visual impairment. Jesus says it was neither.

It is this kind of literalist biblical interpretation that biblical scholar and theologian Rudolf Bultmann was attempting to combat when he wrote that Christians need to demythologize their hermeneutical approaches (Bultmann 1958, 2007). Preaching was important to Bultmann. He grew up hearing his father preach every week. When he was a student at university and graduate school, homiletics was his favorite subject within practical theology, so much so that he focused his dissertation at Marburg, entitled, “The Style of Pauline Preaching and the Cynic-Stoic Diatribe,” on the concept of preaching (Dennison 2008, pp. 66–69). He believed that it is in the preaching moment that decisions about faith are made. One of Bultmann’s primary goals with his research was to make Christianity relevant and appealing to Christians who had adopted a scientific worldview. Many people in his German context no longer believed in the mythological worldview of the Bible. “Mythological worldview” for Bultmann included belief in heaven and hell; the intervention of God and Satan in the daily lives of all humanity; the catastrophic end of the world by orchestrated by God; the ascension of Jesus to sit at God’s right hand; and Jesus’ return to facilitate the final judgment of all of humanity. Bultmann characterized these beliefs as mythological, as none of them can be scientifically verified (Bultmann 1984, pp. 2–10).

Some believe that Bultmann’s challenge of the mythological worldview of the Bible went too far—to the point of obliterating the need for followers of Christ to have faith or belief in anything they cannot see or that cannot be scientifically proven. While this is a

valid concern, at its core, Bultmann's argument is that followers of Christ can have faith in the God of the Bible while also embracing science. Having faith in God and embracing scientific worldviews are not mutually exclusive propositions.

Preachers who are committed to preaching wholeness in their preaching programs should encourage their people to adopt a holistic faith. Holistic faith is one in which they believe that God can and does sometimes heal miraculously. However, God has created and gifted people with abilities to effect healing through medical and scientific approaches, and to believe that even when people do not experience physical or mental healing, God is yet with them.

Preaching wholeness as it relates to mental health requires the advent of a hermeneutic of mental health. Developing a mental health hermeneutic can be aided by input from disability theologians and homiletician Kathy Black and her healing homiletic.

### 3. Theology of Disability and a "Healing Homiletic"

Throughout human history, people with disabilities have been marginalized and discriminated against both inside and outside of religious communities. In order to develop a mental health hermeneutic, we will engage the work of a two theologians and one homiletician. One of the theologians (Nancy Eiesland) and the homiletician (Kathy Black) write broadly about issues of disability. However, though the writings that broadly address people with disabilities also include concerns of those with mental illnesses, only thoughts and ideas that pertain directly to those with mental illnesses will be used to develop our mental health hermeneutic. The second theologian (John Swinton) focuses his writing directly on issues of mental health.

In the 1990s, disability activists and theologians such as Nancy Eiesland began to challenge existing beliefs and practices in the United States and beyond. For Eiesland, full inclusion of the people of God in society and in the church begins with rethinking conceptions of people with disabilities that have been shaped by interpretations of biblical texts and ecclesial policies and practices.

#### 3.1. Nancy Eiesland and the Disabled God

Nancy Eiesland was born Nancy Lynn Arnold in Cando, North Dakota, with a congenital bone defect (Martin 2009). She began her activism work in high school and continued while in college at the University of North Dakota. She went on to Emory University in Atlanta, Georgia, where she earned her Master of Divinity in 1991 and PhD in Ethics and Society in 1995 (Martin 2009). She became an associate professor of Sociology of Religion and Disability Studies at Emory's Candler School of Theology. Eiesland published *The Disabled God: Toward a Liberatory Theology of Disability* in 1994, as well as three other books and numerous articles. She died of genetic lung cancer in 2009. Through her research and theological writing, Eiesland sought to help people with disabilities integrate fully into the life of the church. Though her writings primarily focus upon people with physical disabilities, her work is very relevant to people with mental health disabilities as well.

In her work, Eiesland argues that people with disabilities (of all types) form a minority group both inside and outside of the church because they are excluded and even persecuted by the majority of people who are (temporarily) able-bodied (see more on this below). There are five common criteria used in sociological studies for determining whether a particular people compose a minority group: they are subordinated by prejudice and pejorative treatment by the majority; they are identifiable by common characteristics; they do not volunteer to be part of the group; they are aware that they are members of that minority group; and they are encouraged to marry within their group by both the majority and other members of their minority.

For much of Christian history, theology has been developed by able-bodied people who considered their physical status to be the standard upon which to base and interpret all human experience. The problem with this is that when theologians and faith leaders ignore the unique and varied experiences of people with a range of mental and physical conditions,

theological traditions and doctrines are incomplete. In addition, when theologies are constructed using ableist mental and physical standards, people whose abilities fall outside of those standards are designated as abnormal and incapable of representing the image of God. People with disabilities have been excluded not only from theological conversations and traditions but also from full participation and inclusion in the life of many ecclesial bodies, Christian communities, and society at large. In the 1960s, persons with disabilities began to demand equal rights through the disability rights movement. The academic field of disability studies officially began in 1982. The founders of disability studies observed that people with physical impairments were rendered disabled because of society's refusal to acknowledge and accommodate their impairments.

For example, depression may be a disability if the medicine and psychiatric care needed to manage the condition are not available and accessible. Therefore, disability studies approach this work with the assumption that disability is a social construct. As a result, full participation and inclusion of people with physical and mental disabilities in all aspects of society can be achieved with proper accommodations.

Eiesland reminded her readers that while those designated as "people with disabilities" have many similarities with other minority groups, they also have a particular uniqueness. One similarity people with disabilities have with other minority groups is that they suffer from social stigma. Eiesland wants her readers to understand that the uniqueness of "people with disabilities" is that membership in this group can be achieved by anyone. Every fully able-bodied person has a fifty percent chance of becoming permanently or temporarily disabled during their lifetimes through illnesses, accidents, or genetic conditions. Our chances of becoming physically and/or mentally disabled increase with age. Race, age, and economic status impact the probability of becoming disabled. A total of 16.3 percent of African Americans are living with disabilities compared with 12.8 percent of whites. African Americans are likely to suffer with more severe disabilities than whites.

While the disability rights battle was being fought and won in the 1960s in the larger society, some religious groups used the principle of "separation of church and state" to lobby for exclusions from having to accommodate people with disabilities. Some argued that they did not have the financial resources to make the legally required changes to their physical and technological infrastructures. Eiesland argues that it was their exclusive theological comments that informed their determination to seek exclusions from parts of the 1990 Americans with Disabilities Act. In addition, the hermeneutical practices of some communities inform at least three very damaging perspectives including: the conflation of sin and disability, promotion of the idea of virtuous suffering, and segregationist charity (Eiesland 1994, pp. 72–74).

Eiesland's disabling theology evolved when she had an epiphany during a Bible study one afternoon in Atlanta at the Shepherd Center, a private hospital for treatment of people with spinal cord and brain injuries. Eiesland shared her doubts about whether God cared about her as a disabled woman. She asked the participants how they would know whether God understood their experiences. A young African American man said, "If God was in a sip-puff (wheelchair) maybe he would understand (Eiesland 1994, pp. 75–80)." This image of God was indelibly etched in her memory. A few weeks later, she experienced an epiphany when reading Luke 24:36–40, in which Jesus encounters the disciples after his resurrection and asks, "Why are you frightened, and why do doubts arise in your hearts? Look at my hands and my feet; see that it is I myself. Touch me and see." In that moment, Eiesland realized that Jesus was simultaneously disabled and divine. The piercings of his hands, feet, and side that he sustained during his crucifixion rendered him severely impaired; yet, he was believed by many to also be holy and divine. She believed there were transformative implications for the disabled in the resurrection of a disabled God. From that moment, Eiesland was determined to develop a liberatory theology of disability. She argues that in order to be truly "liberatory," a theology of disability must create new symbols of wholeness and new ways to embody justice. Through the disabled

God, Christian communities have an opportunity to reconceptualize the ways they engage with people with disabilities:

- The disabled God obliterates the contention that disability is a consequence of individual sin. The disabled God was persecuted and suffered because of an unjust system of domination.
- The disabled God enables people with disabilities to participate in the *imago Dei* through their disabilities rather than in spite of them, thereby creating a new model of wholeness.
- The disabled God reconceptualizes bodily perfection as “unself-pitying, painstaking survival” (Eiesland 1994, pp. 102–4). As a result, the definition of bodily perfection changes. Perfection is no longer a body or mind without blemish. Rather, perfection includes impairments from experiences of injustice and persecution.
- Since the disabled God is able to celebrate and experience pain, the disabled God understands the limits of human power.
- Rather than engaging in battles for domination or earthly power, the disabled God allies with the disenfranchised and marginalized in their fights for justice. The disabled God initiates societal transformation without domination.
- The disabled God helps people understand that they are connected to one another through physical impairment and disability rather than in spite of it. When Jesus invited his friends to touch his wounds after his resurrection, he offered humanity a way to critique the social practice of avoiding the physically disabled. By allowing his friends to touch his impairments, he enabled them to share the experiences that brought about his new physical reality.
- The disabled God reminds communities of faith that some disabilities are hidden. Some of the physical damage Jesus suffered was internal and invisible to onlookers. In a like manner, some people in Christian communities have disabilities and impairments that are visible. Some people choose to suffer in silence rather than risk being stigmatized by revealing their disabilities.
- The disabled God fosters human interdependence. A God who needs to be cared for redefines both human and divine power. A disabled God is not all powerful. Humanity is not powerless.
- The disabled God encourages communities of faith to expand the meaning of the term ‘conversion’ to include learning to love our existing bodies. Loving our existing bodies includes aspects of bodily existence previously deemed carnal.
- The disabled God enables churches to reimagine the Eucharist. Congregations need to find creative and inviting ways to accommodate people with a range of disabilities (Eiesland 1994, pp. 103–4).

### 3.2. John Swinton’s Mental Health Hermeneutic

John Swinton is professor of pastoral care and practical theology at the University of Aberdeen in Scotland and a consulting professor at Duke Divinity School. He worked for many years as a community mental health chaplain. He is the author of *Finding Jesus in the Storm: The Spiritual Lives of People with Mental Health Challenges* and *Dementia: Living in the Memories of God*. In an endeavor to give the followers of Christ guidance when interpreting the Bible with mental health concerns in mind, Swinton reminds us that the Bible is a bit strange (Swinton 2020). He quotes theologian Karl Barth, who contended that “the Bible is the point of revelation that introduces us to a strange new world” (Swinton 2020, pp. 204–5). When we read the Bible, we enter into its very different socio-political worlds, which include people, customs, traditions, and worldviews. Despite its “strangeness,” we see ourselves as we read the stories of the Bible. The situations and circumstances in which the people of the Bible find themselves are human stories that relate to human conditions in every time and place. Swinton advises followers of Christ to allow the strange new world of the Bible to help them see and imagine possibilities that they could otherwise not conceive (Swinton 2020, p. 205).



However, with Swinton's challenge of seeing new possibilities comes the reminder that all biblical interpretation is contextual. Interpretations vary according to who is doing the interpreting, because each of us brings with us our world views and biblical and theological assumptions that shape hermeneutical outcomes. As a result, Swinton's first recommendation for interpreting the Bible for people with mental illness in mind is to interpret using their lived realities and experiences. This requires biblical interpreters to transcend their ableist interpretive biases in favor of perspectives that include issues of people with many different and diverse disabilities. Swinton contends that interpreting the Bible with the experiences of people with mental health challenges in mind creates a hermeneutic that is contextual, critical, prophetic, and faithful. The hermeneutic is contextual because it takes into account the lived experiences of people with disabilities. It is critical because it challenges interpretations that misrepresent mental illnesses. It is prophetic because it attempts to disrupt assumptions and overcome cultural distortions to include those who are victimized by systems and structures. The hermeneutic is faithful because of its commitment to provide fresh and new ways of being representatives of Christ in the world (Swinton 2020, p. 206).

As an example used to develop his mental health hermeneutic, Swinton used the perspective of a 32-year-old white social worker who is the mother of two children and who has suffered from depression. She is a charismatic evangelical who had been taught in her church that if she prayed and read the Bible faithfully, God would heal her of her depression. Based on her experience, he made four key findings:

1. Though God has not provided her with miraculous healing, God has not abandoned her. Indeed, God has provided her with all of the support she needs to live well and faithfully, such as a Christian psychotherapist, good Christian friends, a good psychiatrist, and effective medication. Though she technically still has a diagnosis of "depression", the condition no longer dictates the quality of her life.
2. She has been forced to think about what it really means to have an abundant life. Rather than thinking that an abundant life means a sort of perfection—therefore, a life free from depression or any other challenge—she now believes that an abundant life means seeing God in the small things in her life, including her friends, Christian community, and medical support.
3. She discovered that it is okay to bring anger and frustration to God. There are people in the Bible who shouted and screamed at God. However, in her evangelical church, their plights were not highlighted. People like Job have encounters with God in which God does not answer their questions. Just having the encounter with God was good enough to let Job know that God was still with him even in his circumstances.
4. She is now more empathetic with people who find themselves spiritually lost and confused as a result of being directly or indirectly impacted by mental illness. She now believes that empathy is an essential characteristic needed by all who wish to acknowledge the dignity and worth of all of God's people (Swinton 2020, pp. 209–16).

### 3.3. A Healing Homiletic

In her seminal work, *A Healing Homiletic: Preaching and Disability*, Kathy Black analyzes a series of healing narratives in biblical texts from the perspectives of people with disabilities. Her goal is to develop a homiletic to equip preachers to preach disability-related sermons. Before developing her hermeneutic, Black differentiated the meanings of the terms healing and cure. "Cure is the elimination of at least the symptoms if not the disease itself" (Black 1996, p. 50; emphasis original). While healing may include the "elimination or alleviation of the illness," in the case of people with disabilities, "healing often happens in the midst of managing the disability rather than in any kind of 'cure.'" For Black, healing occurs when the community "participates with God in offering possibilities of well-being to one another" (Black 1996, pp. 50–53).

Black develops her healing homiletic by interpreting five biblical texts from the perspective of people with disabilities while incorporating current medical science: John 9:1–41

(a man who was born blind), Mark 7:31–37 (a man who was deaf), Mark 2:1–12 (a man who was paralyzed), Mark 1:40–45 (a man with leprosy), and Luke 8:26–39 (a man possessed by a demon). The chapter in which Black interprets the Luke 8:26–39 text was dedicated to mental illness (Black 1996, pp. 159–79). In this chapter, she shares several traditional interpretations of the text. One interpretation of the text is that the healing demonstrates Jesus' power over evil. The problem that Black finds with this interpretation is that equating mental illness with evil completely discounts the many causes of mental illness identified by mental health physicians and practitioners today. For example, mental illnesses such as post-traumatic stress disorder are caused by witnessing violent acts—some of which can be labeled as evil. Another traditional interpretation focuses on the need for demons to be exorcised or for people to be rescued from the bondage of sin. In response, Black argues that demon possession in the New Testament is not related to personal sin. Instead, demon possession is a random act of evil spirits.

After highlighting some traditional interpretations, Black offers a healing homiletic with the following observations:

1. By healing this man, Jesus returns him, someone who was marginalized by his community, to his rightful place within the community. Jesus' message to people like this man who are homeless and alienated is that they belong.
2. By healing this man, Jesus allows him to regain control of his own life and trusts him to go back home and preach the good news.
3. With this healing, Jesus restores meaning to this man's life by enabling him to be an "interdependent" part of the community rather than being completely dependent on others.
4. Unlike the man in the text, most people with mental illness are not cured in an instant. Often, medical professionals such as doctors and psychiatrists "stand in for Jesus" by using their knowledge and skills to manage illnesses and/or cure them. In addition to medical professionals, people with mental illnesses need the healing presence of those who purport to be followers of Christ to be an ongoing healing presence in their life journeys.
5. People with mental illnesses can contribute to the ministries of the church. Those in the Body of Christ must grapple with and overcome their fear of people with mental illnesses. This fear, which is often accompanied by uninformed or misinformed bias and presupposition, can be a tremendous barrier to healing (Black 1996, pp. 180–86).

### 3.4. *A Mental Health Hermeneutic for Preachers*

The research and writings of Nancy Eiesland, John Swinton, and Kathy Black provides guidance for preachers who are committed to preaching wholeness. God desires for all of God's creation to be whole—to experience well-being of mind, body, and spirit. Wholeness, however, does not mean that all people of faith will experience bodily or mental perfection. Rather, wholeness is about a general sense of well-being and attaining a right relationship with God, other people, the environment, and all of God's creations.

In this work, I have defined mental health and mental illness and provided a list of mental illnesses and conditions that exemplify the more than two hundred conditions that exist. The advent of mental health research, practices, and approaches of mental health professionals, as well as the development of prescription medications, enable many people with mental illnesses to live full and productive lives. However, despite these advances in medical science, people with mental illnesses are still stigmatized and discriminated against both inside and outside of the church. To combat stigmatization and discrimination, this paper includes insights from the three aforementioned scholars to develop a mental health hermeneutic—guidance for preachers when interpreting biblical texts with people with mental illness in mind.

The mental health hermeneutic below is divided into three distinct categories: facts about mental health and mental illness, theological assertions, and general interpretive guidance.

#### Facts About Mental Health and Mental Illness

- Being healed or experiencing wholeness does not necessarily equate to being cured.
- Mental illnesses are caused by genetic, environmental, and social factors.
- People are connected to one another through physical impairment and physical and mental disability rather than in spite of those conditions. The care needed for some people with mental disabilities represents human interdependence. Needing care does not indicate weakness or failure.
- Mental disabilities are often hidden. People suffer in silence rather than openly acknowledging their illnesses to avoid social stigma.

#### Theological Assertions

- While ‘cure’ means the elimination of at least the symptoms of disease, healing occurs when the community “participates with God in offering possibilities of well-being to one another.”
- When God does not provide miraculous healing, God has not abandoned those with mental illness. God’s presence can be experienced through resources such as psychotherapists, good friends, a good psychiatrist or therapist, and effective medication.
- An abundant life is not necessarily a life without illness, disease, or physical disability. An abundant life is a life in which people are able to attain a sense of well-being and are in a right or good relationship with God, other people, the environment, and all of God’s creations.
- People suffering with mental illness can bring their anger and frustration to God. God will hear their concerns and remain with them.
- The value and importance of empathy for people of God will enable people not suffering from mental illness to identify with those who do.
- Since mental illnesses are caused by genetic, environmental, and social factors, the presence of mental illness is not an indication of sin.
- Perfection is no longer a body or mind without blemish. Instead, perfection includes impairments from experiences of injustice and persecution.
- The bodies and minds of people with disabilities participate in the imago Dei through their disabilities rather than in spite of them. Thus, a new model of wholeness emerges in which disability no longer exists in opposition to divine integrity.

#### General Interpretive Guidance

- The lived experiences of people with disabilities should be used to interpret biblical texts when preaching on issues of mental health and mental illness.
- Life is a mixed blessing in which human power has limits.
- Cautions for Preaching on Mental Health
- Most preachers are not psychologists or mental health therapists. Therefore, preachers without degrees or training in the mental health sciences should avoid acting as amateur psychologists or therapists. Even after reading books and articles about mental health and the need to address it from the pulpit, preachers must be aware of the limits of their knowledge and training.
- Preachers should never assert that people engaged in some sort of behavior that led to their mental illness. Mental illnesses are caused by genetic, environmental, and societal factors.
- Preachers should avoid offering group counseling sessions from the pulpit. While preachers certainly highlight issues and concerns about the ways congregants relate to one another, psychological analysis is best left to the professionals.
- As with all sermons, preachers should never use the lived experiences of people within their congregations in their sermons without permission. The stigmatization of people with mental illness makes this practice especially relevant for stories involving the lived experiences of mental illness.
- As with all sermons, preachers should not employ accusatory “you” language when highlighting what the congregation should and should not do. “You” language asserts that the preacher has no room for growth or improvement on the subject unlike the

people in the pews. Instead, the preacher should use “we” language to indicate that everyone, including the preacher, needs to follow the advice and guidance being shared in the sermon.

#### 4. Materials and Methods

The materials used to develop this article are the direct work products of people and entities who are specialists and respected as experts in their fields. For example, the statistics about mental illness were gathered from the National Institutes of Health, which is the medical research agency of the U.S. Department of Health and Human Services ([National Institutes of Health 2024](#)). The definition of mental illness was adopted from the World Health Organization, an agency of the United Nations whose purpose is to connect nations, partners, and people throughout the world to promote health ([World Health Organization 2023](#)).

This article was developed to respond to the opening question, “Wilt thou be made whole?” The impetus of this paper is the author’s concern about the issue of wholeness or well-being as it relates to mental health. The statistics attesting to the hundreds of thousands of people impacted directly or indirectly by mental illness necessitate that mental illness be addressed from the pulpit regularly. People with mental illness should be embraced by and adopted into communities of faith rather than ostracized by them.

##### Mental Health Resources for Preachers

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#### 5. Conclusions

As demonstrated in the introduction, the statistics about mental illness compiled by leading health agencies attest to the prevalence of mental illness and therefore the need for preachers to address issues of mental illness and mental health.

Every week, people of God gather to hear the good news of the Gospel. Many of those gathering need to hear some good news about issues related to mental illness. Good news for them would be that they and/or their family members are not forgotten. Good news would be that God loves them unconditionally. Good news would be that there is a place for their loved ones in the community of faith. Good news would be that they are part of a community that seeks to understand and support them in their struggles. Most importantly, people with mental health concerns need hope—hope that their tomorrows can be better than today. When preachers regularly incorporate sermons about mental health into the preaching program, the entire faith community will learn to acknowledge and embrace their siblings in Christ with mental illness. The mental health hermeneutic

developed in this article provides guidelines for preachers seeking to develop sermons with people with mental illnesses in mind.

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