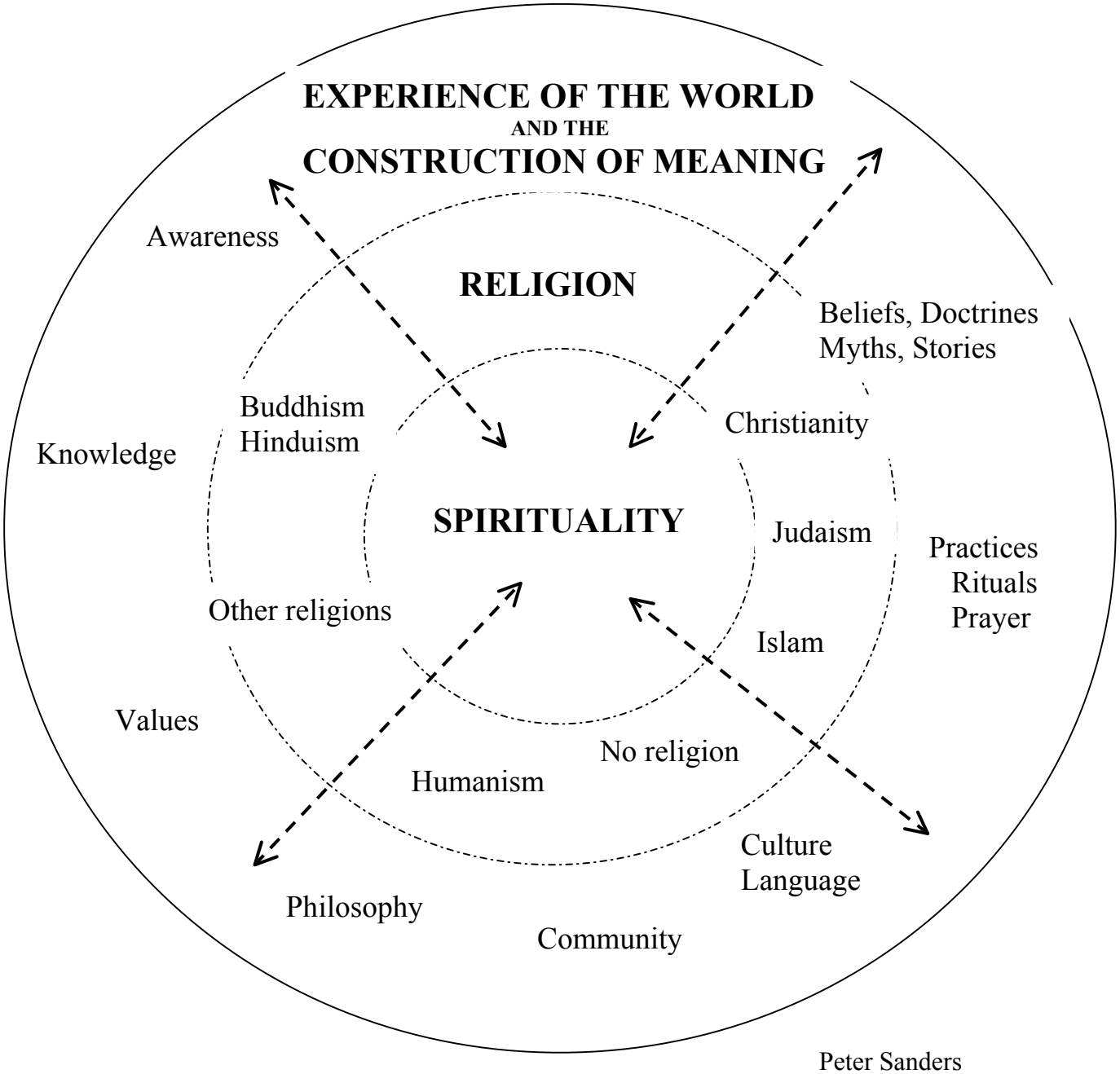
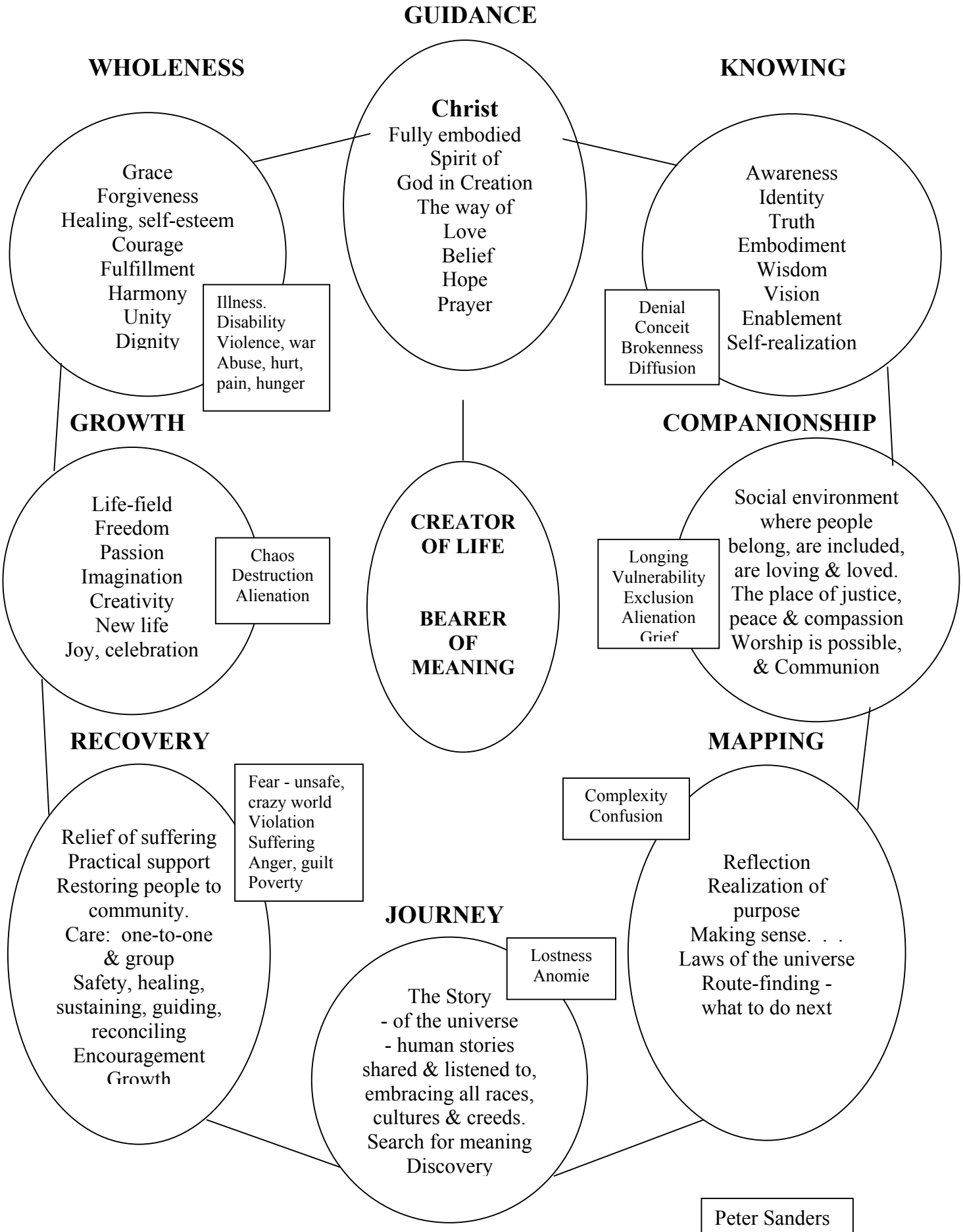
SPIRITUALITY & RELIGION



Peter Sanders
August 2001

HOLISTIC CARE (The whole is greater than the sum of the parts)



Peter Sanders
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SPIRITUALITY IS NOT THE SAME AS RELIGION

by Jerome Stack

At the time I was ordained a Catholic priest 25 years ago, I had no plans to engage in ministry with people suffering from mental illness; the possibility never entered my mind. I had my sights set on other kinds of ministry, but a six-month internship at Napa State Hospital changed all that.

I chose to enter the clinical pastoral education program at that psychiatric hospital simply because it was close to where I lived. To my surprise, I found ministry with the mentally ill challenging and satisfying. Ten years later I became chaplain at another state psychiatric hospital and the rest, as the saying goes, is history.

After 15 years of ministry at Metropolitan State Hospital I find myself reflecting on what I have learned from my experiences, what the mentally ill have taught me, and what sorts of qualities and attitudes seem to be important in dealing with the spiritual needs of the person with mental illness, their families and friends.

Who we are for the person with mental illness is equally important to what we do for them. In the field of mental health we hear much about medications and rehabilitation and education programs. We leam about many things we can do, but what is often missing is a treatment of the role of hope and courage in the journey of a client and his or her family and friends.

A number of years ago I attended an educational program at a local hospital. I have long since forgotten the topic and the speaker, but have never forgotten the core of the welcoming remarks offered by one of the hospital's executive officers. When all is said and done, he suggested, the role of the hospital is to offer its patients hope in the face of their illnesses and disabilities.

While hope springs partly from the array of tools science has developed to combat the symptoms of serious mental illness, these are not the entire picture. Hope and courage are at the core of the person, at that dimension we call spirit. How a person taps that wellspring of spirit, how a person both nurtures and is nurtured by the spirit, is what I call spirituality. It is not the same as religion, although the great religious traditions at their best foster a healthy spirituality.

Spirituality is really our style of being in the world, our overarching vision. It is about how we answer the inescapable questions about the mysteries of life. Spirituality consists of attitudes, beliefs, and practices that animate one's life and which help nourish and deepen a relationship with that which is considered holy. It is about recognizing and tapping that which is most deeply human and therefore most divine. (I should add that I recognize that a great spiritual tradition like Buddhism does not mention God and yet is deeply spiritual.)

With the above in mind, then, I share with you some reflections, some principles which have been helpful to me in my ministry with the mentally ill. These are reflections of a middle-aged white Roman Catholic priest, but I trust they are universal enough to speak to other spiritual traditions as well. I hope that these may serve others who seek to tap and nurture the spirituality of those with mental illness.

Be aware of your own spiritual horizon. Everyone has a spirituality, in that each of us must answer

basic questions like “Who am I?” or “What is the meaning of my existence?” or “Why am I suffering?” We all have answered those questions-sometimes very deliberately and thoroughly, sometimes more casually and semi-consciously. We are all spiritual, even if we don’t belong to a faith group or have a spiritual practice; Some are more in touch with the dimension of spirit than others.

Times of crisis challenge us to probe the mystery of human suffering. We ask “why?” and seek to understand. Such a time of crisis may be an opportunity for us to deepen our own spiritual beliefs, values, and practices, a time of rediscovery or of growth. As we reach out to people in the throes of dealing with mental illness, we need to be very much aware of our own attitudes toward issues such as the origin and meaning of suffering, the role of “organized religion,” and how we have come to define the life that is worth living.

If we fail to “know ourselves,” as Socrates suggested more than two millennia ago, we stand the risk of seeing the spiritual situation of others through the uncritical lens of our own unexamined spirituality. Our judgments may be prejudiced, narrow -and potentially harmful.

Take care of your spiritual needs. You know the routine about the oxygen masks you hear from the flight attendants before takeoff? It holds true for the spiritual as well. You cannot help someone else deal with the spiritual dimensions of his or her life, the spiritual questions surrounding illness, unless you have taken care of your own spiritual health.

Do whatever you need to do-go to your church, synagogue, mosque, pray, meditate, engage in spiritual reading, journal, take long walks, listen to music. You will need a healthy spirit to be with a person grappling with mental illness. There is an old saying that was drummed into us seminarians back in the sixties: “No one gives what he does not have.’” We cannot help animate the spirituality of another if our own spirit has been neglected.

Be willing to accept diversity in religious expression. Mental illness can lead a person to seek a new spiritual path different from that of his or her family and friends. This new religious or spiritual way may seem strange or even bizarre. This may or may not be related to the illness; do not immediately judge that it is.

While some people with mental illness become super-religious and have religious hallucinations and/or delusions, we should not forget that others may also have genuine religious experiences as well.

We used to joke that prayer is conversation with God, but if you tell people that he talked to you they’ll try to lock you up! Many patients over the years have spoken to me of their religious experience and I have found their stories to be quite genuine, quite believable. Their experience of the divine, the spiritual, is healthy and life-giving. Of course, discernment is important, but it is important not to presume that certain kinds of religious experience or behavior are simply “part of the illness.”

Religion may not be the same as spirituality. A friend of mine who was patient here 15 years ago once remarked: “You know, I used to be very religious but I think I am now more spiritual.” What he meant was that he was very much involved in things religious (in this case. Catholic), but that his spiritual life was very much at the surface. As he grew in his faith and began to recover from his schizophrenia, he was able to embrace his faith tradition and make it a more personal, comprehensive and genuine commitment.

Another way of stating the difference is in the motto: “Religion is for people who want to avoid going to hell; spirituality is for those who have already been there and don’t want to go back.” In other words,

spirituality is characterized by a freely undertaken, mature commitment to religious beliefs and practices which are seen as giving direction and unity to one's life. A genuine spirituality produces integration, healing and peace. It is "other-worldly" but very much in tune with "this world" as well.

On the other hand, people can be "religious" without allowing the many resources of their religious tradition to touch their spirits in a significant way.

Humility helps. We don't know all the answers to the riddle of mental illness. We don't know why some people suffer and others do not. Sometimes we think we should know these answers.

In the quest to understand we may be tempted to grasp at any answer, however incomplete. Its attractive to be able to live without ambiguities, to be able to say: "This is what it means. This is the explanation."

Genuine humility before the unknown is difficult, given that strong drive to understand, to grasp, to explain, especially in a world of exciting growth in scientific discoveries. It is, however, one of the most basic spiritual postures. "The fear of the Lord is the beginning of wisdom," says the psalm. "Fear of the Lord" is simply another way of expressing the notion of "humble reverence" in the presence of something or someone greater than I.

I do not mean to suggest that we should buy into the tired cliche about God's mysterious ways in sending suffering to people to test them. At the same time the great spiritual traditions attest to what can be gained through a prayerful grappling with the mystery of suffering and of evil in one's life. The testimony of the late Cardinal Bernardin's final journey with cancer speaks eloquently of such humility in the face of mystery.

Be ready to learn from those you are helping. When I came to the hospital I knew that one of the issues I needed to deal with was my impatience. I learned patience (and am still learning!) from my ministry at Metropolitan. I learned it from so many wonderful people whose lives had been shattered by serious brain diseases and who were yet able to find a measure of peace and happiness by patiently dealing with life on a day-to-day basis.

I continue to marvel at the resilience and courage and hope of the people I minister with. I recall with great fondness a patient who stopped to talk with me one day and said: "God is so good to me. I have so much to be thankful for." This was a woman who had been ill for years. She did not have much that would have been considered essential for the "good life," yet she was thankful for so much - friends, kindnesses, a fine day, a cup of coffee. Perhaps having been stripped of so much she had learned the secret of happiness through gratitude for the simple, overlooked wonders of everyday life.

Be ready to face your own disabilities, and accept them. It's amazing to me how many people - even members of the clergy - are very uncomfortable with the sick and the disabled. I think that one of the reasons they are so scary for many is also that they bring us face-to-face with our own weakness, illness, and disabilities.

We live in a society which is increasingly preoccupied with a "zero defect" mentality. That's fine when it comes to producing automobiles, performing surgeries, or providing other services. We also put a premium on autonomy and independence, and most of us fear having to become dependent on others. (Witness the discussion about euthanasia and suicide.)

People with serious mental illnesses can be among the most severely disabled persons in our society. As we reach out to them we come to recognize the common humanity we share with them, the common

brokenness and weaknesses that are part of our lives as well. For many of us, these are not so obvious or so debilitating, but they are present. We can learn that life is very much about cycles of dependence and independence, and about a healthy interdependence. Learning to be dependent may be as valuable as teaming to be independent.

In reviewing the past 15 years of my life with a primary ministry with persons with mental illness I find myself again and again acknowledging my gratitude for this experience. In m; pastoral work I have encountered so many people - patients, families friends, and staff - who have touched my life and offered food to my spirit. To them and to their great spirits I say “thanks” and dedicate this reflection on spirituality.

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THE USE OF RELIGION

MANAGEMENT

UNBLOCKING / FREEING

UNIFYING FRAMEWORK
BOUNDARY DEFINITION

EMOTIONAL RELEASE

LITURGICAL FRAMEWORK

PRAYER WITH OTHERS
- Acceptance of imperfection
- Assurance -
  - You're OK, lovable
- Gratitude for awesome world,
  - life, love, new life, wholeness, health, hope, strength
- Praying for others
- Grace, forgiveness, healing

RECONNECTING
BRIDGING

LISTENING
ADDRESSING OF PAIN -
- "Opium"

HEALING ENVIRONMENT
REST
NOURISHMENT
RECOVERY

TRANSCENDENCE OF PROBLEMS

BELIEFS PRACTICES

GROWTH

INTERNAL/EXTERNAL
Fusion, Integration

LEARNING BIBLE STORY c.f. OWN STORY (Beliefs, Culture)

FINDING MEANING IN EVERYDAY LIFE
(Enlightenment, Creativity)

COMMUNION
MEDITATION, CONTEMPLATION, WISDOM

EXPRESSION OF MEANING
Song, poetry, reflection together

COHESION, HARMONY
CLAIMING PLACE IN WORLD
FREEDOM TO LOVE & BE LOVED

DEVELOPING RELATIONSHIPS
Dignity, Friendships

SHARING LIFE WITH OTHERS -
Empowerment
Inclusion, Resourcefulness, Hospitality, Help, Service, Justice

EMBODIMENT OF THE TRUTH OF LOVE

SPIRIT RECOGNIZING & CONNECTING WITH SPIRIT

Peter Sanders
September 2001

Excerpts from

CROSSING THE DIVIDE: SPIRITUALITY AND MENTAL HEALTH PRACTICE

Spirituality and Religion

. . . . . A number of writers have suggested that differentiating between spirituality and religion helps to clarify the subject. (Galanter et al). Confusion between the two creates a source of uncertainty and discomfort for many health professionals, who recognise a need to nourish the human spirit, but are unclear or uncomfortable about religious belief (Price et al 1995; Hood-Morris 1996). . . .

. . . In the literature, some authors still use the terms interchangeably, particularly older publications, but it is probably more helpful for most people to make some distinction. There are any number of definitions of spirituality, but some useful ones include:

' a search for existential or transcendent meaning (Galanter 1997);

'the life principle that pervades a person's entire being....that which integrates the biological and psychosocial nature (Price et al 1995)

'Spirituality may or may not include any belief in God. It is one's personalised experience and identity pertaining to a sense of worth, meaning, vitality and connectedness to others and the universe. It is incorporated faith - one's pattern of response to the uncertainty inherent in life where the limits of material and human effectiveness are exceeded. It pertains to one's relationship with ultimate sources of inspiration, energy, and motivation; it pertains to an object of worship and reverence; and it pertains to the natural human tendency towards healing and growth.' (Titone 1991);. . . for others it suggests an experience of the holy. This may be one of sensing the presence of God. Or it may be an experience of knowing another person at such depth and intimacy that God's presence is felt at the very same time. However one defines the word (spirituality), we know it has something to do with transcendence and faith, holiness and meaning, connection and longing,' (PSI 1999)

'Spirituality is realty our style of being in the world, our overarching vision. *It is about how we answer the inescapable questions about the mysteries of life. Spirituality consists of the attitudes, beliefs, and practices that animate one's life and which help nourish and deepen a relationship which is considered holy. It is about recognising and tapping that which is most deeply human and therefore most divine . . . spirituality is characterised by a freely undertaken, mature commitment to religious beliefs and practices which are seen as giving direction and unity to one's life. Genuine spirituality produces integration, healing and peace.' (Stack 1997). . .*

. . . The expression of one's spirituality may include religious practices, and therefore there is clearly some degree of overlap with 'religion'. Religion is generally defined as a set of beliefs and values, practices and commitments within some form of organised structure, such as a church, sect or identifiable group. In the west, it has generally been used to describe organised mainstream religions, such as Christianity, Buddhism, Judaism, Islam etc.

People may also subscribe to a particular religion, or a denomination, without actually actively participating in it (a bit like a brand name!). This is not simply an issue of semantics, for whilst genuine religious and spiritual activity can be a positive resource, simple religious acknowledgment may not provide any deeper resources or community connection. 'Extrinsic religiousness" describes such a state, including the use of religion as a means to avoid suffering, or conversely where fatalism takes hold. God, as an external force to the self, either 'wills it', or is to 'blame' for negative experiences. Extrinsic religiousness leads to the abdication of personal responsibility and existence. 'Intrinsic religiousness' however, is where religious or spiritual belief actually leads to empowerment. The content of belief may be similar, but its internalisation and impact are quite different. Therapists and spiritual counselors need to understand, and work with such distinctions. As Ellis and Smith point out, therapists who seek to use the client's religious beliefs to affect

behaviour (in the case of suicide prevention) are unlikely to be successful unless the person actually does have, and actively practices, such beliefs. (Ellis & Smith 1991)

Developing a common language to discuss spirituality between theology and psychiatry aids communication and dialogue, and assists in avoiding confusion and unrealistic expectations in the practical delivery of spiritual care.

Mental Health Policy

There are specific references to spirituality in the 1997 Mental Health Standards, and much which is implied in the Mental Health Act (1986), and the 1st and 2nd National Mental Health Plans. Some of the principles alluded to can clearly be seen to incorporate the recognition of spirituality. Terms such as 'social' and 'cultural' context, by definition, also include the spirituality and world-view of a person. References can be categorised in two areas.- those alluding to spiritual and religious resources in treatment, care and support, in in-patient and out-patient settings, and those related to me development of collaborative practice with the non-government sector, which includes religious/ spiritual communities.

Acknowledgement of spirituality

- Acknowledgement of spiritual crisis in DSM IV (V62.89)
- 'encourage mental health services to ' take into account the age-related, religious, cultural, language and other special needs of people with a mental disorder'. (Mental Health Act 1986 S.5.a.ii and S.6.a.g)
- '...an approach to consumers and carers that recognises their unique physical, emotional, social, cultural and spiritual dimensions; (National Mental Health Standards 1997 Guiding Principles)
- "The MHS delivers treatment and support in a manner which is sensitive to the social and cultural beliefs, values and cultural practices of the consumer and their carers.
  Notes and Examples: Considers the role of family and community, use of interpreters & advocates, need for consumer to stay with family and community during care, religious practices.' (Standard 7)
- "The MHS monitors and addresses issues associated with social and cultural prejudice in regard to its own staff. Notes and Examples: Cross-cultural training of staff, rotation across settings and programs, education involving consumers and carers from a range of different social and cultural groups.' (Standard 7)
  'The MHS ensures equality in the delivery of treatment and support regardless of consumer's age, gender, culture. sexual orientation, socio-economic status, religious beliefs, previous psychiatric diagnosis, past forensic status and physical or other disability.' (Standard 11.1)
- "The MHS ensures access to a comprehensive range of treatment and support services which address physical, social, cultural, emotional, spiritual, gender and lifestyle aspects of the consumer.' (Standard 11.4)
- 'As soon as possible after admission, the MHS ensures that consumers receive an orientation to the ward environment, are informed of their rights in a way that is understood by the consumer and arc able to access appropriate advocates. Notes and Examples: Consumer advocates, consumer consultants, clergy, legal representation, tour of the ward and introductions, introduction to key worker/case manager, treating doctor, information available in variety of languages and variety of formats. The MHS ensures that the consumer's visitors arc encouraged." (Standard 11.4.e)
- 'The MHS, where appropriate, enables consumers to participate in their usual religious and/or cultural practices during inpatient care. Notes and Examples: Prayer rituals, dietary requirements, visitors, gender issues. contemporary healing methods.' (Standard 11.4.e)
- Psychiatric care is to occur in the 'least restrictive environment possible' (Mental Health Act S.4.2.a), and consistent with national policy (Standards ll.l)(e.g. policies on access etc.) . . .

. . . The neglect of spirituality within the psychiatric discipline is also revealed in literature surveys in the field. 1% of journal articles in the general medical field, and only 3% in the psychiatric area deal with issues

of spirituality and religion (Galanter 1997). More recent studies reveal an increasing number of articles, however.(Giglio 1993), and there is increasing evidence of the therapeutic benefit of spiritual resourcing. . .

. . . Bergin and Larson's research indicated that secular clinicians were more likely to view religious persons as disturbed, naive, neurotic and unsophisticated, attitudes for which there was no supportive data. (in Giglio 1993) Such bias is in essence 'cultural insensitivity'. Rather than refer the person to someone skilled in spirituality as part of a team approach, the spiritual dimension is often likely to be ignored.

One of the critical issues in the debates between psychiatry and religion has been the relationship between psycho-pathology and spiritual experience. If religious delusions occur, does that necessarily imply that all spiritual experience is delusionary. What have they in common, and what are their differences? Should the content, as opposed to the manifestation of delusions, be addressed? . . . .

. . . General mental health and well-being

Spirituality has the potential to bring a range of benefits in terms of mental health. This may take the form of *inner resources* that sustain hope and resilience, and help people create meaning out of life experiences. Additionally, there are die *'external'* benefits that come from attachment to a faith community - friendship, community support and involvement, etc. Faith may promote self-confidence and self-healing, and can encourage hope, altruistic service, and have the benefit of enabling strong social connection. (Giglio 1993)

The correlation between spiritual resources and health benefit in general illness is well documented. Angell (1998) describes it as a 'fundamental form of resilience', and numerous studies reveal enhanced coping abilities in times of stress, illness and trauma, bereavement and depression . (Landis 1995). 'In short, the spiritual drive enables and motivates one to find meaning and purpose in life and to relate to God, however defined. It also provides a common transcendent bond among people, acknowledging the supernatural, and unifies the total personality transcending the physical and psychosocial constituents. Thus, spiritual well-being is considered an essential internal resource necessary for growth during periods of stress. (Landis 1995). This perspective is echoed by Maton (in Lindgren & Coursey 1995) and numerous other studies.

Positive correlations have been shown regarding spiritual resourcing and suicide prevention (Slack 1991; Ellis & Smith 1991).
Supportive relationships and community support, some of the external products of spirituality, arc linked to health-promoting behaviours such as early intervention for medical (and psychiatric) care, and studies have also revealed positive correlations with such psychosocial factors to cardio-vascular and immune response, (in Galanter 1997)

More specifically in terms of mental health, numerous studies report to the benefit of spirituality, and the fostering of hope. (Neeleman & Persaud 1995). Summarising the research data, Sullivan slates, *'Empirical research has indicated that the role of spirituality in the lives of the mentally challenged is complex and varied, ranging from a primary coping device . . . to an essential aspect of a personal support network . . . to sustaining a sense of meaning and coherence in life* . . . Further research is summarised by Carson, who notes that spirituality is a positive influence in recovery and stability for schizophrenia, and is similarly beneficial if this is a resource for caregivers. Spiritual resources also can lessen the severity of depressive and anxiety symptoms, and may serve as a buffer against drug abuse. (Carson 1996) . . .

Reliable diagnostic tools, and discussion starters, have been developed to aid workers assess the spiritual state, and depth of resources, for example Ellison's Spiritual Well Being Scale. (Paloutzin & Ellison 1991) Carson has developed a sample protocol for spiritual assessment, parts of which may be useful in assessing clients' spiritual resources and could easily be incorporated into oilier assessment procedures, formal or informal. (Carson 1996)

Summarising, it is important that as part of assessments, some insight is gained into the spiritual state and the spiritual resources available to the client. This includes some exploration of the nature of psychotic experiences vs. spiritual crisis if present . . . and evaluation of the spiritual resources that may be harnessed to assist in treatment and recovery. . .

. . . Part of the role of therapy will be to help people discover meaning, and to sort out what is helpful and unhelpful for the quality of their lives. It will involve helping them it identify helpful spiritual beliefs, experiences and skills, and the ability to distinguish these from the symptoms of mental illness. (Miller 1990)

> 'A patient should be understood as a bio-psychosocial-spiritual whole. In this conceptualisation, patients and their suffering can be understood in the context of a larger landscape that brings them closer to a transpersonal source of meaning, and to the human community that shares those meanings.' (Waldfogel 1993).

The connections of **social support and relationships** have long been seen as having a strong correlation with improved health and well-being. (Waldfogel 1993. Sullivan 1993)). This includes the encouragement of healthy behaviours such as seeking early intervention, compliance with medication, the knowledge of being loved and belonging, and simply the fact of being networked in and of itself. (Galanter 1997) In a time when people are feeling more and more isolated from traditional extended family and community settings, religious and spiritual communities may provide ready-made safe and supportive environments. This is not to say every religious community is 'ready to go'; all have faults and failings. But many are able to provide a strong sense of belonging, acceptance and social support that is easily accessed, and with a willingness to work in partnership with others. There is also connectedness to self - the congruence of feelings and values. Positive therapeutic relationships and communities will help a person to explore their feelings and values, seeking to discover integration and congruence. Addressing some of the issues mentioned above is critical to this process, but in addition, spiritual resourcing, whether through clergy, chaplains, mentors, or links to a religious or spiritual community. For some people, being involved in a spirituality group can help, as members draw on their varied experiences and offer them to each other, seeking to make sense of life. Social support, Pollner suggests, is also about connections with mythical and divine others. (Pollner in Sullivan 1993)

Finally, there is the human desire for **connectedness to something larger than oneself,** some dimension that helps us create meaning and purpose for our lives. (Bellingham et al 1989). At its core, this is what spirituality is about, and is the activity that also carries a sting in its tail. For if we are to work with people in acknowledging all three dimensions of connectedness, and incorporate them into a holistic strategy, we will also be confronted with our own needs and desires in the area of spirituality. . .

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CLERGY AND MENTAL HEALTH WORKERS NEED TO WORK TOGETHER

Experience shows the need for greater collaboration and mutual learning between clergy and mental health professionals. They need to regard each other as valuable resources to increase the effectiveness of their care for troubled individuals and families.

- Studies have shown that tens of millions of Americans with mental health and family problems first seek the help of the clergy. Clergy often have long-term relationships with people, which enables them to observe changes in behavior that may indicate early signs of distress. Religious communities also have established patterns of responding to crises. Clergy can help mental health specialists gain access to individuals and families in crisis who otherwise would not receive psychological care.

- Clergy are frequently unprepared to assess the mental health problems of those who seek their help. Training clergy in diagnostic skills enhances their ability as pastoral counselors as well as their effectiveness in making referrals. Clergy need to understand that a timely referral is an act of responsible pastoral care.

- Develop a collaborative relationship with several mental health specialists who have a comprehensive knowledge of the mental health services in your community. Make sure they are open to people of faith and have some appreciation for the growing evidence that non-punitive, nurturing religious commitment is a positive coping resource. Interview mental health specialists before you make a referral. Ask detailed questions about their experience, training, and education. How do they develop treatment plans for various crisis situations and other mental health problems? How easily can they be found in a crisis? Are they willing to do some free or low-fee work for those who cannot afford to pay normal fees? Keep a record of available providers you can refer in an emergency.

- Develop a list of professional and community resources before you are faced with a mental health emergency. Where is the nearest hospital emergency room if a person becomes suicidal or overdoses? Where is the local mental health center? How can you contact social service agencies and what can they do in an emergency? Where is a reproductive care center? To whom do you report child abuse in your area? What are the procedures for reporting? Where can you take a runaway teen for mental health care? Develop appropriate plans of action with your mental health colleagues.

- It would be of mutual benefit to the mental health and religious communities to learn from one another. Clergy need more training in mental health evaluative and referral skills, while mental health professionals often lack the knowledge and experience needed to sensitively address religious issues with their clients. Studies indicate that few psychologists receive training in any aspect of religion or spirituality while in graduate or postgraduate school. Mental health professionals could be invited to take part in the training of clergy and begin re-examining their preconceived beliefs about religion and the role of clergy in mental health. Together they could develop more effective working relationships to better serve those who come for help.

Why is depression so common in the First World?

by Jean Vanier

"Depression: Way to Healing" is the title of Jean Vanier's new book. Vanier, a spiritual master, is the founder of the Faith and Light lay movement, which has 1,500 communities in 72 countries. Vanier founded L'Arche community, with the help of two new friends. In the community, men and women of different social backgrounds live with handicapped individuals. Since the birth of the first small French community, 103 additional ones have been established throughout the world, embracing 26 countries and more than 2,000 members.

Q: It is said that depression is the existential evil of our time.

Vanier: I think it's true because today people feel lost.

Q: More than in the past?

Vanier: Before, we had the faith, which gave direction and offered moral guidelines. Today many anchors have been destroyed by the idea that the individual's freedom comes before anything else - except that now we no longer know how to direct this freedom. Today people want much, but they don't know where to direct their vital energies - hence, their feeling of sadness. Moreover, there is early failure in marriages.

Q: Are you saying that depression is the offspring of ideologies: for instance, rationalism, the Enlightenment? Or, perhaps, consumerism?

Vanier: No, ideologies come in second place. As I don't feel loved, I submerge myself in a political project or even in consumerism.

Q: Do you think, therefore, that volunteer work is an antidote to depression?

Vanier: It depends. If it is simply to care for handicapped children or the poor, no. When, on the contrary, it is an encounter with the other, an exchange of love, then it becomes communion and confidence that can heal our wounds. []
* Source: http://www.zenit.org

From **The Journal** pp. 53-55

DEPRESSION: IDOLS, DEMONS AND GRACE

by Bill Gaventa

The article and the book were written, or at least outlined, in my head and on paper. They were going to be based on Isaiah 57:7-13, Matthew 6:25-34, and Matthew 7:13-27,

The first selection came from my reading of the Bible during my first hospitalization for a major depression, and my trying to figure out why this had happened. Isaiah seemed to get it clearest, for "up on a high and lofty mountain" of work and accomplishment I "had set my bed and offered sacrifice." But when I "grew weary from my many wanderings," when I had "lied and did not remember me (God) or give me a thought," God decided to keep silent and close God's eyes. For was not God saying to me,

"I will concede your righteousness and your works, but they will not help you. When you cry out, let your collection of idols deliver you! The wind will carry them off, a breath will take them away. But whoever takes refuge in me shall possess the land and inherit my holy mountain."

I thought he was talking straight to me. As I pored over, again and again, in sleepless nights, the reasons for what had happened to me, they seemed to be in that passage. In my desire for security, I had gotten "off call," accepted a job that seemed to promise the security that I had not had for such a long time - a good salary, a good base and foundation - even if it meant taking on responsibilities for many things for which I did not feel I was qualified and for which I had little interest. But I was sure, at some level, that my capacity for hard work would help me get through it, and eventually work it all out.

I had been wrong. There was so much to do that even I could not do it. There was the unexpected conflict that my being the "good, righteous hard worker" could not control, much less fix and overcome. All that I had done in the past, all the trying to help and accommodate others, all the bending and appeasing to keep the peace, all the anticipating, initiating, and caring to ease the pains of others, did me not one whit of good. All I could see was failure. It was failure that I caused. All that was left was incredible shame for my own pretense that the gods of accomplishment could heal my own feelings of worthlessness.

The second section of the article then, was about learning to trust the day, to trust that God was watching over me even in the midst of all the worry, the panic, the obsessing over money, failure, stigma, and multiple other ruminations that had started keeping me awake at nights months before. These now culminated in a completely sleepless night before my first ECT in my second hospitalization some six weeks after the first. The new medication had not really helped. I had spent three weeks in an outpatient program, and then tried to go back to work. But the anger at myself and at others was still churning, with no place to go except its traditional path of making myself responsible. As I talked with psychiatrists in the days before the first ECT the question in my journal had been "whether or not this is the tin man, or lion, looking for a magical wizard who would restore either the heart or courage that were no longer there." All of the issues were still going to be there: the sense of failure at work, the feeling of disconnection from family and friends, the guilt of failure and denial, the fear it would never change, the painful memory of a good night's sleep, and the fatigue of just trying to keep going from day to day.

But there in the early morning hours before the first ECT were the voices of the first birds, and the words in the journal which came with them:

I sure hope this goes well and I can think somewhat clearly on return. It is clear during the night that the state of my depression and sleeplessness makes this necessary. One thing else is dear — my pattern of giving myself away—fitting in, is so much broader and longer than anything simply related to one part of my life. And the struggle, during the night, to maintain hope and faith, woke to the birds — or rather —the first birds reminded me of "his eye is on the sparrow" and the care — is there — no matter what. Help me, 0 Lord, hold on to that this day and remember the prayers of those for me.

The reading for June 28 in Keep It Simple seemed absolutely "perfect*:"*

Trying to be perfect gets us in trouble. Trying to be perfect means we are trying to control things. We may be trying to cover up something. Maybe we aren't facing our pain. Maybe we've hurt someone and we need to make amends, We need to practice being human. Humans aren't perfect.. In Steps Six and Seven we face our human limits and our shortcomings. We then start the lifelong job of letting them go. To accept our human limits leads us to our Higher Power. We see how we need a guide to life. Our Higher Power makes a perfect guide.

The third part of the article was about what I was going to do to rebuild my life on a more solid foundation, The treatment plans and journaling were all identifying the building blocks. I needed to cut back, to take care of myself, to focus one day at a time, to deal with issues in my primary relationships, to learn to affirm myself and be open with my own feelings, to ask for help and trust that others care for me, and, most of all, to stop pretending to be or feel something I was not.

From partial day, to home, to work, to anxiety, to obsessions increasing, to having to be truthful, to being referred to ECT, to being back in the structured unit. I just seem to want no responsibility and have so little motivation. Was it all denial and pretense? Was I trying? It feels like everything is falling apart - cars, home, dreams, and all my 'fix-it' has run out. Is it the illness, or is it my lack of honesty — truth-telling about what I feel? Or how are they related? Where is the courage or chutzpa I used to have? Or was it compulsion and a desperate search for worth and place?

Now the energy seemed to be back, the first real joy and excitement in six months. I wrote a rendition of the Irish blessing for another patient headed off to her first ECT the next morning and slipped it under her door. I had made plans for a support network when I got out, and committed myself, again, to the "rules" or guidelines I would try to follow out of this pit:

One day at is time
Fight the demon (of suicidal ideation)
Hear the angels (the. messages in all this)
Remember the ups and downs
One piece at a time.

So it was outlined, written, and wrapped up — another accomplishment, a minister and chaplain who had battled depression with God and won. And was I ever wrong.

Twenty-four hours later I was feeling deeper in the pit than I had ever been.

Thirty-six hours later I refused a second ECT out of anger and despair. "Who am I doing this for? And why do it, if all it does is lift one's hopes only to get bashed down again?"

The real illusion, as I look back, was not hope, but control. I might want this article to be about how faith and spiritual resources got me through the depression, but I can't honestly say that was die case at all. Four months later 1 was back in the hospital, after trying to follow those rules, journal and pray, go back to work, even one step at a time.

As I look back, there were people and ones of faith which were crucial in keeping any kind of light alive, such as regular visits by pastors and colleagues, the bedrock support of wife and son, the readings of others' journeys, the Psalmist, and particularly one Australian poet's prayer which I still recite from memory,

"God bless this tiny little boat
And me who travels in it.
It stays afloat for years and years
And sinks within a minute.
And the soul in which we sail
Unknown by years of thinking
Is deeply felt and understood
The minute that it's sinking."

Michael Leunig, The PrayerTree,

North Blackburn, Victoria, Australia
Dove/Harper Coffins, 1991.

But this time, as the voice of the demons had gotten stronger, as] began to sink once again, I was not in control. I was outwardly trying, but inwardly dying, Nothing I could do was going to get me better (I was a failure here as well). It was too painful to stay where I was, and I was so, so tired, and, in a hilly demonic extension of caregiving for others. I could not bear to go back to the hospital because of what it would do to others, As I have said since to others, "Something in me needed to be killed off," and it was really only God's grace and others that kept it from being me. During a November night before another round of ECTs, the demon had a deadly logic:
Worth through work, approval through accommodation, appeasement, avoidance of anger, responsibility for how others feel, caring meant anticipating and fixing, accept blame or blame self— rather than anger — be good as way of dealing with anger — so SI (suicidal ideation) become way of doing something since can't change others, feeling failure. Blaming self, taking responsibility, and being good martyr. An FU (F... Y... !) to others and myself while also justifying that's better for others.

And it was that demonic control that expressed itself back In May in a piece of art therapy that looked like a spider's web over a black hole and whirlpool of anger, despair, and confusion. It was that image that my (fund's eye took into the next series of ECT treatments hoping to be zapped. But I have no idea what caused the change.

I got out the third time just before Thanksgiving with new medication. Very cautiously, I went back to work, against internal and external voices that said I was crazy to go back into the place that had seemed to be a major cause. But each day got a little better. And Advent came, and with it the feeling that "Oh, that's, what light looks like," Was it the new medication, the ECT, the efforts made in therapy, the support and prayers of others, decisions about what to do in my job, new energy that let me begin to deal with the complexities of issues and relationships? I have no idea. I do know that each day has felt like a gift, and that a good night's rest is never to be taken for granted. My gut feeling is simply one of mystery, awe, and gratitude. I can even begin to talk about the "gifts of depression," and the lessons of ignoring a sense of call and direction, but a big part of me still wishes there were easier ways to learn.

A crazy song that reverberates through my head that, "Oz didn't give nothing to the tin man, that he didn't already have.. .so please believe in me." I shared it with Conrad, one of the unit staff during my third hospitalization, who noted that "the tin man had a heart all along, and the lion had courage, even Dorothy was home already.. .they just didn't know it." It's a hell (or perhaps a heaven) of a way to learn.

But no metaphor quite catches the illusion of control, which I felt on the manic night I planned out that first article and book as much, as my favorite story from the journey, a gift from the providential wit of my son. During my third hospitalization, he followed my wife's comment to the therapist about "how a demon seemed to be hold of Dad and we can't get rid of it" with the immediate observation that "it's just too bad there's not a herd of pigs around when you need one."

BILL GAVENTA *is an American Baptist minister, chaplain, and CPE supervisor who works primarily in ministries and services with people with developmental disabilities and their families. This is written in gratitude for a huge second chance to be in those roles, and, more importantly, husband, father, friend, and son.*

"Thank You for Believing Me Well"

> *1 he real act of discovery is not in finding new lands, but in seeing with new eyes.*
>
> Marcel Proust

As a young social worker in a New York City psychiatric clinic, I was asked to see Roz, a 20-year-old woman who had been referred to us from another psychiatric facility. It was an unusual referral in that no information was received ahead of her first appointment. I was told to "play it by ear," and to figure out what her problems were and what she needed. Without a diagnosis to go on, I saw Roz as an unhappy, misunderstood young woman who hadn't been listened to in her earlier therapy. Her family situation was unpleasant. I didn't see her as disturbed, but rather as lonely and misunderstood. She responded so positively to being heard. I worked with her to start a life worth living to find a job, a satisfying place to live and new relationships. We hit it off well, and she started making important changes in her life right away.

The records from the previous psychiatric facility arrived a month after Roz and I began our successful work together. To my complete surprise, her records were several inches thick, describing a number of psychiatric hospitalizations. Her diagnosis was "paranoid schizophrenic, "with a comment on her being "hopeless. "That had not been my experience with Roz at all. I decided to forget those pieces of paper. I never treated her as if she had that "hopeless" diagnosis. (It was a lesson for me in questioning the value and certainty of diagnoses.) I did find out about the horrors for Roz of those hospitalizations, of being drugged, isolated and abused. I also learned a lot from her about surviving such traumatic circumstances.

First Roz found a job, then a place to live away from her difficult family. After several months of working together, she introduced me to her husband-to-be, a successful businessman who adored her.

When we completed our therapy, Roz gave me the gift of a silver bookmark and a note that said, "Thank you for believing me well."

I have carried that note with me and I will for the rest of my life, to remind me of the stand I take for people, thanks to one brave woman's triumph over a "hopeless" diagnosis.

Judy Tatelbaum

Chicken Soup for the Soul at Work

Ed Mark Victor Hansen

The Power of Prayer

The Part It Plays in People's Health

Barbara Mathias
The Washington Post Good Friday, 1994

An elderly woman who thought she had a severe cold, was shocked to learn that what she really had was a significant bout of congestive heart failure. Her physician, Dale Matthews, at Boston University Hospital, was unsure about her prognosis, but three days later he was "pleased to see her greatly improved and with a fluid loss of 25 pounds.

"There was more to her recovery than a superb response to medication," insists Matthews. "There was the part of prayer," something that did not embarrass or surprise him, since from the time she came to him with her illness Matthews prayed constantly for her, as did her family members and deacon from her church. He is "willing to entertain the idea that it had a significant importance in her getting better," says Matthews, an associate professor of medicine at Georgetown.

A Protestant, Matthews has been practicing his rather unorthodox treatment of medicine and prayer for many years. He says he was influenced by his doctor-father and missionary-grandfather. After he takes the physical and social histories of his patients, he routinely asks if they have a religious commitment or if they're comfortable wit prayer. If they're not, he lets it be. If they are, he asks if they would like to pray together at the end of the visit.

Sometimes he says, the response is incredible: "They weep".

Aware that he has to be careful not to unduly influence his patients or to raise unrealistic hope, Matthews points out that while he believes in praying for healing, "more important, I pray that God's will be done".

He makes an important distinction. In the small but growing population of physicians who acknowledge the powerful contribution to human health of the world of medicine, some believe that prayer simply provides a peace of mind and the courage to face whatever lies ahead. (Indeed, numerous studies show that peace of mind, from whatever source, helps in the treatment of an illness) Generally, the majority of prayer-minded physicians profess that prayer can't do it alone, but must be combined with medical treatment.

If everyone's prayers for good health were answered, the world would be in chaos - no one would die and the world would be overpopulated, says Larry Dossey, co-chairman of an NIH panel on alternative medicine and author of "Healing Words: The Power of Prayer and the Practice of Medicine" (Harper). Dossey is not suggesting prayer doesn't lead to healing in some cases, however. On the contrary, he cites recent scientific studies that demonstrate it does 20 percent of the time, though without any scientific method of prediction. That's not as often as believers might think, but often enough for doctors not to ignore.

"The evidence is simply overwhelming that prayer functions at a distance to change physical processes in a variety of organisms from bacteria to humans," says Dossey. These data are so impressive that I have come to regard them among the best kept secrets in medical science. Dossey is referring to laboratory and clinical studies where humans and other living things have been in affected by healers, psychics and persons using mental suggestion or influence.

Given the enormous scientific evidence plus his experience with patients, Dossey firmly believes prayer gives a sense of hope that life is eternal, and that one is not alone. "With prayer there is a realization that the physical illness is secondary in importance in the whole scheme of existence," he says.

Whether a patient prays alone or with the support of hundreds of friends from around the world, he eventually gains a sense of 'prayerfulness', which Dossey describes as a peaceful, accepting attitude that makes life, pain, and death easier. "If the disease disappears, the patient is grateful; if it remains, that too is reason gratitude."

While Dossey is a strong advocate of prayer, he emphasizes that the act itself is very private. Some patients don't want their doctors to spiritually intervene or whisper their invocations at

bedside. Dossey suggests doctors pray privately for their patients. That way the physicians' religious beliefs are not imposed on the patient who is particularly vulnerable to suggestion when ill.

David Larson, epidemiologist and president of the National Healthcare Research in Rockville, thinks that Dossey is being 'wisely cautious' in the skeptical world of medicine. Larson further argues that since good health has been associated with religious commitment, doctors are obligated to learn how to relate to and converse about a patient's spiritual life. Unfortunately, he says, too many doctors have no idea how to respond to a patient's need to pray.

According to Larson., it is not unusual for a seriously ill patient to tell his doctor that he has been praying every day for strength or recovery, or that he wants to pray, but can't, only to have the doctor nod and say, 'Uh-uh,' or worse, nothing at all.

To combat this, Larson, a former senior researcher at the National Institute of Mental Health, has developed a series of seminars and data on the positive influence of religious commitment on a person's health. For example, one documented study on believers of various faiths and non-believers, shows that religious commitment which includes the ritual of prayer is associated with lower blood pressure and lower rates of hypertension. One partial explanation is that certain religions enjoy healthy living habits: Seventh Day Adventists are vegetarians, for example, and Baptists are encouraged to avoid alcohol. Religious beliefs act as a motivator for healthy living, Larson notes.

Larson's study manual, which he plans to distribute nationally, also teaches practitioners how to approach or respond to a patient who wants to pray.

"I am not saying that physicians can always pray, but they could link their patients with someone who will," explains Larson. "The physician can certainly consult with the religious community, which is often not done."

Shimon Waldfogel, a psychiatrist from Philadelphia's Jefferson Medical College, has studied how a doctor's understanding of a patient's religious sensitivity reinforces the doctor/patient relationship and ultimately the treatment and recovery. Doctors who are comfortable asking about a patient's spiritual life, gain the patient's trust. Consequently, the patient gives more accurate information on lifestyle and condition.

Waldfogel is currently examining the effect of spiritual life on HIV and liver transplant patients. So far, the data is showing that religion is an important factor in coping. Given that influence, Waldfogel says, it behooves the physician to ask about the patient's spiritual life.

"Initially, the patient may be caught off guard. but invariably they are very happy to talk about it." he says.