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Time, Hospitality, and Belonging: Towards a Practical Theology of Mental Health

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> We are all called to do, not extraordinary things, but very ordinary things, with an extraordinary love that flows from the heart of God.
>
> —Jean Vanier[1]

The mental health industry is a big and hugely complex entity. In the midst of the high-tech neurological, genetic, and pharmaceutical landscape, it is easy for religious communities to feel nervous and disempowered. What could *we* possibly have to offer that might bring healing in the midst of such approaches to mental health care? Jean Vanier provides us with a rather unusual answer in the quotation cited above. The church is called to do ordinary things with extraordinary love. In response to the complexities of the experience of mental health problems, the church's vocation is not to become a community of psychiatrists. Rather it is called to become a community of disciples who strive to embody and reveal God's extraordinary love. Such a sentiment may sound foolish and perhaps even naïve. But, on reflection, doing ordinary things with extraordinary love is precisely

[1]Jean Vanier, *Community and Growth*, rev. ed. (Mahwah, NJ: Paulist, 1989) 298.

> *Mental health problems are unique experiences that occur in the lives of irreplaceable individuals who have their own unique stories, histories, dreams, and desires; people who are deeply loved by God, and whom God desires God's church to love without boundaries. People's stories may be changed by their encounter with mental health problems but they are not defined by them.*

the heart of the gospel. Indeed, doing things that look foolish to the world is central to the reframing power of Jesus; such small gestures are the heart of discipleship. As the Apostle Paul puts it, "For the foolishness of God is wiser than human wisdom, and the weakness of God is stronger than human strength" (1 Cor 1:25). There is power in small things. In this article I want simply to highlight what it might look like to do ordinary things with extraordinary love and to pay correct attention to small things. Faithful Christian mental health care emerges naturally from such a starting point.

Starting from the Right Place

Let me begin with a deceptively simple observation. What we believe about the world will determine how we look at it; how we look at the world will determine how we name it; how we name something in the world will determine how we respond to it. Much of the way in which we frame the world and make sense of what we see is given to us from powerful knowledge shapers within culture. Fields of knowledge such as medicine, economics, philosophy, media, and others offer us quite specific ways of looking at the world and making sense of our experiences within the world. That is to an extent inevitable. It does however put all of us in quite a vulnerable position insofar as, if we are not careful, we are liable to be drawn into ways of thinking that may make cultural sense but, on reflection, can be oppressive, misguided, and unfaithful. Our thinking about mental health issues is very much prone to such distortions. Even the language we use around psychological issues is deeply telling. If the reader of this article has ever used language such as "schizophrenic," "split personality," "neurotic," or "obsessive-compulsive disorder" in relation to nonclinical issues or even as a way of naming your brothers and sisters, then, if you take time to notice, you will quickly discover just how influenced you are by media and clinical explanations of behavior that is perceived to be unusual.

One of the mistakes that the church tends to make when it begins to think about mental health and ill-health is to begin with the definitions laid down by psychiatry. We then formulate our strategy in the light of this and act in ways that we consider to be "therapeutic." When this happens, the road to recovery becomes defined by a clinical form of categorization that can quite easily surpass—or perhaps better, *bypass*—vital aspects of a person's own story. Let me be very clear on this point. I am *not* suggesting that there is anything wrong with psychiatry or psychiatric categorization. There may well be; I am just not arguing that. My point is that diagnoses and clinical categories may be totally appropriate for the mental health professions, but may not be the best place for the church to begin in its journey towards mental health and the facilitation of recovery from mental health problems. I want to suggest that the church has another starting point and other ways of naming the phenomena that have come to be named as mental health problems. The two are not exclusive; they are just not the same.

For that reason I won't use the term "mental illness" in this article, not because I don't think such a thing exists, but because I don't believe that the term "illness" is the only way or even the best way in which the church can talk about those behaviors and experiences that are currently described in these terms. Mental health problems are first and foremost unwanted intrusions into people's personal narratives. Think of it in this way: Before mental health problems become diagnoses they are deep and meaningful human experiences. They continue to remain deep and meaningful human experiences even after they have been named by professionals as "schizophrenia," "bipolar disorder," "personality disorder," and so forth. Indeed from the perspective of the church, mental health problems may best be described as unusual, unique personal experiences that disrupt people's life stories and that require understanding and respect alongside of cure and rehabilitation, if cure is in fact an option. Professionals, for good reasons, may name such stories in particular ways, but churches, while respecting and learning from that way of naming things, do not have to do so.

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A useful definition for the church might be something like this: Mental health problems are unique experiences that occur in the lives of irreplaceable individuals who have their own unique stories, histories, dreams, and desires; people who are deeply loved by God, and whom God desires God's church to love without boundaries.

People's stories may be changed by their encounter with mental health problems but they are not defined by them. People *can*, however, be redefined by the ways in which their condition is named. The stories of such people can be deeply altered and affected by the meanings that we ascribe to their experience, both positively and negatively. In summary, from the church's perspective mental health problems are best described as:

- a rupture in the stories we tell about ourselves and that are told about us
- a deeply meaningful set of human experiences that are open to a multitude of different interpretations
- places where people encounter the world in ways that are sometimes distressing but always deeply spiritual
- diagnostic categories that have biological, social, and spiritual implications.

If mental health problems are rich and diverse narrative experiences, and if they can in fact be interpreted in a multitude of different ways, why is it that the final point—diagnosis—has come to dominate our thinking?

In beginning to draw out an answer to that question we must start with a theological observation. The language we use around any given subject inevitably and deeply reflects the assumptions that we have about it. Language matters. The Genesis account of creation informs us that a primal vocation of human beings is to name things properly. Adam is given this responsibility:

> Now the Lord God had formed out of the ground all the wild animals and all the birds in the sky. He brought them to the man to see what he would name them; and whatever the man called each living creature, that was its name. So the man gave names to all the livestock, the birds in the sky and all the wild animals. (Gen 2:19–20 NIV)

Whatever name Adam gave to the animals that became their name. Tigers became tigers and sheep became sheep as and when Adam named them. The act of naming has deep creative power: it literally brings things into existence. The primal responsibility that was given to Adam to name things has not ceased. The "small thing" of naming things properly is still of fundamental importance to human beings and is a primary responsibility of the church. Indeed, as we will see, naming things properly is the heart of faithful mental health care.

Diagnosis

Within Western cultures the practice of diagnosis is a particularly powerful form of naming. At one level, it is a way of naming those behaviors that make up the content of certain categories we have constructed to help us to understand unusual behaviors and expressions of strange and disturbing experiences. However, as will become clear, because of the social power of diagnoses it very easily ends up defining those human beings who bear them. Diagnosis is of course not necessarily a bad thing, as long as it is carried out in the right context and the boundaries of that context are clear and adhered to. Unfortunately this is not always the case.

Culturally, mental health diagnoses are highly stigmatized. Unlike other forms of diagnoses (influenza, measles, mumps, etc.), there is a tendency for people not only to <u>have</u> a diagnosis but to <u>become</u> diagnoses.

The best way to think this through is by asking the question: Who are diagnoses for? Mental health diagnoses emerge from the medical professions and in particular the field of psychiatry. They are designed to help psychiatrists or psychologists make sense of certain clusters of experiences and behaviors in order that they can understand the person and use their healing skills to alleviate any distress. This is clearly a good and noble goal. So, a person brings their story to the psychiatrist, the psychiatrist then filters it through whatever theoretical framework she or he has been trained in and provides a diagnosis. Positively, this can be helpful for an individual experiencing distress in that they now have a reason and an explanation for their feelings and experiences and the possibility of effective treatment. From the perspective of the mental health professionals, once an accurate diagnosis is applied, they are then able to use their skills and healing practices to bring about change and hopefully alleviate distress.

That is all good and fine. I would emphasize that I have no major gripe with the professional mental health services. However, there are side effects to diagnoses that easily go unrecognized. First, it is important to remember that diagnoses are designed specifically for the mental health professions to enable them to do their jobs well. They are *not* designed for pastors, pastoral caregivers, laypeople, or anyone outside of that particular field. Others can learn some things from diagnoses in the same way as I might learn from a mechanic that certain sounds are indicative of particular problems in my car. Such knowledge may give me a heads-up on what may be happening, but it won't make me a mechanic or give me in-depth knowledge about other vital aspects of my car. The knowledge contained in a diagnosis is first and foremost for professional purposes. Now, you might be saying, "But isn't it important that a pastor should know what a diagnosis means in order that he or she can understand the person before her?" Well, that is precisely the problem. It might tell you some things about how to frame some aspects of someone's experiences, but it won't necessarily tell you anything about the *person* in front of you. Diagnoses tell us too much and too little about the people who bear them. Culturally, mental health diagnoses are highly stigmatized. Unlike other forms of diagnoses (influenza, measles, mumps, etc.), there is a tendency for people not only to *have* a diagnosis but to *become* diagnoses. This works itself out in at least two ways: through stigma and through biological explanations of mental health problems. One is explicitly derogatory; the other is more implicit and in some senses less likely to be noticed. We will begin with the issue of stigma.

The Problem of Stigma

Stigma is a profoundly pejorative way of misnaming people. We live in a society where, for a variety of reasons, mental health problems are often considered in particularly negative terms. In a society that prizes intellect, reason, and clear thinking and assumes such things to be the essence of what it means to be fully human, being the bearer of a condition that seems to interfere with any or all of these faculties inevitably holds a particular negativity. For this reason mental health problems are highly stigmatized conditions. Stigma is a way of creating a story that hides the humanness of the individual. It functions not dissimilarly to the mark that slave owners would put onto slaves. When a slave was purchased the owner would give the slave his brand. From there on the branded person no longer existed as person. All that existed was the slave owner's brand. This is precisely how stigma works. Stigma occurs when one aspect of a person is highlighted in such a way that people consider it to be the only or the most important aspect of a person's life. When a person's unique story and personal experiences become stigmatized, the person is given a new name that contains a different plotline: depression, schizophrenia, bipolar disorder, and so forth. These stories make some sense within their own context, but become highly problematic when taken out of that context. When this happens, people find themselves forced to live into and out of a story that is no longer their own. Stigma is a way of stealing someone's story and forcing them to accept a false identity. This new story informs them that they are of little worth, that their illness is the reason for everything they are and do, and that other than perhaps their families, the only people who should care for them are people who are paid to care for them. It challenges the meaning of people's personal stories and ultimately erodes our sense of humanness. Naming people properly is the key to destroying stigma.

The Problem with Biological Explanations

One way in which stigma has been addressed in recent years is by medicalizing, neurologizing, or/and geneticizing the causes of mental health problems. Here the intention is to draw mental health problems into the purview of medicine and in so doing help to destigmatize it by showing that mental health problems are no different from physical problems. So Fuller Torrey offers this explanation of schizophrenia:

> Schizophrenia is a brain disease, now definitely known to be such. It is a real scientific and biological entity as clearly as diabetes, multiple sclerosis, and cancer are scientific and biological entities. It exhibits symptoms of a brain disease, symptoms which include impairment in thinking, delusions, hallucinations, changes in emotions, and changes in behavior. And, like cancer, probably has more than one cause.[2]

In this way mental health problems are normalized insofar as they are no longer assumed to be any different from other forms of health problem. At one level that works well. If schizophrenia is the same as the measles or cancer it becomes normalized and destigmatized as it is drawn into a culturally acceptable and respectable narrative. However, like many such explanations, there are unforeseen side effects. John Modrow, a person with schizophrenia, sums up the problem in this way:

> I cannot think of anything more destructive of one's sense of worth as a human being than to believe that the inner core of one's being is sick—that one's thoughts, values, feelings, and beliefs are merely the meaningless symptoms of a sick mind. . . . What the concept of mental illness offered me was "scientific proof" that I was utterly worthless, and would always be worthless. It was just the nature of my genes, chemistry, and brain processes—something I could do nothing about.[3]

[2]E. Fuller Torrey, *Surviving Schizophrenia: A Family Manual* (New York: Harper and Row, 1983) 2.

[3]John Modrow, *How to Become a Schizophrenic: The Case against Biological Psychiatry* (Lincoln, NE: iUniverse, 2003) 200–201. While I think Modrow's point here is a strong one, I am less convinced with his overall antipsychiatry position for the reasons outlined in the conclusion to this paper.

Modrow draws out an interesting distinction between *having* an illness and *being* an illness. If mental health problems are neurological or genetic, that is, built in to the very fabric of who we are, then it is difficult to see how you can find the necessary distance simply to say that you "have" schizophrenia, but it is not all of who you are. If one has cancer, tuberculosis, or influenza, it would be rare for anyone to describe you as "the cancer" or "the flu." But that language that surrounds some mental health diagnoses clearly ontologizes the condition. So we find language like "he *is* a schizophrenic" or "she *is* bipolar" spattering the media and our own personal conversations. When people *become* their illnesses it is easy to forget that they are people. The problem with accepting the terminology of "mental illness" and assuming biomedical approaches to psychological distress to be the only true explanatory framework for understanding mental health and ill-health is that it reduces significant types of experience to "mere pathology." The awareness, the feelings, the experiences of people with mental health problems are easily overpowered by assumptions of meaninglessness. If your delusions, hallucinations, sadness, and anxiety are nothing but misfiring neurons or faulty genes, then it will become very difficult for you to find such experiences meaningful and any different from a fever or a painful throat infection.

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Rethinking Hospitality: Moving from Host to Guest

So what might be the way forward? If the church is to be faithful in its ministry of naming things properly, we will need to begin to think about what that might look like. One way in which we might do so is by reflecting on the nature of Christian hospitality. The world can be a pretty inhospitable place for those who are considered to be different. And yet, at the heart of the gospel is Jesus' deep ministry with and towards those who are perceived as different and unwanted. Jesus sits with tax collectors, sinners, and others whom society has alienated, depersonalized, and stigmatized. There is a pattern in this incarnated hospitality that is worth noticing. One of the extraordinary things about Jesus' ministry is the way in which he practiced hospitality. Sometimes Jesus was a guest in people's houses; sometimes he was a host. The constant movement from guesting to hosting is a primary mark of the hospitable work of the incarnation. This observation is crucial for understanding the nature of the church's life with people who live with mental health problems. To be truly hospitable we need to learn how to be a guest in the house of the "stranger." Rather than assuming that the church's task is to *host* people with mental health problems—somehow to seek to find ways of "looking after them because they can't look after themselves"—we are called to ask what it might look like if our congregations were to become truly hospitable and began to think of themselves both in terms of guest *and* host in the presence of people experiencing mental health difficulties. In other words, instead of simply thinking we need to make room for people with mental health problems in order that *we* can care for *them*, the hospitable calling of the church is to learn to understand the stories of mental health and ill-health and to open itself to being a guest rather than simply a host.

What might it look like if churches were to consider themselves *guests* in the stories of the lives of those who have different experiences? Rather than simply assuming that people's experiences are "nothing but" the product of misfiring neurons, chemical imbalances, or genetic differences, what might it look like if the church was prepared to slow down and take the time to listen to and take seriously the meanings of such experiences, not understood as simply the products of illness, but as important aspects of a person's life story that require understanding and respect rather than simply control and eradication. What kind of impact could it have if the church simply invited people with mental health problems to speak to our congregations about what it actually feels like to go through such experiences and to move from stigma to hope? I suspect that is the approach that Jesus would take—love, listen, and try to understand. When we take time and allow ourselves to move from host to guest, we learn some important and sometimes quite beautiful things. Let me show you what I mean.

Heaven on a Hill and Grieving for lost Friends

I spoke to a woman not so long ago who was diagnosed as having bipolar disorder. She told me about a beautiful experience she had on a mountaintop in Warwickshire where she thought, just for a while, that she was in heaven. It was a quite beautiful experience even though technically it "didn't really happen." It is easy to dismiss such an experience as "nothing but" the effects of mental health problems. But for her it was a deeply meaningful experience, the memory of which even now, two years later, brings her comfort, joy, and hope.

When I worked as a hospital chaplain, I walked alongside a young man, George, who had lived with schizophrenia for most of his life. George was twenty-six when I met with him. The first time we met, George was quite upbeat, and he had good reason to be so. He told me that he had a new befriender. A couple who had volunteered on a befriending scheme had been visiting with George for several weeks and their relationship seemed to be developing well. He told me something that was quite startling: "You know, John, I am twenty-six years old and this is the first time I have had a friend who is not paid to be my friend." I found this quite profound and carry the implications of that encounter with me even now. In the midst of the ravaging storms that were central to George's life was a deep and simple desire: to have a friend. It's not complicated. But if we only look at George through the lens of his diagnosis; if our beginning point is his "big problem" or how best we can accommodate/offer hospitality to him, we miss the small thing that underpins all other things: George is lonely and desires to offer *you* hospitality.

I have a friend, Sheila, who had schizophrenia. She was diagnosed when she was twelve years old and had serious hallucinations, delusions, and various other difficult behaviors. When she reached her twenties, it all stopped. Sheila puts it down to her mother and her friends praying for her incessantly over time. For Sheila this healing was miraculous. Her psychiatrists suggested that she had been misdiagnosed. Both explanations may well be true. But one clearly has more cultural power than the other. Sheila's healing had an unusual side effect. In the midst of the horrible voices that she had experienced, there was one voice, Margaret, who was a constant source of relief and encouragement. When she no longer hallucinated, Margaret no longer existed. Now she has a rather odd problem. How can she explain to people that she has to grieve for someone who never existed in the first place? Sheila is delighted to be free from the manifestations of schizophrenia. But she carries a deep hurt and a continuing sense of grieving for Margaret.

Something like 10–15% of the "mentally healthy" population hear voices. Voice hearing is not particularly unusual. The key is to effectively manage it.

This might sound rather odd until one realizes that something like 10–15% of the "mentally healthy" population hear voices.[4] Voice hearing is not particularly unusual. The key is to effectively manage it. Far from being meaningless manifestations of genetic or neurological deficits, visions, hallucinations, delusions, deep sadness, and manic highs are freighted with meaning and are not as alien to our humanness as the medical model infers. If this is so, then the experiences that some have learned to describe as "mental illness" needn't be understood as radically other, but as on a continuum within which normal and abnormal experiences are perceived as quantitatively rather than qualitatively different. When we begin to think in such ways, the possibility of receiving as well as giving hospitality to "strangers" becomes both interesting and possible.

Sitting with "Strangers": Why the Church Might Have a Mental Health Problem

But who exactly are "the strangers"? It is often suggested that Jesus hung around with marginalized people. At one level that is the case. Many of the people Jesus spent time with were highly stigmatized. They were rejected and outcast—people whom society considered to be unclean. Such people share many

[4]Iris E. C. Sommer, Kirsten Daalman, Thomas Rietkerk, Kelly M. Diederen, Steven Bakker, Jaap Wijkstra, and Marco P. M. Boks, "Healthy individuals with auditory verbal hallucinations; who are they? Psychiatric assessments of a selected sample of 103 subjects," *Schizophrenia Bulletin* (May 2010) 633.

similarities with the experiences of people with mental health problems today. It is often suggested that because Jesus sat with the marginalized the task of the church is to do the same. However, I want to suggest that we may actually have the dynamic wrong. I suspect that it is the church that is actually the stranger.

It is certainly the case that Jesus sat with those marginalized by their culture. However, in sitting with such people, Jesus, who is God, actually shifted the margins. Now, it was the religious authorities that were marginalized.

It is certainly the case that Jesus sat with those marginalized by their culture—the tax collector, the prostitute, the sinner, the demon-possessed—and it is also true that he offered them friendship, acceptance, and a valued place within his coming kingdom (Mark 2:15–17). It is not right, however, to say that Jesus sat with the marginalized. He certainly sat with those whom religious society had excluded and rejected as unclean and unworthy of attention. However, in sitting with such people, Jesus, who is God, actually *shifted the margins.* Now, it was the religious authorities that were marginalized. Those who thought that they were pleasing God with their rituals and laws completely missed the point of what God was up to. They didn't realize that Jesus had moved the margins to a totally different place. Now it was established religion that found itself alienated and marginalized. God was with a totally different group of people doing something quite different: offering friendship and acceptance and revealing the kingdom in and through that friendship. Jesus offered no "technique" or "expertise." He simply gifted time, presence, space, patience, and friendship. He befriended the tax collectors and sinners; he befriended the stranger and the stigmatized. He offered relational space and time to people for whom the world had no time. In and through his friendships, he gave people back their names.

I sometimes fear that something similar might be happening in our own churches. Could it be that the reason some of our churches find little interest in ministering with people experiencing mental health problems or who put such ministry down to something apart from the centralities of the gospel—something for those "interested in such things"—is that they have become marginalized from key aspects of God's redemptive work? By neglecting the marginalized, such churches have become marginalized themselves. If that is the case, then it may be that the kind of reflective recognition of the experience of people with mental health problems that I have encouraged in this article may actually be a prophetic call of faithfulness for the church. Listening to the Spirit and naming things properly may be a first step in the salvation of the church.

If what I have suggested is the case, the task of the church is relatively straightforward: to love people experiencing mental health issues with the passion of Jesus, to respect their stories, and to learn to call them by name. Put slightly differently, the church must make space for friendships. Friendships cannot of course be manufactured, but we can create spaces in our lives and in our communities where friendship becomes at least a possibility. Jesus didn't impose his friendship, but he clearly made sure he was available in the places where friendship with "marginalized people" was an option. Our call is to engage in the ordinary act of friendship with extraordinary love. It is in small things such as this that the kingdom is revealed.

In closing, I want to be very clear on one point: none of what I have said thus far should be read as in any way anti-psychiatry. Quite the opposite. Medication and therapy can be very helpful. But you can take medication without necessarily being defined by your condition. Mental health problems can be deeply destructive and can ruin and profoundly disrupt people's lives; people do need relief. Churches can and should have constructive relationships with the mental health professions. The task is to be hospitable to psychiatry without being defined by it. The stories told by the mental health professions are not the only stories in town. It is in the small stories of friendship, hospitality, love, listening, and acceptance—all of which are modeled clearly in the life of Jesus—that we find the context and the seedbed for extraordinary love. Here we encounter healing even if cure is not an option. The task of the church is not world transformation, but signaling the kingdom through small gestures.[5] Look after the small things and the big things will fall into place.[6]

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[5]Jean Vanier and John Swinton, *Mental Health: The Inclusive Church Resource* (London: Darton, Longman & Todd, 2014) 102.

[6]Some of the material in this essay appears also in my article "Doing Small Things with Extraordinary Love," *The Christian Citizen*, vol. 2 (2014) 16–17.

Mental health stigma: Impact on mental health treatment attitudes and physical health. Journal of Health Psychology. http://journals.sagepub.com/doi/pdf/10.1177/1359105316681430. Accessed April 25, 2017.Â Wong EC, et al. Effects of stigma and discrimination reduction trainings conducted under the California Mental Health Services Authority. Rand Health Quarterly. 2016;5:9. PDF | This digest compiles much of the research relating to international student mental health over the past 20 years. The research digest includes new | Find, read and cite all the research you need on ResearchGate.Â The research digest includes new insights under the themes: Increasing concerns about mental health; Accessing mental health services; Help-seeking; Preventions and interventions; Recommendations. Discover the world's research. 19+ million members. Other social causes of poor mental health lie in persistent living conditions that do not appear at a particular time and then go away but are instead rooted in ongoing circumstances (Turner, Wheaton, & Lloyd, 1995). For example, people who live in social environments that feature high rates of poverty, neighborhood instability, crime rates, dilapidated housing, and broken families are likely to have high rates of psychological distress (Ross, 2000).Â In addition, the periods of time when individuals were born and the countries they live in are associated with their states of mental health. The influence of these factors means that levels of mental health diverge considerably among people in different social locations. Social Integration. Module 1: Introduction to Practical Theology and Mental Health Module 2: Understanding Depression and Anxiety: Towards a theology of liberation and joy Module 3: Understanding schizophrenia Module 4: Bipolar Faith?: Reflecting theologically on bipolar disorder. Module 5: Forgetting Whose We Are: A practical theology of dementia. Teaching Arrangements. All students are required to attend a week of lectures in Dunedin from 1pm on Monday January 27th to 1pm on Friday January 31st, 2020. The provision of long-term mental health care for people with severe mental disorders has been, and still is, one of the major challenges for mental health systems reform in the last decades, for various reasons. Firstly, although these disorders have a low prevalence, the impact they have on individuals, families and societies is huge. The group of schizophrenic disorders are the most important of the severe mental disorders since they are associated with the greatest impact on functioning. Schizophrenia has an estimated point prevalence of 0.4% and a lifetime risk of 1% i.e. one in a hundred