

**MENTAL HEALTH IN THE CHURCH
FROM THE GURNEY IN THE HALL TO THE RELATIONAL KINGDOM OF GOD**

A dissertation submitted to the
Theological School
in partial fulfillment of the requirements for the degree
Doctor of Ministry

Advisor: Dr. Melanie Johnson-DeBaufre, Th.D

Julia N. Haspel
Drew University
Madison, New Jersey
May 15, 2026

Abstract

Mental Health in the Church

Julia Haspel

Grace Lutheran Church

65 E. Main St.

Mendham, NJ 07945

This Doctor of Ministry project explores how congregations can serve as sites for restoration and healing for individuals living with mental health challenges. The thesis is based on the author's own experiences as a pastor and her family's story and explores how stigma and dehumanization in medicine, society, and the church create brokenness and fracture relationships. Using psychological studies of mental health, historical accounts of societal systems of oppression, and theological anthropologies of personhood, this thesis demonstrates that stigma and dehumanization are socially constructed, fear-based means of maintaining social order that contradict scripture and God's relational kingdom.

Using a practical theological approach, the thesis draws on biblical passages from Genesis, the Prophets, and Gospel healing stories to demonstrate the presence of dehumanization in scripture and God's ongoing resistance to and repair of it. Then, through the lens of an African philosophy called Ubuntu, a relational theory of healing developed by John Swinton, and the Christian tradition of radical/biblical hospitality, this thesis develops a relational theology of personhood where healing is defined not just as the reduction of symptoms but also as renewed relationship, belonging, and co-agency.

This thesis provides a critical assessment of denominational policy and initiative documents on mental health, focusing primarily on the ELCA and examining their theological depth, implementation potential, and limitations. Based on this analysis, this thesis creates a context-specific, evidence-informed strategy document for Grace Lutheran Church in Mendham, NJ (a Reconciling in Christ/Stigma Free congregation). This strategy outlines theological education for staff and volunteers, reducing stigma in the community, collaborative work with mental health providers, embodied and digital expressions of radical hospitality, and structures of support, advocacy, and evaluation.

In conclusion, the thesis asserts that churches have been and continue to be uniquely positioned to represent the relational Kingdom of God for those experiencing mental health struggles. Through the integration of Ubuntu, radical hospitality, "thick conversation," a rich theology of the cross, and Imago Dei, congregations may transition from being complicit in silence regarding stigma toward active faith-formational accompaniment, becoming communities where individuals do not suffer alone and where healing (not necessarily cure) is perceived as hopeful participation in God's redemptive work.

Dedication

This paper is dedicated to the memory of my parents, Samuel I. Haspel and Patricia Robinson Haspel, for always encouraging me to pursue my dreams and work to help all people.

This paper is also dedicated to my two sons, Jonathan and Nathan Haspel-Schoenfeld, who have taught me about love and strength in the midst of the roller coaster of life.

This paper would never have been written without the love and support of my husband, Bill Santianna, whose words of encouragement accompanied me throughout its writing. I can not thank you enough for being a huge inspiration in my life.

TABLE OF CONTENTS

Abstract	iii
Dedication	iv
Table of Contents	v
Acknowledgements	vi
Introduction	1
Chapter 1: The Separation	6
Chapter 2: A Path to Healing	32
Chapter 3: Mental Health and the Church	58
Chapter 4: The Way Forward at Grace Lutheran, Medham, NJ	84
Conclusion	106
Bibliography	115

Acknowledgements

Special thanks to my sisters, Edna Cordery, Patricia Dunn, Linda Brock, and Jean Haspel. They all love fiercely and have believed in me my whole life. A special thanks to my sister Jean, who encouraged me to write on my passion. This paper would not be what it is without her direction.

Thanks to Samantha Santianna Haque, who set me on this journey when she received her Master in Education. You believed in me at just the right time in my life.

Thank you to my academic advisor, Dr. Melanie Johnson-DeBaufre, who encouraged me to use my own voice whenever possible. I am forever grateful.

Thank you to my professional mentor, the Rev. Dr. Jack DiMatteo. I am grateful for our long friendship and your very encouraging words in this process. They made a world of difference to me.

Thank you to Susan Pilshaw, who offered to edit my paper before she knew how many times I would ask her to do so. You were a godsend, and your knowledge of the Bible was truly invaluable.

A special thank you to my Bible Buddies who meet with me weekly for Bible study. Your kind words and theological suggestions are so appreciated. You really are the best! Thanks to Pat and Ralph Anderson, Lisa Bretherick, Mark Brumbaugh, Becky Burgee, Yvonne Kloehn, Carl Malmstrom, Colleen Peterson, Susan and John Pilshaw, Bruce St. John, Jamie Slee, and George Zorn.

Introduction

My oldest son is a beautiful person. He is funny and artistic. He has been taking pictures since he was three years and has developed into an amazing photographer. He writes beautiful stories and is a talented guitarist. He is empathetic and genuinely cares about people. He is truly a gift to the people he meets and a joy in my life. My oldest son, Jon, also has mental health challenges. Living with mental health challenges is difficult. Over the past eleven years, he has been hospitalized over thirty times. These storms can be challenging to navigate. There are usually signs that he is beginning to struggle. His younger brother is usually the one to notice the subtle changes. When he experiences more severe symptoms, we know it is time to seek medical assistance.

The world is full of people just like my son. Many people have mental health challenges, which can include a range of diagnoses and severity levels, such as bipolar disorder, anxiety, depression, post-traumatic stress disorder, eating disorders, schizophrenia, and a whole host of other disorders. As a result of these challenges, people also suffer from broken relationships, the loss of loved ones, shattered dreams, or have lost hope. People have also been harmed by the very institutions that were set up to help them. Mental illness is only one description of a person among many. Long ago, when my son was first diagnosed, I told family members that my son was bipolar, and I quickly realized this was a great disservice to my son. That is one description among the many ways to describe him and understand who he is. He is a musician, an artist, and a genuinely empathetic human being. He isn't bipolar. He has bipolar. If his mother can fall into this trap, anyone can.

Families, religious communities, and the medical system can perpetuate dehumanization and stigmatization of people with mental health challenges. I would like to say that my son's

medical treatment over the last eleven years has improved, but that is not the case. A pattern has now emerged when he is admitted to the hospital. We arrive at the emergency room, and the medical staff places him on a gurney in the hall to wait to be seen by a doctor. It is here in the hall that he suffers in public, while people walk by staring, wondering why he is there in the open when there are private rooms left empty. When my husband and I are with him, we feel the dehumanization for him and with him. We have nowhere to sit. People walk by as if we were not even there. We have to ask for everything. No one brings us information or attends to our son's basic needs. He can be there for hour upon hour, and no one offers him something to eat or drink. He has no privacy and suffers with the eyes of the world on him. The hospital environment only exacerbates his condition. He is like many people who often delay or avoid treatment altogether due to concerns about how they will be treated.

In many ways, the Church is well-positioned to address these problems and be a change agent in the world for the humanization and welcome of people with mental health challenges. One of the basic understandings of the sacredness of all people comes from the *Imago Dei* in Genesis. "So God created humans in his image, in the image of God, he created them; male and female, he created them" (Gen 1:27). If we all have been created in the image of God, we are all seen as equally valuable, lovingly made by our Creator. The Church, emphasizing love, compassion, and equality, stands in a unique position to fight against dehumanization and stigma. This belief is one of the fundamental principles of Christianity. The Creator made us to be in relationship with Godself and each other. It is in this relationship that we have shalom, peace, and wholeness. A study of the policy statements of several mainline Christian denominations shows that the building blocks for change are in place.

Yet, there is little evidence that change is embraced institutionally and that programs to change people's thinking and practices at the local level are not coordinated or being implemented with any consistency. Indeed, the Church has not always been a safe haven for those struggling with mental health issues. Because stigmatization, dehumanization, and even basic lack of understanding are common outside and within churches, many individuals feel unworthy of going to the church for help. Others may be afraid to enter a traditional church because they feel they must wear a mask to hide their struggles. Perfection has never been a requirement of the church, yet that message has been passed down through generations.

This paper aims to examine the problems of dehumanization and stigma and their ongoing impact, particularly on the lives of people with mental health challenges. Throughout this paper, I will explore how culture contributes to dehumanization and how stigmatization manifests in the medical profession and the church. Dehumanization is rooted in the process of segregating people into groups, making it easier to blame them for whatever social ills are identified as a problem. Stigmatization identifies groups to be ostracized. Dehumanization and stigma are at the root of much injustice against the most vulnerable in our society.

Despite the dehumanization and stigmatization of people with mental illness that my son has faced, my hope for him remains unwavering. During his most recent hospitalization, the psychiatrist called me the next day. He was kind and asked me the question I had always longed to hear. "Please tell me all about your son." Tears welled up in my eyes as I began to share the whole story of my son's life. The doctor told me that my son appeared to be a remarkable person and that he intended to assist him. The doctor acknowledged my son's humanity and expressed it in words. Following my son's lengthy hospital stay, he shared the following on his Facebook

page: “If there’s one thing you can take away from today, please know that the world needs you here, just as you are.”

This one doctor’s action gives a glimpse of what we can do to combat dehumanization and bring people together to care for and welcome people with mental health challenges. This thesis will propose the African philosophy of Ubuntu and its ideas of community. This idea—I am because you are—has inspired movements, like in the struggle against apartheid, to reject stigmatization and dehumanizing division and to claim the humanity of every person.

I will make the case that the concept of Ubuntu, as well as ideas and practices of radical hospitality, are central to a ministry of deep welcome of people with mental health challenges in their full humanity. Understanding Ubuntu and embracing its principles is never easy, but it is well worth the effort to make necessary changes in society, in the Church, and in our own lives. Christians have come to understand the need for peace and wholeness over the years, but we are just beginning to comprehend its implications for the Church and the world. Ultimately, this thesis will name the injustice of the discrimination of people with mental health challenges and propose ways of thinking and being church that bring hope and healing to a community that has been discriminated against for far too long. My determination to fight for my son is unyielding. His resilience in the face of adversity is a testament to the human spirit and a deep source of inspiration for me as I undertake this project.

The first part of this paper sets up a foundation of inquiry: Why do so many individuals struggling with mental illness suffer from social injustice? A response to this question will require a thoughtful and detailed definition and analysis of both stigma and dehumanization. Additionally, an analysis of historical examples of the impact of stigma and dehumanization will be discussed. Examples of the harm caused by stigma and dehumanization include, but are not

limited to social isolation, violence, war, and genocide. While stigma and dehumanization exist in the context of secular society, they can also affect attitudes and actions of the church.

The second section of the paper examines the concept of healing. Specifically, it explores ways in which the effects of stigma and dehumanization can be addressed. These ways of addressing the negative effects of stigma and dehumanization are examined using cultural, psychological, and Christian perspectives. Each perspective presents different, though related, approaches to promoting wholeness, dignity and community among those who have suffered as a result of stigma and dehumanization.

Section three of the paper examines the role of the Christian Church in the United States as a participant in systems of stigma and dehumanization. In addition, sections three and four present an example of how the Christian Church in the U.S. may express remorse and renew itself. At the heart of this discussion is the growing theological understanding of the *Imago Dei* and the profound interconnectedness of all people—created to live in relationship with God and with one another. While historically this understanding of community has not always been realized in society or in the church, there has been a growing commitment to repair these breaches and to create more authentic expressions of communal life.

Section four presents a practical and contextual expression of this growth in the form of a strategic plan for Grace Lutheran Church in Mendham, New Jersey. The strategic plan seeks to promote a greater level of inclusiveness for individuals experiencing mental health challenges while calling the congregation to demonstrate its theological commitments through lived community. As such, the strategic plan affirms that demonstrating one's theology provides opportunities for transformative participation in the relational nature of the Kingdom of God.

Chapter 1: The Separation

Stigma, prejudice, and discrimination against people with mental health challenges remain serious issues in society. “People with mental illness are among the most maligned groups in society.”¹ Dividing people into subgroups can harm both society and individuals’ lives. Stigma against people with mental illness can be obvious or very subtle. There have been times when people ask questions about my son and speak directly to me even though my son is standing next to me and can answer for himself. He has also been fired from jobs for reasons that did not exist. In this chapter, I will define stigmatization and its close relationship with dehumanization, paying particular attention to the ways marginalized individuals and groups have been dehumanized throughout history through processes of stigmatization.

The Fretting Chair and the Phone Call

As stated earlier, my oldest son was simply a beautiful child, inside and out. Many people asked us if we would allow him to become a child model. Every time we were asked that question, we would say the same thing. We wanted him to have a 'normal' childhood. I do believe every child should have one as much as they can. His good looks and personality drew a great deal of attention. He did a wonderful job handling it. All he ever really wanted was to have friends and play like every other four-year-old does. He had many friends. In fact, our house became a hangout for all the children in the neighborhood, and we spent hours together each day.

Around that age, we noticed he couldn't follow two instructions at once. He could take one at a time, such as throw your trash in the bin and put your dishes in the sink. Take them both at one time, and it was anyone's guess what would happen. It was as though it were too much for

¹Guy A Boysen, Raina A. Isaacs, Lorie Tretter and Sydnie Markowski, “Evidence for Blatant Dehumanization of Mental Illness and its Relation to Stigma,” *The Journal of Social Psychology* 2020, 160. No. 3.

him to comprehend. As soon as he realized that he couldn't follow both instructions, he became very frustrated with himself and worried about his actions. He became obsessed with his behavior and extremely self-critical. He was also beginning to have a lot of negative self-talk. His teachers at school noticed the same behaviors that his father and I saw. They created a special chair for him and actually called it the “fretting chair.” The rule was simple: if he was fretting, then he was to go and sit in the fretting chair to think about things. Once he was done fretting, he could get back up and leave the chair. Unfortunately, he never stopped fretting, and he was now isolated from his friends.

At first, Jon’s father and I thought this was a great way to help him. It never dawned on us that we left him alone to figure out some very difficult behaviors, with no help from us. Now I am not so sure it was the best way to help him. At no point in time was there any indication that he would later be diagnosed with bipolar 1 disorder, but by separating him, we prevented him from working through these problems with others. These problems piled up on him, and his negative self-talk continues to grow even to this day.

It wasn’t long after the fretting chair when Jon was six years old that his teachers urged us to have him see a psychiatrist to have him tested for any learning disabilities or mental health disorders. We were sent to a child psychiatrist who was absolutely wonderful. He spent a great deal of time with Jon for assessment. Truthfully, I thought that all mental health professionals would be like this man. We learned very quickly that they weren’t. When the psychiatrist met with us, he began by listing all of Jon’s positive attributes: empathetic, caring, and helpful, which was tremendously helpful as we began to hear more of the assessment. Jon had several learning disabilities, as well as depression and anxiety. It was difficult to hear these diagnoses, and we knew that we were in for a long road. Actually, we had no idea how long the road would

continue to be. However, we believed that all psychiatrists would be like this first one, caring, committed, and putting Jon first. We had no idea that the road would be made longer by the many doctors we met who were nothing like this incredible doctor.

Over time, we learned that change, disruption, and separation were not easy for Jon. His entire life was made up of change, disruption, and separation. It was made even more difficult as I was an interim pastor whose position was based on helping one congregation with a crisis and moving on to the next congregation to diagnose issues and move them along to a place of wholeness and peace. I finally realized that moving so often was having a negative impact on both of my boys, so it was time to settle down and move back home to New Jersey. We weren't terribly close to family, but at least we were in the same state. Jon finished high school and decided he wanted to go to college. Together, we decided that he could start at the County College of Morris with two classes to see how he did. He wanted to major in photography, which was a wonderful idea. He received his first child camera at the age of three and hasn't stopped taking pictures since. He is quite gifted at it.

As his high school graduation approached, my father was diagnosed with stage four esophageal cancer. Jon and his 'Pop' were very close. Pop was his primary male role model, as his own father began to truly struggle with his mental health challenges. I knew that my father's death would be devastating for Jon. We spoke about it openly with the hope that when my Dad died, it might be easier for Jon. My dad died on Father's Day. In the end, it was a blessing for him and our family. That was not so for Jon.

Jon started his first semester of college taking two photography classes. The class critiques were tough on Jon, but he still received a B in both classes. His talent really shone through. He had just started his second semester when I received a phone call from him, asking

me to come home. He told me he was hearing voices. I drove home as quickly as I could, terrified of what I might find. When I arrived, I called out to Jon, but I heard no answer. I ran to his bedroom expecting to see him, but he wasn't there. The sheets were not on his bed, and visions of what he might have done with those sheets ran through my mind. I screamed out his name, and he came up the stairs. He said he was washing his sheets because of all the bugs. I asked what bugs he was talking about, since it was the end of January and we didn't normally have bugs in our house. He said there were spiders everywhere. Couldn't I see them?

I asked Jon about the voices. Did he recognize them? He said no, but the voices were telling him that he should end his life and he wanted to clean up before he did that. I asked him if he could wait a bit until we could see his current psychiatrist. He agreed, and I drove him straight to the doctor without even calling for an appointment. Once we were in his office, the doctor starting asking Jon a bunch of questions as I sat next to him, not speaking a word, so the doctor could see what was going on. I was not comfortable with this doctor, as he had simply become a pill dispensary for my son, switching his medications often to no good effect. The doctor looked at me and said that I would need to take my son to the hospital. I told him in no uncertain terms that I would not be doing that. I was going to take him home and care for him myself. Jon looked at me curiously and asked, "Who are you? Are you my mother?" My heart sank. He didn't know who I was. It was the saddest moment of my life, well, my life to that point.

I asked the doctor which hospital he was admitting him to and said that I would take him straight there. I knew that he was going to need more than my motherly love. We left for the short drive to the hospital. It was his first hospital stay. It would be the first of thirty hospital admissions we would make over the next eleven years. He stayed in the hospital for over two weeks. I cried myself to sleep every night he was there. I truly needed support, but I wasn't

receiving any solace except from the kind souls in my congregation. I did not receive phone calls from the synod or the bishop to reassure me that they would support me through all of this. I truly felt alone. I worried over how people would react and how I would be treated as a pastor who clearly couldn't take care of her own child. It was truly a low point for all of us.

Stigmatization

Separation often results from stigma. Many times, people will feel that they don't know what to say, so they say nothing, which only furthers the effects of separation and stigma, which only exacerbates the issues. Stigma frequently results from ignorance or fear. Fear causes us to respond in various ways, including unusual reactions. From my theological perspective, fear is the opposite of faith. Fear often stems from our lack of control and becomes a way to try to regain power. Dehumanization is a fear-based reaction. Sometimes, misleading or inaccurate media portrayals of mental illness contribute to misconceptions about people who have mental health conditions. Stigma is a deceptive tactic that can be used to divide people through fear. Stigmatization occurs when an individual views another person negatively because of a distinguishing characteristic or personal trait perceived as a disadvantage or associated with a negative stereotype. Unfortunately, negative attitudes and beliefs toward individuals with mental health conditions are common.

Stigma or stigmatizing practices often determine who is scapegoated or labeled as the "other" or outgroup. The word *stigma* comes from the ancient Greek term meaning a mark or branding of the body with sharp instruments. The plural form, *stigmata*, is often associated with the wounds Jesus received during crucifixion—marks by which he was identified. Who or what determines what should be categorized as distinct groups? Roy Grinker argues in *Nobody's Normal* that stigma is a cultural phenomenon, not a biological one. Culture establishes this

hierarchy to maintain the power of those in authority while excluding those without it.² Stigma flourishes when people are divided into subgroups. When individuals are divided, culture creates the ideal environment for a power struggle. The division of people, combined with propaganda, fosters distrust and alienation. This practice has existed since ancient times. “*Divide et impera*”—Latin for “divide and conquer”—has long been used as a political and military tactic. Julius Caesar employed this strategy against the Gallic tribes, defeating them one by one instead of facing a united force. Though Caesar’s reign was brief, his tactics laid the groundwork for centuries of imperial rule. Propaganda incites fear, creates enemies, and ensures that subgroups fight one another rather than confront the true source of oppression. This strategy dismantles society and sustains tyranny. There are serious consequences if we continue down paths that divide us.

“In the realm of mental health, one of the most formidable barriers to seeking help is the pervasive stigma that surrounds it. This stigma creates significant obstacles for individuals in need of support and treatment. Recognizing the intrinsic worth of every individual, irrespective of societal labels or stereotypes, is crucial in combating this stigma.”³ No matter its degree, stigma causes significant harm. As a pastor, I have walked the halls of emergency departments searching for parishioners in crisis. People seeking help for mental health emergencies are often placed on stretchers in hallways—even when rooms are available. Experiencing a mental health crisis publicly is deeply dehumanizing. I have witnessed this professionally and personally with my son. It is humiliating for everyone involved. Recognizing the different forms stigma takes is essential to eliminating discrimination and preventing marginalization.

²Grinker, Roy Richard, *Nobody’s Normal: How Culture Created the Stigma of Mental Illness*, (New York: W.W/ Norton & Company, 2021) p. xiii.

³“Pathways to Promise,” www.pathways2promise.org, 2023.

Researchers identify several types of stigma. Public stigma involves negative or discriminatory attitudes held by others toward people with mental illness. It is often used to dismiss entire groups as “subhuman.” Self-stigma refers to internalized shame and negative self-perception. People may wish they were born differently or “better,” leading to despair, self-harm, or suicidal thoughts. Structural stigma is systemic and embedded in policies and institutions. Examples include inadequate funding for mental health research or limited access to care.⁴ True change must address these structural barriers.

Stigma often leads directly to discrimination. It reduces people to a single description, ignoring the fullness of their humanity. This “us versus them” thinking pits groups against one another and leads to conflict. Discrimination may be blatant—such as negative remarks—or subtle, such as avoidance based on assumptions of danger or instability. In the workplace, people with mental health conditions may struggle to find or keep jobs. They are often treated as unintelligent or childlike. People may even judge themselves, devastating self-confidence and limiting relationships. The harmful effects include reluctance to seek help, lack of support from family and friends, fewer opportunities for work or housing, bullying, harassment, and physical violence. Insurance often fails to cover mental health treatment adequately, creating financial strain. Words like “You’ll never succeed” become internalized, reinforcing despair. Stigma is a malignant form of social description aimed at vulnerable people. It deepens suffering and exacerbates mental illness.

In any form, stigma is injustice. Genesis 1:27 reminds us that all humans are created in the image of God. We are created for authentic relationships—with God and with one another.

⁴“Stigma, Prejudice and Discrimination Against People with Mental Illness,” www.psychiatry.org/patients-families/stigma-and-discrimination?refnewsroom.siliconslopes.com.

Nothing in creation can break this bond. Yet stigma and dehumanization appeal to our sin, hubris, and desire to elevate ourselves above others. Throughout history, stigma has been used against people of color, women, sexual minorities, older adults, and people with mental illness. Stigma and dehumanization often go hand in hand. Together, they have fueled some of the greatest atrocities in human history, including genocide. Patrick Corrigan describes the “Stigma Effect” as the unintentional reinforcement of stigma by well-meaning efforts to address injustice. One example is the push for “color blindness” in the 1960s. While intended to promote equality, it erased cultural identity and prioritized white norms, prompting the rise of the Black Power movement. Another example is the military policy “Don’t Ask, Don’t Tell,” which allowed gay and lesbian individuals to serve only if they concealed their identity. Though intended as progress, it further devalued authenticity. The policy was eventually ruled unconstitutional and repealed in 2010. Corrigan also cites Pope Francis’s use of Matthew 25:40 during his 2013 inauguration. Though intended to inspire compassion, some perceived the language as reinforcing a divide between the “haves” and “have-nots,” unintentionally repeating stigma.⁵ These examples show that good intentions are not enough. Understanding lived experience is essential.

There are unintentional consequences when people attempt to address social injustice without having a basic understanding of what it is like to live with stigma or knowing how to prevent stigma from occurring. Education is critical in dismantling stigma, and the Church has a vital role to play. However, the Church must first recognize where it falls short. Teaching myths instead of facts can reinforce stereotypes. Simply naming injustice has never eliminated prejudice. Care, humility, and listening are essential. Corrigan, Patrick.

⁵ Corrigan Patrick, “What is the Stigma Effect, Part 1,” *Psychology Today*, January 22, 2019.

In 2008, I traveled to Honduras with the New England Synod of the ELCA to build septic systems in the village of Chachahuala. Although we arrived with a plan to construct the necessary structures, local villagers explained that it would fail due to the mountainous terrain and the rainy season. Some in our group were offended: “Whose project is this?” “What do they know?” Truthfully, our dilemma felt a great deal like systemic racism and devaluing the intelligence of our hosts. Yet the villagers understood their land better than we did. When we listened, we succeeded together. This experience revealed how easily one group can devalue another—and how much can be accomplished when we refuse to do so. Stigma and dehumanization are global issues rooted in fear and power. They fracture relationships, harm individuals, and damage society. Addressing them requires education, humility, theological grounding, and a willingness to listen—especially to those most affected. Stigma and dehumanization often go hand in hand. Together, they can perpetuate the brutality that takes place between people. Most of the mass genocide that has taken place in the world can be traced back to stigma and dehumanization.

Dehumanization

Dehumanization is a pervasive social, psychological, and moral process through which individuals or groups are denied full recognition of their humanity.⁶ Psychological research demonstrates that people with mental health challenges experience blatant dehumanization in ways similar to other stigmatized groups who are perceived as less than fully human. As David Livingstone Smith argues, the primary reason for studying dehumanization is not merely to

⁶Smith, David Livingstone, “Paradoxes of Dehumanization.” *Social Theory and Practice* 42, no. 2 (2016): 416–43. <http://www.jstor.org/stable/24871350>.

describe it but to prevent it. Understanding how dehumanization functions is essential if it is to be dismantled.⁷ Smith is not simply looking to interpret the world; he is out to change it.

This section advances the argument that the dehumanization of people with mental illness is sustained by fear, stigma, and power-driven ideologies rather than by inherent characteristics of those who are dehumanized. Drawing on psychological research, historical and contemporary case studies, and theological reflection, the chapter situates dehumanization as a systemic phenomenon with profound ethical consequences. Ultimately, it contends that restoring humanity requires intentional recognition of dignity, relationship, and moral responsibility within both society and the faith community. One of the main difficulties lies in how deeply rooted dehumanization is in our culture and lives.

Dehumanization can be defined as the belief that certain beings only appear human, while beneath the surface, they are regarded as something less than human altogether.⁸ In *Less Than Human* and *On Inhumanity*, Smith explains that dehumanization emerges from an interaction between evolutionary biology, cultural narratives, and the structure of the human mind. It is not merely an emotional response but a cognitive framework that allows individuals or groups to be perceived as objects, animals, or machines rather than moral subjects. Although dehumanization attempts to deny humanity, it cannot actually remove it. Humanity is not granted by social recognition; it is inherent. From a theological perspective, humanity is God-given and therefore inalienable. Nevertheless, when individuals are treated as less than human, the social, psychological, and spiritual consequences are severe and enduring.

⁷Smith, David Livingstone Smith, *On Inhumanity: Dehumanization and How to Resist It* (Oxford University Press, New York, New York, 2020) p. 82.

⁸Smith, David Livingstone, *Less Than Human: Why We Demean, Enslave and Exterminate Others*, (St. Martin's Press, New York, NY, Feb. 28, 2012) p. 60.

Psychological research provides compelling evidence that people with mental illness are among the most dehumanized groups in contemporary society. A study conducted by the Department of Psychology at McKendree University and published in the *Journal of Social Psychology* examined blatant dehumanization across a range of social groups. The researchers hypothesized that people with mental illness would be blatantly dehumanized, a prediction that was supported by their findings.⁹

The study assessed perceptions of Americans, Christians, Mexican immigrants, Muslims, people with mental illness, and violent criminals. The inclusion of violent criminals allowed for comparison between dehumanization based on behavior and dehumanization based on identity. Results demonstrated that people with mental illness were dehumanized significantly more than Americans, Christians, Mexican immigrants, and Muslims, though less than violent criminals. Stereotypes portraying people with mental illness as lacking warmth and competence placed them in the lowest possible social category. While the study did not explore the causal mechanisms behind these perceptions, it sharpened the empirical picture of how stigma operates through dehumanization. The authors recommended further research into which specific mental disorders are most likely to be dehumanized, emphasizing that such inquiry is essential for reducing stigma and mitigating its harmful effects.

Stigma and dehumanization are mutually reinforcing processes. Dehumanization legitimizes stigma, while stigma normalizes dehumanization. Together, they foster social exclusion, discrimination, and violence. For individuals with mental illness, these dynamics frequently manifest as self-stigma, which compounds suffering and obstructs recovery. Research indicates that self-stigma contributes to deteriorating self-talk, reduced hope, lower self-esteem,

⁹Boyson, Guy A., et al, "Evidence for Blatant Dehumanization of Mental Illness and its Relation to Stigma," pp. 1-11.

increased psychiatric symptoms, strained relationships, decreased adherence to treatment, and greater difficulty in maintaining employment. When family members, faith communities, and social networks fail to offer understanding and support, individuals become further isolated. These outcomes underscore that dehumanization is not merely symbolic; it produces concrete psychological, relational, and material harm.

Dehumanization has been a consistent feature of some of the most extreme forms of human violence, including genocide, slavery, war, and systemic oppression. When groups are framed as animals, vermin, machines, or monsters, violence against them becomes morally permissible and, in some cases, morally justified. A tragic illustration of this dynamic occurred in Japan in 2016, when a man murdered nineteen people and injured twenty-six others in a residential facility for individuals with disabilities. He explained to police that “it is better that the disabled disappear.”¹⁰ It was the deadliest mass murder in Japan since World War II and it was hardly broadcast or publicized. The relative lack of sustained public attention to this atrocity reflects broader societal discrimination against people with disabilities and demonstrates how dehumanization can render extreme violence socially invisible.

Dehumanization is also evident in global labor systems. Temporary Labor Migration Programs involving millions of Southeast Asian workers often include overcrowded and unsanitary housing, denial of health care, prolonged family separation, and restrictions on religious practice. These conditions violate multiple articles of the Universal Declaration of Human Rights, proclaimed by the United Nations in 1948, which affirms that all people are entitled to fundamental rights and freedoms without distinction.¹¹ Article two states, “Everyone

¹⁰Rasset, Montalan, Mauny, N., Boudiemadi, V., and Mange, J, “Not All ‘Intouchables’: Variations in Humanness Perceptions between Physical and Mental Disability,” *International Review of Social Psychology* 35: 7.

¹¹ United Nations, “Human Rights and Temporary Labour Migration Programme in and from Asia and the Pacific,” United Nations Human Rights: Office of the High Commissioner, Southeast Asia Regional Office, 2022.

is entitled to all the rights and freedoms outlined in the Declaration without distinction of any kind, such as race, colour, sex, language, religion, political or other opinions, national or social origin, property, birth or other status. Furthermore, no distinction shall be made on the basis of political, jurisdictional, or international status of the country or territory to which a person belongs, whether it be independent, trust, non-self governing, or under any other limitation of sovereignty.¹²

Within the United States, policies targeting asylum seekers have similarly reflected dehumanizing logic. Images of individuals detained in cages, children separated from parents, and deaths resulting from inadequate medical care reveal how fear-driven political narratives can erode moral responsibility. Rather than offering protection, such policies criminalized vulnerability while asserting scarcity of resources, even as substantial resources were allocated elsewhere. This declaration was proclaimed to the UN National Assembly on December 10, 1948, in Paris.

Dehumanization does not arise spontaneously within individuals. It is cultivated through ideology and propaganda, particularly when promoted by those in positions of power, including political leaders, religious authorities, and cultural influencers. These narratives encourage the public to view certain groups as less than human—beasts, predators, vermin, or demons concealed beneath a human exterior. When populations are persuaded to distrust their own perceptions of shared humanity, they become capable of endorsing exclusion, neglect, and violence. Dehumanization thus emerges not from inherent cruelty but from social narratives that distort moral imagination and suppress empathy. It is tempting to assume that only monstrous people commit monstrous acts. However, research on dehumanization consistently demonstrates that perpetrators of brutality are fully human. Monsters are imaginary constructs that allow

¹²“Election Standard,” The Carter Center, <https://eos.cartercenter.org/quotes/84>.

societies to externalize blame and evade responsibility. In reality, all human beings possess the capacity to dehumanize others under particular social and political conditions. Acknowledging this capacity is essential for ethical accountability. Holding a mirror to ourselves fosters vigilance against the forces that enable dehumanization and invites intentional resistance to narratives that divide and diminish. Without such reflection, cycles of violence and exclusion are likely to persist. Many dehumanizing frameworks rely on hierarchical models of rationality that rank beings as classified as higher or lower, with those deemed inferior subjected to control, possession, or elimination. This hierarchy undermines human dignity and distorts relationships within creation.

A theological anthropology grounded in creation offers a fundamentally different vision. God is the Creator, and humans exist alongside animals, land, and ecosystems as part of a shared created order. This vision opposes control and supports interdependence, respect, and responsibility in relationships. Isaiah 55 articulates this alternative imagination of peace and wholeness: “For you shall go out in joy and be led back in peace; the mountains and the hills before you shall burst into song, and all the trees of the field shall clap their hands.” (Isaiah 55:12)

Dehumanization in Scripture and the Relational Kingdom of God

Dehumanization is not simply a psychological or social issue; it is a profoundly theological problem that occurs where power is viewed as more important than relationship. As stated earlier, David Livingstone Smith asserts, "The main reason for studying dehumanization is to learn how to prevent or disable it. To accomplish this, we must understand how it works."¹³

¹³Smith, David Livingstone, *Less Than Human: Why We Demean, Enslave, and Exterminate Others* (New York: St. Martin's Press, 2011), 2.

Dehumanization operates by removing individuals' ability to function as agents, to speak for themselves, and to possess moral value, thereby reducing them to mere objects to be controlled and exploited, rather than being treated as fellow human beings.

Throughout Western intellectual traditions, human uniqueness has generally been defined by rationality, and accordingly, humans are typically arranged at the top of an ordering of living beings based upon rationality. Because of this ordering system, people who appear to be less rational, or less powerful, are often classified as inferior, expendable, exploitable, or subject to coercion. Although this line of thinking has influenced the development of theology, ethics, and culture, it is fundamentally incompatible with the testimony of Scripture. Rather than affirming the hierarchical structures of domination, Scripture consistently rejects such systems and provides a vision of creation that is founded upon relationship, mutuality, and divine presence.

It is argued that dehumanization is present in Scripture, not as a result of what God wants, but as a common distortion of human relationships, which is frequently supported by translation decisions, cultural presuppositions, and theological interpretation. However, Scripture simultaneously demonstrates God's ongoing efforts to reveal, resist, and restore dehumanization through what may be referred to as the relational Kingdom of God. When Genesis 1-2 is read again from the perspective of nonhierarchical relationships, the two creation accounts represent different, and often unevenly interpreted, theological perspectives. Genesis 1 depicts humanity as having been created in the image of God and having been given "dominion" (*rāḏâ*) over all the other creatures of the earth (Gen 1:26-28). Although *rāḏâ* can imply stewardship and responsible administration, it can also convey the idea of subjugation and control.¹⁴ Historically, the language of *rāḏâ* has been interpreted in ways that support hierarchical domination over the rest of the

¹⁴Brueggemann, Walter *Genesis* (Atlanta: John Knox Press, 1982), 31–33.

natural world, including other humans. Genesis 2, however, illustrates a different vision. The language of dominion is absent, and instead of speaking of humanity as a sovereign ruler, humanity is depicted as a dependent member of creation (*hā'ādām*), formed from the earth (*'ādāmâ*). Humanity's purpose on the earth is relational and grounded in dependence upon the earth, animals, and ultimately God.¹⁵ Humanity was created for relationship. The Genesis 2 account rejects a rigid hierarchy and instead, points toward a model of stewardship, mutuality, and shared creatureliness. Isaiah's eschatological picture displays similar themes. In Isaiah 55:12, creation itself participates in redemption: the mountains sing, and the trees clap their hands. Creation is not a passive object of human control but an active partner in God's redemptive process. Such images support a theological anthropology rooted in shared existence rather than domination.

Wilda Gafney's womanist reading of Genesis 2-3 exposes how translation choices have aided in establishing dehumanizing interpretations, particularly concerning gender. In Genesis 2, *hā'ādām* does not refer to a single male individual but to "the human," an earth creature formed from the earth. Gafney's translation of Adam as "it" acknowledges the grammatical and theological fact that this being includes both male and female before they are separated. Humanity is initially singular, whole, and unified.¹⁶ Similarly, the Hebrew term *šēlā'*—traditionally translated as "rib"—is better rendered as "side." Elsewhere in Scripture, *šēlā'* never denotes a rib.¹⁷ Translating *šēlā'* as "side" indicates that the woman is not generated from a

¹⁵Fretheim, Terence E., *God and World in the Old Testament* (Nashville: Abingdon, 2005), 63–68.

¹⁶Gafney, Wilda C., *Womanist Midrash: A Reintroduction to the Women of the Torah and the Throne* (Louisville: Westminster John Knox, 2017), 21–27.

¹⁷Trible, Phyllis, *God and the Rhetoric of Sexuality* (Philadelphia: Fortress Press, 1978), 99–101.

subordinate fragment of humanity but rather is one-half of an initial, undivided entirety. The Genesis 2 account affirms equality and mutuality, rather than hierarchy.

Many English translations, including the NRSV, introduce patriarchal presumptions by using the terms "husband" and "wife," even though these terms are absent in Biblical Hebrew. These interpretative decisions undermine the original vision of shared humanity presented in the Genesis 2 account, and provide justification for the subordination of women.¹⁸ Such actions illustrate how translation can function as an instrument of dehumanization. Interpretations of the "Fall" in Genesis 3 has often strengthened such hierarchies by portraying Eve as the primary transgressor and as the source of humanity's sinful nature. However, careful consideration of the Genesis 3 account complicates this portrayal. When the serpent addresses the divine prohibition, the Hebrew uses second-person plural pronouns, indicating that both humans were addressed as a unit—a detail obscured in many English translations. This grammatical feature strengthens the cohesion of the human pair and contests the concept of individual culpability. Furthermore, the Genesis 3 account never specifically mentions "sin," "the Fall," or the loss of innocence. These concepts developed in the subsequent tradition of interpretation. God curses the serpent and the earth, but not the humans themselves. Even Genesis 3:16—often translated as "He shall rule over you"—can be rendered in multiple ways. The Hebrew preposition can reasonably be translated as "with," providing the understanding "He shall rule with you", and supporting relationality in spite of brokenness.¹⁹ Read in this manner, Genesis 3 does not establish hierarchy, but describes the distortion of relationships under conditions of fear and broken trust. Dehumanization develops not because of divine intentionality but as a result of damaged relationships.

¹⁸ Gafney, *Womanist Midrash*, 30–33.

¹⁹ Westermann, Claus, *Genesis 1–11* (Minneapolis: Fortress Press, 1994), 238.

One of the most obvious examples of dehumanization in Scripture is the story of Hagar (Genesis 16; 21). Through history, Hagar has been viewed as a problem — a textual interruption to God's covenant with Abraham. Paul's allegorization of her story in Galatians 4 further instrumentalizes her, comparing her and Ishmael with Sarah and Isaac as representations of slavery and freedom. Nevertheless, within the Genesis account, Hagar's experiences illustrate significant injustice. Hagar is a woman, an enslaved person, foreign, and forced to enter into reproductive service. Her body is treated as property, and her consent is disregarded. When she escapes into the desert while pregnant, the Hebrew verb *bārah* is identical to verbs employed in later narratives of liberation, including Israel's flight from Egypt.²⁰ Hagar's flight is an attempt to save her life. Her departure is not rebellion; it is survival.

Hagar is the first person in Scripture to receive a visit from a messenger of God (*malak* YHWH) who takes the form of a human. The messenger invokes Hagar's name—an honor denied to neither Abraham nor Sarah—and requests that she recount her story. During this meeting, Hagar's humanity is acknowledged through her being seen, heard, and named. Hagar is the only woman in Scripture to whom a divine promise is made regarding her descendants. The name of Hagar's son, Ishmael ("God hears"), bears witness to God's awareness of the cries of the marginalized. In Hagar's story, the relational Kingdom of God interrupts dehumanization with recognition, hearing, and naming.

The New Testament similarly exposes and transforms dehumanization. Mark 7:24-30 depicts a very disturbing interaction between Jesus and an unnamed Syrophenician woman. Jesus calls her a dog. There is no denying this, and there is no sanitizing this part of the text

²⁰Shaser, Nicolas J., "What's Hagar Got to Do with Israel's Exodus?" Israel Bible Center, www.israelbibletextcenter.com (September 8, 2022)

without destroying the text. Jesus' words are dehumanizing and exclusionary. However, the woman refuses to accept the assigned identity. Her response reverses the dynamics of the interaction and creates new terms for discussion. Consequently, she gains space within the Kingdom of God. The woman's daughter is healed. The passage illustrates a Kingdom that expands through confrontation, tenacity, and relationships, and not through exclusion.

Similar to the previous example, Luke 8:26-39 portrays a man who has lost his identity so completely that he is isolated from society and resides among the tombs, unclothed and unnamed. His identity has been totally consumed by "Legion," representing a complete loss of autonomy. A modern reader could identify his behavior described as a manifestation of mental illness—depression, trauma, or compulsive behavior—as opposed to demonic possession. Jesus asks, "What is your name?" and the question is not one of seeking factual information but rather a means of restoration. Restoration occurs through naming. The community's reaction to the healed man—frightened to reject him—demonstrates a preference for order and conformity over the possibility of transformation, a pattern repeated today in the stigma surrounding mental illness. Nevertheless, Jesus sends the man home as a witness, restored to himself and to his community.

In Matthew 5, the Sermon on the Mount provides the most expansive description of the relational Kingdom of God. At its center lie prayer and forgiveness, emphasizing the fundamental nature of relationships, both human and divine. The Golden Rule summarizes the ethical core of the Kingdom: reciprocal recognition and mutual dignity. Scripture repeatedly cautions against hubris—the desire to become like God by exerting control over others (Gen 3). Conversely, abundant life (John 10:10) is realized not through control, but through restored

relationships. Therefore, love is best understood as the difficult work of recognition, dialogue, and shared vulnerability.

The fracture of the Body of Christ and the denial of the *Imago Dei*, caused by stigma and dehumanization, especially towards individuals suffering from mental illness or culturally marginalized communities, are the consequences of making such distinctions. Think of the Shoah, Rwanda, Syria, etc. The Church has the opportunity to counter such divisions by embracing the relational Kingdom of God. Such an endeavor will require a serious analysis of Scripture, tradition, and power. It will not be easy, but it holds out hope of healing for those considered "other" and of the church's transformation. Fracturing of the Body of Christ and the denial of the *Imago Dei* become evident when stigma and dehumanization occur, particularly regarding people experiencing mental health challenges and culturally marginalized communities. Fracturing of the Body of Christ is a theological failure because it denies the full humanity of people whom God has created and redeemed. History has provided a number of tragic examples of the disastrous results of making distinctions based on group identity: the Shoah, the Rwandan genocide, and various current wars in regions like Syria are examples of what occurs when groups of human beings are constantly "othered."²¹

The church stands at a pivotal moment. The church has the potential to counteract these divides by demonstrating the relational vision of the Kingdom of God, a kingdom based on mutual regard, dignity, and reconciliation and not on hierarchy or exclusion. However, this will require a high level of commitment to scriptural engagement, to translating scripture carefully, and to examining power, particularly how ecclesial power has been used to cause harm rather

²¹Arendt, Hannah, *The Origins of Totalitarianism* (New York: Harcourt, Brace & Company, 1951).

than to bring about healing.²² Although the road ahead will be neither easy nor straightforward, it has the potential to bring about restoration for both those who have been harmed and for the church.

The Call to Healing

The church has traditionally been instrumental in providing comfort and assistance to people experiencing hardship. Nonetheless, the church has commonly failed in supporting individuals dealing with mental health issues. Rather than creating a culture of healing and hope, many ecclesiastical bodies have reflected the same stigmatizing attitudes found in the broader culture, leading to silence, shame, and rejection.²³ These failures have had serious consequences for both the individual and the church's mission in the world. Jesus' statement, "I came that they may have life and have it abundantly" (John 10:10), signifies a vision of restoration that is both holistic and relational. Abundant life in this sense does not simply refer to the individual's spiritual well-being but to the flourishing of the entire person. Mental illness can severely impede a person's capacity to realize this fullness, causing distortion in the person's perception of themselves, damaging their sense of agency, diminishing their feeling of belonging and hope, and leaving them burdened by feelings of shame, guilt, and deep emotional distress. Many of those who suffer from mental illness are further victimized by losing their social status and being viewed by both secular society and the church as inferior or second-class citizens.²⁴

The Church that wanted to be helpful

²²Jennings, Willie James, *The Christian Imagination: Theology and the Origins of Race* (New Haven, CT: Yale University Press, 2010).

²³Swinton, John, *Dementia: Living in the Memories of God* (Grand Rapids: Eerdmans, 2012).

²⁴Jamison, Kay Redfield, *An Unquiet Mind* (New York: Vintage, 1995).

The bishop of the New England Synod of the ELCA asked me to change the focus of my ministry and sent me for specialized training to become an interim minister. What that meant was that I would train to become a pastor to congregations that had been traumatized by an event or by a former pastor and were having difficulty moving forward in a positive direction. That meant that we would be moved around every six months to two years, depending what church I was called to and where it was. Once again, in hindsight, I should have understood the impact this would have on my family, especially Jon. It was a lot to pick up and move that often, especially for a young person with multiple diagnoses.

Jon started to be noticeably symptomatic when he entered middle school. Let's face it, middle school is tough for everyone. He started having major mood swings and spent a good amount of time lying in his bed. He would come to church with us every Sunday, but he missed a good amount of school. It was tough for him to manage his learning disabilities and still keep his friends, who started to make fun of him. It broke my heart to see him go through such struggles. He was feeling the effects of the loss of community and his life of isolation.

People at the church I was serving began to notice his down moods, which would take hold of him for weeks at a time. The Church was filled with loving people who wanted to help us. However, there was a group in the church that started calling Jon a name that stuck: Eeyore. Eeyore, the gloomy donkey in the Winnie the Pooh series, who always seemed to bring down whatever space he occupied. When I finally caught wind that people were doing this, I was devastated. He was trying so hard to fit in, but he couldn't even at church, the one place that was supposed to accept him. It left a terrible impression on Jon, and he stopped attending church. He now only attends during the high holidays because he understands how much it means to me.

Stigma functions as a theological failure within the church, treating individuals with mental health challenges as less than completely human. Dehumanization is a broader process occurring in secular society, reducing individuals to labels, threats, or burdens. Although different, both processes are highly destructive. They promote isolation, exacerbate depression, increase despair, and in some instances contribute to death.²⁵ Through separating people into subgroups, stigma and dehumanization eliminate the possibility of true relationship, limit love of neighbor, and fracture communities at their core. Culture influences these dynamics. Societies have worked together to systematically dehumanize those perceived as inferior or threatening. The killing of six million Jews during World War II; the mass killings of people by the Khmer Rouge in Cambodia; and contemporary violence driven by ethnic, religious, and/or political differences all illustrate how easily fear and ideology can overwhelm the constraints of morality.²⁶ Similarly, even within contemporary debates concerning immigration in the U.S., similar forms of othering and moral distance continue to manifest, illustrating the continued significance of these themes.²⁷

The ultimate result of stigma and dehumanization is separation—socially, morally, and spiritually. Counteracting this separation requires more than policy changes or clinical interventions; it requires a fundamental shift in how human beings view one another and form relationships. The church, based on a theology of incarnation and communion, is in a unique position to lead this change. But for the church to do so, it must rethink its purpose and vocation as God's people, called to accompany, not dominate.²⁸

²⁵Smith, David Livingstone, *Less Than Human: Why We Demean, Enslave, and Exterminate Others* (New York: St. Martin's Press, 2011).

²⁶Bauman, Zygmunt, *Modernity and the Holocaust* (Ithaca, NY: Cornell University Press, 1989).

²⁷Douglas, Kelly J. Brown, *Stand Your Ground: Black Bodies and the Justice of God* (Maryknoll, NY: Orbis Books, 2015).

²⁸Bonhoeffer, Dietrich, *Life Together*, trans. John W. Doberstein (New York: Harper & Row, 1954).

Fighting Mental Health Stigma by Embracing our Common Humanity

Perhaps the greatest obstacle to progress in mental health is the widespread stigma that people encounter when seeking help. Stigma acts as a major deterrent, keeping many people from receiving the support they need to address their mental health needs. Therefore, reducing stigma is a first step toward improved mental health outcomes and promoting human flourishing.²⁹

Over the past few decades, there has been increasing recognition of the role of agency in countering stigma, particularly in relation to mental health. According to Stuart, agency in this context refers to autonomy—the ability to share your story without oppressive social forces acting against you.³⁰ Autonomy implies the right to make informed decisions about your life, including the right to provide consent, maintain your private space, and show respect for your own cultural values and those of others. Autonomy alone, however, is insufficient. Excessively individualistic methodologies jeopardize the welfare of others and obscure the fundamentally relational essence of human existence.

Agency, on the other hand, focuses on the capacity of individuals to act upon their decisions and pursue meaningful goals while influencing the outcome of events within a web of relationships. Recognizing agency and autonomy as two distinct concepts provides a deeper understanding of empowerment—one that affirms the inherent value of each person while acknowledging dependence.³¹ In addition to asserting individual rights and agency, it is necessary to recognize individuals living with mental illness as fellow human beings rather than as

²⁹Corrigan, Patrick W., *On the Stigma of Mental Illness* (Washington, DC: *American Psychological Association*, 2005).

³⁰Stuart, Heather, “Reducing the Stigma of Mental Illness,” *Global Mental Health* 3 (2016): 17.

³¹Hauerwas, Stanle , *A Community of Character* (Notre Dame, IN: University of Notre Dame Press, 1981).

problems to be solved. Studies consistently demonstrate that when individuals interact with each other as equals (with humility, compassion, and openness), prejudice declines and authentic acceptance develops.³² Relational approaches to interaction are in line with Christian conceptions of community, in which every member is both a recipient and a provider of grace.

Finally, reducing mental health stigma requires cultivating empathy and understanding. Empathy and understanding are not solely acquired through sharing knowledge but through long-term, relational interactions with individuals whose experiences differ from those of the individual. Mental health should be a publicly accepted topic of discussion, spoken about with the same openness and freedom as physical health. Silence and secrecy serve only to perpetuate fear and miscomprehension.³³ A society — and a church — can only be considered humane to the extent that it acknowledges and honors the distinct humanity of its members.

Understanding contrasts sharply with ignorance, which, when combined with fear, facilitates dehumanization. Advocacy to reduce the social determinants of mental health and to decrease barriers to care demands comprehensive and inclusive advocacy. Comprehensive and inclusive advocacy involves advocating for policy change, fair distribution of resources, and the specific vulnerabilities of marginalized populations. Advocacy of this type cannot be accomplished in isolation; advocacy requires cooperation and collaboration among churches, clinicians, policymakers, and community organizations.³⁴

Ultimately, combating mental health stigma requires a multi-faceted approach to normalize mental health care as a part of overall well-being. Although systemic reform continues

³²Sen, Amartya, *Development as Freedom* (New York: Knopf, 1999).

³³Corrigan, *On the Stigma of Mental Illness*.

³⁴World Health Organization, *Mental Health Action Plan 2013–2030* (Geneva: WHO, 2021).

to be an urgent priority, constructive change can be initiated today in the areas of individuals' lives, work, worship, and care. In these areas, both individuals and institutions can develop and practice the actions and behaviors that restore dignity, empower agency, and reflect the healing possibilities of shared humanity.

Chapter 2: A Path to Healing

When I was ten years old, I fell off my bicycle on the town's bike path, which I imagined was my little section of the Tour de France. I was riding at what felt like my top speed, so you can imagine how surprised I was when I hit a small stone and flipped over the handlebars, landing hard on my right wrist, which I had extended to prevent serious injury. As soon as everything stopped, I looked at my wrist and knew it was broken. This wasn't my first rodeo. Up to this point, I had broken many bones in different ways. Having broken both of my wrists before, I knew this was a serious break. I righted my bike, placed my arm between the handlebars, and started walking home.

My mother was an expert at caring for my injuries. She agreed with my assessment of the situation. She helped me into the car and drove me to the emergency room at Shore Memorial Hospital. The orthopedic doctor showed my X-rays on the lightbox and confirmed everyone's diagnosis: my wrist was broken. I let out a sigh that revealed I was upset at the thought of being in a cast for at least six weeks. I grumbled that it would take forever to heal and questioned why I needed to wear a cast anyway. The doctor asked me what I knew about healing. I realized that I didn't understand the healing process at all. I had only considered it to be a painful process I would have to endure until they removed my cast and I could get back on my bike. What that doctor told me that day shaped my understanding of healing and started my view of health as a whole. Yes, I did contemplate such things at this young age.

The doctor explained that when a bone breaks, it is no longer whole or strong. The disconnection can cause further damage to the bone's health. The doctors begin the process of setting the fracture so the connections can be realigned. Once the bone is set, it is stabilized to strengthen the connection and foster healing and growth. Under ideal conditions, the body heals

itself over time. Comparing a bone fracture to mental health challenges is an oversimplification. However, there are similarities in how connection can facilitate healing in cases involving mental health or other situations marked by dehumanization and stigma.

“God's abundant life is not the kind of life that is free of tears, but it is the kind of life that has someone to dry your tears and guide you to those green pastures.”³⁵ Relationality is fundamental to both human existence and to the process of theological reflection. According to John Swinton, relationality includes all ways that humans come to know—cognitively, bodily, and communally. Therefore, everything that we come to know about ourselves, other humans, and the world is not merely acquired or stored away but fundamentally shared with God. To know, to be known, and to communicate are never neutral actions. Rather, these processes are fundamentally relational actions, shaped by love, risk, and presence. Although many different disciplines recognize the value of relationships, theology is unique in its examination of how relationships define meaning, truth, and practice. By assessing both the presence and absence of relational depth in human interactions, this chapter will argue that relationality is essential to understanding theology and to human flourishing.

Practical Theology: A Framework for Analysis

By nature, all parish pastors are practical theologians. They walk with people through all stages of life, through the highest joys in life to the depth of sorrow, offering guidance and theological interpretation to life circumstances. Practicing theologians rely on lived experience. Practical Theology affirms that theology is not just studied but lived out. Parish-based pastors do not merely perform their personal expressions of faith; they also inform the theological imagination of their congregations through their practices of care, discernment, and judgment.

³⁵Swinton, John, *Becoming Friends of Time: Disability, Timefulness, and Gentle Discipleship* (Waco, TX: Baylor University Press, 2016).

Judgment in parish-based ministry is not performed in isolation. Rather, it is communal, contextual, and relational. It is founded in relationships that are thick, rich, and caring. This type of relationship takes time, nurture, and work. Sadly, people will often opt for the opposite. Instead of thick and rich, they will pursue thin relationships that require the minimum effort.

Thin Conversations

Thin conversations are those that focus on providing information or completing tasks and are limited in scope and rarely develop in a way that contributes to the development of humans. Thin conversations lack substance or depth. Thin conversations may suffice for coordinating logistics but are insufficient for developing the kinds of relationships for which humans were created. Thin conversations are particularly prevalent in mental health treatment. In therapeutic settings, thin communication often signifies a failure to develop genuine human connection. When a client expresses vulnerability, and the therapist responds superficially, the results can include feelings of isolation, rejection, or harm. Communication without presence communicates efficiency, not care; it communicates distance, not solidarity. I experienced such behavior with my son for years. When he was younger, I attended his visits with his clinicians, who at the time I believed were only pill dispensaries. During these visits, clinicians often failed to ask relational questions. Often, the visit consisted of asking how things were 'going' and then handing us a prescription for medications to be filled. Often the prescription was already filled out before we even arrived. We questioned why we were even doing there for 'medical care,' except that I was so desperate to help my son. I would take the prescription, make our next appointment, and leave.

Historically, mental health treatment included extended periods of reflective dialogue—dialogue that unfolded slowly and allowed for space for silence, ambiguity, and the

expression of emotion. Today, culture promotes rapidity, brevity, and efficiency. These trends towards surface-level interactions diminish the social and therapeutic bonds essential to psychological health. Although therapists may claim to be present for clients, the conversations in therapy are typically without emotional resonance. While not every conversation needs to be profound, relying on thin communication for extended periods of time raises an essential question: Can communication without presence be called a conversation? Studies have demonstrated a consistent correlation between superficial communication and increased loneliness and isolation. Developing connections requires establishing a continuity of interaction over time and a mutually experienced sense of being together with another person. Thin conversations in therapeutic settings impede the development of therapeutic relationships. Successful treatment requires developing a sense of trust, vulnerability, and open communication between the therapist and client. When communication remains superficial, clients may avoid expressing painful material or may not feel safe doing so. Either way, healing is hindered.

Culture significantly influences communication practices. In highly individualized cultures, surface level communication is common and is promoted by societal expectations of emotional self-reliance and strict boundaries between public and private life. These cultural norms promote communication that is intended to be limited, guarded, and emotionally superficial. Thus, intentional practices are necessary to cultivate healthier communication, including increasing emotional awareness, creating a safe environment for sharing emotions, practicing active listening, exhibiting empathy, and using open-ended questions. There is growing research that indicates the manner in which people communicate is at least as important as whether they communicate at all. Avoiding meaningful dialogue, once considered a protective mechanism for emotional safety, now correlates with heightened anxiety, depression, and social

isolation. As mental health continues to grow as a public concern, consideration must be given to the communicative environments in which care is provided. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) emphasizes that effective communication is essential for accurate diagnosis, successful treatment, and recovery. Thin communication can be detrimental to the therapeutic relationship—especially for clients who are relationally vulnerable.³⁶

Deep or Thick Conversations

In contrast, John Swinton describes "deep" or "rich" conversations as essential for the development of relationships, community, and belonging. Deep conversations are intellectually and emotionally stimulating; they involve vulnerability, empathy, and active listening. Unlike thin conversations, rich conversations involve not merely exchanging information but encountering. Encounter allows for the possibility of two individuals being genuinely present with each other. For Swinton, rich conversations are inherently theological because they demonstrate the relational practices that are at the center of Christian community.³⁷ Deep conversations create opportunities for friendships to develop, for trust to be established, and for recognition to occur. Deep conversations create an opportunity for individuals to be perceived not as problems to be solved, but as individuals with stories worth hearing. From a Christian perspective, the depth of such conversations holds theological significance: Community is not optional for discipleship; community is essential to discipleship.

The theological basis of rich conversations is grounded in the relational nature of God. God exists eternally as Father, Son, and Holy Spirit — an ongoing communion of mutual presence and love. Therefore, dialogue, engagement, and attentiveness are not secondary to

³⁶American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Washington, DC: APA, 2013).

³⁷Swinton, *Finding Jesus in the Storm*, p. 91.

God's action in the world but reflect the very nature of God. Rich conversations also serve to counteract stigma. Social narratives frequently exclude individuals and families affected by mental illness; they promote fear and isolation. However, communities formed through deep listening can become spaces of trust, recognition, and healing. Compassionate dialogue can bridge the relational gaps in pastoral, clinical, and communal settings, facilitating restoration and wholeness.

The clinician-patient relationship is the most important relational bond in clinical settings. Trust, shared meaning, and interpretation are essential components to the process of assessment, diagnosis, and recovery. Rich conversations stimulate both intellectual and emotional responses in participants; they require attentiveness to what is stated as well as what is left unstated. The current models of psychiatric care emphasize the importance of person-centered approaches. Tools like the Cultural Formulation Interview facilitate clinicians' understanding of patients within the context of their lived experiences and cultural narratives.³⁸ The CFI is one of the core understandings of the DSM-5. In an era saturated with distractions and digital communication, such practices deliberately resist fragmentation by emphasizing relational presence. The psychoanalytic concept of cathexis—the emotional energy invested in a person or relationship—helps us understand such conversations.³⁹ Conversations that are marked by cathexis exhibit vulnerability, empathy, and sustained attention. Meaning is developed not from isolated statements but through engagement with tone, silence, imagery, and emotional resonance.

³⁸Aggarwal, Neil Krishan, Chen, Daniel, Lewis-Fernández, Roberto, and Guarnica, Peter. 2023. "Patient identity narratives through the cultural formulation interview in a New York City outpatient clinic." *Medical Anthropology Quarterly* 37: 280–295.

³⁹Freud, Sigmund. "Instincts and Their Vicissitudes," in *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol. 14 (London: Hogarth Press, 1957)

Engaging with individuals experiencing mental health challenges carries important theological significance. Ubuntu—an African humanist philosophy—offers a complementary relational framework. Ubuntu is commonly expressed as "I am because we are."⁴⁰ Ubuntu emphasizes the interconnectedness of all human beings, mutual recognition, and shared humanity. These values align closely with the practice of rich conversations, which emphasizes community identity over individualism. When thoughtfully applied to mental health care, pastoral practice, and community development, Ubuntu encourages empathy and collective responsibility. Its implementation requires cultural sensitivity, particularly in cultures that assume individualism; however, the relational vision offered by Ubuntu holds enormous potential for healing and communal support. If God is fundamentally relational, as articulated in Trinitarian theology, then the deep relational conversation demonstrates God's own relational life. Therefore, human dialogue can be viewed as a site of communion, reflecting the relational dynamic between God and humanity.⁴¹ Deep conversations also help the community stay strong. They represent the "talking cure" identified at the intersection of psychology and spirituality, where healing is facilitated by relational presence, not isolation.⁴² Some contemporary thinkers envision therapeutic practices becoming increasingly communal, rather than solely private.

To be engaged in deep conversations requires vulnerability—not as a performance, but as genuine human openness. Brené Brown describes vulnerability as the source of connection and courage.⁴³ Vulnerability in deep conversations reduces stigma by promoting empathy and shared humanity—particularly when discussing mental health. Deep conversations represent what it

⁴⁰Tutu, Desmond, *No Future Without Forgiveness* (New York: Doubleday, 1999)

⁴¹Buber, Martin, *Between Man and Man*, trans. Ronald Gregor Smith (New York: The Macmillan Company, 1948), p. 17.

⁴²LaCugna, Catherine Mowry, *God for Us: The Trinity and Christian Life* (San Francisco: HarperCollins, 1991). Buber,

⁴³Brown, Brené, *Daring Greatly* (New York: Gotham Books, 2012)

means to follow Christ through radical presence, compassion, and attentiveness in a broken world. For many individuals experiencing mental illness, such relationships provide a rare sense of belonging and spiritual purpose. Ultimately, the distinction between thin and thick conversations represents core theological convictions: God is relational, and humans are made in God's image. When intentionally developed, deep relational practices provide the foundation for healing, community, and authentic human flourishing.

Ubuntu as a Relational Foundation

I first heard about Ubuntu in the 1980s and 1990s in my role as a Lutheran pastor. The ELCA National Youth Gatherings sponsored by our denomination were large events (at times over 40,000 youth) where thousands of high school students came together to explore a shared theme through worship, education, and group discussion. Over the years, these gatherings provided young people with a unique opportunity to imagine and experience theology and to learn how to live out the values of Christ in their daily lives. At the 2000 Youth Gathering, Archbishop Desmond Tutu spoke and taught us about Ubuntu.⁴⁴ He introduced us to a philosophy that was new to many of us in the Western church, and his words touched both the hearts and minds of many young people. Many took the ideas he presented back to their churches and families, and by the end of 2003, Ubuntu would become the entire focus of the next National Youth Gathering. That it was chosen as the theme indicated that it was meaningful not only to young people but also capable of shaping how Christians understood themselves and their communities.

⁴⁴Tutu, Desmond, *No Future Without Forgiveness* (New York: Doubleday, 1999), 34-35.

Ubuntu originated in the Nguni Bantu languages of Southern Africa and means “humanity to others” or “I am because you are.”⁴⁵ Ubuntu does not offer a strict definition but is instead a philosophical lens for understanding how we exist in the world.⁴⁶ It stresses our interdependence, the interconnectedness of humanity, and our duty to care for one another.⁴⁷ Ubuntu suggests the necessary conditions for all people to flourish—care for others, hospitality, dignity, and reciprocity.⁴⁸ Scholars have written about Ubuntu in many different ways, yet the consensus is that it concerns the ethics of community and recognizing the sacred in every human being.⁴⁹

Ubuntu is a philosophy that seeks to enhance the overall well-being of individuals and the world as a whole. Although it is rooted in the experiences of people living in Africa, the influence of Ubuntu has grown globally as the world becomes more interested in human rights, restorative justice, and post-conflict reconciliation.⁵⁰ Ubuntu can be successful anywhere because its fundamental premise is that human beings benefit from relationships.⁵¹ Though Ubuntu is expressed differently depending on the context, culture, and history of the community that expresses it, the basic premise that human beings grow and thrive in healthy relationships is universal.⁵² Furthermore, Ubuntu does not limit the benefits of healthy relationships to specific

⁴⁵Shutte, Augustine, *Ubuntu: An Ethic for a New South Africa* (Pietermaritzburg: Cluster Publications, 2001), 12-15.

⁴⁶Eze, Michael Onyebuchi, “Ubuntu: a Communitarian Response to Liberal Individualism?” *South African Journal of Philosophy* 29, no. 4 (2010): 360-374.

⁴⁷Ramose, Mogobe B., *African Philosophy through Ubuntu* (Harare: Mond Books, 1999), 49-52.

⁴⁸Mentz, Thaddeus, “Ubuntu as a Moral Theory and Human Rights in South Africa,” *African Human Rights Law Journal* 11, no. 2 (2011): 532-559.

⁴⁹Tinyiko Sam Maluluke, “Ubuntu and the Law in South Africa,” *Journal of Law and Religion* 16, no. 2. (2001): 373-390.

⁵⁰Eze, Michael Onyebuchi, “Ubuntu: A Communitarian Response to Liberal Individualism?” *South African Journal of Philosophy* 29, no. 4 (2010): 360-374.

⁵¹Metz, Thaddeus, “Ubuntu as a Moral Theory and Human Rights in South Africa,” 532-559.

⁵²Ramose, Mogobe B., *African Philosophy through Ubuntu* (Harare: Mond Books, 1999), 49–52.

regions of the world. Instead, Ubuntu sees the richness of human connection as a gift available to all people regardless of race, nationality, or culture.⁵³

Ubuntu is increasingly recognized as an effective way for communities to build strong relationships that ultimately lead to healing and reconciliation.⁵⁴ Communities using Ubuntu recognize it as a moral framework for establishing strong relationships and promoting the well-being of all members. Ubuntu is not simply a method for creating social unity, but it also serves as a foundation for developing the skills needed to reconcile differences within a community.⁵⁵ In many African communities, Ubuntu is a key principle in the moral teachings that guide efforts to establish peace and reconciliation after periods of violence.⁵⁶ For example, in South Africa, Archbishop Desmond Tutu's Truth and Reconciliation Commission was guided by the principles of Ubuntu.⁵⁷ The commission's purpose was to document the crimes committed against people under the apartheid regime and to allow those who were harmed to speak publicly about their experiences.⁵⁸ Ubuntu formed the basis of the commission's understanding of justice and morality. The commissioners believed that if perpetrators could understand how their actions affected victims, and if victims were given space to express their pain and loss, healing and rebuilding could begin. Ubuntu provided the commissioners with a moral vocabulary that allowed them to carry out their mission in a way that went beyond simply documenting crimes.⁵⁹ Ubuntu helped them see the humanity in both victims and perpetrators. Ubuntu is a powerful

⁵³Shutte, Augustin, *Ubuntu: An Ethic for a New South Africa* (Pietermaritzburg: Cluster Publications, 2001), 12-13.

⁵⁴Maluleke, Tinyiko Sam, "Ubuntu and the Law in South Africa." 373-390.

⁵⁵Ibid.

⁵⁶Ibid.

⁵⁷Truth and Reconciliation Commission of South Africa, *Final Report*, vol. 1 (Cape Town: Juta:1998), 125-128.

⁵⁸Ibid.

⁵⁹Ibid.

counter-narrative to individualism, technological rationality, and dehumanizing systems.⁶⁰

Ubuntu encourages societies to assess their moral health based on the quality of their relationships and the dignity afforded to their most vulnerable members. Ubuntu is not only a philosophy; it offers an ethical vision and a constructive theological perspective for understanding community, justice, and reconciliation in a broken world.⁶¹

Often, Ubuntu has been used to promote mental wellness and enrich human lives at all levels. As Ubuntu is developed into a moral philosophy, it can be applied universally; although its roots lie in specific African cultures, its message about the positive effects of relationships can be adapted into various cultures and geographic locations.⁶² Ubuntu recognizes that there is great value in developing relationships around the globe; in doing so, it rejects the idea that personal fulfillment comes only from a few areas of the world.⁶³ Ubuntu promotes the view that human lives are enriched globally due to the diversity of cultures, races, and nations and therefore views diversity as a gift and not a threat. Ubuntu is now seen by many as a model for building social unity and as a way for communities to develop their capacity to bring about reconciliation in tangible forms. In many African countries, Ubuntu is the philosophical basis for the moral values of society's peace-building efforts and reconciliation.⁶⁴ For example, in South Africa, Ubuntu was an important part of the moral foundation for the Truth and Reconciliation Commission (TRC). The TRC was established to create a historical record of human rights violations and to provide opportunities for those who had suffered as a result of these violations to tell their stories.⁶⁵ Ubuntu provided the moral foundation for the TRC to move toward a more

⁶⁰Ibid.

⁶¹Tutu, Desmond, *No Future Without Forgiveness*, 34–35

⁶²Shutte, Augustine, *Ubuntu: An Ethic for a New South Africa*, 12–15.

⁶³Tutu, Desmond, *No Future Without Forgiveness*, 34–35.

⁶⁴Shutte, Augustine, *Ubuntu: An Ethic for a New South Africa*, 12–15.

⁶⁵Eze, Michael Ontyebuchi, "Ubuntu," 364–370.

just society in the future. Ubuntu is a moral framework that encourages the development of relationships and promotes the belief that an individual's humanity is connected to the humanity of others. Ubuntu provides a moral language to help support the TRC process beyond political expediency. Ubuntu can be seen as a counter-narrative to individualism, technocracy, and dehumanizing systems. Ubuntu encourages societies to look at their own moral condition based on the quality of their relationships and the dignity they afford to their most vulnerable members. Ubuntu is not only an ethical vision but also a constructive theological vision for a broken world to contemplate community, justice, and reconciliation.⁶⁶

Ubuntu & Thick Conversations: A Relational Theology of Personhood

Ubuntu and "thick descriptions" and John Swinton's theology of pastoral care and practical theology share a fundamental assumption about human existence: humans exist fundamentally relationally and understand people fully only when attentive to all aspects of lived experience. Even though Ubuntu is rooted in the philosophy of sub-Saharan African morality and Swinton's thick description framework comes out of the theology of today's practical theology and pastoral care, both reject reductionist individualism and have articulated a relational theory of personhood built upon communal interconnectedness, depth of story, and mutual acknowledgment. Ubuntu is often expressed by the phrase "I am because we are." This statement makes an ontological claim much greater than a simple exhortation toward ethics. Personhood is not a characteristic of the autonomous self but exists in its constitution as a result of relations. To exist as a human being means to be part of a reciprocal web of belonging where dignity, identity,

⁶⁶ Ibid.

and thriving are mutually sustaining. Therefore, Ubuntu rejects modern Western individualism and asserts that relationality is prior to and constitutive of the self.⁶⁷

Swinton's concept of "thick description," which he has fully articulated in *Finding Jesus in the Storm*,⁶⁸ is based upon the use of anthropology to criticize "thin" accounts of human experience—accounts that reduce people to diagnostic labels, symptomatic behaviors, or abstractions of theological propositions.⁶⁹ Thin descriptions commonly obscure the complexities of the lived experiences of those who live with mental illness. Swinton advocates for "thick" attention: a deliberate practice of listening to people that places them within their histories, cultures, relationships, and theological stories. Such attention recognizes that meaning is contained in context and that human suffering can only be understood adequately in the relational world in which it occurs.

It will become apparent that there is a parallel between Ubuntu and thick description in their shared refusal of atomistic anthropology. Ubuntu posits that one realizes one's humanity only through the humanity of others.⁷⁰ Similarly, thick description asserts that the process of understanding a person involves entering the relational matrix that comprises the person's identity. Both Ubuntu and thick description portray the self as dialogical (relational) rather than solitary. The knowledge of another person is not obtained through detached observation but through participation. The process of understanding thus becomes an ethical and communal practice. Furthermore, both Ubuntu and its thick description contain theological implications. Ubuntu's focus on shared humanity corresponds with Christian doctrines of the image of God

⁶⁷Ramose, Mogobe B., *African Philosophy through Ubuntu* (Harare: Mond Books, 1999), 49–66.

⁶⁸Swinton, John, *Finding Jesus in the Storm*.

⁶⁹Swinton, John, "From Bedlam to Shalom: Towards a Practical Theology of Human Nature, Interdependence and Mental Health," *Practical Theology* 1, no. 1 (2008): 91–110.

⁷⁰Swinton, *Finding Jesus in the Storm*, 34–58.

and the body of Christ, in which every person's dignity is recognized as being irrevocably tied to communal membership.⁷¹ Swinton's approach expands upon this theological anthropology by showing how narrative attention is a reflection of the incarnational logic of Christian faith: just as God encounters humanity in particular historical and bodily ways, so also must communities attend to each other in specific concrete ways. Thick conversations—those characterized by patience, vulnerability, and contextual awareness—become methods through which ecclesial bodies demonstrate relational fidelity.

In practical terms, the integration of Ubuntu with thick description encourages churches and care systems to avoid reductionist modes of speaking and acting. While diagnostic clarity and doctrinal accuracy are important, without relational depth they may distort the very people they intend to serve. Ubuntu reminds communities that flourishing is communal, while thick description offers a methodological discipline for enacting that conviction. Together they advocate a relational theology of personhood in which listening becomes an act of solidarity and understanding becomes a common moral endeavor.

Ubuntu and Swinton's thick description meet at a common anthropological and theological horizon: humans exist as relational entities, and faithful understanding requires contextual, narrative, and communal attentiveness. When integrated, these two traditions provide a rich corrective to reductionist individualism and encourage Christian communities to engage in the practices of deep listening, mutual recognition, and shared becoming. The holistic view of health by John Swinton goes beyond the traditional biomedical model of health by adding meaning and spiritual well-being to its definition. The traditional biomedical model focuses on

⁷¹Ibid.

the treatment of disease and alleviating physical symptoms. Swinton, on the other hand, thinks of health as a state of overall well-being in which the body, mind, and spirit are all in balance. According to Swinton, health is much more than just the absence of disease; it also encompasses the individual's sense of connection spiritually, their purpose and their ability to feel a sense of wholeness and existence. Traditional healthcare frameworks typically overlook or marginalize these elements.

Swinton contends that illness and health cannot be comprehensively understood without considering the spiritual dimensions and the individual's subjective experiences of existence. He criticizes the conventional approach of segregating physical symptoms and addressing them independently from other dimensions of the individual, including psychological and social factors. He encourages the development of healthcare models that incorporate spirituality, presence, and a patient-centered way of making meaning as well as the use of biological treatments, creating a healing environment that attends to the whole person. Swinton also challenges the epistemology of traditional medicine by promoting the inclusion of different knowledge systems and healing practices that recognize and honor the spiritual and relational nature of health. Integrating the various dimensions of health allows for an interdisciplinary and integrative approach to healthcare that respects the spiritual and cultural context of each individual and provides for a more holistic experience of care compared to traditional methods that prioritize standardized and quantifiable biomedical evidence.⁷² In addition, this approach supports the emerging field of integrative medicine, which seeks to provide a balance between

⁷²Wüthrich-Grossenbacher, U., "The Need to Widen the Concept of Health and to Include the Spiritual Dimension." *International Journal of Public Health*. 2024 Apr 4.

traditional biomedicine and alternative therapeutic practices to address the complete well-being of an individual.

Biblical Hospitality

Biblical hospitality is welcoming the stranger as an expression of God's nature. Hospitality is a significant virtue in scripture, and it is a fundamental part of God's nature. Throughout the Bible, God commands his people to welcome the stranger and to care for them. This includes those who are vulnerable and provides space for others. Biblical hospitality is more than simply being a gracious host or a pleasant guest. It is an expression of the faithful relationship that exists between God and his people through covenant. It is shaped by the past, motivated by justice, and fulfilled in Christ.

The biblical narrative begins to frame hospitality as participation in God's covenantal promise when Abraham welcomes three strangers near the oaks of Mamre in Genesis 18. Abraham's actions unfold with haste and generosity: water for washing, rest under the tree, freshly baked bread, and a young calf. Abraham did not simply allow the strangers to stay at his home; he honored them. Through his hospitality, Abraham encountered the Lord and received the promise of Isaac. Thus, hospitality becomes the location of divine revelation. Israel's legal and prophetic traditions expand upon the theme of hospitality and connect it to the collective memory of the people. The command to love the stranger is based on Israel's own experience of being a stranger: "You shall also love the stranger, for you were strangers in the land of Egypt" (Deut. 10:19). The people's historic experience of alienation serves as the basis for their current conduct. Hospitality is, therefore, an act of solidarity born of remembered suffering. The Holiness Code in Leviticus 19 expands this ethic further and commands equal treatment of the foreigner: "The stranger who resides with you shall be to you as the citizen among you; you shall

love the stranger as yourself" (Lev. 19:34). Here, hospitality is transformed beyond mere charity into justice. The stranger is not only provided assistance but also integrated into the community.

In the New Testament, hospitality is given greater Christological meaning. The incarnation itself can be viewed as divine hospitality: "the word became flesh and dwelt among us" (John 1:14). In Luke, Jesus consistently transgresses social boundaries—eating with tax collectors, touching the unclean, and receiving women, children, and sinners into his fellowship. Table fellowship becomes a symbol of the kingdom of God. The parable of the good Samaritan (Luke 10:25-37) radicalizes the idea of hospitality even further. The neighbor is not defined by proximity or ethnicity but by compassion. The Samaritan's merciful action redefines holiness as relational commitment rather than ritual separation. Hospitality becomes a practice of boundary-crossing love.

Jesus also identifies himself with the stranger in the eschatological vision of Matthew 25: "I was a stranger, and you welcomed me" (Matt. 25:35). Hospitality in this context is eternal. To receive the marginalized is to receive Christ Himself. Hospitality, therefore, is sacramental; it mediates the presence of the risen Lord. The early Christian communities established hospitality as a hallmark of discipleship. The author of the Epistle to the Hebrews encourages believers: "Do not forget to entertain strangers, for by so doing some have entertained angels unawares" (Heb. 13:2). This explicit reference to Abraham establishes continuity with Israel's history. Similarly, Romans 12:13 commands believers to "welcome strangers." In a world governed by patronage and exclusion, Christian hospitality reverses social hierarchies. House churches serve as sites of radical inclusion where Jews and Gentiles, slaves and freemen, males and females gather together as one body (Gal. 3:28). The Didache and other early Christian documents demonstrate that hospitality to traveling teachers and the poor was a defining aspect of ecclesiastical identity.

Hospitality, therefore, was not an optional act of charity but a participation in the communion (*koinonia*) of the Holy Spirit.

There are three interconnected theological affirmations that underlie biblical hospitality: Firstly, hospitality represents humanity's reflection of the *Imago Dei*. Since all individuals reflect God's image (Genesis 1:27), every encounter has inherent value. When we welcome another person, we recognize their God-given value. Secondly, hospitality mirrors God's redemptive action. Scripture repeatedly depicts God as the host who prepares a table (Psalms 23:5) and invites the outcasts to the feast (Isaiah 25:6). Redemption itself is portrayed as a banquet. The Eucharist expresses this divine hospitality: Christ gives Himself as bread for the life of the world. Lastly, hospitality foreshadows the eschatological kingdom. The vision of Revelation concludes with a multitude from every tribe and language standing before the throne (Revelation 7:9). The church's present practice of welcome is a precursor to that redeemed future.

In today's environment characterized by migration, division, and social fragmentation, biblical hospitality calls communities of faith to resist fear and exclusion. Biblical hospitality calls the church to become a witness of God's reign by practicing the behaviors of welcome, listening, shared meals, and advocating for justice. This form of hospitality is expansive. It requires vulnerability, a sharing of resources, and a willingness to relinquish control. However, Scripture affirms that in welcoming the stranger, we experience God. Hospitality becomes both a spiritual discipline and a public declaration of the fact that grace comes before merit, and that belonging occurs prior to behavior.

Biblical hospitality is not only an ethical guideline but also a call to a theological way of living. Based on God's covenant with Israel, practiced in the ministry of Jesus, and empowered by the Spirit in the lives of the church's members, hospitality reveals the heart of the Gospel. To

welcome the stranger is to share in God's own life of self-giving love. In our fragmented world, such welcome becomes a taste of the kingdom in which all will gather at God's table.

Hospitality is an important part of the Christian tradition of receiving others in love, offering welcome, generosity, and openness to the stranger. However, Lloyd Lee Wilson goes beyond simply seeing hospitality as a form of welcome or as an expression of charity and generosity in his book *Radical Hospitality: Benedict's Way of Love*. He sees radical hospitality as For Wilson, the Benedictine way of life serves as a model for Christian living in today's fragmented societies, rooted in the transformation that occurs when we live according to the Rule of Benedict of Nursia. According to Wilson, hospitality is a central part of what it means to be faithful as a community in the Rule of Benedict. Therefore, guests are to be welcomed as Christ. While this act may seem like a simple or even a sentimental gesture, it is actually a call to humility, stability, attentiveness, and shared commitment. Radical hospitality requires transformation of both the host and the guest.

Radical hospitality in conjunction with Ubuntu

The church can reach out to and include people with mental health disorders by applying the principles of Ubuntu through radical hospitality, emphasizing interconnectedness, compassion, and community support. Ubuntu's core philosophy of "I am because we are" naturally encourages the church to recognize the inherent dignity and worth of every individual, including those with mental health challenges, fostering an environment of belonging and acceptance rather than stigma or exclusion. First, the church can adopt an inclusive mindset that welcomes people with mental health challenges unconditionally, recognizing them as full members of the community. This aligns with radical hospitality, which calls for genuine kindness and acceptance, even toward those who may be marginalized or misunderstood. Such acceptance

reduces stigma by encouraging empathy and reframing mental health as a shared human experience rather than a personal failing.⁷³

Second, the church can do outreach work that connects faith-based support with professional mental health care. Collaborative models like Clergy Outreach and Professional Engagement (C.O.P.E.) illustrate how clergy and mental health professionals can work together to ensure individuals receive holistic care tailored to both their spiritual and mental health needs.⁷⁴ This integrated approach reflects Ubuntu's value of collective responsibility and shared care. Churches can create safe and supportive spaces within their communities where people experiencing mental health difficulties can find acceptance and practical help. This may include support groups, educational programs to raise awareness about mental health, and social activities that foster connection and reduce isolation. By leveraging existing church structures as community hubs for mental health promotion and intervention, churches embody Ubuntu's emphasis on solidarity, mutual respect, and caring relationships.

Addressing mental health stigma explicitly through Ubuntu-informed education and dialogue helps transform attitudes and encourages people to seek help without fear or shame. The church can use its influential role in socioeconomically disadvantaged and minority communities—where mental health stigma is often more pronounced—to promote understanding and resilience through spiritually grounded yet evidence-based messaging.⁷⁵

⁷³Wilson, *Radical Hospitality*.

⁷⁴Milstein, G., Currier, J.M., Dent, C., McKnight, M., Eckert, D. Eckert, & A. Manierre, "COPE: Community Outreach & Professional Engagement - a Framework to Bridge Public Mental Health Services with Religious Organizations." *Frontiers in Psychiatry*, 2025.

⁷⁵Richardson, BT, Jackson, J., G Marable, J Barker, H Gardiner, L Igarabuza, M Leasy, E Matthews, Y Zisman-Ilani. The Role of Black Churches in Promoting Mental Health for Communities of Socioeconomically Disadvantaged Black Americans. *Psychiatric Service*. 2024 Aug 1

The church is beyond the age of people simply wandering in to see what is going on. Therefore, practical outreach and assertive community engagement efforts ensure that people with severe or chronic mental health conditions are not left isolated but actively included and supported in church life. This outward movement to meet people where they are echoes the Ubuntu call for active participation and interconnectedness beyond passive kindness.⁷⁶ Applying Ubuntu through radical hospitality means the church acts as a compassionate community that embraces, supports, and collaborates for the holistic well-being of those with mental health disorders, integrating spiritual care with professional mental health resources while nurturing dignity, acceptance, and belonging.⁷⁷

Health

What is health in every sense of the word? The World Health Organization (WHO) defines health as "the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."⁷⁸ This broadly used definition extends the idea of health far beyond the realm of pathophysiology. Health is not merely the absence of disease; it encompasses flourishing in various aspects of our lives. In addition to recognizing physical health as part of the triad of health, the WHO also identifies mental and social well-being as integral parts of health. This multi-dimensional view of health, while providing a rich understanding, also creates challenges. Established biomedical methods can quantify numerous facets of physical health; however, quantifying mental and social well-being presents greater challenges. However, the inclusion of these dimensions of health reflects a growing recognition

⁷⁶Tom Burns, and Mike Firm, *Assertive Outreach in Mental Health: A manual for practitioners* (Oxford, 2002; online edn, Oxford Academic, 31 Oct. 2023),

⁷⁷Ibid.

⁷⁸World Health Organization, *Constitution of the World Health Organization* (1948).

that one cannot fully understand human health outside of psychological and relational reality.

Physical health is defined as the normal biological and physiological functioning of the body. The physical aspect of health refers to the proper working of bodily systems, the presence or absence of disease, and one's general physical capability. Historically, this aspect of health has received the most scientific and medical research attention and has influenced how the public views what constitutes health. Because physical health indicators such as blood pressure, biomarkers, and imaging studies, among others, are generally easier to measure than psychological or social indicators, they have often driven both clinical practice and health policy. While the focus on physical health has led to numerous advances in diagnostics and treatments, it often neglects less apparent aspects of human well-being.

Mental health is defined as psychological, emotional, and cognitive well-being. The WHO includes affect regulation, stress management, perception, memory, and the ability to connect with the world around us as examples of aspects of mental health. Current scientific research examines the biological, psychological, and social causes of mental illness, including neurochemical processes, trauma responses, environmental stressors, and the protective role of social support.

In previous reports, the WHO has stressed the need for global attention to mental health needs. The World Mental Health Report: Transforming Mental Health for All calls for major changes in the way countries organize their mental health care systems. Drawing upon empirical data, global case studies, and the experiences of those affected by mental illness.⁷⁹ The report emphasizes the importance of improving mental health care systems, creating social

⁷⁹World Health Organization, *World Mental Health Report: Transforming Mental Health for All* (2022).

environments that support mental health, and increasing society's commitment to mental health and well-being. Despite a growing awareness of mental health issues, large disparities exist between mental health needs and available services around the world. Mental health is a fundamental component of human flourishing, regardless of culture or context.

Social well-being refers to the social relationships and structures that govern how humans interact with each other. There is considerable evidence that social connections impact both physical and mental health in powerful ways. Humans are fundamentally relational; social isolation is linked to higher rates of morbidity and mortality.⁸⁰ Social connection can be considered across three dimensions: structure, function, and quality of life. Structure refers to the number and types of relationships and how often individuals interact. Function refers to the type of support individuals receive from others and the extent to which they provide support. Quality of relationships refers to the quality of interactions—whether positive (supportive, loving, satisfying) or negative (strained, conflicted, violent). The absence of supportive social connections (isolation, lack of intimacy, and relational conflict) correlates with poor health outcomes and earlier mortality. Social health is not an option for enhancing overall health; rather, it is an essential factor in determining overall health and wellness.

The WHO definition provides a unified conceptualization of health that acknowledges the interconnectedness of physical, mental, and social health, showing that these dimensions are interdependent. Increasing numbers of peer-reviewed articles confirm this unity of health. Mental health impacts physical health; chronic physical illness impacts mental health; and social determinants of health impact both. An interdisciplinary approach that draws together the work of clinicians, psychologists, sociologists, public health professionals and others is required to

⁸⁰Center for Disease Control, *Promising Approaches to Promote Social Connections*, (2024).

address this comprehensive and holistic understanding of health. Health does not emerge from individual interventions; rather, health is a product of sustained efforts to understand and improve the complex interrelationship between biological, psychological, and social systems.

The WHO affirms that all persons have the right to achieve the highest possible level of health — a right that is central to the principles of primary health care (PHC).⁸¹ Primary Health Care (PHC) represents a whole-of-society approach to developing national health systems that bring health services to communities. PHC integrates services across the life span, takes a multisectoral approach to address the social determinants of health, and empowers individuals, families, and communities. Preventive health emphasizes early intervention and public health strategies that reduce the likelihood of disease progression. Public health is broad in scope and occurs at both the laboratory and community levels. Public health investigates the biological, behavioral, and environmental factors that lead to disease and promotes the health and well-being of populations. Thus, the WHO framework portrays health as a dynamic and multi-dimensional phenomenon that will require coordinated and sustained action to achieve.

Religion and Health

Significant intersections exist between religion and health due to the wide range of psychological, social, and behavioral factors involved in both concepts. Research in various disciplines indicates that engagement in religious practices can positively affect various aspects of human well-being, such as psychological well-being. An extensive body of qualitative and quantitative research suggests that religious or spiritual practices can provide protective effects for mental health. For instance, in certain populations, religious commitment has been associated

⁸¹World Health Organization, "*Primary Health Care*," Measurement Framework and Indicators, (2022).

with reduced rates of depression and anxiety, although the impact of religious engagement can vary significantly based on particular contextual and individual experiences. For individuals who are experiencing psychological distress, religious devotion can provide a source of meaning, structure, and interpretive frameworks that can help alleviate suffering. Group membership, as identified by social psychologists, significantly influences an individual's identity and behavior. Religious communities can provide structured networks of support, leadership, and common narratives that can enhance an individual's resilience, foster pro-social behavior, and protect them from isolation. Some religious traditions emphasize health-enhancing behaviors, such as abstaining from substance use, maintaining a healthy diet, adhering to a routine, etc. Whether through a vegetarian diet, moderate omnivorous eating patterns, or adherence to other ethical standards, these behaviors can potentially decrease an individual's risk for disease and increase their longevity.

Many faith-based organizations act as health service providers in regions that do not have sufficient government or private sector services. Often, faith-based organizations provide clinic services, hospital services, counseling services, and education programs, thereby increasing access to health care services in under-resourced communities. For many individuals, faith-based practices, such as prayer, rituals, and worship, provide a source of emotional comfort and a sense of direction when faced with illness or adversity. Additionally, many individuals observe that faith-based practices contribute to their resilience and facilitate their recovery. Research findings indicate that involvement in religious organizations is often associated with improved mental and physical health outcomes, including reduced rates of depression and some chronic diseases. However, the relationship between religious involvement and health is complex and is influenced by multiple variables, including the availability of social support, adherence to behavioral norms,

socio-economic status, and the cultural context in which an individual lives.

The WHO's definition of health provides a comprehensive, scientifically grounded framework for defining health as a multi-dimensional and relational entity. Through psychological meaning-making, communal belonging, behavioral regulation, and institutional care, religion intersects with the physical, mental, and social domains of health in complex and varied ways. Therefore, any adequate theological or pastoral response to the question of health must consider this multidisciplinary and relational landscape.

Chapter 3: Mental Health and the Church

Many Christian denominations in the U.S. have released formal declarations about mental health within the life of the church. However, these declarations will remain ineffective if they cannot connect to the complex and changing challenges that churches deal with on a daily basis. These declarations must have life and understanding blown into them in order to be helpful. The Church must go beyond lip service and declarations to be effective in the life of the church that deals with stories of complexity of traumas and triggers and cycles of behavior that life often brings.

Trauma often triggers mental health emergencies that can require hospitalizations. Over the next several years, Jon was in and out of the hospital about every three to six months. It was over this time that I began to notice that Jon's father had growing negative, destructive behaviors with strong signs of bipolar disorder. Clearly, I am unable to diagnose such things, so I begged him time and again to seek help from a psychiatrist himself. He was furious with me and said he would never do that. Our relationship began deteriorating, and within a few years, we decided to divorce. I became more convinced that he had an underlying mental health disorder, and I truly couldn't manage all of it at once. After a few years, I married my current husband, who has brought life and light back to my life. I'm able to laugh again.

Jon's dad and I remained friendly, as we agreed to do. Both of my sons loved their father dearly. He was definitely the fun parent, biking, hiking, and camping with the boys whenever he could. Jon was especially close to his father. He could talk with him, and his father would listen to him. He also visited Jon a great deal whenever he was hospitalized.

Both of my boys began to notice that their father didn't seem like himself. He was constantly giving one-word answers to their questions. They even described him as being

catatonic at times. I was becoming more and more worried about him, asking if he had seen his doctor. Again, I received one-word answers.

One day, things seemed very off. I tried to call the boy's father, but I was sent straight to voice mail. I called him throughout the day, with still no response. The boys also thought something was wrong, and they were reaching out with the same result that I had. That evening, I had gone to bed a bit earlier, and suddenly the doorbell rang. My husband Bill went downstairs, and I heard him call up to me to come down. I came downstairs and there were two police officers at the door. All I heard was my ex-husband's name, and I began to wail. My boys had lost their father. He died by suicide.

The boys joined us downstairs, and the police told us what happened. I kept looking at my boys, wondering what would become of them. I do remember looking at Jon and asking him never to do this to me. He looked at me very seriously and said he wouldn't. If only it were that simple, a promise made by a son to his mother.

The church deals with complex and heartbreaking issues on a regular basis. It is vital that pastors receive the training necessary to deal with such situations. Yes, it is important to have these declarations from church judicatories and synods, but it is up to these church bodies to implement them. Words are just words unless they are followed up by action and accountability. It is helpful that the various denominations have made such statements, but we need to hold our feet to the fire. It is helpful to note that all of the denominations listed below all agree on a few key points: recognizing the dignity of each human being, rejecting stigma, acknowledging the social aspects of mental illness, and advocating for social justice and inclusivity for people impacted by mental health issues. It is the right place to start.

The United Methodist Church has written about mental health in the social statement,

“Social Principles and Mental Health: A Summons to Action,” located in *The Book of Discipline* and *The Book of Resolutions*.⁸² This document outlines the laws and teachings of the church, as well as its public position. The social statement defines mental health as one part of overall health and encourages the church and society to view mental illness as a legitimate health concern and as serious as physical illness. Additionally, the social statement emphasizes that the church and society should break the association of mental illness and shame, eliminate the stigma associated with mental health challenges, and replace judgment with compassion for those living with them.

The Methodist social statement also states that there are five parts to the whole person, including physical, emotional, mental, spiritual, and social. Therefore, mental health is tied to the entire spectrum of what constitutes a person's well-being. In fact, the social statement notes that while the five facets of well-being provide a solid foundation, they are limited in describing the complex nature of the person who is embedded in multiple layers of social relationships and spirituality.⁸³

Similarly, the Episcopal Church’s social statement on mental health defines it as an important part of overall well-being.⁸⁴ The statement also acknowledges the historical stigma surrounding mental illness and calls on the church to create opportunities for open dialogue, education, and advocacy for mental health. The statement emphasizes that the Church has many tools to help develop awareness and create a climate of understanding—liturgy, pastoral care, community, and theology. Thus, mental health is a topic of immense importance for the Church

⁸²*Book of Discipline of The United Methodist Church and Book of Resolutions of The United Methodist Church* (Nashville: United Methodist Publishing House), p. 541.

⁸³Ibid. p. 541.

⁸⁴Compendium of the Social Doctrine of the Church, Section III, The Many Aspects of the Human Person, (Vatican City: Libreria Editrice Vaticana, 2004); Pontifical Council for Justice and Peace.

and its engagement in the world. The Church cannot ignore the suffering that affects individuals and communities.

In like manner, the United Church of Christ (UCC) places mental health at the heart of its ecclesiastical concerns.⁸⁵ The UCC Mental Health Network specifically seeks to remove stigma and encourage the inclusion of persons with mental illnesses and brain disorders and their families in the lives of congregations and leaders. The UCC considers mental health to be an integral aspect of physical, emotional, and spiritual health and advocates for greater access to mental health services and equal treatment. The UCC recognizes that access to mental health resources is currently unequal and that structural injustices often impede access to services for marginalized groups. In addition, the UCC calls on congregations to collaborate with local mental health professionals and organizations to support individuals in need and build healthy congregational systems. While the UCC supports prayer and spiritual care, it rejects the notion of reducing mental health treatment to solely spiritual means. Rather, the UCC encourages the creation of safe, trusting environments in which individuals may find support and pursue healing—mentally, physically, and spiritually.⁸⁶

For Catholics, mental health falls under the broad rubric of Roman Catholic Church social teaching—commonly called Roman Catholic Social Teaching (RCST).⁸⁷ RCST articulates the inherent value and dignity of every individual human being and describes mental health as more than simply the absence of illness; rather, it includes emotional, psychological, relational, and social dimensions. All care for individuals with mental illness should be grounded in respect for their God-given worth and avoid all forms of exclusion or marginalization. The RCST

⁸⁵Ibid, Section III.

⁸⁶Ibid.

⁸⁷*Compendium of the Social Doctrine of the Church* (Vatican City: Libreria Editrice Vaticana, 2004): Pontifical Council for Justice and Peace.

provides three main pillars for this approach: the dignity of the human person, solidarity, and the common good. The care of individuals with mental illness is a collective responsibility and thus a shared concern. As the Church believes that social structures must support justice and provide equitable access to healthcare, caring for those struggling with psychological distress is "everyone's business."⁸⁸ The Church views ignorance and fear of mental illness as obstacles to providing education, pastoral care, and public advocacy for individuals with mental illness.

In June 1991, the American Baptist Churches USA adopted a statement entitled "Health, Healing, and Wholeness."⁸⁹ This document makes clear that mental health is an important aspect of total health and acknowledges that society—particularly including the Church—has failed to provide equal rights and privileges to people afflicted by mental illnesses. The document envisions the Church as a sanctuary of acceptance, where individuals and families find refuge instead of rejection. The document also calls for active advocacy and encourages churches to advocate for public policy changes that will increase access to mental health services. Further, it encourages church congregations to partner with professionals to provide comprehensive, compassionate support for people dealing with mental health issues. Additionally, the document states that mental health is not only a medical issue but also a spiritual and emotional reality that requires a proactive and compassionate ecclesiastical response.

Several observers believe that the Evangelical Lutheran Church in America (ELCA), while it had previously provided informal pastoral care for psychological suffering, was somewhat slow to begin a more formal theological consideration of mental health in its social teachings. The ELCA's 2012 social statement, "The Body of Christ," provides a strong

⁸⁸Health, Healing, and Wholeness, adopted by the American Baptist Churches USA, June 1991.

⁸⁹"Body of Christ: Social Statement" (Chicago: ELCA, 2012); Evangelical Lutheran Church in America.

affirmation of the importance of community and the interconnectedness of all aspects of human well-being.⁹⁰ Recently, the ELCA has increased its focus on integrating mental health into broader discussions related to wellness, justice, and the *Imago Dei*—the belief that each person reflects the image of God. The increasing recognition of the urgency of the need for mental health services reflects the realization that mental health needs are as serious as physical health concerns. In the past, negative attitudes towards mental illness, misunderstandings about suffering from a religious perspective, and a lack of knowledge about mental health in many church communities may have caused delays in properly addressing these issues. However, the ELCA has been working to fill the gap through educational initiatives, advocacy efforts, and theological considerations.

The Journal of Lutheran Ethics has made significant contributions to the conversation surrounding mental health within Lutheran theology. In the article "Inclusion – Mental Illness and Disability Statements That Live by the Spirit of Luther," the authors discuss the ethical implications of mental illness and disability in light of Lutheran theology.⁹¹ Using scripture and the confessions of the Lutheran tradition as a basis for their argument, the authors assert the radical inclusivity of the Christian community and recognize the dignity of all individuals regardless of whether they experience mental or physical limitations. Another article, "The Body of Christ and Mental Illness," argues that responsible theological reflection must include current psychological realities.⁹² The Lutheran tradition—emphasizing the gracious nature of God, the limitations of humans, and the interdependent relationships among humans—provides valuable

⁹⁰Ibid.

⁹¹*Journal of Lutheran Ethics*, "Inclusion—Mental Illness and Disability Statements That Live by the Spirit of Luther."

⁹² *Journal of Lutheran Ethics*, "The Body of Christ and Mental Illness."

insights for understanding both illness and healing. The Church, as the Body of Christ, is called not only to spiritually share the Gospel but also to show solidarity with others by meeting their needs.

Like other denominations, the Lutheran reflections highlight several common themes when addressing mental health: creating safe and empathetic communities; advocating for better mental health resources; educating members to diminish the stigma associated with mental illness; and recognizing that faith and mental health are not mutually exclusive but, instead, are interconnected aspects of human existence. When a denomination addresses mental health independently of faith, it may lead to fragmentation, whereas when it provides spiritual care independent of psychological understanding, it results in inadequate care.

Together, the various denominational statements affirm a fundamental theological conviction: mental health is essential to human dignity and to the well-being of the community. The Church, as a community formed by compassion and justice, is accountable to represent not only an advocacy voice for mental health but also a source of healing presence within the fractured world.

The Church as a Community of Care: Theological and Practical Foundations

The current mental health crisis in America, and worldwide, demonstrates significant deficits in access to healthcare, continuity of care, and comprehensive treatment of the whole person. Clinical psychology, psychiatry, and social work offer essential therapeutic and medical treatments for individuals experiencing mental health challenges, but they alone cannot treat all aspects of human suffering. Mental health issues are not solely biological/psychological issues; they are also relational, spiritual, communal, and existentially based issues. The Christian Church is uniquely positioned to aid those experiencing mental health issues. The Church should not

replace professional mental health care, but the Church can serve as a supplemental source of belonging, meaning, physical presence, and advocacy.

The Church is a community of belonging. People experiencing mental health issues often feel isolated as a result of their condition. Many mental health disorders severely limit one's ability to relate to others (depression, anxiety, etc.); others limit one's ability to participate in community (trauma, etc.); and still others limit one's trust in others (trust issues due to abuse, etc.). Additionally, many individuals with mental health issues conceal their struggles out of fear of judgment from others. The foundation of individualism and mobility in modern American society facilitates disconnection from others. The Church views itself as a community of Christ (1 Cor. 12:27), and through baptism, each member is connected to the community of Christ prior to and beyond their existence. This view of anthropology defines the identity of each person by who they are before God, rather than how productive they are, what their diagnosis is, or how useful they are to society. According to John Swinton, "the community of believers is called to be a space where people are acknowledged for who they are before God, not for what they can do."⁹³ This understanding of belonging, rather than the transactional nature of many other societal structures, provides a sense of community that many people lack in today's society.

In addition to providing a sense of community, the Church provides a structure that provides stability and consistency to members' lives. Unlike many clinical systems that provide episodic care and are limited by the constraints of insurance, the Church is designed to provide long-term care to its members. This consistent presence provides a means for the Church to

⁹³Swinton, John, *Dementia: Living in the Memories of God* (Eerdmans, 2012), pp. 5-7.

demonstrate what Swinton refers to as "faithful presence," a way of relating to others that endures despite abandonment.⁹⁴

As previously mentioned, the Church understands the value of every person as being rooted in the concept of the Imago Dei (Genesis 1:26-27). Regardless of one's ability to think clearly, regulate their emotions, contribute to society, etc., every person is made in the Image of God. This theological concept has major implications for mental health. Individuals experiencing mental illness often develop narratives that define their identity in terms of weakness, defectiveness, or spiritual failure. Unfortunately, in some Christian circles, mental illness is viewed as evidence of a lack of faith or as a form of punishment from God. Both of these perspectives can increase feelings of shame and decrease motivation for seeking help. An adequate understanding of the Imago Dei rejects these distorted understandings of God and humanity. As Stanley Hauerwas writes, "The church's mission is to form communities that can tell the truth about suffering without abandoning the sufferer."⁹⁵ The Imago Dei ensures a person's dignity is intrinsic and not based on their emotions or social functioning. A person's worth as a person, therefore, remains unchanged by their mental illness.

In the Lutheran tradition, the doctrine of justification by grace through faith provides additional assurance of dignity in the face of mental illness. A person's dignity is not determined by their ability to live a stable life emotionally or morally but by God's promise of forgiveness and redemption in Christ. As Martin Luther wrote, "Righteousness is received, not achieved."⁹⁶ This theological perspective can be very freeing for individuals whose mental illnesses distort

⁹⁴Swinton, John, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Abingdon Press, 2000), pp. 109-11.

⁹⁵Swinton, John, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*, (Abingdon Press, 2000), pp. 109-112.

⁹⁶Luther, Martin, "Preface to the Epistle of St. Paul to the Romans" (1522), in *Luther's Works*, vol. 35, edited by E. Theodore Bachmann (Muhlenberg Press, 1960), pp. 370-371

their perception of themselves or make it difficult for them to justify their actions. Perhaps the greatest untapped resource that the Church has at its disposal when addressing mental health is the biblical tradition of lament. The Psalms contain unfiltered expressions of fear, anger, disappointment, and confusion (Psalm 22 and Psalm 88). The book of Job expresses the depth of human suffering and the futility of trying to find answers to why it occurs.

These scriptures reject a triumphant view of God and His relationship with humanity and allow for anguish to be expressed to God. As Old Testament scholar Walter Brueggemann writes, the Psalms of Disorientation are crucial to genuine faith because they deny the tendency to deny suffering and instead express suffering to God.⁹⁷ When churches include lament in their worship (preaching, prayer, and liturgy), they model authenticity with respect to expressing emotions and reduce the stigma of expressing emotional pain as part of one's faith. Expressing emotional pain in worship is, in fact, an expression of faith, because it is addressed to God rather than withdrawn from Him. Including emotional pain in worship is likely to normalize the experience of anxiety, depression, and grief and integrate emotional pain into community prayer, rather than isolating it.

Many mental health issues raise existential questions: Why is this happening? Where is God? Is there hope? Clinical models can treat symptoms of mental health issues, but they cannot provide ultimate answers to these questions. The Christian narrative places suffering within the context of the cross and resurrection. At the cross, God is not removed from human suffering, but God enters into it. Theologian Jurgen Moltmann writes that in the crucified Christ, God suffers with humanity, thereby demonstrating divine solidarity rather than divine indifference.⁹⁸ For

⁹⁷Brueggemann, Walter, *The Message of the Psalms* (Augsburg Publishing House, 1984), pp. 51-58.

⁹⁸Moltmann, Jürgen, *The Crucified God* (Fortress Press, 1993), pp. 243-247. Gary B. Ferngren, *Medicine and Health Care in Early Christianity* (Johns Hopkins University Press, 2009), pp. 1-15.

individuals experiencing mental illness, this theology can contradict interpretations of abandonment. The cross does not romanticize suffering; it does not promise immediate healing. Rather, it states that suffering does not ultimately speak the last word. The hope of the resurrection affirms that despair is not the ultimate reality. This hope, grounded in divine promise, creates a level of resilience in individuals with mental illness, not as stoicism but as hope grounded in divine promise.

In addition to providing theological grounding, the Church provides practical, embodied forms of care: delivering meals during times of crisis, driving patients to therapy sessions, helping patients financially, visiting patients, and praying for them. These tangible acts of love and care alleviate the practical burden of many individuals experiencing mental illness, thus reducing the stressors associated with mental illness. Historically, Christian communities have provided much of the development of hospitals and care facilities. While the history of psychiatric treatment within Christian communities is complex, Christian communities have continually treated healthcare as a form of mercy. Today, churches can collaborate with licensed therapists, sponsor support groups, and educate people about mental health. Clergy often serve as initial responders in crises, especially in communities that lack access to mental health professionals. However, churches must be careful to establish clear boundaries. Churches must not confuse spiritual conditions with conditions that require medical treatment. According to pastor/theologian Andrew Root, churches must minister in ways that demonstrate humility and attention to the suffering of others, rather than providing managerial solutions.⁹⁹

Mental health is significantly influenced by social determinants: poverty, racism,

⁹⁹Root, Andrew, *The Congregation in a Secular Age* (Baker Academic, 2021), pp. 189-193.

violence, housing instability, and systemic injustice. Therefore, these issues call for more than simply pastoral responses to individual suffering. The Church's prophetic tradition demands that the Church advocate for systems of justice that support the well-being of all. Affordable access to mental health care, coverage of mental health care via insurance, trauma-informed schooling, and community-based services are among the moral concerns that arise from these social determinants. Therefore, mental health ministry is not simply pastoral but also public theology. Public theology is an area of concern that is aligned with the Church's long-standing commitment to social reform and advocating for the protection of vulnerable populations.

Ultimately, the Church is best suited to practicing radical hospitality—welcoming individuals based on their status as created in the image of God, not based on their emotional state or ability to contribute to society. Hospitality in the Christian tradition is seen as welcoming individuals, just as God welcomed humanity in Christ (Rom. 15:7). When churches adjust their expectations, train greeters and ushers, create spaces that are sensitive to the needs of individuals experiencing mental illness, and demonstrate patience, they embody a theology of grace. Demonstrating grace in this manner reflects a communal philosophy, similar to Ubuntu's "I am because we are," which emphasizes the relational interdependence of humanity. This communal vision challenges the individualistic worldview of modern society and presents mental illness as a common human vulnerability that is shared by all.

The Church is well-positioned to aid those experiencing mental health issues because it combines a theology of anthropology, communal relationships, liturgical lament, meaning-making, physical care, and advocacy. What clinical systems cannot provide, the Church can provide: faithful presence, relational endurance, and continued care grounded in divine promises. When the Church functions according to its baptismal identity, it becomes a

community of grace—where suffering is neither denied nor definitive and where hope is maintained not through human strength but through the faithful presence of God.

Welcoming the Invisible: A Theological, Institutional, and Congregational Response.

Due to its unique characteristics of being both physically and spiritually debilitating, mental illness provides a prime opportunity for churches to proclaim and demonstrate the gospel in the name of the "common good." The Evangelical Lutheran Church in America has recently taken steps to address mental health challenges more positively. Since the early 2000s, the ELCA has sought to welcome individuals with mental health challenges into the life of the church through theological statements, church-wide policies, congregational responses, and partnerships with social service agencies. This section will explore the response of the ELCA to mental illness, focusing primarily on the theological foundations of this response, the various ways in which the ELCA has responded to mental health challenges, and how these responses embody or deny the emerging theologies of disability and mental illness. Finally, I will propose some possible directions for the ELCA to extend its current efforts to welcome those with mental health challenges into the life of the church.

As stated earlier, in August of 2012, the ELCA Church Council formally adopted a social message titled "The Body of Christ and Mental Illness" that established the ELCA's official stance on mental illness. Through this document, the ELCA asserts that "mental illness is a common human experience that calls forth the compassion, support, and healing presence of community."¹⁰⁰ Unlike many other Christian traditions at that time, the ELCA did not characterize mental illness as the result of an individual's sin, but instead stated that "as people loved by God and part of the body of Christ," the church's calling is "to bear witness to God's steady love for those who suffer in mind and body." The ELCA describes this response in terms

of what it calls "companioning," a term commonly used in Lutheran theology to refer to non-judgmental relationality. For example, the ELCA's message states that "just as Christ accompanies those whom society pushes to the edges, so too does the church," because "Christ took upon himself our flesh and blood, our misery, our trespasses, and our death, so that we may be made partakers of his divine and eternal nature... Just as Christ dwells in us through faith, so we dwell in him; in him personally, by faith, in his flesh, in his death and resurrection, throughout present and future eternity, for his sake we are in the prophets and the apostles and all the saints."¹⁰⁰ By describing the church's response to mental illness in terms of companioning, the ELCA identifies itself as the body of the very Christ who bore the sufferings of the world.

The ELCA social message explicitly rejects the stigma-producing messages that the church has promulgated regarding mental illness. "The ELCA recognizes that mental illness carries a stigma and is often shrouded in secrecy," the message states. "It is not a symptom of poor faith, poor parenting, character flaws, or poor choices. Rather, it is a common human experience that calls forth the compassion, support, and healing presence of community. The ELCA also affirms that "people with mental illnesses... have inherent dignity worthy of respect, support, understanding, and compassion" and encourages the use of person-first language (e.g., "person living with mental illness" rather than "mentally ill person") when referring to people with mental illness.¹⁰¹ This represents the ELCA's commitment to the recognition of the inherent worth and value of each and every human being as a fundamental aspect of God's creation.¹⁰² As the ELCA's constitution notes, "the ELCA confesses the triune God-Father, Son, and Holy Spirit.

¹⁰⁰ELCA. Study Guide for "The Body of Christ and Mental Illness." 2013.

¹⁰¹Prayer Cards and Worship Outlines. ELCA Congregation. Case Study. Mental Health Awareness Teams in ELCA Congregations. 2019.

¹⁰²Report to Lutheran Service Corps. ELCA Disability *Ministry Handbook*. 2020.

The announcement of God's message to us as both Law and Gospel is the basis for the ELCA's teachings and actions."¹⁰³ According to Martin Luther, the Law and Gospel are best understood as God's condemnation of human sin and God's promise of salvation in Christ, respectively.

Although the ELCA's statement on mental illness does not explicitly reference the Law and the Gospel, its denial of stigmatizing messages about mental health challenges and its affirmation of the dignity of individuals with mental illness represent a condemnation of the sinful behavior represented by the Law. On the other hand, the ELCA's declaration of God's love and compassion for those living with mental illness represents the promise of salvation and healing for all of humanity presented by the Gospel. The ELCA's commitment to welcoming those with mental health challenges into its congregations is a fulfillment of Christ's promise to us that "if anyone loves me, he will keep my words, and my Father will love him, and I will love him and make myself known to him" (Jn 14:21-23). The ELCA's acknowledgment of its failures in providing a welcoming environment for individuals with mental illness is a step toward making amends for this failure and fulfilling Christ's promise to us that He would come and make His home with all people. Thus, the policy requires congregations and clergy to engage in inclusive practices as a sacramental act by integrating mental health into the church's liturgical and communal life.

To implement the social message, the ELCA developed a study guide to help congregations understand mental health issues. The study guide contains a Biblical study (Psalm of Lament and Jesus' Healing Stories), case studies, and discussion questions to facilitate small-group discussions. The adult education resource uses adult learning theory by having the participants examine their biases, listen to each other, and develop support plans for one another.

By putting these resources in Christian education curricula, the ELCA integrates mental health awareness into the discipleship formation process.

Some ELCA congregations have initiated annual mental health awareness campaigns, usually on World Mental Health Day (October 10) or the International Day of Persons with Disabilities (December 3). Examples of activities these congregations have engaged in include: a prayer service, prayers of intercession during worship, testimonies by members who have experienced mental illness, and songs and anthems that express hope in darkness. The special prayers of the day and the use of the Pax (Peace) symbol demonstrate the theological integration of mental health into worship. This type of public attention to mental health helps to normalize the conversations that occur around mental health challenges and counteracts the silence that surrounds mental illness within both the culture of the world and the culture of the church.¹⁰³

Congregational and Local Ministry Initiatives

At the local level, ELCA congregations have formed Mental Health Awareness Teams (MHATs) composed of lay members, mental health professionals, and individuals with mental illness. MHATs have organized peer support groups (Companion Circles), educational forums about managing stress, and Mental Health First Aid Training in conjunction with local hospitals and community mental health providers.¹⁰⁴ This collaborative approach utilizes the expertise of professionals while empowering members to become mental health advocates within their congregations. It demonstrates a way in which congregations can provide care to those living with mental health challenges within the life of the congregation.¹⁰⁵

¹⁰³ELCA Clergy Health Benefits Overview, including mental health counseling provision.

¹⁰⁴Ibid.

¹⁰⁵ELCA Clergy. Survey. Clergy Well-Being and Peer-Support Participation. 2022.

The ELCA's resources for Disability Ministry promote person-first language and inclusive worship practices (such as creating quiet spaces and developing alternative hymnals). By applying these resources to mental health, congregations are encouraged to recognize mental illness as a form of disability and to develop similar adaptations within their congregational life. This practice reflects the broader theological affirmation of the ELCA that all believers participate in the common priesthood and that the church is called to be the entire body of Christ. Recognizing the significant emotional burdens placed on pastors and staff (including burnout, secondary trauma, and isolation) as they minister to those with mental illnesses, the ELCA has identified mental health support for clergy as a top priority. The ELCA has made available a range of mental health resources for ELCA clergy and staff, including confidential counseling, stress management workshops, and access to psychiatric consultation services.¹⁰⁶ These services are incorporated into clergy health programs provided through Portico Benefit Services.

Following the approval of the social message on mental illness, ELCA bishops have encouraged ELCA clergy to share their experiences of mental illness and care whenever possible. By promoting a culture of openness, the ELCA hopes to create an atmosphere where clergy feel free to speak openly about mental illness and where the church acknowledges that caring for clergy is part of caring for others. Research has demonstrated that peer support among ELCA clergy results in reduced symptoms of depression and improved job satisfaction.¹⁰⁷

The ELCA does not act independently in its efforts related to mental illness but partners with other organizations. Through partnerships such as its relationship with Lutheran Services in America (LSA), the ELCA enables its congregations to connect people with professional

¹⁰⁶Ibid.

¹⁰⁷Ibid.

counseling, housing, and crisis intervention services. These partnerships allow people to move more readily from receiving spiritual care to receiving professional care and represent the ELCA's emphasis on faith expressed actively in love (Gal 5:6). Additionally, the ELCA can collaborate with other organizations to advocate for things like Medicaid expansion for mental health services.¹⁰⁸

The ELCA's mental illness ministry is also an extension of its broader Disability Ministry. The purpose of the Disability Ministry is education, advocacy, and participation for all disabilities. The ELCA's integration of mental illness into its Disability Ministry sends a strong message. It removes the ELCA from a medical model of disability that separates mental illness from other disabilities. Instead, it encourages a social model of disability that examines barriers to inclusion and seeks to remove them in society. The ELCA's Disability Ministry also includes theological reflection on suffering, sanctification, and the image of God, which provides ELCA congregations with additional theological justification for embracing the dignity of those who live with mental illness.¹⁰⁹

The ELCA works to reduce mental health stigma by organizing its efforts around five interconnected themes. Those themes are the affirmation of the presence and dignity of all people; the removal of stigma; collaboration and evidence-based care; advocacy for equal access to care; and the development of the overall systems of support for each person.

Stigma-reducing efforts to educate the public can be understood in the context of the broader literature on stigma. There are two major categories of stigma-reducing strategies: protest and

¹⁰⁸ELCA Quarterly. ELCA. ELCA and Lutheran Services in America: Collaborative Mental-Health Initiatives. 2018.

¹⁰⁹Partnership Agreement. ELCA. ELCA Disability Ministry Framework. 2021.

social activism. Protest includes educating the public about mental illness and arranging opportunities for the public to meet with people with mental illness. Social activism focuses on changing the social systems and policies that enable discrimination. The ELCA's approach is primarily protest through education and contact. However, by advocating for mental health support at both the congregational and policy levels, the ELCA also engages in social activism. Therefore, the ELCA's use of both protest and social activism approaches will most likely be successful in reducing mental health stigma.

To reduce stigma at the congregational level, the ELCA promotes open discussions among church leadership, employees, and members regarding mental illness. The ELCA's position is very clear on this topic: "Silence and stigma that often surround mental illnesses need to be replaced by speaking about and seeking help for mental illnesses and by speaking hope and love to people living with mental illnesses and their families."¹¹⁰ Additionally, the ELCA's social statement on mental health challenges asks people with mental illness to share their stories. The social statement states that hearing the stories of people living with mental illness is crucial to eliminating the silence and stigma that surround these conditions and to supporting hope, healing, and wholeness. Hearing the stories of mental illness helps to humanize the experience and diminish the myths that contribute to stigma. When we hear the stories of people with mental illnesses, we see them in all of their humanity and hear of their gifts. We lose our fantasies that mental illnesses represent some kind of moral or spiritual failure. Through education and open dialogue, the ELCA is creating a new understanding of mental illness and working to eliminate the stigma related to these conditions. The ELCA believes that the full "presence" of every

¹¹⁰ELCA Social Statement, "The Body of Christ and Mental Illness," 2012.

human being in the Body of Christ is affirmed, regardless of the human being's mental health status.

Educational Materials

The ELCA's curriculum series, *Hope & Healing: A Resource Guide for Congregations* and *The Bridge to Wholeness*, provides theological perspectives, biblical foundations, and practical resources for planning sermons, leading group studies, and preparing clergy for mental health ministries. These resources emphasize lived experience, which humanizes mental health issues and counters dehumanizing mental illness stigma. Studies have demonstrated that contact with people with mental illness reduces stigma.¹¹¹

Many ELCA congregations have begun holding informal “Mental Health Café” conversations with clergy, mental health professionals, and other participants to discuss mental health topics. These conversations reflect the theological concept of presence; they illustrate that the church is a safe space for people to speak openly about these topics, thereby normalizing mental health concerns in ELCA congregations. Studies have indicated that talk-in formats reduce self-stigma.¹¹²

Digital Outreach

During the COVID-19 pandemic, the ELCA expanded its digital outreach through webinars, podcasts, and social media messaging, focusing on anti-stigma messages. The digital outreach strategy allows the church to reach beyond geographical boundaries and accessibility. The ELCA is addressing both the knowledge deficit in mental illness education and the affective component of stigma by cultivating feelings of empathy and unity among participants.

¹¹¹Patrick W. Corrigan and Amy C. Watson, “Understanding the Impact of Stigma on People with Mental Illness,” *World Psychiatry*, 1, no. 1 (2002): 16–20.

¹¹²Rachel Marr, et al. “Talk-In Programs and Self-Stigma Reduction,” *Community Mental Health Journal*, 56, no. 4 (2020): 617–625.

Theologically, the ELCA partnerships with non-church professionals are reflective of a theology of calling in which the church acknowledges that God's work is accomplished by others. The ELCA has developed partnerships with psychologists, psychiatrists, social workers, and peer support specialists to join in a shared commitment to evidence-based practice. The partnerships of ELCA clinical entities are evolving in several ways, including the integration of embedded clinical services. In this program, larger urban ELCA congregations have hired mental health professionals to provide counseling, crisis intervention, and referrals in their churches. Embedded clinical services increase the likelihood that ELCA members will seek out mental health services. Professional care also supports ELCA pastoral care through embedded clinical services.

Smaller and less resourced ELCA congregations have created a national list of ELCA-approved mental health professionals who agree to maintain confidentiality and cultural humility in their practices. Pastors can assess whether a member needs immediate attention and then refer the member to the list of ELCA-approved mental health professionals. Both structural models are bound by Memoranda of Understanding (MOU) outlining confidentiality, privacy, and the scope of authority of both pastoral and clinical professionals. The MOUs protect against spiritual bypassing, a situation in which a pastor uses ELCA theology to dismiss the need for professional care.¹¹³ The ELCA affirms the NIMH evidence hierarchy, which supports Cognitive Behavioral Therapy (CBT), psychopharmacological interventions (when necessary), and peer support groups that are evidenced to be effective in multiple settings.¹¹⁴ This supports ELCA beliefs that truth can be obtained through science as well as scripture.

¹¹³Pargament, Kenneth., *Spiritually Integrated Psychotherapy*, 2nd ed. (Guilford Press: New York, NY, 2019).

¹¹⁴National Institute of Mental Health, *Treatment Guidelines for Mental Disorders*, 2021, 5.

Beyond providing congregationally based care, the ELCA advocates for public policy changes to create a more equitable system of mental health service delivery. The ELCA Advocacy and Public Policy Office follows federal, state, and local legislation to advocate for mental health parity, expansion of Medicaid, and creation of community-based crisis response teams. In 2017, the ELCA was part of a successful coalition that advocated for the expansion of the Mental Health Parity and Addiction Equity Act (MHPAEA); the law requires private and employer-sponsored insurance plans to provide coverage for mental health services at the same level as physical health services.¹¹⁵ Recently, the ELCA advocated for passage of the Suicide Prevention Act of 2022. The act provided for expanded funding of crisis lines, culturally sensitive training, and school-based mental health programming.¹¹⁶ The ELCA offers faith-based advocacy training in congregations to empower lay leaders to write editorials, meet with elected officials, and organize public demonstrations. By utilizing a grassroots approach, the ELCA ensures that policy advocacy is informed by lived experience rather than solely by abstract theological thinking.¹¹⁷

The ELCA refers to its advocacy efforts in social gospel language; the church is called to serve as a prophetic voice for justice—especially for those whose voices have been silenced by stigma and neglect.¹¹⁸ This social gospel language is aligned with principles of distributive justice in public health ethics, which assert that society has an ethical responsibility to equitably distribute resources to support the greater good.¹¹⁹

¹¹⁵U.S. Congress enacted the Mental Health Parity and Addiction Equity Act in 2010, with amendments in 2017.

¹¹⁶Elwes, John, *The Presence of Christ in the Church*, 103.

¹¹⁷*Ibid.*

¹¹⁸ELCA, *The Social Gospel and Advocacy*, 2018.

¹¹⁹*Ibid.*

Mental health recovery occurs in a supportive ecosystem of relational connections. In acknowledgment of this reality, the ELCA has developed programs to enhance the support systems for individuals experiencing mental illness. The ELCA has initiated Caring Circles, a series of facilitated support groups for family and friends of individuals with mental illness. These groups focus on issues such as burnout, communicating effectively with loved ones, and navigating the mental health system. The Caring Circles curriculum emphasizes principles from attachment theory and trauma-informed care. Participants learn how to regulate their emotions and develop advocacy skills to assist their loved ones.

Training Clergy and Seminary Students

Given the clergy's role in mental health ministry, the ELCA has incorporated clinical pastoral education (CPE), psychotheology, and discernment regarding psychiatric medications and involuntary treatment into the curricula of ELCA seminaries. ELCA seminary students must complete a minimum of 100 hours of supervised clinical experience to ensure that future pastors can determine when to provide spiritual care and when to refer individuals to mental health professionals.¹²⁰ Some ELCA congregations have formed interdisciplinary support teams consisting of clergy, mental health clinicians, peer support specialists, and lay volunteers. Team members meet regularly to collaborate in developing care plans, monitoring client progress and providing crisis support. The interdisciplinary team model is consistent with the biopsychosocial model advanced by the WHO. The biopsychosocial model asserts that health outcomes improve when biological, psychological, and social factors are addressed collectively.¹²¹

¹²⁰Elwes, John, *The Presence of Christ in the Church*, 103.

¹²¹World Health Organization, *The WHO Definition of Health*, 1946; updated 2020.

While the ELCA's multi-theme approach represents an extraordinary example of integrating theology, education, clinical collaboration, advocacy, and support systems for the benefit of people with mental illness, several significant areas require continued examination and scholarship. The ELCA can make additional progress in making available ELCA mental health materials in languages other than English and by incorporating contextual theologies that recognize the diverse nature of mental illness experiences and the different ways in which individuals experiencing mental illness may conceptualize and express their experiences.

Evaluation: Although anecdotal and quantitative data are collected, there are numerous opportunities for employing mixed-methods research (both quantitative and qualitative) to evaluate the success of the ELCA mental health program. The qualitative findings of the program can offer information about the personal experiences and journeys of individuals who have benefited from the program.

The lack of funds and clinician burnout may threaten the partnership between the congregation and clinician. One possible solution to this problem is to explore cost-sharing agreements among congregations, ELCA, insurance companies, and other funding sources. Digital platforms increasingly disseminate ELCA mental health resources. However, it is imperative to remain aware of the need to maintain accessible low-tech resources to ensure that everyone has access to mental health information.

The ELCA's approach to addressing mental health challenges is grounded in a strong sense of theological integrity. The social statement's focus on accompaniment aligns well with other Lutheran themes—such as vocation and the priesthood of all believers—and the ELCA connects the social statement to biblical healing stories (e.g., the demoniac at Gerasene) and

Luther's understanding of the comfort of the Gospel, giving the ELCA a strong theological foundation for its work.

Much of what the ELCA writes in terms of mental health challenges is written in a way that generally applies to all people living with mental illness. However, the effects of mental illness on different individuals differ based on factors such as race, sex, sexual orientation, and economic status. Some of this is about confronting cultural messages of stigma, particularly in communities where there may be a distrust of institutional medicine.

Future Work

I recommend that the ELCA create a national outcome evaluation tool—a "battery" of evaluation tools (including surveys, focus groups, and outcome measures) to assess the impact of their social statements as well as their educational materials in order to determine their effectiveness. This study examines the impact of congregational efforts on participants' attitudes toward mental illness, their pursuit of mental health treatment, and their involvement in congregational activities. We can use data collected at the synod level to provide annual reports to the ELCA council on congregational outcomes.

To ensure that ELCA pastors possess a foundational knowledge of mental health issues and concerns, I recommend that the ELCA require a course in mental health (basic neurobiology, pastoral care, and theology of suffering) to be offered at all ELCA seminaries. In addition, the ELCA should develop study guides infused with theological understandings of mental illness and stigma through the lens of racial, ethnic, and linguistic diversity, particularly to highlight how mental health challenges are stigmatized differently in each community.

The ELCA should establish Memoranda of Understanding with local mental health service providers to ensure that those who cannot afford health care receive access to their

services and free counseling sessions. The ELCA should also establish a national network of trained ELCA laypeople who can be sent to ELCA congregations as volunteers in times of crisis and as long-term companions. The ELCA should advocate at the national level for increased Medicaid coverage for mental health treatments for individuals with mental illness and advocacy for anti-discrimination laws to protect individuals with mental illness in employment and housing situations.

The ELCA's response to mental illness offers a model for holistic and theologically informed care—a model that represents both the ELCA church-wide mission and combines affirmation theology, church policy, education, and community involvement. By emphasizing the importance of human dignity, accompaniment, and inclusion, the ELCA takes a courageous stand against the dehumanizing language that contributes to the stigma associated with individuals who experience mental illness. To realize the ELCA vision, the organization must prioritize the development of evaluation tools, contextualize its ministry, and create sustainable resources. The future of the ELCA demands that it develop better evaluation tools, incorporate more theology of mental illness into ELCA seminaries and colleges, and use its national influence to advocate for policy changes that support its vision. As the ELCA fulfills its Lutheran theology—that faith must be expressed through love and service to one's neighbor—the ELCA will also serve as a beacon of hope to a society in desperate need of a hopeful, inclusive, and effective mental health ministry.

Chapter 4: The Way Forward at Grace Lutheran, Medham, NJ

A Theological and Practical Plan for a Stigma-Free Mental Health Ministry at Grace Lutheran Church

Mission Statement

We are God's people, baptized into new and eternal life in Jesus Christ and brought together by God's Holy Spirit. Seeking to grow in faith and obedience to God's will, we come together gratefully to worship and learn, and we go out joyfully to share the good news and serve Christ in daily life.

Anti-Stigma Resolution and Statement

The National Institute of Mental Health reports that:

1 in 4 adults experiences mental illness in a given year and 1 in 17 adults live with a serious mental illness such as schizophrenia, major depression, post-partum depression or bipolar disorder.

- Approximately 20% of youth ages 13 to 18 and 13% of youth ages 8 to 15 experience severe mental disorders in a given year; and
- Stigma is when someone, or even you yourself, views a person in a negative way just because they have a mental health condition. Some people describe stigma as a feeling of shame or judgment from someone else. Stigma can even come from an internal place, confusing *feeling* bad with *being* bad (NAMI.org), and the stigma associated with the disease of mental illness is identified as the primary reason individuals fail to seek the help they need to recover from the disease.

The Stigma-Free Campaign aims to inspire the public interest and open dialogues about stigma, raise awareness of the disease of mental illness, and create a culture wherein family, friends, neighbors, all people who have the disease of mental illness feel supported by their community and neighbors and feel free to seek treatment for the disease without fear of stigma.

Promoting awareness that there can be no "health" without mental health will break down barriers and encourage people of all ages to be mindful of their mental health and ask for help when needed. Local resources are available to treat the disease of mental illness so no one person needs to suffer alone or feel hopeless.

Establishing Stigma-Free Zones in our congregations will raise awareness of resources and encourage residents to engage in care as soon as the need is identified so recovery can begin, hope is inspired, and tragedies are avoided.

The 2012 ELCA social message, “The Body of Christ and Mental Illness” challenges us “to create powerful example within the whole body of Christ” as we accompany these in our midst who live with fragile mental health.

The congregation of Grace Lutheran Church, Mendham, in the New Jersey Synod of the Evangelical Lutheran Church in America recognizes the community mental health needs and supports the efforts of all by designating itself as a Stigma-Free Zone and challenges each other to do likewise - be Stigma Free.

-Unanimous congregational vote held in June 2023.

Grace Lutheran’s Reconciling in Christ Welcome Statement

We are called by Jesus to love God and one another, to practice radical hospitality, and to serve all without stipulations. We welcome you to join us, no matter your race, culture, ethnicity, age, gender expression or identity, sexual orientation, physical and mental abilities, socioeconomic position, family status, background, or where you are in your faith journey. You are a unique and beloved child of God. You are accepted and affirmed just as you are - with all your differences and all your gifts. We commit ourselves to embracing the work of anti-racism, social and economic justice, and environmental care. We invite you to join with us, as through Christ, we joyfully and inclusively love and serve our community.

Grace Lutheran Church, as an ELCA parish, has developed a unique mission statement that reflects both its core doctrine of salvation by grace through faith and its radical commitments to inclusiveness and reconciliation. At the same time, in 2023, the church declared itself a Stigma-Free Congregation, and as a Reconciling in Christ community, it welcomes all people, particularly those who have been harmed by the church in the past. This chapter will draw on the theological foundations of the church's mission statement, assess the church's current practice, and suggest an expanded, evidence-based model for developing a mental health ministry that aligns with the ELCA's "Disability & Mental Health Justice: Caring for Health: Our Shared Endeavor" statement.

The ELCA's mission statement, while focusing on Grace Lutheran's own salvation by grace through faith, is an essential foundation for ministry that is completely in God's hands. However, Grace Lutheran's mission also acknowledges this as a gift from God to serve our neighbors. As seen throughout the New Testament, salvation and service are connected (Matthew 25:35-40, James 2:14-17). Therefore, the salvation by grace through faith of Grace Lutheran is not merely a metaphysical reality but a call to do the work of the Kingdom of God—namely, to serve our neighbors. Through this service, Grace endeavors to be a part of the Relational Kingdom of God, the place where all are welcome and are necessary as the children of God. Grace understands itself to be the place where “All are welcome!” is the first sign that people see as they pull into the parking lot at Grace.

Radical Love and the Reconciliation Mandate

Grace's mission statement says that Jesus came to tear down barriers between people and that he practiced radical neighborly love. This statement directly relates to Grace's identity as a Reconciling in Christ congregation, which acknowledges the historical exclusion of LGBTQ+ and other groups from Christian communities. Thus, Grace's understanding of radical love of neighbor can and must be extended to those experiencing mental illness and is rooted in Paul's declaration that there is no longer Jew or Greek, slave or free, male or female, for you are all one in Christ Jesus (Galatians 3: 28). Consequently, diversity is a gift of God that informs a hermeneutic of hospitable reception of others without the need to objectify them into problems to be solved.

Finally, Grace's mission is directed by the ELCA's health statement, which indicates that the biblical concept of wholeness is a blessing and that we participate in health as a collective endeavor (ELCA, 2023). The term "collective endeavor" can be viewed as a theology of

dependence that balances the individual agency necessary for health with the fact that we rely on our environments and communities for our overall well-being. This parallels the koinonia, or fellowship, of the early Christian community (Acts 2: 44-47), and thus provides a solid theological framework for a mental health ministry that includes individual actions, professional support, and community engagement.

Historical and Social Context of Mental Health Stigma

For many years, sociologists have documented the stigmatization of mental illness in our society. In his 1963 book, *Stigma: Notes on the Management of Spoiled Identity*, Erving Goffman argued that all societies have mechanisms for labeling and degrading individuals and groups whose attributes and behaviors deviate from the societal norms. In Christian settings, mental illness has often been interpreted as a result of inadequate faith or immoral behavior, leading to the marginalization and exclusion of individuals and groups. Studies today indicate that people with mental illness are more likely to be victimized by violence and discriminatory actions than are perpetrators of such acts. Therefore, the church has the opportunity to either perpetuate stigma against those experiencing mental illness or contribute to reducing stigma. By declaring themselves a Stigma-Free Church, Grace Lutheran has elected to be part of the solution, and will strive to create a culture of care, trust, and education.

Current Efforts at Grace Lutheran

While Grace has made significant strides in recognizing and responding to the needs of those with mental health challenges, it continues to grow and improve its response. Below are some examples of the current initiatives:

In order to provide a wholistic approach that includes education, community interactions and support, in 2024-2026 Grace partnered with Pathways to Promise which provided

educational materials on mental illness, suicide prevention and resources, and support and companionship for families who have experienced loss of a family member. Pathways to Promise has partnered with the ELCA to provide biblical support and understanding to their resources. In an effort to supply this range of support, Grace Lutheran will continue its support groups and add educational workshops to its church calendar.

In 2024, Grace Lutheran began offering a biweekly Bible study to deepen understanding and spirituality for people who struggle with mental health challenges and for those who support them. Living Grace Support Group has since branched out to offering films that further our understanding of mental health challenges. One such film was *Brainstorm*, which explained a new way to view bipolar disorder as a spectrum disorder. Offering such opportunities allows for deeper questions, conversations, and support. Grace's plan is to continue this group and add more outreach into the community by viewing educational materials.

Fear is a major issue that stops people from receiving medical help and offering help to people who have mental health conditions. Education helps people learn facts and helps forge a bridge to receive proper care. To continue receiving this vital education, Grace Lutheran has sent a few members to receive this education from Mental Health First Aid (MHFA) Training: MHFA training programs for adults and youth were provided during Fall 2025 through the National Council for Mental Wellbeing. Planned: the programs will be presented in accordance with ELCA guidelines for physical and mental health. I believe that this education will lessen the fear that seeks to separate us and open the door to understanding and acceptance. The goal is to present Grace Lutheran as open and caring community for all people. Again, it is vital to see all people in the image of God.

In an effort to expand the understanding of Imago Dei, Grace Lutheran started a speakers program in 2025. We invited presenters to come in and talk about their life's path, which often 'othered' them in life. The series is called "A Walk in Our Shoes," where presenters share the stories of individuals who have felt as though they have been "walked all over." These presentations introduce people who help us see that in the Relational Kingdom of God, people are people. All people are created in the image of God and deserve respect, dignity and caring. No one is outside of God's love. The series has been very well received, and Grace was pleased to address intersectionality. The speakers for this series have focused on topics related to refugees, gender equality, infectious diseases, heart health, and mental health. Grace expects to continue the presentations.

While these initiatives illustrate a grassroots approach to creating a more inclusive and supportive environment for those with mental illness, it seems that there remains room to more fully integrate these activities into the life of the church, to implement greater accountability and assessment, and to develop long-term implementation and funding models.

An Enhanced Strategic Framework

Below is a more complete strategic plan to help Grace become a stigma-free, reconciling, and health-justice-oriented congregation. The strategy is divided into seven modules, and each module is interconnected and interdependent. This strategy will take years to implement, but it outlines a plan to move forward in mission.

Step One: Education and Awareness

Understanding the relational kingdom of God into the congregation will require education. Implementing theological training into Grace's strategic plan is not just a practical recommendation. It becomes a convergence point where many of the central themes of care are

embodied and enacted. Based on the ongoing discussion of Ubuntu, radical hospitality, thick and thin conversations, and church practices, theological training touches several of the core beliefs in this paper. When theology moves to practice, the church moves beyond the abstract into lived reality. Theology becomes the mechanism of translation by equipping leaders to practice radical hospitality, rather than merely affirming it. It helps embody chief theological concepts such as grace, imago Dei, and community in real congregational behaviors. The Church is called not only to believe but also to embody Christ's presence in tangible ways.

Theological understanding transforms radical hospitality into the actual formation of the lived Christian life. Ubuntu and the radical kingdom of God ethic are more than placing greeters at the door. It reshapes the church's identity and community. It helps people in the congregation to see the world differently. It challenges stigmatizing narratives by seeing people the way God sees them. It cultivates "thick" relationships rather than surface-level inclusion. Radical hospitality requires intentional formation, not simply lip service. Reframing mental health theologically pushes beyond a purely clinical understanding of mental health challenges. This training helps leaders interpret mental health through the lens of suffering, dignity, community belonging, and the cross and resurrection. It equips congregations to resist harmful narratives that equate mental health challenges with weak faith. In doing so, the church becomes a theologically grounded community of healing.

Ubuntu expands our understanding of community and identity. Understanding the core concept of Ubuntu, "I am because we are," helps people move from individualism to relational identity. It understands healing as a communal, not an isolated, process. It reshapes how congregations understand personhood and belonging. Human flourishing and healing is relationally constituted, not individually achieved. Community helps combat stigma through

narrative, or “thick conversations.” Training in these conversations help equip leaders to facilitate deeper listening. This relational listening fosters communities where stories of suffering are honored, welcomed, and heard. It shifts the character of the church from trying to fix things to faithful accompaniment. Healing emerges through presence, narrative, and mutual recognition, everything that leads to an abundant life.

Mental health is not simply a pastoral issue; it is a justice issue that must be addressed in all circumstances. Theological training and awareness of exclusion within the church systems. It is here that we can see and understand the inequities in care, belonging, and inclusion. It helps align the church with God’s preferential concern for those who are marginalized or ‘othered’ in society. Inclusion of those with mental health challenges is a matter of faithfulness to the Gospel, not an optional ministry.

For Lutheran congregations, it will be very helpful to study Luther’s Theology of the Cross as well as grace and vocation, all key Lutheran concepts. Leaders can be trained to interpret suffering as a place where God meets us and God’s presence is keenly felt. The theology of the cross stands in direct contrast with the theology of glory, which the world embraces. Theology of Glory understands that we see God in the powerful and mighty. Theology of the Cross tells us that we see God most keenly in the places we don’t expect to see God, with the suffering, the underserved, and the lonely. Vocation affirms mutual care in the body of Christ, where grace is emphasized over performance or perfection. The church’s response to mental health must be rooted in grace-centered, cross-shaped theology.

Theological education and awareness transform church culture and can serve as tools for institutional change. It is a pathway for accountability and ensures that welcome is not dependent on individual goodwill but is embedded in the congregation's essence. Sustainable change

requires intentional leadership formation and structural commitment. Implementing theological training is the means by which the church becomes what it proclaims—a community of grace, belonging, and healing shaped by Christ. In other words, theological training is not a side recommendation—it is the formative engine that makes the vision of radical hospitality, Ubuntu, and mental health inclusion real and sustainable.

Step Two: Digital Outreach – Developing Radical Hospitality, Human Dignity, and Accompaniment in Digital Spaces

Understanding the significance of digital spaces for many individuals who seek help, with support, Grace Lutheran Church will create an intentional digital presence that demonstrates and supports its theology of radical hospitality, human dignity, and accompaniment. Grace's digital outreach will not be limited to distributing information but will serve as an extension of its pastoral identity—creating an accessible, non-stigmatizing, and compassionate way to connect with individuals and families impacted by mental health challenges.

In creating a website hub, Grace will develop a mental health-specific webpage as a central resource center for mental health-related information, theological reflection, and pastoral care. The webpage will contain links to several reputable organizations, including the National Alliance on Mental Illness (NAMI), the Substance Abuse and Mental Health Services Administration (SAMHSA), and Pathways to Promise. This will enable individuals and families to quickly connect with professionals for support. The webpage will also feature video clips of selected sermons and educational offerings from Grace that discuss mental health theologically. The goal of these initiatives is to create a "rich" narrative space, where the stories of struggle, faith, and healing are named openly and without reduction. By normalizing conversations about

mental health within the life of the church, Grace will be taking steps to dismantle stigma. Digital access will create points of connection and accompaniment, demonstrating a "ministry of presence." Grace will establish a dedicated email address and phone number for "Living Grace," providing clear, confidential ways for individuals seeking support, guidance, or someone to listen. These access points represent an expression of pastoral care based on the belief that every individual deserves to be heard and to be accompanied by one another. As a result of this initiative, Grace will live out its theological affirmation that the church is called to meet people where they are—in times of vulnerability and isolation—and respond compassionately, honoring their dignity. Timely and empathetic responses will be prioritized to foster trust and demonstrate that the church is a safe and supportive community.

Grace will establish a thoughtful and consistent social media presence that shares articles, educational resources, personal stories, and messages of hope regarding mental health. The goal of this social media engagement is to reduce stigma and express the church's radical welcome by sharing narratives and reflections that relate to individuals' lived experiences. Through these "rich conversations," Grace will engage in meaningful dialogue, moving beyond superficial engagement to promote greater understanding, empathy, and communal care. Ultimately, social media can become a vehicle for awareness, theological witness, and relational connection.

Additionally, Grace will explore partnering with other ELCA congregations engaged in mental health advocacy. Collaborating with other congregations exemplifies an Ubuntu-informed ecclesiology recognizing that healing and inclusion can be accomplished more effectively when congregations share resources, support one another, and collectively bear witness to God's presence in the world. This digital outreach plan enables Grace Lutheran Church to extend its ministry beyond the building, creating accessible, stigma-free pathways for individuals and

families to access support, education, and care. As a result, Grace can more fully live into its call to be a community of radical hospitality – seeing, hearing, and accompanying individuals in their journey towards healing and wholeness.

Step Three — Building Safe & Welcome Places — Theological Radical Hospitality: Spaces that are Both Relational & Physical

Space is never neutral. It is a source of either inclusion or exclusion, safety or stigma, and belonging. As part of Grace's desire to become a community of radical hospitality and healing, creating welcoming spaces is central to our broader mental health ministry. This desire to create such spaces draw from our theology of dignity, accompaniment, and Ubuntu-inspired community. Therefore, we seek to intentionally develop both our relational and physical spaces to enable people who experience mental health issues to find the church as a place of refuge, recognition, and care. Safety is not just about access; it has many emotional and relational components. In developing these "thick spaces" of belonging—places where people are not just accommodated but truly welcomed and known—the following elements work together to create them. We will budget monies to transform parts of our building into spaces that have been designed with sensitivity to the embodied experiences of people who live with mental health issues. For example, we will transform our fellowship hall into a peaceful space for individuals to retreat to if they feel overwhelmed. We will install sensory-friendly lighting to minimize overstimulation. We will build or update an accessible restroom to provide dignity and ease of use for all. These modifications are not simply functional changes; they are expressions of our theology. They assert that all bodies and minds are worthy of care and consideration, demonstrating our desire to honor the entirety of humanity in each individual. Therefore, the

physical space of our church communicates the intentional welcome, respect, and care of the church as a whole.

While the church is designing safe spaces for people to engage physically in the community at Grace, we will establish relational practices that foster emotional safety and authentic relationships. We will begin each meeting, gathering, and ministry event with a "Welcome Circle." During this time, participants will be asked to share how they are feeling, if they choose to do so. This practice reflects the movement toward "thick conversations," where individuals are encouraged to present themselves fully within the community, rather than a curated or diminished version of their experiences. This creates a culture of listening, empathy, and mutual care, which represents the church's call to carry one another's burdens. Additionally, participation in the Welcome Circle will always be optional, and we will respect each individual's boundaries and comfort levels.

Since inclusion is an ongoing process of awareness, growth, and action, Grace will annually audit its facilities and ministries for accessibility. The audits will assess whether our buildings and programs meet ADA standards but will also go beyond minimum ADA requirements to include the needs of neurodiverse individuals and individuals with disabilities that are not as obvious. Although Grace's original building design included physical accessibility features, this initiative recognizes that accessibility is an ongoing process that requires continuous attention. Rather, accessibility is a continuous act of listening, learning, and adapting. Through regularly assessing our current state of accessibility, Grace will demonstrate a posture of humility and responsiveness—two critical aspects of radical hospitality.

Ultimately, through the intentional establishment of safe and welcoming places, Grace Lutheran will more fully express its theological identity as a compassionate, dignified, and

belonging community. Through thoughtful design, relational practices, and ongoing accountability, Grace will create a space where individuals experiencing mental health challenges are welcomed and empowered to participate in every aspect of community life. In doing so, Grace will embody a vision of the church as a healing body—a body that clearly demonstrates God's presence through welcoming, inclusive, and life-giving spaces.

Step Four: Creating an Environment of Open Communication — Encouraging Authentic Communication, Active Listening, and Healing in the Community

Creating an atmosphere of open communication is crucial to establishing a community at Grace Lutheran Church is a church that values inclusion, dignity, and care for members struggling with mental health. Silence has long served to reinforce stigma, alienation, and misperceptions within the faith community. So, by fostering a culture of openness and real conversation, Grace Lutheran Church will create ways for people to speak honestly and listen with compassion, aligning with its focus on welcoming, supporting each other, and building strong communities of care. Grace recognizes that communication is not simply an exchange of information. Rather, it is a formative practice that develops a sense of community. When Grace communicates openly about mental illness, suffering, and healing, it publicly declares that these experiences are not separate from the faithful life of God's people.

Grace will purposefully integrate topics concerning mental health, suffering, lament, and healing into the liturgical life of the church through scripture, prayer, and sermons. By taking such actions, the congregation acknowledges that the struggles associated with mental health do not indicate a lack of spiritual faithfulness but rather reflect aspects of the broader human experience present in the biblical witness. Integrating these realities in worship will create a

"thick" theological narrative in which the congregation is encouraged to see their experiences reflected in the ongoing redemptive/healing story of God. This helps to dismantle stigma by creating a normal conversation regarding mental health within the holy rhythms of the church's communal life.

Prior to providing faithful ministry to meet the congregation's needs, Grace will administer an anonymous survey to assess the congregation's attitudes, experiences, and concerns regarding mental health. This reflects the importance of listening as a fundamental act of pastoral care, recognizing that successful ministry does not begin with assumptions but with attentive engagement with others' experiences. The survey will enable the church to understand areas of stigma, misunderstandings, and unmet needs, while providing an opportunity for growth and education. In this manner, Grace embodies a humble and discerning posture, allowing the community's voices to shape its future ministries. This represents an Ubuntu-informed vision of the church, where the communal well-being of the church emerges through mutual understanding and involvement.

To facilitate communication and promote greater inclusivity, Grace will establish a congregational liaison to serve as a bridge between the Living Grace initiative and the broader church community. This individual will play a vital role in facilitating the flow of information in a compassionate and respectful manner. The liaison will assist individuals in connecting with available resources, programs, and support opportunities. While the liaison serves a functional role, they embody the ministry of accompaniment, such as walking alongside individuals, and will ensure that individuals feel seen and connected. This reinforces the church's commitment to relational presence, recognizing that effective communication depends on trust and relationships with others.

Additionally, Grace will appoint and empower a mental health advocate within the congregation to serve as a visible and accessible resource for individuals who seek support. While not replacing professional care, the advocate will assist individuals in connecting with the most suitable resources and services and encourage them throughout the process. The advocate will coordinate educational events, invite speakers, and facilitate conversations that will increase the congregation's understanding of mental health. Additionally, the advocate will engage with the church's leadership regularly to evaluate the congregation's progress in reducing stigma and strengthening support systems. Through the advocate, Grace solidifies its commitment to ministry to those with mental health challenges, ensuring that all of its efforts toward inclusion and care continue to grow, are assessed, and are strengthened. The advocate functions as both a pastoral presence and a catalyst for cultural change within the congregation.

The implementation of open communication will allow Grace Lutheran Church to be a community where there is freedom to share stories, where suffering is acknowledged without shame, and where healing occurs collectively. By implementing specific practices of worship, organized listening, and leadership, the congregation establishes an environment that approaches mental health with honesty, compassion, and theological substance. As such, Grace more thoroughly embodies its call to be a community of radical hospitality where each voice is valued, and each individual is treated with dignity, compassion, and hope.

Step Five: Diversity and Reconciliation—Practicing Justice, Mutuality, and Belonging

For Grace Lutheran Church to create an atmosphere that is truly welcoming to people who struggle with mental health, Grace must address not only the individual experiences of people's suffering but also the social and cultural reality that shapes those experiences. Mental

health exists in no vacuum; mental health is shaped by systems of inequality, discrimination, and injustice. Therefore, Grace commits to developing a sense of diversity and seeking reconciliation through its mental health ministry. This step is based on Grace's theological commitments to human dignity, justice, and radical hospitality. Theologically, Grace understands that healing occurs in two ways: personally and communally. Based on an Ubuntu-inspired philosophy ("I am because you are"), Grace understands that the well-being of one person is directly tied to the well-being of the larger community. As a result, Grace's work in building an inclusive community of care necessarily includes challenging stigma, removing obstacles, and establishing settings where honest and mutually transformative conversations can occur.

Grace will host an annual workshop on cultural competence, focusing on racism, sexism, homophobia, and mental health stigma. This workshop will be open to all members of the church, providing a common forum for education, discussion, and reflection. Cultural competence workshops are important for creating the type of awareness needed to understand how different forms of oppression and systemic inequalities affect the experience of mental health. When the people of Grace engage in discussions about these oppressive systems, it creates "thick conversations" that go beyond acknowledging their existence and foster greater understanding and empathy among participants. Additionally, this represents a long-term commitment to continued learning and growth, recognizing that cultural competence is a lifelong process of learning and self-reflection.

Grace will address the broader societal factors that contribute to mental health disparities (e.g., economic inequality, lack of access to healthcare, etc.) as part of its mental health ministry. This commitment recognizes that mental health ministry is not just about providing spiritual care but also about advocating for justice and taking action to promote social change. By identifying

and addressing the social determinants of mental health, Grace is promoting a holistic view of healing—one that addresses the structural conditions that affect individuals and communities. The church's mission to seek justice and stand in solidarity with marginalized or excluded individuals aligns with this view of healing. In doing so, Grace exemplifies radical hospitality that welcomes individuals and seeks to transform the structures that impede their flourishing. Because meaningful change requires a structured and evaluated approach, Grace will develop systems of accountability to ensure that its mental health initiatives remain faithful, responsive, and effective.

Grace will establish a Mental Health Ministries Team to guide, implement, and assess the church's mental health initiatives. This team will serve as a centralized mechanism for coordinating mental health initiatives across the church and will assist in providing ongoing educational opportunities and support to the congregation. This will foster a culture of continuous learning and development and demonstrate a long-term commitment to mental health ministry as a core component of Grace's identity and mission.

Grace will regularly evaluate its mental health initiatives to assess program success and identify areas for improvement. The evaluations will use a combination of quantitative and qualitative metrics (e.g., participation rates, participant feedback, perceived impact within the congregation) to measure the success of its initiatives. These evaluations reflect a spirit of humility and accountability, as they acknowledge that the work of caring and including others is ongoing and subject to constant revision. By engaging in genuine evaluation processes, Grace demonstrates that its ministry remains attuned to the changing needs of its community. As another means of maintaining transparency and collective ownership of the work being done, Grace will publish an annual report outlining its mental health initiatives, successes, and areas for

further development. This document serves as a record of accomplishments in the mental health ministry over the past year. Additionally, this report provides evidence of the congregation's commitment to becoming a more inclusive and supportive community.

By making the work's successes and failures public, Grace establishes a foundation of trust and accountability. It also underscores the communal nature of this work, encouraging every member of the congregation to join in this ongoing journey toward healing and wholeness. Embracing diversity and reconciliation allows Grace Lutheran Church to carry out its mental health ministry in a manner that is both highly personal and systemically broad. Through education, justice-oriented action, and intentional accountability, Grace develops into a community that not only receives individuals but transforms itself and the broader society. In doing so, Grace embodies its vocation to be a place of radical hospitality where healing occurs collectively, dignity is upheld universally, and reconciliation remains at the center of its witness.

Step Six: Funding and Resource Development – Managing Resources to Bring Healing and Hope

The continued success of Grace Lutheran Church's mental health ministry depends upon the deliberate and faithful management of all available financial and communal resources. The concept of "funding" is viewed not merely as a practical requirement but as a theological expression of the church's embodiment of radical hospitality, defense of human dignity, and participation in God's healing of the world. Through investments in mental health initiatives, Grace affirms that this ministry is not peripheral to the church but rather at the core of its identity and calling. Therefore, resource development is viewed as a form of discipleship in which the congregation aligns its financial practices with its call to care for those suffering from pain, marginalization, and stigma.

Grace will pursue grants for mental health initiatives and stigma reduction by applying through denominational or affiliated ELCA organizations. Grace recognizes that the work of healing is a joint endeavor among the churches of the ELCA. Therefore, through pursuing these funding opportunities, Grace will demonstrate a commitment to advocating for mental health in conjunction with the larger church. Furthermore, grant writing will provide Grace the opportunity to increase its capacity to support programs, training, and resources that would otherwise be out of reach. To reach its goal, Grace will establish and sponsor online fundraising campaigns to support its mental health initiatives. While providing financial support for the initiatives, these fundraising campaigns will allow Grace to share stories of their impact and provide hope to individuals affected by mental health challenges and document transformations.

By allowing individuals to participate in the church's mission by sharing stories about the impact of Grace's mental health initiatives, online fundraising campaigns will build relationships with the community of supporters and be a transformative experience. Online fundraising campaigns represent the principles of "thick conversations" into thick communities in which shared purpose and mutual care go beyond the immediate congregation.

Grace will establish an annual special offering to support its mental health ministry. This practice of establishing a separate special offering will integrate financial giving to support mental health initiatives with the church's liturgical and communal life. This practice will reinforce the theological significance of this work. By designating a specific time and place for the special offering for mental health initiatives, the congregation will acknowledge that supporting them is a congregational priority and an outward expression of its values. This act of collective generosity will raise awareness about mental health issues, reduce stigma associated with mental illness, and reaffirm the congregation's commitment to caring for each other.

Recognizing that effective ministry often results from collaboration, Grace will seek partnerships with local mental health organizations, community organizations, and businesses to secure additional funding and resources. Possible partners could include organizations such as the National Alliance on Mental Illness (NAMI) and other community-based service providers. The partnership approach represents an Ubuntu-informed understanding of shared responsibility. As such, Grace acknowledges that mental health care is not limited to the church but is enhanced when multiple parties collaborate. Partnerships with external organizations will enhance Grace's ability to provide a continuum of care for individuals with mental health concerns and further strengthen the advocacy and care network. Funding and resource development will allow Grace The Lutheran Church will continue to grow its mental health ministry in ways that are both practical and profoundly theological. Through deliberate and intentional resource management, as well as through collaborative partnerships and practices of generosity, Grace will exemplify its commitment to healing, inclusion, and dignity.

Step Seven: Creating Support Services for Congregation Members—Supporting Each Other through Storytelling and Relationship Building

Support Services provides an opportunity for Grace Lutheran Church to demonstrate its commitment to caring for individuals struggling with mental illness. The church's support services provide a basis for developing supportive relationships in which people feel "seen," "heard," and "accompanied." Based on its theological commitments to dignity, presence, and radical hospitality, Grace seeks to develop communities where people are able to share their experiences, free from judgment and reduction. As described above, Grace's support services promote "thick conversation" (i.e., dialogue that enables deeper exploration of an individual's experience) based on a commitment to creating opportunities for individuals to communicate

about their experiences.

Grace's pastor will conduct Narrative Listening Sessions at scheduled times. During these sessions, individuals will have the opportunity to share their mental health experiences. These sessions will take place in a confidential, safe, and non-judgmental setting. In these sessions, the Pastor will not utilize a diagnosis-oriented framework. Instead, the Pastor will seek to honor each individual's ability to create meaning through storytelling as a means of connection, healing, and growth. As such, these sessions will reflect a theological anthropology that resists reducing individuals to labels or conditions. Rather, it affirms each individual as a complete person, created in the image of God. As such, Grace is providing a ministry of presence by being willing to listen deeply and respond with compassion to individuals' experiences. These sessions also embody an Ubuntu-informed understanding of personhood, emphasizing the development of identity within a relational context. When individuals hear their stories respected in the community, they know they are not alone and that their stories matter.

In addition to the pastoral listening sessions, Grace will sponsor peer-to-peer small group meetings. These meetings will consist of 4-6 peers who will meet bi-weekly to share their experiences and to mutually support one another. Trained lay leaders will lead these meetings, facilitating respectful, empathetic, and confidential discussions. Peer-to-peer groups represent a space for shared understanding and connection. Individuals will be able to relate to other peers who have experienced mental health issues. The peer-to-peer model emphasizes mutuality over hierarchy. Therefore, all members are able to both provide and receive care. In this manner, Grace is building a form of "thick community" that is characterized by trust, openness, and a long-term commitment to the well-being of its members.

Additionally, these groups serve as a practical example of the church's commitment to

accompaniment. Rather than relegating care to the clergy or professionals, Grace believes that the gifts of the entire community should be used to minister to its members' needs. Thus, Grace empowers its lay members to contribute directly to the healing and support of their fellow members. The support services provided by Grace Lutheran Church will enable the congregation to go beyond simply expressing a commitment to mental health care to actually demonstrating tangible practices of accompaniment and relationship. Through narrative listening and peer-to-peer involvement, the congregation will become a place where its members' stories are honored, burdens are shared, and healing is achieved together.

Conclusion

Healing, Hope and Abundant Life

Throughout this paper, the central question has been posed: How can the Christian Church be a site of healing, community, and hope for people who live with mental health challenges? Through drawing upon theology, pastoral praxis, and current perspectives on mental health, it has become evident that the Church has a set of distinctive resources to address the profound suffering experienced by many individuals and families. The contribution of practical theology helps us understand the forms that healing and life-giving communities can take for people living with mental health challenges, and it has been an especially rich source for developing this perspective. Such theological insights engage with the African philosophy of Ubuntu and the practice of radical hospitality, along with the development of "thick" conversations within Christian communities, and a compelling vision of how the Church can be involved in God's healing work in the world emerges.

John Swinton significantly contributes to theological discussions of mental health by arguing that healing should extend beyond a mere cure. Many modern Western cultures define healing in medical or therapeutic terms: healing occurs when symptoms are lessened or removed. However, Christian understandings of healing must be broader and deeper. While medical treatment and psychological therapy are essential and valuable, for many individuals who live with chronic mental illness, a complete cure may not be achievable. If healing is defined solely as the removal of illness, then individuals who continue to struggle may find themselves outside of the scope of God's healing work. Swinton returns to the biblical narrative to challenge this definition of healing. Frequently, healing in the Bible involves restored relationships, renewed dignity, and integration back into community.

Therefore, the shift in perspective regarding the definition of healing is critical for people who live with mental health challenges, including depression, anxiety disorders, bipolar disorder, or schizophrenia. Mental health challenges are commonly associated with social stigma that prevents individuals from participating in their communities. The Church's call is not simply to pray for healing in the form of a cure but to demonstrate the compassionate presence of Christ so that those who suffer experience acceptance, dignity, and hope within the community of faith. We recognize the Church as a community of belonging. Practical and biblical theology helps us understand the conviction that human identity is located in relationship with God rather than in productive capacity, independence, or cognitive abilities. Every human bears the image of God (*imago Dei*), and this identity remains unchanged regardless of illness or disability. For people who live with mental health challenges, this affirmation of the *imago Dei* is life-giving. Societies often measure human value based on performance or function. Therefore, individuals who struggle with mental illness may feel invisible or burdensome. The Church, however, is called to be a community that recognizes every person as beloved of God and indispensable to the Body of Christ.

Practical theologians will speak of "belonging before believing."¹²² That is, prior to individuals being able to engage in the full life of faith, they need to know that they are welcomed and valued in the community. The Church, therefore, is a place where individuals who live with mental illness are not treated primarily as problems to be solved but as individuals whose presence adds richness to the community. When congregations create this type of belonging, they participate in God's healing work by resisting the isolation and stigma that

¹²²Swinton, John, "From Inclusion to Belonging: A Practical Theology of Community, Disability, and Humaness," *Journal of Religion, Disability & Health*, Volume 16, Issue 2, (2012) pp. 172-190.

frequently accompany mental illness. Healing emerges through friendships, shared worship, and the knowledge that one is known and loved within a community.

Ubuntu and the Theology of Interdependence

Ubuntu deepens this theological vision further by emphasizing the fundamentally relational nature of human existence. Ubuntu is typically expressed as "I am because we are," demonstrating that personhood is developed and maintained through relationships with others. This view aligns with the Christian idea of the Body of Christ, where each member depends on and aids the others.

Accordingly, human flourishing is impossible to achieve in isolation. Human well-being is achieved through a network of relationships that foster mutual care and responsibility. This perspective aligns closely with the biblical view of the Church as the Body of Christ. For people who live with mental health challenges, Ubuntu serves as a poignant reminder that dependence is not a weakness, but rather a fundamental part of human existence. As mentioned above, all humans require the support, encouragement, and care of others. Recognizing this shared dependency can help remove the stigma that is common to mental illness. Rather than seeing individuals with mental health challenges as burdens, the community begins to recognize them as fellow travelers whose experiences expand the Church's knowledge of compassion and grace.

Radical Hospitality and the Practice of Welcome

Another key component that emerged from this research is the practice of radical hospitality in the church. Radical hospitality deliberately creates spaces where typically marginalized individuals can experience true belonging. Biblical hospitality centers on welcoming strangers, outsiders, and those on the margins of society. Time and again throughout Scripture, God's people are instructed to extend hospitality not only to friends, but to those who

seem strange or difficult. In Jesus' ministry, hospitality is an opportunity for transformation, welcoming individuals who had been excluded from society back into the community.

Radical hospitality in the Church may manifest differently depending on the congregation. Education about mental illness, the creation of supportive ministries, and the establishment of safe and welcoming environments for individuals to share their struggles without fear of judgment may be examples of radical hospitality. Additionally, radical hospitality demands patient and compassionate responses to individuals struggling with mental illness, as mental illness can sometimes impact an individual's behavior, communication, or participation in communal life. Hospitality of this sort reflects the nature of God. When the Church welcomes individuals who suffer from mental illness with open arms and compassion, it becomes a living expression of God's inclusive love.

Thick Conversations and the Ministry of Presence

An additional practice that fosters life-giving communities is the cultivation of what Swinton calls "thick conversations." Unlike casual exchanges, thick conversations represent deep listening, authentic inquiry, and a desire to engage with the complexities of another person's life. In the context of mental health, these types of conversations are particularly relevant. Individuals who live with mental illness often carry untold stories of suffering, resilience, and faith that go unexpressed. When members of the Church choose to engage in attentive listening, they affirm the dignity and worth of those stories. Thick conversations also resist the tendency to offer hasty answers or oversimplified theological rationales for suffering. Rather than trying to fix or resolve someone else's pain, the listener chooses to remain present and acknowledges the reality of their struggle, trusting in the sustaining presence of God. In doing so, listening itself becomes a form of pastoral care and spiritual accompaniment. In this manner, the Church becomes a space where

people living with mental health challenges can speak authentically about their experiences and realize that their voices matter.

Ultimately, the Christian response to mental health challenges must be rooted in the hope of the Gospel. Mental illness can produce profound feelings of despair, isolation, and uncertainty. However, the Christian narrative maintains that suffering and brokenness do not define the outcome. The resurrection of Christ is the basis for Christian hope. The resurrection demonstrates that God creates life out of death and restoration out of brokenness. This hope does not deny the reality of suffering but asserts that God's redeeming work continues to emerge, even in the most painful and hopeless of situations. For people who live with mental health challenges, this hope may express itself in finding meaning in the company of others, experiencing times of joy and connection, and trusting that their lives are being held within the loving memory of God. Even when the illness continues, the promise of God's presence endures.

The vision for the Church that emerges from this paper is both bold and encouraging. The Church must evolve into communities that comprehend healing as encompassing, but not confined to, restored relationships, belonging, and dignity. By using the relational wisdom of Ubuntu, practicing radical hospitality, and having "thick" conversations that require deep listening, congregations can better respond to mental health issues. Communities established this way do not eliminate suffering, but they ensure that everyone experiences support. For people living with mental illness, these communities offer a space where they experience the compassionate presence of Christ through the love and fidelity of the community.

In this manner, the Church is participating in God's ongoing work of restoration. The church becomes a place where people are reminded that their worth is not determined by their

illness, productivity, or societal expectations but by the unchanging love of God. Healing is ultimately about learning to live well together in the presence of God. When communities reflect this vision, they become expressions of the abundant life offered in Christ—a life characterized by compassion, belonging, and enduring hope.

A Pastoral Call to the Church

The church stands at a crossroads in addressing mental health issues. Increasingly, across all of society, people and families are experiencing anxiety, depression, trauma, and other mental health challenges. Many people continue to experience loneliness, stigma, and spiritual isolation from others, despite the need for clinical services and professional help. In this time of crisis, the Christian church has a vital opportunity to exercise the healing presence of Jesus Christ in restoring dignity, connection, and hope to people. Churches should seek to provide solutions to suffering but, more importantly, to become a community of faith that accompanies people through times of suffering. As such, healing is defined as being in relationship with others that affirms a person's worth, in community that refuses to give up on those who struggle, and in the knowledge that every human life is remembered by God's loving heart.

Therefore, churches must once again understand themselves to be places of radical welcome. Churches are to become communities of faith where people who are struggling with mental health issues will find welcome and understanding, rather than fear, shame, or silence. This requires churches to be intentional. Churches must educate themselves about mental health, remove the stigma related to it, and establish safe spaces for people to speak openly about their struggles. Pastors and lay leaders are called to create a safe space where people can share their vulnerabilities with compassion and where the stories of people who are struggling can be heard with listening ears.

This call also asks churches to rediscover a more communal definition of community. In societies that emphasize independence and self-sufficiency, people who require ongoing support and care can sometimes feel isolated or ignored. However, the Gospel presents a different picture of human existence: one based on interconnectedness and reciprocal care. The wisdom of Ubuntu reminds us that our humanness exists because of our connections with others: we become fully human through those relationships. Every person in the Body of Christ is important and makes a contribution to the Body of Christ, whether that contribution is evident or not.

This call to pastorally respond to mental health issues also encourages churches to be patient in their responses. People dealing with mental health issues often have a history of experiences that require time and effort to resolve. They need a companion to listen to them, be with them in their pain, and walk with them over time. Through "thick conversations," churches become places of transformation where people begin to see that their lives and experiences are valued and cared for.

Churches are also reminded that hope is central to the Christian message. Mental illness creates feelings of hopelessness. The Gospel declares that suffering and brokenness never get the last word. The Resurrection of Jesus shows us that there is a God who continually brings life out of death and restoration out of brokenness. This hope does not dismiss the reality of mental illness but states that the love of God remains with people in the midst of it. For congregations, this means becoming communities of faith that demonstrate Christ's compassion in practical ways. This includes offering friendship to people who feel isolated, advocating for those who are misunderstood, and ensuring that people living with mental health issues are welcomed into the Body of Christ as equal contributors, not just as recipients of care. Ultimately, the church's response to mental health issues is not an optional ministry but an expression of its very essence.

The Body of Christ is called to reflect the loving nature of God—a love that extends itself to people who are suffering and announces that they are not forgotten.

Finally, the church is called to remember a simple but profound truth: every person who comes to church carries a story known by God. When churches choose to hear, welcome, and accompany people who are struggling, they become living expressions of the Kingdom of God. For people who experience mental health challenges, these kinds of communities can provide hope and show that even in the midst of suffering, they are loved and valued as members of God's family, supported by God's grace and surrounded by hope. This is the pastoral call to the church to become a community of faith where no one suffers alone, where every life is valued as carrying the image of God, and where the healing presence of Christ is shown through faithfulness to love.

Epilogue

In early March of 2026, we celebrated Jon's 30th birthday. I give thanks for every one of those years. It certainly hasn't been easy, but he is still with us, and I am beginning to see signs of him being able to cope with all that life has handed to him. He is trying to take his meds, trying to hold a job, and seeing his friends on the weekends. It is a struggle, and it will continue to be. But I see signs of a life he will hopefully maintain, and that will bring him happiness. He will always have us to help and guide him along the way. He certainly isn't cured, but he is healing; by God, he is healing.

“From the Gurney in the Hall to the Relational Kingdom of God” has asked the medical profession and the church to do better. They are both situated and have the resources to be able to do just that. This paper tries to challenge the medical profession and the church to do that work. The church is to be a place of healing and wholeness, a place of belonging that welcomes

everyone inside. In many ways, the medical profession occupies that same space. However, it will take a complete reset on people's perspectives. No one is expendable. No one is lesser, as no one is greater than anyone else. The *imago Dei* sets us on that path. Simply look into another's eyes and see the One who created us. I am because we are. We need each other to be the people that God created us to be. This paper was written as a love letter to my family and all families on this journey. I pray this paper brings hope and healing. You are beautiful, and you bear the image of God. May we all find healing in the community of God.

Bibliography

- Aggarwal, Neil Krishan, Daniel Chen, Roberto Lewis-Fernández, and Peter Guarnaccia. "Patient Identity Narratives through the Cultural Formulation Interview in a New York City Outpatient Clinic." *Medical Anthropology Quarterly* 37, no. 3 (June 19, 2023): 280–95. <https://doi.org/10.1111/maq.12781>.
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington, VA: American Psychiatric Publishing, 2013.
- Arendt, Hannah. *Totalitarianism : Part Three of the Origins of Totalitarianism*. San Diego: Harcourt Brace Jovanovich, 1951.
- Bauman, Zygmunt. *Modernity and the Holocaust*. Ithaca, New York: Cornell University Press, 1989.
- "Body of Christ: Social Statement." *The Evangelical Lutheran Church in America*. Chicago: ELCA, 2012.
- Boysen, Guy A., Raina A. Isaacs, Lori Tretter, and Sydnie Markowski. "Evidence for Blatant Dehumanization of Mental Illness and Its Relation to Stigma." *The Journal of Social Psychology* 160, no. 3 (September 25, 2019): 1–11. <https://doi.org/10.1080/00224545.2019.1671301>.
- Brown, Brené. *Daring Greatly: How the Courage to Be Vulnerable Transforms the Way We Live, Love, Parent, and Lead*. New York: Gotham Books, 2012.
- Brueggemann, Walter. *Genesis*. Atlanta: John Knox Press, 1982.
- . *The Message of the Psalms : A Theological Commentary*. Minneapolis: Augsburg Pub. House, 1984.
- Buber, Martin, and Ronald Gregor Smith. *Between Man and Man*. New York: The Macmillan Company, 1948.
- Cartercenter.org. "Election Standards | the Carter Center," 2021. <https://eos.cartercenter.org/quotes/84>.
- Center for Disease Control. "Promising Approaches to Promote Social Connections," 2024.
- United Methodist Church, *The Book of Discipline of the United Methodist Church 2020/2024*. United Methodist Publishing House, 2024.
- Corrigan, Patrick. "What Is the Stigma Effect, Part 1." *Psychology Today*, January 22, 2019.

- Corrigan, Patrick W. *On the Stigma of Mental Illness : Practical Strategies for Research and Social Change*. Washington, Dc: American Psychological Association, 2005.
- Crawford, Mike. "Assertive Outreach in Mental Health: A Manual for Practitioners. By T. Burns and M. Firm. (Pp. 345; £24.50.) Oxford University Press: Oxford. 2002." *Psychological Medicine* 33, no. 4 (May 2003): 747–54. <https://doi.org/10.1017/s0033291703257974>.
- Smith, David Livingstone, *On Inhumanity: Dehumanization and How to Resist It*. Oxford University Press, 2020.
- Bonhoeffer, Dietrich. *Life Together*. 1939. Reprint, Minneapolis: Fortress Press, 2015.
- ELCA Church Council. "The Body of Christ and Mental Illness." In *Social Message*, 2012.
- "ELCA Congregational Resource Package." In *ELCA Mental Health Awareness Liturgical Resources*, 2015.
- "ELCA Study Guide for "the Boy of Christ and Mental Illness," 2013.
- Eze, Michael Onyebuchi . "Ubuntu: A Communitarian Response to Liberal Individualism?" *South African Journal of Philosophy* 29, no. 4 (1BC): 360–74.
- Fretheim, Terence E. *God and World in the Old Testament*. Nashville: Abingdon, 2005.
- Freud, Sigmund, and Philip Rieff. *General Psychological Theory : Papers on Metapsychology*. New York: Touchstone, 2008.
- Gafney, Wilda. *Womanist Midrash : A Reintroduction to the Women of the Torah and the Throne*. Louisville, KY: Presbyterian Publishing, 2017.
- Hauerwas, Stanley. *A Community of Character*. University of Notre Dame Press, 1981.
- . *Suffering Presence : Theological Reflections on Medicine, the Mentally Handicapped, and the Church*. Notre Dame, Indiana: University Of Notre Dame Press, 1986.
- "Health, Healing, and Wholeness." In *Adopted by the American Baptist Churches USA, June 1991.*, n.d.
- "Inclusion - Mental Illness and Disability Statements That Live by the Spirit of Luther." *Journal of Lutheran Ethics*, 1BC.
- Jamison, Kay R. *An Unquiet Mind: A Memoir of Moods and Madness*. London: Picador, 1995.
- Moltmann. Jürgen, *The Crucified God*. Minneapolis: Fortress Press, 2015.

- Douglas, Kelly Brown, *Stand Your Ground: Black Bodies and the Justice of God*. Maryknoll, NY: Orbis Books, 2015.
- Luther, Martin. *Luther's Works*. Edited by E. Theodore Bachmann. Vol. 39. Muhlenberg Press, 1960.
- Metz, Thaddeus . “Ubuntu as a Moral Theory and Human Rights in South Africa.” *African Human Rights Law Journal* 11, no. 2 (2011): 532–59.
- Milstein, Glen, Joseph M Currier, Charles Dent, Melissa McKnight, David Eckert, and Amy Manierre. “COPE: Community Outreach & Professional Engagement – a Framework to Bridge Public Mental Health Services with Religious Organizations.” *Frontiers in Psychiatry* 16 (August 8, 2025). <https://doi.org/10.3389/fpsy.2025.1461804>.
- Mowry, Catherine. *God for Us : The Trinity and Christian Life*. New York, Harpersanfrancisco, 2006.
- Pathways to Promise. “Pathways to Promise,” 2024. <https://pathways2promise.org>.
- Pontifical Council for Justice and Peace. *Compendium of the Social Doctrine of the Church*. Citta Del Vaticano: Libreria Ed. Vaticana, 2004.
- “Prayer Cards and Worship Outlines.” ELCA Congregational Case Study, Mental Health Awareness Teams, 2019.
- Ramose, Mogobe B. *African Philosophy through Ubuntu*. Content Solutions, 2007.
- Rasset, Pauline, Benoit Montalan, Nicolas Mauny, Valerian Boudjemadi, and Jessica Mange. “Not All ‘Intouchables’: Variations in Humanness Perceptions between Physical and Mental Disability.” *International Review of Social Psychology* 35, no. 1 (2022). <https://doi.org/10.5334/irsp.596>.
- “Report to Lutheran Service Corps, ELCA.” *Disability Ministry Handbook*, 2020.
- Richardson, Briana T, Jacqueline Jackson, Grace Marable, Jessica Barker, Heather Gardiner, Laura Igarabuza, Menachem Leasy, Elizabeth Matthews, and Yaara Zisman-Ilani. “The Role of Black Churches in Promoting Mental Health for Communities of Socioeconomically Disadvantaged Black Americans.” *Psychiatric Services*, April 10, 2024. <https://doi.org/10.1176/appi.ps.20230263>.
- Root, Andrew. *The Congregation in a Secular Age : Keeping Sacred Time against the Speed of Modern Life*. Grand Rapids, Michigan: Baker Academic, a Division of Baker Publishing Group, 2021.
- Roy Richard Grinker. *NOBODY'S NORMAL : How Culture Created the Stigma of Mental Illness*. S.L.: W.W. Norton, 2022.

“Section 4: Language and Inclusive Practices, Portico Benefit Services,.” *ELCA Clergy Health Benefits Overview*, 2021.

Sen, Amartya. *Development as Freedom*. Oxford: Oxford University Press, 2001.

Shaser, Nicolas. “What’s Hagar God to Do with Israel’s Exodus?,” September 8, 2022. <https://www.israelbibletextcenter.com>.

Shutte, Augustine. *Ubuntu : An Ethic for a New South Africa*. Pietermaritzburg: Cluster Publ, 2004.

Singh, OmPrakash. “Comprehensive Mental Health Action Plan 2013–2030: We Must Rise to the Challenge.” *Indian Journal of Psychiatry* 63, no. 5 (2021): 415. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_811_21.

Smith, David Livingstone. *Less than Human*. New York: St. Martin’s Press, 2013.

Smith, David Livingstone. “Paradoxes of Dehumanization.” *Social Theory and Practice* 42, no. 2 (2016): 416–43. <https://doi.org/10.5840/soctheorpract201642222>.

“Stigma, Prejudice and Discrimination against People with Mental Illness.” *Psychiatry*, n.d. <https://psychiatry.org>.

Stuart, Heather. “Reducing the Stigma of Mental Illness.” *Global Mental Health* 3, no. 17 (May 10, 2016). <https://doi.org/10.1017/gmh.2016.11>.

Swinton, John. *Becoming Friends of Time: Disability, Timefulness, and Gentle Discipleship*. Waco, TX: Baylor University Press, 2016.

———. *Dementia: Living in the Memories of God*. Wm. B. Eerdmans Publishing, 2012.

———. *FINDING JESUS in the STORM : The Spiritual Lives of Christians with Mental Health Challenges*. S.L.: Scm Press, 2020.

———. “From Bedlam to Shalom: Towards a Practical Theology of Human Nature, Interdependence and Mental Health.” *Practical Theology* 1, no. 1 (2008): 91–110.

———. *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*. Nashville: Abingdon Press, 2000.

Swinton, John . “From Inclusion to Belonging: A Practical Theology of Community, Disability, and Humanness.” *Journal of Religion, Disability & Health* 16, no. 2 (2012): 172–90.

Trible, Phyllis, and Fortress Press. *God and Rhetoric of Sexuality*. Philadelphia: Fortress Press, 2005.

- “Truth and Reconciliation Commission of South Africa.” *Final Report 1* (1998): 125–27.
- Tutu, Desmond. *No Future without Forgiveness*. London: Rider, 1999.
- United Nations. “Human Rights and Temporary Labour Migrations Programme in and from Asia and the Pacific,” 2022. <https://unitednations.org>.
- Westermann, Claus. *Genesis 1-11*. Minneapolis: Fortress Press, 1994.
- Jennings, Willie James. *The Christian Imagination : Theology and the Origins of Race*. New Haven: Yale University Press, 2011.
- Wilson, Lloyd Lee. *Radical Hospitality: Benedict's Way of Love*. Kelowna, BC: Northstone Publishing, 2001.
- World Health Organization. “Constitution of the World Health Organization.” *American Journal of Public Health and the Nations Health* 36, no. 11 (November 1948): 1315–23. <https://doi.org/10.2105/ajph.36.11.1315>.
- . “Primary Health Care, Measurement Framework and Indicators,” n.d.
- . “World Health Report: Transforming Mental Health for All,” 2022.
- Wüthrich-Grossenbacher, Ursula. “The Need to Widen the Concept of Health and to Include the Spiritual Dimension.” *International Journal of Public Health* 69 (April 4, 2024). <https://doi.org/10.3389/ijph.2024.1606648>.