

# INSIGHT GROWS WITH FACE-TO-FACE ENCOUNTERS

**D**uring my first week at the Catholic Health Association, Pam Schaeffer, editor of *Health Progress*, invited me to write an article for this publication. I asked what the theme of the March/April issue would be. Pam told me, “Mental health; but don’t worry about writing on that subject. Just introduce yourself to our readers.”



**BRIAN SMITH**

“This should be a piece of cake,” I thought. “I will simply outline my educational and professional career path and how I hope to use this experience in my new role as senior director of mission integration and leadership formation at CHA.” But, taking the simple route has never been how I approach anything in life. I began to ask myself, “What does mission integration have to do with mental health?” I knew I needed to wrestle with this question.

I often use a model of theological reflection when organizing my thoughts. I learned this method during a retreat given in 1986 by Bishop J. Terry Steib. Bishop Steib used the story of the disciples on the road to Emmaus as a model for theological reflection. The model parallels the Scripture passage found in Luke 24: 13-35:

1. Name the experience (verses 13-16)
2. Reflect on the experience (verses 14-24)
3. “Converse” with wisdom tradition (verses 15-27)
4. Insight (verses 31-32)
5. Response and action (verses 33-35)

## **NAME THE EXPERIENCE**

Recently, I have been remembering my personal and professional experiences with people who are mentally ill. Beginning with relatives who have been treated for depression, my experience working with children who have Down syndrome, adult schizophrenic patients in a state mental hospital and working in Catholic health facilities with inpatient behavioral health patients, I relived many of these encounters with people who have a mental illness.

One person in particular, whom I will call Tony, made a big impact on how I view mental illness. When I met Tony, he was homeless, out of work and had a serious addiction to drugs and alcohol. Periodically, he would have psychotic episodes, which made people afraid to be around him.

One day while I was visiting Tony, he told me his story. He had been born into a wealthy family, sent to the best schools and had been living off his family’s trust. When he got into drugs and lost his job, his family disowned him and he soon found himself living on the streets. Tony asked me my age and if I had any chronic illness. We were exactly the same age, and I told him I had chronic hypertension, which runs in my family. Tony told me alcoholism and mental illness ran in his family. Then he looked into my eyes and said, “The only difference between you and me is you wear your disease on the inside and I wear mine on the outside.”

## **REFLECT ON THE EXPERIENCE**

As I look back on that experience some 20 years ago, I realize I learned a lot from Tony. He helped me face my own “dis-ease” at being around people with mental illness. I now know we had more in common with each other than differences. The famous quote by the English preacher John Bradford began to take on meaning for me: “There, but for the grace of God, go I.” Who was I to avoid or judge my brother or sister, when that could be me? We all have wounds — some on the inside and some on the outside.

Mental illness is like other chronic diseases. To manage my hypertension, I take medication, watch my diet, exercise and meditate. A regimen of medication and changes in thought patterns and behaviors helps many with mental illness manage their disease. There are so many similarities.

So why are people with chronic mental illness treated so differently? Why are they shunned and stigmatized? Some of that is due to fear of what we do not understand; but I suspect some also springs from the realization, “There, but for the grace of God, go I.” It is easier to avoid those with mental illness than to face the fact that this could be me.

### WISDOM TRADITION

Those of us who minister in Catholic health care are rich in wisdom traditions to draw upon. Doing so is my favorite part of theological reflection, and like a kid who wants to start with dessert before his dinner, I always need to make sure I don’t skip the first steps in order to get to it. But once I have named and reflected on the experience, I find I can begin an internal dialogue by asking myself: “Of what Scripture passage, church teaching, Catholic heritage or other wisdom tradition does this experience remind me?” For example:

**The stories of Scripture:** Are the stories of Jesus healing those possessed by demons, really stories of healing those with mental illness? How did Jesus treat this group of individuals who were shunned by family, community and their religion? Notice Jesus’ healings are holistic (body, mind and spirit) and restore the person to themselves, their family and the community (See Mark 5: 1-20; 9: 14-2).

**Church teaching:** There are statements by the church on human dignity, but some that deal explicitly with mental illness include: Pope Benedict XVI’s message for the 2006 World Day of the Sick; Pope John Paul II’s speech, *Mentally Ill Are Made in God’s Image*, (Vatican City, 11/30/2003) and the 1978 Pastoral Statement of the U.S. Catholic Bishops on People with Disabilities.

**Catholic heritage:** Catholic social teaching, especially the principles of human dignity and preferential option for the poor, have always stressed the importance of working on behalf of the marginalized. The history of Catholic health care in the United States shows a commitment by many religious congregations, dioceses and health systems to people with mental illness and disabilities.

**Mission and core values:** Catholic health systems hold the foundational belief that all humans are created in the Divine image, even though people do not always appear or act in a godly manner. System mission statements generally reflect a desire to heal in the manner Jesus healed. The sys-

tems may explicitly or implicitly state such core values as dignity, respect and care for the poor, vulnerable and underserved.

**Insight:** My insights regarding mental illness did not come instantly, as they did for the disciples on the road to Emmaus, “when they recognized Jesus in the breaking of the bread.” They came gradually and required that I wrestle with my discomfort, learn more about mental illness and get to know people with chronic mental illnesses.

For example, when I was working on my master’s degree in clinical psychology, I learned mental health is a continuum and at any given point, people move from healthy to “dis-eased.” Like the rest of the body, the brain may have a genetic predisposition to mental illness, or environmental factors (head trauma, stress, for example) may affect our mental health.

But most of my insights into mental illness have come through face-to-face encounters with people struggling with depression, bipolar disorder, psychosis, schizophrenia, chemical addiction, Alzheimer’s disease or other mental disabilities. Looking past the disease and into the eyes of a Tony has been where true learning takes place. As in most situations of ministry, I have always been left feeling I was the one who received the healing.

### RESPONSE AND ACTION

Now comes the part of the exercise in which I measure my response and decide what to do. As I organize my thoughts around mission integration and serving the mentally ill, I recognize:

**When our healing is holistic (body, mind and spirit) and restores persons with mental illness to communion with themselves, the community and God, we are healing as Jesus healed.**

■ In serving with respect and dignity our brothers and sisters who have chronic mental illness, we fulfill our mission as Catholic health care providers. When our healing is holistic (body, mind and spirit) and restores persons with mental illness to communion with themselves, the community and God, we are healing as Jesus healed. We are reaching out to the shunned and stigmatized of our day and letting them know God’s love and presence is meant for all. By restoring

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self-worth and surrounding them with a loving, supportive community, we give them a glimpse of the Kingdom of God. This is a powerful witness to the patient, their family, the communities we serve and our staff.

■ During periods of financial difficulty, hospitals always look at the profitability of service lines. Behavioral health units are usually not profitable; at first glance, they may be an easy target for budget cuts. However, many times Catholic systems keep these services open because no other entity in the community is serving this population, and the institution sees serving a vulnerable population as living its mission and continuing its heritage.

In both health systems where I previously worked (Trinity Health and CHRISTUS Health), service lines that care for vulnerable populations — women, children and the mentally ill — require special mission discernments before they are reduced or eliminated. In the case of CHRISTUS Health, as with some other Catholic health systems, elimination of this type of service requires the permission of the sponsoring congregation(s). Making sure vulnerable populations are served

takes precedence over margin — that is the preferential option for the poor.

■ Catholic health care's voice of advocacy must continue to work with other entities to expand appropriate care, at all levels, for the mentally ill. Federal and state budget cuts to mental health programs in the 1980s and 1990s have resulted in many of the mentally ill living on the streets or in our prison system. As health care coverage expands under the Affordable Care Act, we will need to be vigilant to make sure this marginalized population receives the care it requires. Community needs assessments and community benefit planning must bring resources together to care for people with chronic mental illness in the same way we bring resources together to care for those with other chronic diseases such as diabetes, hypertension and congestive heart failure.

I continue to learn the importance of taking time for reflection. Connecting everyday experiences to the broader wisdom tradition of Scripture, tradition and our Catholic health care heritage always brings me deeper insight and calls me to respond. This simple methodology of theological reflection has served me well as a mission leader. It brings integration to many areas of health care: mission, operations, finance, community need, patient care, pastoral care, chronic disease management and advocacy. That is the wonderful thing about reflection. You never know whom you are going to run into on your own road to Emmaus.

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JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

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Reprinted from *Health Progress*, March - April 2013  
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