



Editor's note: *The text of this theological reflection is printed here courtesy of the author and of Covenant Health, Canada's largest Catholic health care organization. Readers are invited to view the collection of reflections at www.covenanthealth.ca/about-us/mission-vision-values/theological-reflections.html.*

The Mentally Ill as Neighbor: Seeing the Christ Who Dwells Within

BY GORDON SELF, D.MIN.

The light shines in the darkness, and the darkness did not overcome it.¹

That question — “Always?” — must spur both the personal and the collective conscience to a sincere reflection on our behavior towards those persons who are suffering from mental illness. Is it not true that all too often these persons encounter indifference and neglect, when not also exploited and abused?²

The provocative question, “Always?” raised by Blessed John Paul II invites a deeper-level reflection in how we treat those living with mental illness. Too often, lofty theological statements such as respect for the intrinsic dignity of every human being, as affirmed in the same 1996 papal address, are in practice selectively and inconsistently applied. We do not “always” reach out to our neighbors, let alone even recognize their presence or needs. Our actions instead reveal a range of behavior and a set of attitudes that can at one moment be loving and supportive towards vulnerable persons, and, in another, be judgmental and reserved. A sincere and honest reflection may in fact reveal hidden biases and resistance, especially in treating those whose mental health needs and addictions are challenging. Despite the promise of light overcoming darkness in the opening chapters of John’s Gospel, there is still an enduring pall of stigma cast over mental illness in our society.

In response to these challenges, Covenant Health and Catholic Social Services, a subsidiary of the Catholic Charities Society, are developing a joint strategy to enhance access, capacity and innovation in the delivery of mental health services in Alberta, Can-

ada. But the invitation to bring a “sincere reflection” regarding the needs of those living with addiction or complex mental health needs, and our corresponding response to meet their needs with compassion and skill, will benefit from a deeper-level analysis to supple-

ment our joint addiction and mental health strategy.

Thus, along with the principles named in the strategy, we are spurred to give equal attention to the moral and theological dimensions that inform our work and in whose name we serve. As Catholic organizations, we profess being called to continue the healing ministry of Jesus. Our call must be accurately interpreted in light of the Gospel and the social justice tradition of the Catholic Church to provide practical support to the people in our care, in the real circumstances in which they present themselves. The theological reflection is intended to ground our strategy within a larger moral vision of



hospitality. We are called to welcome those living with addiction and mental illness as our neighbor, and to promote a model of care where transformation and resiliency in their lives is always possible.

WHO IS MY NEIGHBOR?

Feb. 12, 2013, marked the second annual national campaign to raise public awareness of mental illness in Canada.³ This grassroots coalition driven by business, media, sports and community service organizations is aimed at fighting the stigma that prevents Canadians from talking openly about

The campaign recognizes that until we are willing to talk openly, honestly and candidly about the ravages of mental illness, this client population will remain underserved.

mental illness, and, in turn, accessing appropriate help. The anti-stigma message is one the campaign's four action pillars, along with care and access, research and workplace best practices. What is remarkable about this highly successful campaign is it represents a possible shift in the public consciousness that has historically been reluctant to acknowledge the incidence of mental illness in everyday families. The campaign recognizes that until we are willing to talk openly, honestly and candidly about the ravages of mental illness, this client population will remain underserved.

The Covenant Health/Catholic Social Services Joint Addiction and Mental Health Strategy project charter also focuses on identifying and removing barriers to access, of which the enduring stigma around mental illness is arguably one of the greatest hurdles to overcome. The possible reasons for stigma are many: demeaning language in which persons with mental illness have often been labeled; the seemingly futile, revolving-door nature of the illness; historic confusion and conflation of mental illness as demon possession; expectations to “get over” depression, and so forth. Whatever the reasons, the message is clear — it is not OK to talk about mental illness.

Beginning in 2010, the Parliamentary Committee on Palliative and Compassionate Care convened hearings in Ottawa and hosted round tables across the country to address the needs of vulnerable Canadians, signaling it is well time

for such conversation. Their report, to which Covenant Health provided stakeholder input, acknowledged the lingering stigma surrounding elder abuse and suicide, but also the positive role public education can and must play to counter these two growing epidemics in our country. The report offers a number of other valuable recommendations to strengthen our own addictions and mental health strategy, including policy and legislative changes.⁴

Even when such taboo topics are broached, we are not equal in terms of offering consistent support and understanding to every vulnerable person. Those living with addiction are further stigmatized by a culture that tends to blame those lacking sufficient will power to overcome their addictive behaviors, without appreciating the lifetime nature of recovery from severe addictions. Social policies such as the “war on drugs” in effect equate those addicted to illegal substances to the enemy, or at least an accomplice to drug traffickers in perpetuating a nefarious cycle of supply and demand. Even when our heart goes out to those living with addiction, we often feel inadequate and helpless in knowing how best to support these individuals, offering instead our sympathy and pity — no less demeaning.

At a deeper theological level, stigma raises the question of whom we consider neighbor and our corresponding moral obligations to show hospitality. As long as we are silent about addiction and mental illness in our culture and render invisible those living with it, we are not obligated to offer them care. Of course, we *do* provide a range of health care and social services to support those with addictions and mental illness, but the lack of a well-resourced, comprehensive and integrated approach would suggest we still fall behind in our moral obligations to be hospitable to all those requiring our care.⁵ Catholic social teaching affirms the preferential option of the poor, but more often we see a disproportionate level of funding and attention allocated to expensive, scarce and technologically focused care that may benefit only a few.⁶ Given how mental illness touches the lives of so many families, it is a matter of justice that we advocate for their care.

In the parable of the Good Samaritan (Luke 10: 25-37), Jesus asks who, of those encountering a man found beaten and left on the side of the road, shows mercy. In contrast to the other pious travelers who saw the vulnerable man and crossed over



to the other side of the road to avoid contact, the socially despised Samaritan stops and gets off his animal, despite great personal risk in doing so. To dismount on a secluded stretch of highway, knowing bandits may be lurking nearby, exposes him and makes him vulnerable to attack. Thus to be a neighbor means first, to have both the capacity to truly see another human being, and second, to risk becoming vulnerable in the process in helping them.

When no quick technological fix is possible, the compassionate caregiver must be willing to be present to help others bear their suffering. This commitment of presence is measured over time, given the nature of addiction and mental illness where relapse and readmission is common. The Good Samaritan makes arrangements in advance with the innkeeper, promising to repay whatever is owed for the wounded man's care. In like fashion, our commitment to service, and thus to vulnerability, requires a consistent presence.

THE RESTORATION TO COMMUNITY

Whenever we cross by on the other side and ignore the needs of the most vulnerable, we deprive both client and caregiver of shared community. It is relatively easy to hide behind our professionalism to resist forging relationship, especially with those who challenge our comfort level or personal sensibilities. Veiled judgments of other people frequently betray some degree of self-condemnation and the struggle to reconcile fragments of our own life. Thus we resist looking

We see Jesus often providing practical instruction to those he has healed in order to sustain their well-being and continued restoration.

too closely at a person's story under the pretext of preserving professional boundaries. As such, our attempts at healing are only half-realized. Hospitality calls us, rather, to risk getting to know another person. If we have dared to look into the face of those who suffer and truly listened to their story, we are changed. Judgment may give way to compassion.⁷

Throughout the Gospels we see Jesus, who not only heals but restores people to community. The woman suffering with hemorrhages for 12 years is not only physically and psychologically restored — undoubtedly self-conscious of her constant

bleeding that kept her isolated and in a state of shame — but also is lifted up socially and ritually cleansed (Mark 5:25-34). Forced to the fringes of society, she presses through the crowd in order to touch, ironically, the fringe of Jesus' cloak. At once, Jesus recognizes power going out from him, underscoring that real substantive change in our lives and in our society often comes from the edges, not the center (as represented by the crowd). Like Jesus, we need to recognize those on the edge of community who are reaching out to be restored, seeking to grab hold of whatever services that are available.

Moreover, we see Jesus often providing practical instruction to those he has healed in order to sustain their well-being and continued restoration. In the same Gospel story, after healing the woman with the chronic bleed, he continues on his way to Jarius' house, whose daughter, he has been told, had just died. After Jesus raises the young girl, he tells the family to give her something to eat (Mark 5: 35-43). In like fashion, an innovative, integrated model of mental health care must ensure appropriate resources and home care supports to facilitate the sustained healing and reintegration of people back into the community. Sometimes it is basic supports such as food and housing that are required.

RECLAIMING A HOLISTIC APPROACH

An integrated and holistic model of addiction and mental health services must attend to the entire dimension of human experience, including the spiritual. While "care of souls" (Latin, *cura animarum*; and from the Greek, soul or *psychē*) was historically a focus of the shaman's or healing practitioner's craft, such language is rarely embraced by the psychiatric community today, let alone incorporated in any serious way within the therapeutic process. Innovative approaches to addiction and mental illness, however, should consider all scholarly peer-reviewed research on the role of spirituality in healing and the value of faith communities to support people in their recovery. A fully integrated approach to mental health care requires reconciling enduring biases that have split off the role of a healthy spirituality to help a person cope with and make meaning of their illness. For example, 12-step programs, which ultimately are based on spiritual principles, are arguably one of the most powerful therapeutic resources available.

Insofar as religious delusions and scrupulos-

ity is not the very pathology requiring treatment, integrating appropriate spiritual care in the treatment plan can help facilitate recovery. Given the faith-based identity and philosophy of the organizations sponsoring this strategy, real leadership

Rather than keeping before us the needs of those most vulnerable and finding a way to collaborate to balance the common good, stakeholder consultations sometimes seem to become focused on not upsetting the privileged.

can be shown in exploring innovative approaches and research in the role of spirituality in mental health to help bridge the world of psychology and theology.⁸

Admittedly, there are numerous Scriptural passages with references to “demons” and “unclean spirits” that, if not carefully interpreted in the historical context in which mental disorder was understood at the time of Jesus, can thwart good patient care and further alienate spirituality from its inclusion in contemporary therapeutic practice. In fact, the National Catholic Partnership on Disability framework guiding the church’s ministry for and with people with mental illness stipulates that the “word of God affirms the dignity of all people,” but “interpretation of Scripture should be consistent with the current understanding of mental illness.”⁹ We can speculate that the many demons Jesus and his disciples exorcised may very well have been various mental disorders listed in the *Diagnostic and Statistical Manual of Mental Disorders* today. To abandon proven scientific methods for historically misplaced remedies can do significant harm and undermine the integrity and reputation of quality mental health care.

However, the historic differences in the meaning attached to mental illness and the treatment modalities they prompted should not take away the deeper appreciation of what Jesus modeled. First, the Scriptures reveal Jesus “healed all kinds of diseases and cast out demons,” indicating he saw in his healing ministry a concern for the entire health needs of the community. Along with those born blind or disabled, or those suffering from chronic illnesses such as leprosy or anemia, Jesus did not discriminate in reaching out to those struggling with pathological illnesses of the mind, including spiritual conflicts. Jesus’ entire healing

ministry reflected a holistic approach in caring for body, mind and spirit.

Second, we see again and again the personal encounter of Jesus with those he healed. Jesus frequently makes himself available to the sick and

suffering, positioning himself in a boat so he is accessible to the throngs gathering by the shore or stopping to engage one calling out for his attention from the side of the road as he passed by. When large crowds prevent timely access to Jesus, the people resort to ingenuity in bringing the sick to him. They remove the roof above where Jesus is teaching in order

to lower a paralyzed man into the room (Luke 5:17-26).

Ensuring access to care is challenging enough in today’s busy health care environment where time, resources and space must be judiciously allocated to ensure people are getting the appropriate care. But likely the greatest barrier in accessing quality addiction and mental health services is simply public reluctance to acknowledge and legitimize the needs. Unlike the persistence of those who found creative ways of bringing the sick to Jesus, seldom does our society open a little space in the proverbial roof of its own collective consciousness to admit where paralysis of thinking exists. And unlike the example of Jesus, we do not always single out the voice of the addict or the person with bipolar disorder in the marketplace clamoring for attention. Often, we simply do not hear their cry at all. The person whose behavior is disruptive and combative risks being ignored altogether.

Additionally, “Not in My Backyard” (NIMBY) resistance to shelters and residential housing to support those living with mental illness and addiction reveals how selective we are in embracing the Gospel imperative. Rather than keeping before us the needs of those most vulnerable and finding a way to collaborate to balance the common good, stakeholder consultations sometimes seem to become focused on not upsetting the privileged. Such logic is “exclusionary versus humane.”¹⁰ NIMBY resistance can become even more pronounced when candid conversation about the realities of addiction raises questions about how best to provide practical therapeutic support to prevent a greater harm.¹¹

As we advance our addictions and mental health strategy, we need to be vigilant that we



serve to work *with*, not do *for*, others. Models of care and residential housing that reduce the experience of depersonalization and institutionalization by creating greater sense of community where human life can truly flourish is indeed the gold standard. But it begins first with the caregiver's own capacity to hear, touch and be *with* another in journeying with their mental illness and addiction. There is no community if we are not able to be present and hospitable to others. This is the deepest expression of compassion, to be with another in their suffering (Latin *cum*, "with or together," and *passiō*, "suffering or submission"). It is from this stance of authentic compassion — not pity or sympathy — that our model of care is envisioned.

TOWARDS AN INTEGRATED MODEL OF CARE

Along with integrating quality therapeutic practices in our model of care, we must ensure that our attitudes are truly compassionate. Scripture reveals lingering attitudes that need to be challenged and reinterpreted. For example, the healing of the Gerasene demoniac by Jesus recounts the story of a young man possessed by "Legion," for there were reportedly many demons within the man. He lived among the tombs and hills, tearing apart the chains with which the fearful local villagers attempted to bind him, and he would cry out and bruise himself with stones (Mark 5: 1-20). Today, there are unfortunately still many chains we place on those who roam about on the fringes of society. We bind those living with addiction and mental illness through institutionalized approaches to care that isolate the person from community. We chain people through pejorative labels and stereotypes. We incarcerate the human spirit by defining people by their diagnosis, unable to appreciate the entirety of their being of which mental illness or addiction may be only part of their life story.

The insidious messages that mental illness and addiction are shameful and should not be named publicly are the very stones people continue to stumble over and bruise themselves upon. While the barriers that thwart timely access to quality, compassionate care may be many (legion), in counter-fashion our strategy must be even more robust, innovative and effective to ensure client needs are met. Like Jesus, we must be prepared to confront those barriers and cast them aside.

We must use our resources to debunk myths surrounding mental illness and addiction and to educate the public in how to recognize signs of illness and where appropriate help can be found. Public misunderstanding, judgment and fear are the real demons that must be cast into the nearby herd and run into the sea and drowned.

After the possessed man is healed, Jesus instructs him to go home to his family and tell everyone how much the Lord has done for him. In like fashion, our model of care must continually work to reconnect people to community, to celebrate and support a person's ongoing recovery, much as we celebrate cancer survivors to give hope to others who struggle with similar challenges. The Gospel story concludes that "all the people were amazed" at the transformation in this person's life. While much transformative work happens every day in modern addictions and mental health programs, as long as we are uncomfortable as a society to acknowledge the issues, neither will we be able to celebrate those amazing stories of recovery that can give hope to others, too. We need to affirm the resiliency of the

The insidious messages that mental illness and addiction are shameful and should not be named publicly are the very stones people continue to stumble over and bruise themselves upon.

human spirit and the promise that indeed "the light shines in the darkness, and the darkness did not overcome it."

What, then, should a transformative model of care look like? The 7th century Irish patron saint for mental illness provides a way of engaging this model theologically. After the death of her mother, St. Dymphna was pursued by her grief-stricken father and subsequently martyred in Geel, Belgium, for refusing to yield to his delusional romantic affections. Devotion to St. Dymphna began to emerge hundreds of years later when the tomb containing her body was discovered, followed by a number of reported cures and miracles attributed to her, notably people living with epilepsy and mental illness.¹² Her influence continued, and beginning in the 13th century, the people of Geel adopted a deinstitutionalized model of care in treating mental illness that was truly innovative and that has lasted to this

day. The villagers took the mentally ill into their homes upon discharge from the local infirmary in order that the ill might be reintegrated back into the life of the community.

This 700-year-old model of care was dependent on the community's active participation in helping restore and sustain the health of its most vulnerable citizens. The Government of Alberta's addiction and mental health strategy likewise identifies among its five achievable goals the role of communities in becoming actively engaged and supportive of people affected by addiction, mental health problems and mental illness.¹³ While we have much to learn from contemporary models of care, we also have a rich tradition in Catholic health care and social services to inform our work.

Involving the community as partners in healing will require increased public awareness and understanding and the ability to break through stigma, as also noted in both the Covenant Health/Catholic Social Services and Government of Alberta strategies. But along with public education, we need to ensure there is a comprehensive system in place to provide the appropriate level of support along the entire continuum of care, including resources to train interdisciplinary professionals with the requisite skills and technical competence. Calling on families and community volunteers to support those with mental illness and addiction will be thwarted if there is not proportionate attention given to grow mental health services in our province in a real and tangible way. The innovative approach modeled by the citizens of Geel worked because they made it a priority. They made practical choices and personal sacrifices for the sake of justice. They took to heart what is truly meant by the preferential option for the poor.

CONCLUSION

We return to the questions posed at the beginning of this document. What are our moral obligations to those who live with addiction and mental illness? What does a sincere reflection of our attitudes and behaviors reveal? John Paul II writes:

Thus the response to the theme's question is clear: whoever suffers from mental illness "always" bears God's image and likeness in himself, as does every human being. In addition, he "always" has the inalienable right not only to be considered as an image

of God and therefore as a person, but also to be treated as such.¹⁴

The answer echoes what Jesus teaches in the parable of the Good Samaritan. The person who first recognizes the person in need and then is willing to take personal risks for the sake of a hurting brother and sister is the true neighbor.¹⁵ Such acts of hospitality underscore that it is not just the vulnerable person we serve, but Christ himself. There is no illness, circumstance or condition that can ever rob a person of his or her intrinsic dignity and incalculable worth. Each person reveals the dignity owed to them by virtue of being made in the image and likeness of God.

The implications of this assertion are anything but lofty and pious. Because of this claim, we cannot simply pass by on the other side of the street and pretend we do not see the addict, or not support the person with compulsive disorders, or ignore the silent cry of the clinically depressed. Once we see another person, we in effect see ourselves for who we are. We see within, perhaps for the first time, the Christ who dwells in the depths of our heart as well as in our neighbor, calling us to compassion and justice.

GORDON SELF is vice president, mission, ethics and spirituality at Covenant Health, Edmonton, Alberta, Canada.

NOTES

1. John 1:5.
2. John Paul II, "Mentally Ill Are Also Made in His Image" (speech, 11th international conference sponsored by the Pontifical Council for Pastoral Assistance to Health Care Workers, Vatican City, Nov. 30, 1996): 6. See: www.ewtn.com/library/PAPALDOC/JP96N30.htm.
3. See: *Bell Let's Talk 2013*, <http://letstalk.bell.ca/en>.
4. See: <http://pcpcc-cpspsc.com/wp-content/uploads/2011/11/ReportEN.pdf>.
5. *The Institute of Health Economics 2008* reports mental health services only receive 5.5 to 7.3 percent of health care dollars, despite mental illness representing 15 percent of total burden of diseases in Canada. As quoted in *Creating Connections: Alberta's Addiction and Mental Health Strategy* (Edmonton, Canada: Government of Alberta, September 2011), 5. See: www.health.alberta.ca/documents/Creating-Connections-2011-Strategy.pdf.
6. *Health Ethics Guide*, 3rd ed. (Ottawa: Catholic Health Alliance of Canada, 2012), Article 152.



7. For example, *In the Realm of Hungry Ghosts: Close Encounters with Addiction*, (Toronto: Knopf, 2008). Dr. Gabor Maté argues that drug-seeking behavior is more to numb unimaginable, traumatic pain than it is about the pursuit of pleasure. Maté recounts numerous case stories of addicts whose family of origin involved horrific abuse, abandonment and betrayal, calling for our compassion, not judgment.

8. Jeffrey H. Boyd, "Self-Concept: In Defense of the Word Soul," in *Care for the Soul: Exploring the Intersection of Psychology and Theology*, ed: Mark R. McMinn and Timothy R. Phillips (Downers Grove, Ill.: InterVarsity Press, 2001), 102-117.

9. See: <http://www.ncpd.org/ministries-programs/specific/mentalillness/framework>.

10. See reference to "the logic of exclusion versus the logic of humanity" in *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues, Background Papers* (Montréal: Canadian HIV/AIDS Legal Network, 1999), B2-B3.

11. Some such practical interventions like clean-needle exchanges, condom distribution or safe site injection facilities are loosely coined "harm reduction" strategies. They remain controversial within the Catholic community as a form of complicity with evil, despite a growing body of clinical evidence that supports their efficacy.

12. *Welcome and Valued: Building Faith Communities of Support and Hope with People with Mental Illness and their Families* (Washington, D.C.: National Catholic Partnership on Disability, 2009), 72-73. For a full account of the story of St. Dymphna, see: www.ncpd.org/node/1119.

13. Government of Alberta, *Creating Connections*, 8.

14. John Paul II speech, "Mentally Ill Are Also Made in his Image," 8.

15. See, for example: Christopher P. Vogt, "Recognizing the Addict as Neighbour: Christian Hospitality and the Establishment of Safe Injection Facilities in Canada," *Theoforum* 35 (2004): 317-342.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, March - April 2013
Copyright © 2013 by The Catholic Health Association of the United States
