Introduction

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On a dark and dreary night, there was a knock at the door of the pastor's study from a thinly clad man seeking refuge from the bitter cold. He was hungry and weary with exhaustion. Before the pastor could call the local homeless shelter to secure food, clothing, and lodging, the man launched into a bizarre story of having heard the voice of God speaking to him through the small transistor radio that he had managed to protect from others on the street.

The man related in graphic detail how the voice of God had convicted him of his sin and that his eternal fate was sealed in everlasting damnation. He was overwhelmed by the immensity of God's indictment and at times the auditory messages were accompanied by frightening visions of torment in the pit of hell. The intensity of his voice rose in a crescendo of laments as he poured out his abject fear of God and of "other people" who he was convinced were intent on harming him.

The pastor was both frightened and flabbergasted by the experience and attempted to calm the man down and assure him that his fears were unfounded. But the man became more agitated as he sensed the pastor did not believe his story. After some time had passed, the man nearly collapsed because of hunger and exhaustion and was persuaded to accompany the pastor to the homeless shelter where he would receive food, clothing, and a place to sleep for the night.

The homeless man in the above vignette undoubtedly was suffering from a mental illness that resulted in his being homeless, pushed to the margins of society, having no advocate for his well-being, and no treatment available for his malady. Irrespective of the ultimate diagnosis, there are literally millions of people on the streets, but also in our synagogues, churches, and mosques, who are suffering from a variety of mental illnesses, as well as family members and significant others who are often clueless as to what is happening to their loved ones. Knowledge about available treatment in terms of assistance remains for many a mystery.

The phenomenon of mental illness with its various manifestations is chronicled far back into antiquity. Papyri from ancient Egypt have described in rather graphic detail the symptoms of mental illness and the varying attempts that were made to deal with it. Those who are mentally ill might be considered as the "modern-day lepers" who suffer from a socially "unsanctioned illness" and who continue to be misunderstood and mistreated by society and religion alike as a consequence. I have used the designation "unsanctioned illness" to name those illnesses in society that bear the stigma of social discrimination. The consequence of stigma is experiencing a sense of "disgrace shame" that results in both denial and a conspiracy of silence, which precludes such illnesses from being treated and openly embraced, discussed, and treated.

Utilizing "leprosy" is an apt metaphor for mental illness, as the parallels between the two can be traced in the long history of discrimination endemic to both illnesses. The biblical tradition captures in varying narratives the stories of those afflicted with and affected by the dreaded disease of leprosy. Individuals who contracted this contagious disease were confined to colonies on the geographical fringe of society. Similarly, people suffering from mental illness were also for centuries sequestered away in private homes (if a family was able to afford such) or they were remanded to institutions providing custodial care that prohibited them from interacting with the mainstream of society. The debilitating effects of isolation are paramount with both diseases. Ignorance concerning mental illness has historically often resulted in brutal treatment of suffering persons, of their being fettered both literally and figuratively by the chains of helplessness and hopelessness.

Should lepers wander away from their appointed colonies, they were to announce to all who came near that they were "unclean," the stigmatization of society and the judgment of religious protocol relegating them to a less-than-human status. The biblical Holiness Code provided specific rubrics with respect to how lepers were to be dealt with in society (Leviticus 13 and 14; 2 Kgs. 5:1-27). The desire to be free of this curse that plagued so many in the ancient world gives rise to the stories of Jesus healing them written in all three Synoptic Gospels. Restoration back into the community was as notable as the healing itself (see Matt. 8:3; Mark 1:42; Luke 5:12-13). People with mental illnesses have suffered parallel experiences in their lives.

People who are mentally ill often have the feeling that they are "unclean" and therefore "set apart." They frequently are pejoratively labeled with inhuman epithets, thus spawning inhumane treatment. Even though their malady is neither infectious nor contagious, they are often treated as though coming into even remote contact with them will somehow contaminate or sully the character of other people.

The stigmatization associated with both leprosy and mental illness elicits feelings of "disgrace shame" (Albers 1995) within the afflicted as well as the affected persons. These dynamics have a profound effect upon the sufferer and her or his family that prompts a devaluation of the whole family system's sense of worth and value. The net result is a progression of evaluative judgments by others, resulting in depersonalization, dehumanization, and finally "demonization" of the one afflicted. Such attitudes detract from the integrity and respect that deserves to be accorded to all people, irrespective of their diagnoses. It stands to reason that the conspiracy of silence surrounding mental illness is alive and well because the humiliation experienced in such a diagnosis exacerbates the phenomenon of denial, which in turn precludes possible treatment and care.

With these illnesses, the social reaction of "fear" is pronounced. As philosopher and theologian Martin Buber would characterize the situation, the person suffering from these illnesses is treated as an "it" rather than a "thou" (Buber 1958). Maintaining physical, emotional, and spiritual distance becomes the *modus operandi* that exacerbates the plight of the sufferers and their families. While most major religious traditions

would affirm the inestimable value of human beings, both leprosy and mental illness detract from that precept, resulting in further marginalization and alienation of the sufferer.

More specifically, religious traditions have not been helpful in creating a compassionate disposition toward those with mental illness, as various sacred texts, such as the Bible, would evidence. Seeking to explain the sometimes bizarre behavior of those who were mentally ill, the origin of the phenomenon was ascribed to "demon possession." Demon possession basically meant that there were external malevolent powers loose in the world which were working in opposition to the benevolent powers of God. The fate of those so "possessed" has had a long, brutal, and bloody history perpetrated by society and religion. The marginalization of such people can be seen in the biblical narrative written in Mark 5:1-20. While the layers of that narrative are likely too thick to make a medical diagnosis, the evidence extant in the story might suggest that this man suffered from a mental illness that featured psychotic episodes, all attributed to being possessed by demonic powers. Exorcism was the singular "treatment of choice," simply because knowledge of mental illnesses as we know them today had not yet been discovered. Consequently, varying resources of current therapeutic intervention likewise were not at the disposal of human beings in ages past.

It was not until the early twentieth century that significant research was devoted to studying the etiology, symptoms, and treatment of mental illnesses. Significant progress has been made in the medical area of psychiatry, which treats these illnesses as biological phenomena, often exacerbated by environmental conditions. As with other unsanctioned illnesses such as HIV-AIDS, addiction, and dementia, it is imperative that the shroud of secrecy, shame, and silence be shattered so that the millions of people adversely afflicted with and affected by these illnesses may find a source of hope, acceptance, and new life within varying communities of society. This includes religious communities since, if someone claims a religious community, this is where they often turn for help in a time of crisis. Such was the case of the man described in the opening vignette.

The focus of this particular book is to provide a "wholistic" approach to dealing with mental illnesses. (The *w* has been added to the word *holistic* to denote that it is inclusive of the person's spirituality.) The basic

assumption is that human beings are complex creatures, as exhibited in the interrelated functions of the body, mind, and spirit. In past literature, the angle of vision on mental illness reflected the specialized discipline of those who were attempting to assist those afflicted as well as those affected. Many volumes have been written with regard to the medical aspects of mental illness, but fewer books have been written relative to the social, economic, and political implications of these varying illnesses. There is an even greater paucity of literature regarding the spiritual and/or religious aspects of mental illness.

The purpose of this book is to develop an integrated and interrelated approach that honors the work of the specialists in psychiatry, psychology, and theology. It presents this approach as a dialogue between the disciplines so that each in her or his own specialty might work in partnership and not at cross-purposes, as often has been the case in dealing with mentally ill people. The participants see each other as colleagues working in a wholistic fashion to bring to light the most relevant and helpful material for readers. The fact that representatives of both medical and religious disciplines are willing to engage in a mutual endeavor such as this is a blessing for all who are involved as we seek to articulate in clear fashion the realities that people face when dealing with mental illnesses.

The methodology for accomplishing this task was to seek out highly competent psychiatrists who have done in-depth study of the more common and most challenging mental illnesses that afflict people. Knowledge is power and knowledge likewise is able to burst the bonds of fear that many people experience when the phrase "mental illness" is uttered. People who provide care within the context of a religious community often have little basic information regarding mental illnesses. The principal *modus operandi*, then, is to say, if one suspects that mental illness may be an issue, "This is beyond me, I can't do anything, I can only refer these people to others." If one is to be "wholistic" in one's approach to these illnesses, then it is imperative that referrals and conversation flow both ways between medical and religious caregivers, so as to provide the best possible opportunity for all those who provide care to do so in an effective and efficient manner. This book seeks to capture those conversations in a helpful way that can be shared with others.

The structure of each chapter is uniform, as the psychiatrist writes first about the medical aspects of the disease so as to provide accurate information about each diagnosis. As caregivers become more acquainted with the symptoms and dynamics of the illness, the caregiver is in a better position to respond appropriately to those afflicted with and affected by the illness. The logic is that one needs to know something about what is transpiring before being able to response in an effective way.

Pastoral theologians here utilize the resources of their respective faith traditions in dialoguing with mental health providers and bringing to the table the realities of spirituality as people within faith communities experience it. For the people who claim a particular faith tradition, there are rites, rituals, traditions, and insights that are germane to assist in their healing. Their spiritual life is an integral part of who they are, and they look to their tradition for support, guidance, and care. But there are also people within faith communities who are critical of psychiatry and dismiss the important material that can be learned from psychiatric research. The hope is that with both disciplines as dialogical partners, this historical suspicion that has resulted in the internecine warfare between science and religion might be bridged in a meaningful and helpful way. In a postmodern society, human beings oppose being thought of only as biological entities or only as spiritual entities; rather, there is a hue and cry for meaningful and effective dialogue to occur so that there is mutual benefit for healing and health.

In addition to presenting a wholistic approach to the topic, it is also the intent of this volume to encourage "open dialogue" among people in varying faith communities as they seek to address effectively the agony and anguish that is often experienced when a person in the family or in the wider community is diagnosed with a mental illness. The "conspiracy of silence" is a phenomenon that is still very much with us in our society despite the fact that significant steps and progress have been made in this area of human concern. As already noted, that conspiracy of silence may be due in large part to the fact that mental illnesses are unsanctioned illnesses in many cultures. Perhaps this is true because historically there was an assumption that while other organs of the body might malfunction, it was unthinkable that the brain should ever malfunction. One of the gifts of psychiatric research is to demonstrate conclusively

that in the case of mental illness, it is a result of what Nancy Andreasen names in the title of one of her books, *The Broken Brain* (1981). That title captures an important reality that helps to shape the attitude that people might have concerning mental illness. Mental illness is not a result of purely psychological or spiritual problems; it also involves the reality of a "broken brain" that can be visually demonstrated by various brain-imaging techniques.

The collective knowledge and the wisdom that this approach spawns is essential for anyone providing care to realize and understand. Mental illness is *not* about blaming the one afflicted, nor indicting those who are affected, nor attributing causation to malevolent powers; rather, it is the experience of the "total person"—body, mind, and spirit, if one chooses to use those traditional categories. Given that reality, it is judicious that the dialogue not only be initiated, but also perpetuated and expanded upon with the passing of time. Overcoming prejudices that are deeply ingrained in society, religious communities, and within each of us as individuals is no small task! There are many things that need to be "unlearned" as a result of the mythology that has taken root in the minds and hearts of people when it comes to mental illness. This can only take place through intentional educational endeavors and constant and continual dialogue between all parties involved, irrespective of the discipline. It is a dialogue that needs to take seriously the important role that all people play who with their arts, skills, convictions, and knowledge can articulate in a clear and integrative fashion what it means to be whole and what it means to be fully human.

One needs to concede that the diagnostic process is in and of itself a precarious undertaking. The *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition* (DSM-IV) (1994), in providing criteria for diagnostic purposes, makes it amply clear that acceptable behavior is predicated on what is considered as appropriate given the cultural context in which the person lives. What may be construed as bizarre behavior in one cultural setting can be assessed differently in another culture, It is impossible to be fully conversant with the idiosyncratic cultural norms in one's own context, much less those present in other parts of the globe. It is prudent for psychiatrists to exercise caution in the diagnostic endeavor and it is incumbent upon caregivers likewise to

familiarize themselves with cultures other than their own, The DSM-IV is clear in its diagnostic analysis that cultural norms are to be taken into consideration, since the manual itself is basically a product of Western society. Ministry often presents a plurality of cultures in a given community and sensitivity to those cultural realities will hopefully preclude arrogant attitudes and alarmist actions.

Finally, the decision regarding which of the manifold illnesses should be treated in this volume was no small task. The DSM-IV presents five diagnostic categories, or "multiaxial assessments." These categories are broken down into constituent parts and each part has varying permutations of the general diagnosis as it relates to the specificity of that illness in its varying expressions. The point is that this results in hundreds of possible diagnoses being presented, each with its particular criteria and symptoms. There are more than seven hundred pages of such material, covering scores of varying diagnoses, so it is impossible to address all of them.

A case certainly could be made for these diagnoses all meriting consideration, but since that is impossible, this book's contributors deemed it most workable to focus on nine of these diagnoses that are either most common in this society or are most challenging. For example, depression has often been called "the common cold of mental illnesses" and so will likely be the mental illness most frequently encountered in caregiving. Addiction is perhaps the next most commonly confronted illness. While there has been more written on these two subjects, we deemed it important to include them, as soft research has indicated that despite the prevalence of literature, many who provide care are not familiar enough with these diagnoses even though ample literature is available. Similarly, schizophrenia and borderline personality disorder may be two of the most challenging when it comes to mental illnesses. Thus this volume hopes to address both the most common and the most challenging so that the reader has some sense of these experiences in their lives and the lives of others.

It is important to be aware that there are many people who experience "co-occurring" diagnoses; that is to say, they may be suffering from three, four, or more illnesses at the same time. For example, it is *not* unusual to see someone who is addicted to alcohol also experiencing

depression and in some cases also post-traumatic stress disorder. This is where the dialogue between medicine and spirituality is so crucial so that the care of the whole person and her or his family can occur. It is possible to have enough knowledge and insight so as to do no harm, but a caregiver can also be of significant help. It is incumbent upon us all to be as prepared as we possibly can be for those occasions, because it is not a matter of *if* those opportunities will come, but *when* they will occur, for lay and clergy leaders alike.

The knock on the door can come in the dead of the night, or any time during the day. The reasons occasioning that knock, or prompting an extemporaneous conversation, or occasioning a crisis in an individual or her or his family in the vast majority of instances will be attributable to one or more of the illnesses treated in this volume. It is our hope that this volume will serve you in a meaningful and helpful way to respond in the most appropriate fashion to these inevitable encounters.

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