Church will breathe it as well. I pray that we can truly call one another friends.

Notes

1. Sharon H. Ringe, *Wisdom's Friends: Community and Christology in the Fourth Gospel* (Louisville, KY: Westminster John Knox, 1999), 64–65.
2. Ibid., 75.
3. Ibid., 76.
4. John Swinton, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville, TN: Abingdon, 2000), 10.
5. Ibid., 36–37.
6. Ibid., 143.
7. Ibid., 145.
8. Robert C. Dykstra, *Images of Pastoral Care: Classic Readings* (St. Louis, MO: Chalice Press, 2005), 3.
9. Ibid., 1.
10. Ibid., 12.
11. Ringe, *Wisdom's Friends*, 88.
12. Ibid., 85.
13. Both "abides" in verse 17 and "be with you" in verse 16 are translations of the Greek word *meno*.

7

Diagnoses and Demons

"Patient histories are stories," the latest psychiatrist said to me, as he asked me questions in a more free-form manner than the other doctors I'd met with. "I'm trying to write a story I like here. Stories lead, supposedly, to diagnoses. Diagnoses supposedly lead to treatment."

"That's a lot of supposedlys," I observed.

"Well, yeah. Because what? We have the Truth or something?" The capital 'T' was evident in his tone. I laughed, but wasn't quick enough on my toes to make the implied Pontius Pilate joke.

That was the first time I met the psychiatrist who diagnosed me with bipolar disorder, after months of guesses and shifting diagnoses. The conversation was not exactly an advertisement for the precise science of psychiatric medicine.

"What is bipolar anyway?" the doctor asked with a shrug. "There aren't just two poles. I believe in the Trinity. Well, worse than that. I'm a pagan. I believe in multiple poles." The theological jokes—the guy knew his audience—and the cheerful honesty of his responses to my questions were, actually, very helpful. For many people, talking to a doctor is intimidating. For me, a confused and struggling psychiatric patient, the intimidation factor was cranked up a notch. What would this new person say about the invisible thing supposedly going on inside of my body, my spirit, my mind? But here was a doctor, well-versed in his field, explaining to me that a psychiatric diagnosis involved quite a bit of storytelling. Stories

lead, supposedly, to diagnoses. Diagnoses supposedly lead to treatment. And I know something, at least a little something, about stories.

What is the story that we tell about mental illness? Is it even an illness? Is it demon possession? Is it just personal anguish, best resolved with the power of positive thinking? The question of what story we tell about mental health struggles is an important one because, if it's not asked out in the open, we will never be quite clear what we are talking about when we talk about healing or recovery, either.

The idea that diagnosing mental illness was a type of storytelling was not what I had heard from other psychiatrists, and I suspect the reason is quite simple. The dominant understanding of mental illness most psychiatrists are working with is a medical model; for those steeped in a medical model, storytelling likely sounds a bit too ephemeral, too subjective, for the serious medical practitioner.

The medical model of mental illness is important. I am grateful for it simply because I have been, and continue to be, a recipient of the model's healing potential. I take medication to manage my mental illness. Currently, Lithium and Buspirone are my psychiatrist's drugs of choice to help keep my moods stable, and my mind, body, and emotions at some sort of peace with each other. Suggestions that drugs are for the weak or foolish, or that a good walk in the woods or run in the park is all the medicine I need to feel better, annoy me on good days, wound me on bad days, and, on mediocre days, are likely to lead me to climb onto one of several soap boxes I keep for just such occasions. The medical model also gave me language to talk about an experience that, as I have mentioned previously, often felt beyond my ability to articulate. To say I have bipolar disorder does not communicate everything about my experience, but it does communicate something, and that is

important. It also helps me to make decisions on when and how I talk about my mental health struggles. If I had some other type of illness or disability—diabetes, say, or chronic migraines—I wouldn't necessarily announce it to strangers in a bar, or tell a potential employer in a first interview. Neither would I go to great lengths to hide it from friends or coworkers, or from my spouse. The language of illness gives me a shared context that is broader than my own experience of mental and emotional anguish to refer to when making decisions about self-disclosure.

The medical model of mental illness is important, too, because it is intended to be an antidote against stigma. For example, the National Alliance on Mental Illness (NAMI) website has this to say about mental health conditions: "They are medical conditions that cause changes in how we think and feel and in our mood. They are not the result of personal weakness, lack of character or poor upbringing."[1] NAMI not only insists that mental health conditions are medical conditions, but also contrasts this medical understanding with understandings that tend to shame or blame those suffering or their families. John Swinton, writing specifically in reference to neurobiological explanations for schizophrenia, explains how the "reasons for this major emphasis on biology are partly an attempt to normalize and destigmatize mental health problems and partly a response to the work of people . . . that essentially sought to blame the parents of people with schizophrenia for their condition."[2] In contrast to speculative theories that seek to place blame on family members or personal failings, the medical model offers an explanation for mental health struggles that focuses on finding cures rather than finding fault.

For faith communities in particular, the potential for this shift in understanding around mental illness seems obvious. When illness strikes a member of a congregation or their family, congregations know what to do, almost instinctively. Prayers are offered. Cards are written. Casseroles are baked and delivered. A pastor, or perhaps a trained lay caregiver, contacts the

family to request a visit. And all of these actions are understood as an offering of care and healing for the sick person, not in contradiction to the advice and care of medical professionals, but alongside it. Often, if the family is struggling to pay for the cost of medical care, the congregation will take up a special offering to provide financial assistance. What most congregations *don't* do is inform sick people that if they just pray and have faith, they will be cured without needing to consult a medical professional. We don't tell people their diabetes is a result of personal sin. We don't tell people to just pray away their cancer, or that going to see a doctor is evidence of a lack of faith. Yet these are all things that people with mental health struggles often hear from congregations. Churches do not often deliver casseroles to the family of the child with schizophrenia.

Mental illness presents many unique challenges, not the least of which is the long-term nature of severe mental illness. Any critique of the way churches handle mental health struggles is bound to be a generalization, one that might ignore those faith communities who do, indeed, respond with care and concern. Not only did clergy and congregants from my church visit me in the hospital, but my pastor opened up her home to my family, allowing my mother to stay there when she drove up from North Carolina to be closer to the hospital. Congregations, in other words, know how to be communities of care for people who are sick. The medical model offers a healthier approach to mental illness, not only for the medical professionals, but for communities of faith as well. It, then, has much potential for good. It also has its flaws.

The medical model is, ultimately, a story—a narrative we tell about mental health and mental illness. Like any story or metaphor, it conceals even as it reveals, highlighting particular plot points or symbolic references while downplaying others. For one thing, the medical model has an individualistic focus on pathology, often failing to take into account both the contexts in which individuals function and the resilience and

resources of individuals and communities. In order to diagnose a person with a mental illness, a doctor does not look into a microscope or send blood samples to a lab. A psychiatrist listens as a person tries to put into words an experience that is often beyond or below words. Then the psychiatrist attempts to cross reference that often fragmented story with a list of symptoms in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). This is the "story-writing" to which my doctor was referring, and it is not an exact science. More to the point, it focuses on a list of things that are "wrong" or "disordered" in an individual patient, reducing their story to symptoms and often failing to take their context into consideration. John Swinton analyzes some of the problems with this approach:

> The danger is that the interpretative power of the medical model comes to dominate all other understandings in such a way as to blind us to some of the highly significant realities that surround the lived experience of schizophrenia. . . . An overemphasis on the biological aspects of mental health problems tends to locate the persons' difficulties primarily within the boundaries of their own bodies. The persons' problems are *theirs*, and the treatment is focused on specific, neurobiological defects within individual people. However, bodies do not operate in a vacuum, and mental health problems are considerably more than technological problems that need simply to be solved through the development of greater neurological knowledge and improved pharmacological intervention.[3]

By focusing on individual pathology, in other words, the medical model ignores the relational context of the person who is suffering. It tends to treat the person as a problem, or set of problems, to be fixed, rather than as a whole person with resources and relationships and resilience in addition to their wounds.

The way we use the language of mental illness doesn't help matters. The language the medical model supplies can be a

relief to the sufferer, but it can also be used to label, denigrate, or harm. We might refer to someone dismissively as "crazy," but referring to them as "a schizophrenic" is no less dismissive, even though it is medical terminology. At best, the medical model allows me to say, "It's not my fault I am feeling this way. I just have a condition." At worst, it leads me to say, "Well, I guess there's something wrong with me, after all." As a result, a model designed, in part, to combat stigma can actually, if misapplied, cause or exacerbate stigma. By focusing on pathology and locating the pathology primarily within an individual, psychiatric diagnoses can inadvertently increase the sense of isolation already being experienced by the person suffering. "It's not your fault, you just have a disease" is not necessarily received as the encouraging word that proponents of the medical model would like it to be. Since the reality of societal stigma continues to impact the individual—not to mention other societal systems such as race, sexual orientation, gender identity, or economic inequality—the person is left with the sense that all of their suffering comes from an invisible internal disorder when much of it can be attributed to concrete external factors. The medical model runs the risk of what pastoral theologian Cedric C. Johnson refers to as "psychoanalytic functionalism," that "divorces its study of the subject from the historical and political contexts in which they were formed."[4] In contrast, Johnson proposes an "integrative approach" that "entails assessing interpersonal dynamics, family systems, sociocultural systems outside the family, economic and political systems, as well as religious, spiritual, or other meaning-making systems."[5]

It's not that the biomedical model is "wrong," only that it can be reductionist. It can reduce complex human experiences into a mono-story that does not take into account the whole human person in their contexts and relationships. Reductionism can also go in the other direction, reducing the experience of mental health struggle to an emotional or spiritual problem and ignoring biology, which is exactly what the medical

model pushes back against: "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."[6] Reducing mental illness to a spiritual experience often results in telling people not to seek professional help, because, after all, they need only prayer and faith. That is harmful. Reducing mental illness to a medical experience results in telling people they need to seek professional help, and then offering no other forms of help—no care for their spiritual, emotional, and relational lives, and no exploration of the questions of meaning and purpose that arise from their mental and emotional turmoil. Swinton points out that many people who struggle with mental health challenges find themselves in a situation in which "the primary form of relationship that is open to [them] is with the 'specialist,' the professional who is *paid to relate to them.*"[7] People suffering, particularly from severe mental illness, soon find their relationships sorted into two categories: those who want nothing to do with their experience of mental illness, and those who offer conversations that are clinical, utilitarian, and professionalized. Both are alienating and isolating, in the midst of an experience that is already alienating and isolating, which is the exact opposite of what the medical model purports to create, and it leads to frustrating, and often strange, conversations with the professionals who are supposed to be helpful to the person suffering. Take, for example, the routine psychiatrist appointment, which, on a good day, with my life bumping along without plunging up or down into the chaotic swirl of a bipolar episode, goes something like this:

Doctor: How are you doing?

Me: I'm fine.

Doctor: Are you having any symptoms?

Me: Not really. Life goes on.

Doctor: Are you taking your medication as prescribed?

Me: Yup.

Doctor: Do you notice any side effects?

Me: Just the usual.

Doctor: Do you need a new prescription?

Me: Yes.

Doctor: Great. Here it is. That'll be approximately $4,000, but I don't really know because I've outsourced my billing to a different company. Call them with any questions. Have a nice day.

I don't mean to denigrate the work of psychiatrists. Doctors are under an immense amount of pressure in the United States, and psychiatrists in particular tend to be overbooked and overstretched. There aren't enough mental health professionals to go around. You can see, however, that the above conversation does not provide much room for a complex or holistic understanding of mental health. And the outsourcing of billing isn't a fiction. I have dealt with it multiple times, always to the detriment of my mental health. One hospital repeatedly sent me notifications that I was past due on payments and that they would be sending the bill collectors after me. Each time, when I called to protest that I had, in fact, paid them, they explained they knew that, but that the billing company's records hadn't caught up with theirs. And this was a mental health facility, that appeared unconcerned with the mental strife caused by my receiving such a notification.

I've heard many stories of psychiatrists who dismiss or even denigrate the faith commitments of patients, sometimes even suggesting that religious practices are delusions or aspects of mental illness. I had one hospital psychiatrist take up half of a session criticizing the time I'd spent as a mission worker after college, using our time together to question my political and religious beliefs as I sat there, suffering acutely. Another psychiatrist, post-hospital, asked me whether my faith had kept me from committing suicide. When I said that I thought it had, he said, "Yes, I've often had religious clients who didn't commit suicide because they believed they would go to hell." That is not, at all, what I believe—in fact, that's a belief that I find harmful and toxic—but the psychiatrist didn't make much room for a deeper or more complex story about religious belief.

Of course, psychiatrists should not be expected to be pastors or theologians, any more than pastors should be expected to be psychiatrists. There are some wonderful examples of increasing collaboration between mental health professionals and people of faith,[8] although I sometimes fear that the collaboration is somewhat one-way, educating pastors about the medical model without a similar openness on the part of mental health professionals to learn the stories and perspectives of people of faith. But one need not engage in this type of collaboration in any formal sense to be open to the stories of people of faith or, more importantly, to be open to the stories of meaning, purpose, and identity that people, as whole persons, bring to the psychiatrist's office. To paraphrase Swinton, if we assume that mental illness is "nothing but" neurobiology, we miss out on the complex dynamics of the whole human being in our care, including their spiritual life.[9] If my psychiatrist was right—if patient histories, and the diagnoses which emerge from them, are stories—then caring for people means creating room for people to tell their full stories. And our stories include but cannot be reduced to our biology, our medical conditions, or our theology.

If the medical model is a form of story that conceals as well as reveals, the same can be said for any other attempt to explain the experience of mental illness or mental health struggle. The form of story that the church has at times told about mental illness has often been unhelpful at best and harmful at worst. "The rise of Christianity," writes Andrew Solomon, "was highly disadvantageous for depressives."[10] Solomon is one of many

authors who chronicle the role Christian theology has played in stigmatizing mental health struggles. He argues that the "history of depression in the West is closely tied to the history of Western thought," from the ancient world through the Middle Ages, the Renaissance, the Enlightenment, and finally the modern age.[11] He traces the stigma of mental illness back to the Dark and Middle Ages, during which "depression was seen as a manifestation of God's disfavor, an indication that the sufferer was excluded from the blissful knowledge of divine salvation."[12] "Melancholy was a particularly noxious complaint," Solomon observes, "since the melancholic's despair suggested that he was not suffused with joy at the certain knowledge of God's divine love and mercy."[13] The stigma remains, as does the association with evil and even the demonic, as Sarah Griffith Lund points out in her book *Blessed Are the Crazy*:

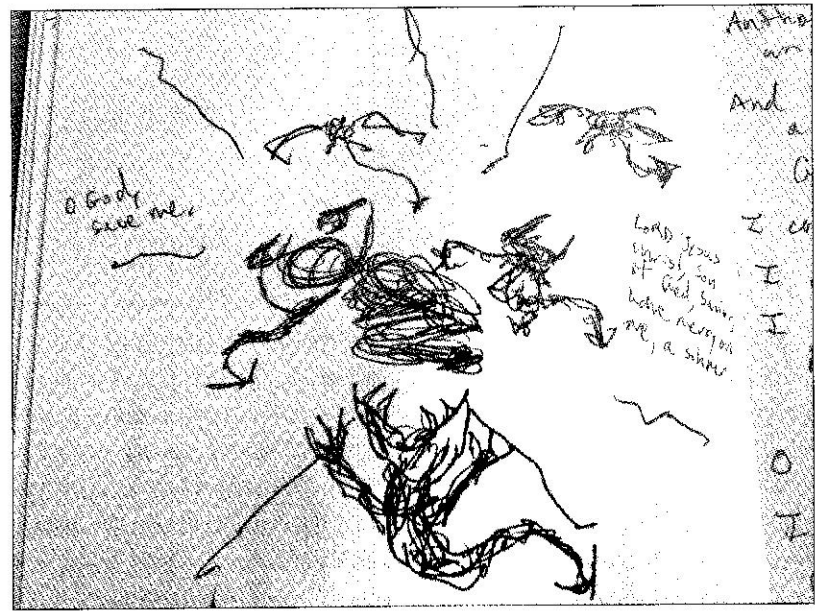
> Many faith communities still believe and preach that mental illness is strictly a spiritual disease caused by personal sin and not related to biochemistry. . . . Some preachers insist mental illness is only curable through exorcism, explaining that mental illness is a spiritual disease caused by demon possession.[14]

The conflation of mental illness with the demonic is given biblical backing in many churches: "The idea that Jesus alone can cure people of mental illness comes from an interpretation of biblical accounts of Jesus healing people."[15] Writing about her son David's experience with schizophrenia, theologian Rosemary Radford Ruether traces the resilience of the "theory of demonic possession" as the source of mental illness, recounting that at one point in his illness David actually decided he was possessed and requested a meeting with a priest for exorcism.[16]

Let me pause here to say that if you have experience with a church that told you your mental health struggles were a result of bad demons or bad faith, or that they could simply be prayed away, then you have been the victim of an injustice.

This is oppression and intentional stigmatizing—quite literally demonization—at its worst. I understand if this next bit is completely unhelpful for you, if you want to stay as far away from any talk of demons as you can. In fact, if you want to skip ahead, I will move on from demons after the end of this chapter.

I did not grow up in a church that associated mental illness with demonic possession. I grew up in a church that didn't talk about mental illness at all. The silence around the topic was, in hindsight, deafening. For me, the association of mental illness with demons was a liberating move, a way to bring the insights of my faith tradition to bear on an experience that, with no words to name it, was confusing and terrifying. "I am no Saint Anthony," I wrote in my journal, "and I don't think I will survive this." The note was accompanied by a stick-figure depiction of Saint Anthony the Great, tormented in the desert by a horde of demonic critters.



It wasn't that I believed I was literally possessed by evil supernatural beings, nor do I believe that the stories of Saint Anthony are stories about mental illness, anymore than I believe that every story of demonic possession in the Christian tradition is, in fact, a story about people with mental health problems who simply didn't have the scientific and medical knowledge we have now. Yet there was something about stories of demons and exorcisms that spoke to my experience in a way that the language of psychiatry could not. Whether or not it was the healthiest way to think, whether or not it was accurate, I can only tell you that, in the throes of my illness, I *felt* like I was being possessed. I felt like there was some outside force, or, if not outside, some not-me force, moving and pushing and prodding my actions and thoughts in order to do me harm.

In the hospital, I found myself reading the story of the man possessed by demons named Legion with new eyes. The story, found in the fifth chapter of Mark's Gospel, was familiar to me. As a young adult mission worker and then as a seminary student, I had learned to read the story through the socio-political lens of interpreters who pointed out that "Legion" was the name for a unit of the occupying Roman imperial army.[17] The story had political implications: a man freed from the occupying forces, the Legion, in an exorcism that included that death of hundreds of pigs—pigs that would have been tended to feed the decidedly un-kosher appetites of that same Gentile occupying army. The man, despite this possessing—this occupying—force, could not be kept chained, refused to remain docile, and resisted. His anger and pain were actually the sane reaction to the violence of occupation, revealing the subtle harm of his fellow townspeople's passive response to injustice. This is a powerful and valid interpretation, one that has particular meaning for people who continue to live under military occupation or the threat thereof. In the hospital, though, different pieces of the story stood out to me. The man is described as

a burden on his friends and family, someone who wears people out with needing to keep him safe; "and no one," the story reads, "had the strength to subdue him." But they tried anyway, specifically because the man was harming himself: "Night and day among the tombs and on the mountains he was always howling and bruising himself with stones." Here is a man overpowered by an invisible but seemingly foreign force, harming himself, unable to be subdued or comforted, crying out for an end to the torment. After Jesus's miraculous (and surprisingly porcine) healing, the man is described as "clothed and in his right mind." When he begs to accompany Jesus, he is instead instructed to return home to his friends and family and share the story of his healing.

It is hard to put into words how very much I wanted to be clothed—in my own clothes, not in a hospital gown and missing shoelaces—and in my right mind, and to be sent home to tell stories about healing.

My story reveals how the same text can be used to create stigma and harm and to offer healing and freedom. People who are perceived by society as not being "clothed and in their right mind" can be outcasts, their condition simultaneously feared and normalized. The idea that their problems are caused by demonic possession, that they are in need of exorcism, can be incredibly harmful. And yet, the imagery and emotion of this story resonated with me in a way that clinical language did not. My internal experience of mental illness didn't feel medical; it felt existential. There is something powerful about the biblical language of demons and healing that is worth reexamining, even in an age skeptical of such matters. In his book *Reviving Old Scratch: Demons and the Devil for Doubters and the Disenchanted*, psychology professor Richard Beck reflects on his experiences leading a Bible study in a maximum security prison. There, he found, his own skeptical reaction to language about the Devil and the demonic bumped up against the reality of evil faced daily by the inmates:

> I learned to get over my awkwardness in talking about the Devil out at the prison. Caring as I do about injustices such as mass incarceration, capital punishment, and all the other problems related to our criminal justice system, my concerns about social justice brought me to the prison. But once I was *inside* the prison I quickly discovered that my disenchanted worldview clashed with the spirituality of the inmates who spoke about the Devil and demons all the time. Behind prison bars, Old Scratch is real as can be. And I had to figure out a way to make sense of it all.[18]

Beck argues that, by eliminating talk of the Devil from our faith life, Christians in a post-modern context lose one of the core narratives of the Christian story: the struggle between Jesus and the powers of evil. This, in turn, leaves us without a robust spiritual language to confront evil and injustice. Similarly, I would argue, disenchanted and skeptical Christians often lack a robust language to confront the suffering caused by mental health struggles.

None of this is to say that we should return to a medieval understanding of mental illness as demon possession. At the same time, the powerfully evocative imagery of faith should not be so easily dismissed as delusional or superstitious when it can be a powerful resource for naming and healing. While Andrew Solomon does not hesitate to trace, in detail, the negative impact such theologizing of mental illness can have on those suffering, he nevertheless named his book *The Noonday Demon*, quite intentionally conjuring the connection between the demonic and the depressive made by monastic theologians like Cassian and Evagrius in the fifth century:

> I have taken the phrase as the title of this book because it describes so exactly what one experiences in depression. The image serves to conjure the terrible feeling of invasion that attends the depressive's plight. There is something brazen about depression. Most demons—most forms of anguish—rely on the cover of night; to see them clearly is to defeat them. Depression stands in the full glare of the sun, unchallenged by recognition. You can know all the why and the wherefore and suffer just as much as if you were shrouded by ignorance. There is almost no other mental state of which the same can be said.[19]

Solomon's imagining of depression as the demon who continues to haunt and possess, even in the full light of a sunny noon, is a powerful articulation of the often-nameless suffering of mental illness. As he himself is quick to point out, the phrase is not his at all, but is rather derived from the Latin Vulgate translation of Psalm 91:

> His truth shall compass thee with a shield: thou shalt not be afraid of the terror of the night.
> Of the arrow that flieth in the day, of the business that walketh about in the dark: of invasion, or of the noonday demon.[20]

More modern translations render this last phrase, not as "the noonday demon," but rather as "the destruction that wastes at noonday," making clearer the parallel with the previous phrase, "the pestilence that stalks in darkness." As is often the case, the ancient text has insightful wisdom to offer a modern debate. For the ancients, there was no clear distinction between the plague and the powers that be.[21] It is the destructive capacity of the plague and the demonic, not the sourcing of it, that is of utmost importance. Notice, too, the reference in the Latin to "invasion," for the ancients saw, quite clearly, the parallel between the personal experience of sickness and possession and the sociopolitical experience of invasion and occupation.

It is perhaps no coincidence that this same psalm, Psalm 91, is one of the scriptures quoted by the devil in the desert temptation of Jesus. Early on in the first three gospel accounts of Jesus's life, Jesus is baptized by John. We are told that the skies open and that the voice of God declares Jesus to be

beloved of God. Can you imagine that kind of assurance—a voice from heaven saying that you are loved, valued, cared for, and accepted? Yet in each of those accounts, Jesus immediately finds himself in a wilderness, hungry, alone, and haunted by a demon who is immune to daylight.

Jesus, we are told, was tempted by the devil. In Matthew and Luke, where we are given more details about his temptation, the devil quotes Psalm 91. Matthew 4:5–6 tells us: "The devil brought Jesus into the holy city and stood him at the highest point of the temple. He said to him, 'Since you are God's Son, throw yourself down; for it is written'"—and he quotes the psalm—"'*I will command my angels concerning you, and they will take you up in their hands so that you won't hit your foot on a stone.*'" Jesus's tempter says, in essence, "Have faith, Jesus. If you're so high, so beloved—if you're here, literally at such a high point, at the pinnacle of this holy place, go ahead and throw yourself down."

I don't think that the devil makes people kill themselves. I don't think mental illness is caused by literal demon possession. And yet it sure does sound familiar to me: a voice that can come to you even when you've just been told how loved you are, that can make you feel lonely and isolated, make you doubt your mission and your passion and your identity. It might not have horns and a tail and a pitchfork, but that voice is very real.

What is notable about the story, when it comes to how we relate to people wrestling with the noonday demon, is that the devil shows up to test Jesus's faith, and Jesus responds by saying, "Don't put God to the test." A test, as it turns out, is not what people need when they're feeling alone in the wilderness. They don't need a test of faith. They don't need to be told that if they just tried harder or prayed harder or thought more positively they would feel better. They don't need judgment. They need acceptance. Friendship. Companionship.

Testing and accusing are quite in keeping with the biblical imagination of the devil. The name Satan actually comes

from the Hebrew, *ha-satan*, who was originally understood, not as the enemy of God, but as a member of the Heavenly Council responsible for prosecuting humans. The name means something like "the accuser." By the time of the New Testament, this accuser had come to take on an increasingly contentious, even evil, demeanor, but the implication was the same: Satan, or the Devil, accuses, tests, and opposes the person of faith. Contrast this image with the *parakletos*, the Advocate, whom I wrote about in the previous chapter. If the Accuser is the lawyer for the prosecution, the Advocate is the lawyer for the defense. To rely on the *parakletos* is to be reinforced against the accusations and testing of the demonic. To invoke Christ in opposition to the suffering of mental illness is not to ask for a magical exorcism, but to cry out for the accompanying and comforting presence of a friend:

> Unlike many agents with whom people with mental health problems may come into contact the task of the Christlike friend is not to *do* anything for them, but rather to *be* someone for them—someone who understands and accepts them as a person; someone who is *with* and *for* them in the way that God is also *with* and *for* them; someone who reveals the nature of God and the transforming power of the Spirit of Christ in a form that is tangible, accessible, and deeply powerful.[22]

The story I have begun sketching here—a story of the accusing demons of mental illness being cast out by the accompanying friendship of the Spirit of Christ—is not the only possible spiritual story to tell. Robert Albers, for example, writes of those suffering from mental illness as "modern-day lepers" with an "unsanctioned illness"—his term for "those illnesses in society that bear the stigma of social discrimination."[23] His metaphor calls to mind the healing ministry of Jesus, though, in the first century context of Jesus, the distinction between healing and

exorcism is blurry. John Swinton, for his part, writes of persons struggling with mental health problems in terms of the poor, and the central place of the poor in liberation theology.[24] Monica Coleman critiques the combative metaphors we often use to talk about illnesses, and speaks of her own journey to "refuse to go to war against myself."[25] She quotes Parker Palmer, who in the midst of his own experience with depression was questioned by a therapist:

> You seem to look upon depression as the hand of an enemy trying to crush you. . . . Do you think you could see it instead as the hand of a friend, pressing you down to ground on which it is safe to stand?[26]

While Coleman can't quite bring herself to refer to her depression as friend, she nevertheless commits herself to "peaceful, healing language" and practices.[27]

I can't bring myself to call bipolar my friend, at least not at this point in my life. As you have seen, I use language of struggle and wrestling, though, like Coleman, I do try to avoid warfare language—language that, for example, Richard Beck employs in *Reviving Old Scratch*. But all of these different approaches take seriously the lived experiences, embodied stories, and chosen language of those who experience mental health challenges. The internal landscape of mental illness cannot be captured fully or expressed by clinical or medical language. "When I feel strong," Coleman writes, "I save the clinical diagnosis for clinicians who use it as shorthand to guide them in helping me be healthy. I don't think of myself as ill or disordered, as the dominant language in the field might indicate. I think of myself as 'Monica' who lives with a 'condition.'"[28] No matter what language we use, we are telling a story. Surely those having the experience ought to have a say in how that story is told.

What story do we tell about mental illness? A medical story frames recovery in terms of medicine, which can be a powerful, and useful, and good story. A problematic spiritual story can frame illness in terms of possession and recovery in terms of exorcism. More robust spiritual stories, in all their variations, can frame recovery in terms of presence, acceptance, and friendship. Perhaps, in the end, better stories are the most powerful healing, the most powerful exorcism, we have to offer.

Notes

1. "Learn More," National Alliance for Mental Illness, *https://www.nami.org/Learn-More*.

2. John Swinton, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville, TN: Abingdon, 2000), 78.

3. Ibid., 81–82.

4. Cedric C. Johnson, *Race, Religion, and Resilience in the Neoliberal Age* (New York: Palgrave Macmillan, 2016), 5.

5. Ibid., 6.

6. Robert H. Albers, et al., eds., *Ministry with Persons with Mental Illness and Their Families* (Minneapolis, MN: Fortress Press, 2012), 7. The editors are referring to a book by Nancy Andreasen, *The Broken Brain: The Biological Revolution in Psychiatry* (New York: Harper & Row, 1984).

7. Swinton, *Resurrecting the Person*, 83. Emphasis in original.

8. E.g. Albers et al., *Ministry with Persons with Mental Illness*, Mental Health and Faith Community Partnership of the American Psychiatric Association, *https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership*, and the National Alliance on Mental Illness FaithNet, *https://www.nami.org/NAMIFaithnet*.

9. Swinton, *Resurrecting the Person*, 82.

10. Andrew Solomon, *The Noonday Demon: An Atlas of Depression* (New York: Touchstone, 2001), 292.

11. Ibid., 285.

12. Ibid.

13. Ibid.

14. Sarah Griffith Lund, *Blessed Are the Crazy: Breaking the Silence about Mental Illness, Family, and Church* (St. Louis, MO: Chalice Press, 2014), 84, 94.

15. Ibid., 94.

16. Rosemary Radford Ruether with David Ruether, *Many Forms of Madness: A Family's Struggle with Mental Illness and the Mental Health System* (Minneapolis, MN: Fortress, 2010), 70–71.

17. "A Roman *legio* was composed of about six thousand soldiers and an equal number of support-troops. To residents of the Roman Empire, the Roman legion symbolized the occupying forces whose power was overwhelming and whose presence meant the loss of control over every dimension of their own society. . . . Given the play on words present in the name 'legion,' one would need to ask if the Gospel writers are not also

engaging in political allegory when they speak about the people's fear." Sharon Ringe, *Luke* (Louisville, KY: Westminster John Knox, 1995), 120–21.

18. Richard Beck, *Reviving Old Scratch: Demons and the Devil for Doubters and the Disenchanted* (Minneapolis, MN: Fortress Press, 2016), xviii.

19. Ibid., 292.

20. Ibid., 293.

21. Walter Wink, *The Powers That Be: Theology for a New Millennium* (New York: Galilee/Doubleday, 1998).

22. Swinton, *Resurrecting the Person*, 143.

23. Albers, et al., *Ministry with Persons with Mental Illness*, 2.

24. Swinton, *Resurrecting the Person*, 13ff.

25. Monica A. Coleman, *Not Alone: Reflections on Faith and Depression* (Culver City, CA: Inner Prizes, 2012), 150.

26. Parker J. Palmer, *Let Your Life Speak: Listening for the Voice of Vocation* (San Francisco: John Wiley & Sons, 2000), 66.

27. Coleman, *Not Alone*, 149.

28. Ibid., 150.