

Healing Presence

BY JOHN SWINTON

How do people with profound mental health problems suffer? In our highly medicalized culture, we define and respond to disease from a biomedical model. We want to fix the 'bad spot.' But suffering is a richer concept, and true healing requires friendship and community.

We think we know what suffering is, but is this always the case? Within our highly medicalized culture, a biomedical model of health and ill-health shapes our understanding of suffering and how we should respond to it. Health, we assume, is the absence of disease and symptoms of illness. Disease is identified as a discrete 'bad spot' within a person's body or mind, and this bad spot becomes the locus of our efforts to relieve suffering. If we can excise or 'cure' that bad spot, then we think we have succeeded in our healing task.

But deeper reflection on human experience reveals that suffering is a much richer concept than this medicalized perspective allows us to see. Physician Eric Cassell offers this richer definition:

Suffering occurs when an impending destruction of the person is perceived; it continues until the threat of disintegration has passed or until the integrity of the person can be restored in some other manner. It follows, then, that although suffering often occurs in the presence of acute pain, shortness of breath, or other bodily symptoms, suffering extends beyond the physical. Most generally, suffering can be defined as a state of severe distress associated with events that threaten the intactness of the person.¹

Cassell points out that suffering (1) is not confined to physical or psychological symptoms alone, (2) is not measurable only in terms of pain, and (3) cannot be assessed on a scale that is universal—that is, applicable to all

people irrespective of context, personality, and situation. Rather, he suggests, suffering occurs when we experience a loss of meaning, purpose, hope, and value that leads to a disintegration of our sense of self and our identity as a valued person. Suffering, therefore, is unique to each individual and filled with personal meaning.

“Suffering is personal,” agrees David B. McCurdy, “it has to do with the meanings that illness (and treatment) holds—for *this* person. Ultimately, a key ingredient of suffering is the person’s experience of a threat to integrity or ‘intactness’—in any or all dimensions of life, the bodily among them.” Because no two people experience an illness in exactly the same way, he suggests “the meaning that illness or injury holds for a person depends on factors in that person’s history and relationships that others simply do not know.”²

How we experience suffering is shaped by our distinctive personality and unique life experiences, by our personal expectations, values, and hopes, and by the particular ways in which we see and understand the world. It is also shaped by our culture and the ways we are taught to deal with pain. As Cassell and McCurdy indicate, the degree and form of suffering we experience is linked tightly with the meaning we place on the events that cause our suffering, the consequent situation of our misery, and ourselves.

TWO NARRATIVES OF SUFFERING

Let me put two powerful narratives of suffering before us. In the first one, which is recounted by psychiatrist John Strauss, we encounter a young man who has been through the ravages of schizophrenia:

This 28-year-old man had had the first onset of his schizophrenia ten years previously. He had spent three years in hospital, and then from the period between seven and five years before my interview had been able to manage outside the hospital. However, five years before my interview, he had been readmitted to hospital and had remained there since. As part of our interviews, we try to delineate the various general levels of illness, at several times in the past. We then determine levels of social relations and work functioning, symptoms and hospitalization during those times and plot a time line of course of disorder. This line is generated by rating scales of established reliability. In this particular study, we also enquire about the worst year the person has had since becoming ill. I expected that when I asked that question of this young man he would say that it was one of the times when his functioning scores were lowest, his symptoms highest, and when he was in hospital. He said the worst year was about six years ago, a time when by our scores he was doing fairly well and was not in hospital. He said

that he had been living with his mother and then finally had been kicked out of her house and was living in an apartment. About two weeks after leaving her house he called home. She answered the telephone. He started talking, but when she heard his voice, she said ““You have the wrong number” and hung up. He said that was the worst year of his life. My heart sank as he told his story. It was not difficult to understand what he meant, but the worst year according to him and the worst year according to our rating scales were very different. Who was right?³

As we reflect on the life experiences of people with schizophrenia, it is clear that they undergo rejection, stigmatization, isolation, and relational disconnection with self and others. Some of this relates to the illness itself. But much (and arguably most) of the negative experiences of schizophrenia relate to the way our society interprets this form of mental health problem and constructs deeply negative identities around individuals.⁴

Notice that in the psychiatrist’s clinical gaze, the young man’s suffering derives primarily from his experience of the clinical symptoms of schizophrenia. With his medical tools and methodological assumptions, the doctor can only measure schizophrenia by its symptoms, so he assumes they are the primary cause of the young man’s suffering and that control of them would be a movement toward mental health. However, from the perspective of the young man, suffering and mental health look quite different. Unpleasant as the symptoms of schizophrenia clearly are for him, the most devastating form of suffering comes from his broken and apparently irreconcilable relationship with his mother. This fragmented relationship and its meaning for his self-perception and life expectations form the core of his suffering, and not the symptomatic manifestations of the illness.

Of course, in some ways the two perspectives are connected. But only one perspective—the clinical—is taken into consideration when the psychiatrist reflects on this young man’s treatment. Whose perspective on suffering should take priority in understanding the meaning of mental health and suffering, and in prescribing forms of treatment and rehabilitation? Are vital dimensions of human suffering being overlooked by the ways that we conceptualize particular mental health problems?

The second narrative of suffering comes to us from Scripture:

A man with leprosy came to him and begged him on his knees, “If you are willing, you can make me clean.”

Filled with compassion, Jesus reached out his hand and touched the man. “I am willing,” he said. “Be clean!” Immediately the leprosy left him and he was cured.

Jesus sent him away at once with a strong warning: “See that

you don't tell this to anyone. But go, show yourself to the priest and offer the sacrifices that Moses commanded for your cleansing, as a testimony to them." Instead he went out and began to talk freely, spreading the news. As a result, Jesus could no longer enter a town openly but stayed outside in lonely places. Yet the people still came to him from everywhere.

*Mark 1:40-45 (NIV)*⁵

We might approach this story in two very different ways. On the one hand, we might assume that its cultural context is not particularly important. Then we can impose our understanding of medicine to produce a picture of Jesus as "the great physician" who breaks into natural history and miraculously removes the bad spot—in this case leprosy—in order to return the person to health, which we construe as life without disease. Jesus functions just as a surgeon would today, but instead of using antibiotics and scalpels, he draws upon Divine power to heal the sick person.

If we read the story that way, however, we will miss its crucial *theological* meaning. Of course, the healing was an act of compassion that freed the man from his disease—and at this level we rightly may compare contemporary medicine to Jesus' action. The miracle speaks of the compassion of Jesus and the desire of God to care for the sick and wounded. However, if we stop here we miss the real significance of the miracle.

Living in a culture that understands illness from a biomedical model, we focus automatically on the pathology, the leprosy. However, to more accurately understand this story, we must focus on the *meaning* of leprosy—not on the clinical diagnosis, but on the social and theological meaning of the condition. In first-century Mediterranean culture, to have leprosy

meant a person was "unclean" and thus unworthy of participation in the Temple rituals. Denied access in this way to the Temple, the person's exclusion was not simply from the community, but seemingly also from God. The primary suffering that accompanied leprosy was not its biological symptoms, as important as these certainly were, but the *pollution* and *exclusion from holiness*. Within a culture that was totally God-centered, such

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exclusion was equally painful as, if not more painful than, the clinical manifestations of the illness.

When he touches the man, Jesus himself becomes polluted and enters into the social and spiritual death of leprosy. By entering into the man's stigma and social isolation, God in Christ shifts the boundaries. This is an

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important point. We often talk about Jesus sitting at the edges of acceptable society, but such a suggestion is misleading. By sharing in the social exclusion of those whom society had marginalized, Jesus *shifts the margins*: those previously marginalized people now form the heart of God's coming Kingdom.

And those religious people who sought to marginalize the "unclean" find themselves on the margins, cut off from true relationship with God, and mired in a form of spiritual alienation which was manifested so horribly in the crucifixion of Jesus. When Jesus enters into relationship with the marginalized and shares in their 'social death,' he initiates a process of resurrection for people like this man with leprosy. They become full persons and are reintegrated into the community, which itself is necessarily transformed by his healing actions.

These two narratives of suffering, of the young man today with schizophrenia and the man long ago with leprosy, provide rich insights into the nature of suffering. The parallels between these stories are not coincidental. They are prophetic reminders of the social position of the church community and its potential healing responses to disease. Our choice of whom we choose to stand with is a deep indication of our faithfulness.

PRACTICING CHRIST-LIKE FRIENDSHIP

How should the church as a community respond to the suffering of people with profound mental health problems such as schizophrenia? To have schizophrenia in our culture is to be alienated, stigmatized, often friendless, and, interestingly, often prevented from expressing one's spirituality. Schizophrenia is a totalizing illness. Unlike someone with influenza or measles, a person diagnosed with schizophrenia loses their personal identity and actually becomes the illness: a "schizophrenic." Once this happens, all of their experiences are interpreted through the lens of cultural assumptions about the illness. Because these assumptions about schizophrenia tend to be negative, so the social identity that a person with this condition develops is negative.

Even the person's spiritual experiences are interpreted through the lens of pathology. There is strong evidence to suggest that mental health services tend to exclude spiritual expression as pathological and they actively seek to disengage spirituality from the therapeutic process.⁶ Here we can see a pattern of exclusion from their community, personal relationships, and God that is strikingly similar to the experience of people with leprosy in Jesus' day.

"Six hundred years ago lepers were exiled, cut off from the normal social intercourse in case they infected everyone else," notes a prominent psychiatrist, Bob Johnson, in his reflection on the plight today of people with severe personality disorders. "A few dedicated people worked with them, improved their standard of living and long before anti-leprosy drugs were available, enabled them to live longer. The optimum treatment for this dread disease, then as now, was human comfort. How can we do less to our own mentally ill, merely because the current dominant section of the psychiatric profession has determined that personality disorders are as 'untreatable' as leprosy once was? Isn't it time to apply other criteria?"⁷ Though Johnson is speaking specifically of people with personality disorders, his statement is equally applicable to the type of suffering we have been discussing.

The friendships that Jesus formed with persons during his ministry both revealed and initiated their friendship with God. Christ becomes our model as we consider how the practice of friendship can ease the suffering of people with profound mental health problems who live in our communities and desire to find a spiritual home.

Friendships, of course, are critical for developing and maintaining spiritual and psychological health. From our friends we gain a positive sense of identity and an awareness of value, meaning, and purpose; in our friendship with God, we discover our ultimate significance. Above all, friendships express love. Indeed, when a human friendship is practiced out of a relationship with the Triune God, it becomes a concrete expression and manifestation of God's love for the world.

Jesus' friendships were qualitatively different from two types of friendship that are so common today—those based on the principle of social exchange or the principle of likeness. In the first type, based on social exchange, we gauge our friends by what we can get from them. If we find the relationship to be personally satisfying, we will stay with it. But we are under no moral obligation to be faithful. Consequently, when we do not get what we want from a relationship, we seek another one that is more fulfilling. In the second type, the principle of likeness assumes that friendships emerge between individuals who share interests and activities—in other words, like attracts like. The friendships of Jesus, however, were based on a very different principle: the principle of love and grace. Jesus

fellowshipped with people who were radically unlike him—tax collectors, sinners, people considered religiously unclean, and women—and through their friendship, he resurrected their personhood. His friendships were unbounded by cultural assumptions and available to those whom society marginalized, stigmatized, and refused access to God.

In this ministry of befriending people with mental health problems, there will be moments of sadness, joy, frustration, and uncertainty. But if the church does not offer such friendships, who will?

CREATING “SPACE” IN COMMUNITY

Can we really become friends with people who have severe mental health problems? We may be tempted to throw up our hands and cry, “We don’t have the expertise! We would not be able to cope with ‘such people’ in our

community.” Yet to cut off the possibility of effective community care with a stream of negatives in this way is simply to hide behind prejudices and stigmatizing labels that prevent us from knowing real persons who are suffering. Sometimes we forget that mental health problems are first and foremost human experiences before they become diagnoses. Did we see such negativizing attitudes in the ministry of Jesus? Do we hear Jesus calling for the expert each time he encounters someone who is marginalized, disturbed, or socially alienated?

Forming friendships with people who are marginalized and different is not an easy task. Yet, if we can create forms of community with “safe space” for people to develop such friendships, even if these friendships are transient, then we will have moved some way towards faithfulness and Christ-likeness.

Creating this “space” for friendship requires making room for individuals, despite their differences and difficulties, to participate meaningfully in church life. To do this, churches may need the guidance of mental health experts and collaboration with professional agencies. Mental health chaplains and parish nurses, for instance, can be facilitators of friendships for people with profound mental health problems.⁸ However, to suggest that professionals be liaisons for relationships is not to suggest that they do the befriending on behalf of the church community. Collaboration between a community and mental health professionals has the mutual goal of accompanying individuals as they find their way into the community and to provide support that will enable the church community to rejoice in the newfound diversity. The church’s task is to provide a physical and spiritual space where people perceived by society as “different” can find a home, where there is neither Jew nor Greek, male nor female, mentally ill nor

mentally healthy, but only travelers struggling together to sustain faith in God and trust in one another.

In this ministry of befriending people with mental health problems, there will be moments of sadness, joy, frustration, and uncertainty. But if the church does not offer such friendships, who will? To do so is to remain faithful to the One who touched the man with leprosy and said, "I am willing." To do so is to offer them true healing—relief from suffering and a chance to maintain their connection with God and others despite the turbulent storms they must endure.

NOTES

1 Eric Cassell, *Suffering and the Goals of Medicine* (New York: Oxford University Press, 1991), 640.

2 David B. McCurdy, "The Doctor's Relationship with Suffering" (online at www.faihandculture.us/resources/papers/mccurdy.pdf).

3 John S. Strauss, "The Person-key to Understanding Mental Illness: Towards a New Dynamic Psychiatry," *British Journal of Psychiatry Supplement*, III (October, 1992), 19-26. The story is on p. 18.

4 See my *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville, TN: Abingdon Press, 2000).

5 Scripture quotations marked (NIV) are taken from the HOLY BIBLE, NEW INTERNATIONAL VERSION®. NIV®. Copyright© 1973, 1978, 1984 by International Bible Society. Used by permission of Zondervan. All rights reserved.

6 See my *Spirituality and Mental Health Care: Rediscovering a 'Forgotten' Dimension*. (London: Jessica Kingsley Publishers, 2001).

7 Bob Johnson, "Modern Day Lepers," in *Personality Disorder and Human Worth: Papers from a Conference Organised by the Board of Social Responsibility* (London: The Church of England, 2001), 20.

8 For other concrete suggestions, see *Resurrecting the Person*.



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