

## Sanity Begins At Home

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**[A non-specialist, provisional, reflection; not representative of church teaching, nor of advocacy policy]**

As a non-medical person with not so much as '0-level' psychology, but merely 11 years in mental health advocacy, my attempt to question our approach may seem alarmingly *grandiose*. Until now, my ideas on the subject have been confined to editing *Insight*, (a local advocacy-related journal) and chairing occasional conferences in North Herts<sup>1</sup>. My professional priority, in advocacy, is to listen. Rather than regarding these difficulties as exceptional, or as a deficiency, I look for common-ground and shared experience. From this observational standpoint only, I shall reflect upon sanity and its impairment.

How might *all of us* promote better provision of mental health management? After research itself, what should take precedence: more efficient symptom-suppression, a more tolerant society, positive images, social inclusion, more employment opportunities, or containing and managing risk? With such an embarrassment of plausible goals, a scatter-gun approach may have some advantages. Yet this overwhelming variety of goals, strategies and conditions, causes inevitable fuzziness of focus. Broken minds do not make for as *unified* a study as broken bones. Every professional and carer abides by a specific discipline or method, and this diversity might help us to 'cover our bets', but it can also make the service users themselves dizzy with diagnosis and overloaded with short-term therapies which are abruptly withdrawn. It is not exceptional to meet people who have been given as many as four or five different diagnoses over several years, and many more different treatments. Diversity of judgement, on this scale, is surely rare or even unknown in other areas of health provision. Much has been written on the inadequacy of applying a medical model to matters of the mind and emotional responses<sup>2</sup>. Alternatively, emphasis upon sanity itself might both comprehend *and* transcend mere medical models; even open the door to the theological perspective of how our frail minds are a dim reflection of the mind of God. (For me, *all* subjects are ultimately theological, but this reflection is not preaching by the back door, so Biblical quotations are few.)

Sanity is not an abstract ideal but something - in greater or lesser proportions - that we actually experience, as, sadly, we also all experience its opposite, if only during sleep, since everyone is "mad" in their dreams (the derivation of our term *trauma*). We see and speak with people who are not actually present. We accept this behaviour, not on the basis of its logic but upon its universality. The fact that sanity is suspended whilst sleeping was something well recognised within Christian worship, where many evening prayers were offered for serenity during repose. So changing our fundamental perception of sanity itself is necessary, and should balance that medical tendency to multiply labels. Sanity, reason, objectivity and humour can be exercised, we can learn to construct rational, objective arguments, and we can hone those skills. We must also learn that even the best reasoning, of the best of us, is frail. This is not an invitation to scepticism or to a debased 'romantic' disparagement of reason. Our powers of memory, for instance, so often let us down (again, for some more than others) but this does not mean that we can discount or dispense with even our faintest recollections. We are not only bound to use memory, but to trust and even to cherish it. The really sensible, sane person, however, should be open to evidence or coherent argument that calls any particular recollection into question. To say that reasoning and memory are fallible is merely a commonplace, we must make the best of them, for there are simply no substitutes.

We who work within a medical environment persevere, despite inevitable limitations; but could we ever jam the revolving door of remission and relapse? Perhaps, caught in our own revolving doors, ever eager to hear some new thing but content to continue some well-worn practice, we have no room for truly traditional insights. For instance, people today seem less

well prepared for adversity than they might have been years ago, and this prevailing unpreparedness may impact upon us all. By adversity I mean, not just when the kitchen blows up, but experiences of emptiness and worthlessness; when (apparently) we have little to show for life except pain or disappointment.

Yet past and present ages may be equally at fault for their prevailing assumptions that sanity is dependable. Sanity never has been accounted lucky, but standard-issue, - as we say, '*normal*' - rather as we are accustomed to affirm that all babies are beautiful, even though actual experience contradicts such bland generalisations. It is commonplace to say how (in body) we are fit for our age, or blessed with a strong constitution, but who ever expresses relief that they are as *sane* as they are? Sanity does not admit of degrees, apparently. In Britain, at least, we do not so much believe in mental illness as in *madness*. Such assumptions about the gulf between sanity and insanity still seem relatively unchallenged and unchanged, despite our heightened awareness of e.g. the impact of stress/bereavement upon each one of us. Sanity is undoubtedly a controversial term, as is 'normal' (originally a mathematical term?) Sanity should be understood to differ from 'normal.' Sanity is both tangible and intangible - like its near namesake sanctity - few have it in full. In fact, what is perfect sanity actually like, has anyone ever witnessed it? Celibacy has been described as the most unnatural of all sexual perversions, perhaps sanity is the most unnatural of all psychological conditions? Unnatural and imperfect as it is, mercifully, it is not unknown, nor wholly unattainable.

How might sanity be developed, strengthened and reinforced, especially in readiness for adversity? Were former ages better braced for sorrow and even loneliness? Our compensation-culture appears to focus upon aftermath, blame and damages, and thus ignores pre-emptive coping mechanisms. Our only pervasive pre-emptive strategy appears to be an ever-spiralling legislation to enforce risk-aversion - compulsory sun-block for construction workers and the like. Yet the facts of life are (directly) about risk and (ultimately) about loss. I positively detest sport, especially team sports. Having once challenged someone to define what benefits it could ever possibly bring, I was startled by the unhesitating response: "sport teaches us how to lose." Perhaps so; we play - not merely sport, but life itself - to win, yet we have to digest the ultimate inevitability of losing all our winnings, the death-rate still stands at 100%. So it is not smoking, but procreation, that should be banned; for procreation is a death-sentence in every instance. Humanity has generally tried to resist this fact, seemingly, ever more strenuously. Meanwhile, team sports have become a celebration of unreality - i.e. celebrity - but, 'winning' in its commercial sense, is seen in increasingly individualistic terms. Once, continuation of the family line, the family business, or the family estate - for wealthier sections of society - helped to give stability and purpose to the changes and chances of this mortal life. Investing in home, and in family, posterity, was a counteroffensive against personal loss.

Contrastingly, nowadays when we attempt to transcend individualism - instead of a rugged realism respecting the transitory nature of existence - we are frequently confronted by the *false-grief* that now masquerades as a caring response to (mostly) high-profile disasters and celebrity deaths. This false-grief<sup>3</sup> (and I make no apology for any judgemental overtones here) seems to be a particularly sinister manifestation of what Durkheim might have classed as an example of 'effervescence.' It might also act as an outlet for our personal, longstanding distress and rage at an existence that is forever revolving around attachment and loss. Possibly some of us feel safer mourning within a mob for an 'innocent' person. Such a gathering might even function as a surrogate and idealized home and family. Giving way to real, personal grief, either on one's own or within one's actual family is, apparently, too shameful and embarrassing, or even a squandered emotion with an insufficient number of spectators?

Are we suppressing our emotions at the wrong times only to vent them equally

inappropriately? It is not, surely, that suppression as such (of either sentiments or symptoms) is bad in itself. If, for example, we 'fancy' someone (or several people) in the workplace (when they feel otherwise) suppression becomes a social and economic necessity. Managing this without drugs *might* increase one's sense of responsibility - "experience is what you get when you don't get what you want" - whereas drug-assisted social restraint decreases self-esteem. Either way we may fail to take sufficient satisfaction from self-control and see it merely as stunting and dejecting. For everything there is a season, there is a fitting time (KairoV) for exuberant self-expression, as for suppression and even a time to be crazy (if only when sleeping).

One of the ways in which we were once schooled to withstand adversity was with a solid training in religious practice. Although people were not taught relaxation techniques and the like, much attention was paid to suffering, with suggestions as to its purposes. Buddhists taught their followers how to come to terms with the passing nature of existence, without which we lack fundamental insight. If we have e.g. a china cup the inescapable fact of its existence is that it will break, if not next year than in the next 100 or 10,000 years. Philosophers of antiquity addressed these subjects. Commenting upon the 'love of life' some observed the hidden irony of "mortals who love life". a stoic called Chrysippus held that love of life is an unreasonable desire (*Fragmenta moralia* 397). Jews, and later Christians, personalised the problem by recognising that the Holy One gave judgement on our actions in life. Thus the harmful effects of sin were depicted in terms resembling those now reserved for environmental pollution or smoking. Impersonal decay became restated as personal separation from the knowledge of God<sup>4</sup>. The result of sin was suffering - in this world and beyond. Not only does the avoidance of- what was classified as sin - often contribute to a calmer way of life, but the struggle against temptation (itself an excellent exercise in drug-free 'suppression') better braced people for life's traumas and reinforced a sense of responsibility towards others. Moreover, the connexion between sin and suffering instilled a degree of resignation in a positive sense.

There may also have been a negative sense to *resignation*, especially in the association of insanity with moral deviancy. Devil-possession terminology might have relieved the sufferer, somewhat, of culpability, but not of 'guilt by association'; 'why-the-devil was x targeted rather than y?' As an explanation, possession-terminology may have one advantage over the medical model since even the devil does not make us dizzy with diagnosis! So, anciently, the treatment *might* be exorcism [literally "cutting out"] although we should never assume that this was invariable for mental disorders. In medieval Flanders, sanity began at home, "survivors" were (and are still) actually placed in family homes in Geel, near Antwerpen. Over in fifteenth century England, when Henry VI suffered two episodes of severe depression, no exorcism is recorded (although obviously prayers would have been offered daily); rather, the most detailed accounts of the prescribed (herbal) formulae survive<sup>5</sup>. Medieval culture was not all hobgoblins and rabbits' feet. Rather we find a balance between therapeutic approaches. We should not approach the past 'looking for trouble' but with a better mind. The same goes for religious practice. Yes, there are horrendous instances of bogus exorcisms and false attributions of demonic activity. Faith communities need to learn these lessons. Religious guides who cannot exercise humility and restraint are no more keeping the faith than those who surrender their legitimate healing ministry to the institutions of secularism.

If poor mental health is now increasing, as is claimed, to what extent, if any, might this be related to the decrease in *traditional*<sup>6</sup> religion? Promoting religion primarily as therapy, or inoculation, is obviously false. For the traditional Christian the collateral effects<sup>7</sup> of faith extend to certain material benefits precisely because we are not immaterial beings. Yet one does not follow Christ for free loaves and fishes. Looking for consistent and quantifiable

material benefits from a spiritual discipline dooms us to disappointment; it is not a "life-style" in the consumerist sense, as Job and Christ's Crucifixion make abundantly clear. Mental, spiritual and physical well-being are certainly related. Recent research from Dr. Paul Surtees (Cambridge University) indicates a straightforward relationship. In his seven year study of more than 20,000 people it appears that those able to work through problems and curb stress have an appreciably lower risk of suffering a stroke. Spiritual maturity should bring emotional maturity, but I think that 'Christian healing' may often fail because it is applied as the last resort rather than the first. It is often applied in an immature way, moreover God is not honoured by the disparagement of proven medical methods.

Those estranged from any religious affiliation, however, are not likely to benefit from religious insight or practice of any type. At best, 'outsiders' might think in terms of the ten suggestions rather than the Ten Commandments, even though such traditional, and much despised, warnings against pleasure-seeking (as opposed to sustained happiness) will always hold good. Increasingly, reports of research (and I am, alas, relying upon journalism rather than academic papers) point to the appreciable extent to which recreational drugs and heavy alcohol use impair sanity. Again, classical religions often censure such abuses of the body. At the *lowest level* we could say that what traditional faiths hold in common often constitutes a pool of ancient, tested wisdom. I would say more besides, but at the least we might acknowledge this much.

Genuine reorganisation within hospitals or community care, necessary as it is, should not eclipse the need to consider goals that are closer to home, in fact actually in the home. In physical health we are just beginning to think of prevention before cure, yet sanity and mental well-being are not yet actively promoted. Returning to our earlier discussion, our first mistake is to suppose that most of us are indefectably sane in essential respects. We think that we are *naturally* and rightfully sane in much the same sense in which we insist that we are naturally accomplished lovers or drivers. Do such self-satisfied assumptions bear scrutiny? Few of us presume that we will be able to play the French horn or become chess champions, [nor are we blamed for not excelling at such endeavours] but some faculties are taken as our inalienable rights. If someone should question our sanity (or driving), even in a discrete way, we usually sustain a narcissistic injury!

Not only do we insist upon our sanity, but even upon its permanence. It is precisely such assumptions that need to be challenged at the outset, and that means fundamentally - though optimistically, perhaps - the home, and at school. Physical education is given in schools, why not mental education and emotional exercises? On 6<sup>th</sup> October 2006, a survey commissioned by teachers' union NASUWT indicated an increasing difficulty in supporting pupils with mental health symptoms. Over in Spain, schools, allegedly, have been presenting pupils with questionnaires in an attempt to detect the early signs of schizophrenia. A questionable strategy on so many levels, but at least it means that mental health is not seen as a peripheral afterthought<sup>8</sup>. Inevitably school-psychology would not be of the highest quality, it could even be objected that, in psychology above all studies, a little learning is a very dangerous thing. Nevertheless, at the risk of proliferating 'bachelors of psychobabble,' any attempt to tackle stress and emotions at school has the *potential* to do good as well as harm. 25 years ago who would have imagined that schools would address bullying? 10 years ago who would have anticipated any effort to improve the nutritional value of school meals? Indeed mental health issues are already being set before young people *by stealth*. In the soaps, and especially on children's T.V., topics such as self-harming are portrayed with a concluding voice-over "if you have been affected by any of the issues in today's programme, call..." Less positively, however, not only is this stealth-strategy haphazard, but it perpetuates the supposed 'spookiness' of mental difficulties by making a drama out of a crisis. We need to try to take the drama out of mental health, not heighten it. If someone is depicted with an asthma attack

this is seldom over-sensationalist, if however someone is seen cutting themselves<sup>9</sup> a more horrified reaction can be anticipated. This is not to say that such things should be excluded from dramas, but if we should regard sanity as a sliding-scale, rather than absolute, the horror of impaired mental health could be reduced. Nothing can make any subject more boring and commonplace than by setting it within a school curriculum, so let's put it there soon, thereby expunging that creepy element. By attempting to address bullying (albeit most inadequately) schools have set precedents, raising an expectation that they should graduate to engage with further issues of stress and well-being.

It could be objected that the whole subject is just too obscure and complicated for children, but one nine year old had her book published (on her experience of the trauma of divorce) whilst another (at the tender age of eight) has just published her positive experiences of 'beating' cancer. As yet, however, I have not heard of any boys of comparably tender years venturing into print (perhaps reinforcing the stereotype that males are less confident with emotional matters). The 'one-size-fits-all' approach of schools is a positive breeding-ground for many of the assumptions that I have been attempting to typify and challenge. Schools "must try harder." Tactful discussions about loss and bereavement, aggression and bullying, could be introduced to pupils at an early stage - and reintroduced, in increasing detail and depth, at later stages, leading on to subjects such as shame, and anxiety. Having suggested such measures, one would not want to see history repeating itself with a 'one-size fits-all' psychology, particularly if those leading such sessions had merely rudimentary experience.

It would be ghastly if an expensive anodyne programme produced 'Stepford-pupils' who might mature into the 'bland leading the bland', droning on about finding "closure." In stressing that we might learn to exercise our same and logical faculties I am not recommending some humourless, super-sensible approach. Humour is surely one of the key ways in which sanity is promoted, crucially in our ability to laugh at ourselves. Moreover, a measured dissatisfaction with life is an essential constituent, and even dysfunctional episodes are part of the ebb and flow of our experiences of life and the frail/*fallen* human spectrum. In Latin theology we are accustomed to speak of a 'fallen world'<sup>10</sup>. In a fallen world one cannot wonder at fallen responses. Moreover, the suggestion has even been mooted that mental illness is a sort of litmus test of society itself. Service users are the new 'canaries' who give warning of the (mental) toxicity of our environment<sup>11</sup>. Some service users, when claiming recovery, have given testimonies that "Jesus is the answer," to which I would ask "and what was the question?" I have no wish to doubt that God gives both healing and purpose; to pray for healing is a positive command of God because through healing God is glorified in the creation which He willed into existence. Nevertheless, the Holy One gives us other gifts, besides healing, such as the strength to cope, to gain insight and help others similarly circumstanced. It is right for an asthmatic to pray for an outright cure, but equally legitimate to pray for greater abilities and powers to control the condition.

Paradoxically, a characteristic of - what I understand by sanity - is not to take fright at insanity. Mental illness troubles some of us precisely because these variant mental states may highlight the ever-present, unresolved tensions, futilities and nonsensicalities in all human existence. These, in turn, point to human non-existence from which all our fears emanate, the fear of death itself. The Christian way does not chime in with the way that so many people actually feel about existence. Even if they grudgingly accept that we all have to die, they balk at the teaching of some Scripture passages that *we deserve to die*. The problem is not merely one of weakness versus wellness, but a moral and theological one. To insist that "Jesus is the answer" (to what are often highly selective questions) so often amounts to failing to ask the essential, preliminary ones. I do not subscribe to the Calvinist doctrine of the *total depravity* of humanity, but firmly in the total frailty (and deep-rooted fallibility) of mankind. God is glorified in weakness more than in 'problem-solving.'

The User movement, quite rightly, attributes purpose and value to the experiences of 'survivors,' refusing to settle for the sympathy of strangers or, alternatively, a subjective sense of victimhood. The problem with cases of 'recovery' is that they are necessarily on an individual basis, and no one can guarantee that relapse is impossible or even unlikely. Obviously we aim for best mental health, but if we encounter its impairment we can also derive positive lessons from the life-experiences of ourselves and others, this is the *sane* response.

That sense of purpose can best be inculcated and nurtured in the home - and home can be one's faith, just as much as one's physical family. Home is as 'foundational' as it gets, but it is not something to be sentimentalised. If 'home' signifies a faith community, its track-record could be better. Sadly I have, more than once, heard of a chapel where users of mental-health services are positively made to feel unwelcome; and the same can be said if home means (genetic) family. Both institutions can be avoidant when it comes to mental health, yet these are precisely the provinces that can make significant contributions to a person's mental state, for good or ill. Ironically, although the Latin Christian tradition taught that we are born into sin (that is, among other things, into grave imperfection), it side-stepped the possibility of a fundamentally frail and flawed sanity within that common human nature. Having acknowledged that everyone was implicated in both physical suffering and weakness of resolve, why did the Latin theological tradition not reach that next obvious conclusion? Centuries on, even *Monty Python* came closer, with their precept "Do not adjust your mind, there is a fault in reality."

How might families/parents be induced to study and reflect upon sanity; theirs and their children's, and how best to nurture it? Many families so often resort to denial. All those negative presuppositions about mental health are in the home, "in spades!" It may be permissible for *celebrities* and *historical figures* to have 'eccentricities'. If Churchill suffered from depression that is understandable, even acceptable; but when it is attributed to one's brother Kevin it can *only* be down to Kevin's own weakness, imagination, attention-seeking or immaturity . . . 'not in my back yard'. Within families this subject will always be one of those satirical 'irregular' verbs: "I am a character, you are an eccentric, he wears a bow tie... they are dangerous psychopaths." The exception, where families more often accept the extent of such a problem, is in cases of dementia. These symptoms, at least, are rarely put down to attention seeking. Furthermore, even fervent believers do not generally anticipate healing for sufferers. Certainly there is no Gospel account of an elderly dementia sufferer being cured. Otherwise, however, it is the home environment that is actually aggravating poor mental health. Social devaluation affects everyone within a given household, but those who cope best will disparage those who cope worst.

Sanity is not dispensed by experts and *could* not originate in hospitals, it begins with security and nurturing. A recent report suggests that Mental Health professionals perpetuate a myth that "with enough effort we can achieve a state without suffering".<sup>12</sup> Although professionals may play a part in our relative recovery of sanity, we need to find ways to reinforce good mental health from the cradle; it is only by recognising its contingent character that we can prepare for its decline. Service users are blamed and reproached, frequently, for their lack of insight into their *It's* condition. Can this be any surprise when we are all predisposed to view our sanity as absolute? When sanity is seriously impaired it is too late to gain optimum discernment. Preparation for such times of testing demands a complete transformation in the way that we view ourselves, our minds and our acceptance (or otherwise) of suffering.

We pay a high price for our aspirational, success-driven culture. Some forms of positive thinking have a lot to answer for; and if life were so great (as we are *counselled* to regard it) positive thinking would be superfluous. We should surely pause to consider the *source* of much that passes for motivation - commerce and success-culture. These subcultures have no

interest in vulnerability, illness, and loss, other than to make money out of them. Beyond this exploitability, however, weakness and pathos constitute a sort of heresy and obscenity in vast swathes of modern society. Success-culture is no friend to damaged people, only to those who profit by it.

Anti-stigma campaigns and consciousness-raising events such as World Mental Health Days have limited scope as they are fleeting; and, worst of all, they give the impression that those involved with Mental Health are yet another whinging minority group. Furthermore, they focus upon disorder and not sanity. Their subtext often seems to suggest "Don't indulge in contempt because next week it could be you." If, however, sanity were continuously promoted - with the frank acknowledgement of its provisional nature - then we should *all* gain greater insight throughout our lives. Insight is not just for service users, it is both a practical and spiritual necessity. What, however, should be the subject of our insight? We should recognise that the human condition is not only frail by reason of its mortality but, ultimately, frail by reason of its reasoning.

Fr. Michael Mowbray Silver, St. Luke's Day, 2007



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1 Dr. David Armes (Luton University) rendered considerable assistance and also suggested the titles: Support for Healthy Living, Strategies for Healthy Living and Dizzy with Diagnosis. (Dr. Armes is a Ph. D., not a medic). The first two were held at the Lister Hospital Postgraduate Centre, Stevenage; the third at the Spirella Centre, Letchworth. I edited the local journal Insight for over 3 years.

2 This 'medical model' is frequently questioned; perhaps we are over-defensive. Pregnancy/childbirth is not a sickness, but 'treatment' is delivered by doctors and nurses in hospitals, more often than not.

3 The most outlandish example of false-grief, to date, - surely - was reported as "Chicken gives birth to urban myth," The Times, Tuesday, October 25, 2005, p. 24. Liverpool residents had been laying flowers, toys and cards by a wall in Anfield where the foetus (of a chicken) had been found, in the belief that it was human. Despite a local paper confirming that it had come from a chicken, the people refused to be deflected from their 'grief-fix.'

4 Not only was sin seen further, as a rejection of the person of God Himself, but His help (grace) was seen as indispensable in the repairing and avoiding of sin.

5 The ancient rite of healing (anointing/unction) had, by medieval times, become 'last rites' and, even today, is not routinely employed in mental health cases.

6 'Traditional' is the operative word, as many forms of Christianity, and other faiths, have been 'genetically modified' to emphasise a 'feel-good factor.' My own inclination, by contrast, is that the Gospel has to be bad news before it can become good news.

7 We need to define what we mean by 'benefits.' Christianity not only promises healing but a personalised Cross. For those schooled primarily by success-culture the Cross is not on the agenda.

8 I do not have documentary evidence, but I was told on good authority by a psychiatrist in Hertfordshire on 26th September, 2005

9 As in November 2005 episodes of the children's B.B.C. 1 series Byker Grove.

10 The doctrines of the Fall and Original Sin are more specifically North African and classically expressed in St. Augustine of Hippo's works. Eastern Christianity's view on Original Sin is not expressed in terms of total incapacity or depravity.

11 An idea expressed by Dr. Chris Manning at Viewpoint launch on 28th October, 2005. In former times, in coal mining, canaries were used as a detector of toxic gases. If the canary died, the miner got out as quickly as possible. These are the 'colly-birds' of the carol *12 Days of Christmass*, now often printed incorrectly as 'calling-birds.'

12 A recent report from Dr. Diane Gehart and Dr. Eric McCollum of California State University in Journal of Marital and Family Therapy.