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In his chapter "Spirit and Spirituality," Macquarrie comments upon the positive possibility of spiritual achievement by an individual but questions whether groups are able to realize that elusive quality. Social conflicts abound, demonstrating how unspiritual the life of society is. Can this ever be changed ? he asks. Will social morality always be "a matter of power politics"?

> But surely Christian spirituality envisages a broader strategy than the spiritualization of the individual. In calling the church "the community of the Spirit" we are implying that here there is … a society with the capacity to go out from itself. It has been said that the church is the only society which exists primarily for the benefit of the nonmember.[16]

In conclusion, we may call the Church to a Christian discipleship in all spheres of life. If the Church, with its vision of righteousness and wholeness, is excluded from social involvement, then whom will the Church suggest for the task ? The sectors of power and influence, professions and business, labor and politics, have no adequate ethical ground from which to re-create, sanctify, and energize. These sectors of power all have particularized ethical norms for self-regulation, but lack an ethic equal to the depth of human demand and need.

George Forell, in answering the question: "Why did the church not speak up against Nazism ?" said, "Now, this church should have probably said more. But when all is said and done, the only p. 95 people that said anything were the churches. Certainly the legal profession said nothing. Certainly the medical profession said nothing. Certainly the schools and the university professors said nothing." There was no university *Kampf*, or a medical association *Kampf*. The only *Kampf* in Germany was the *Kirchenkampf*.[17] This illustrates my claim that the community of the Spirit is able to speak because it possesses the moral force. The ethic of the Spirit offers both the structure and substance of a "categorical imperative" to humankind. The ethics of the Spirit offers the dynamic for its actualization. This ethics of the Spirit is the ethics of the Church. Even now in our apocalyptic time, the Spirit is moving over the face of the world; and through the community of the Spirit, God is commanding: "Let there be light"; and behold, light breaks forth, and God says, "It is good."

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Nervous Breakdown: A Patient's View[1]

by ROBERT SMITH

[16] Macquarrie, *Paths*, pp. 50–52.

[17] George W. Forell, "Luther and Conscience," *Bulletin of Gettysburg Lutheran Theological Seminary* (winter, 1975), pp. 18–19.

[1] It must be emphasized that this is one person's account of his condition and that one cannot generalize from a particular case.

DURING August-September, 1977, I was hospitalized suffering from acute anxiety and acute depression. This period was one of great confusion, compounded by the fact that I did not have any prior knowledge of nervous disorders and was terrified by the experience. In fact very little appears to have been written in the religious or the secular press concerning nervous disorders. As a result of these experiences, encouraged by family, doctor and hospital staff, I resolved to write of my experiences in an endeavour to help others to appreciate such disorders from the perspective of the patient. As I wish this to be a personal account, I have made no attempt to consult books dealing with the problem. Some works, however, have influenced my thinking, though not all in a positive sense: Tournier,[2] Miller,[3] Goffman,[4] and Little.[5] In addition the workshops and publications of John Mallison[6] had considerable impact on my attitude to participation in group therapy sessions.

Several times the question has been asked, 'How did your experience affect you as a Christian?' What follows is my answer to that question. *From the outset it must be emphasized that what follows is the account of my experience and that another person's experience may be quite different*. p. 97

1) *Background*

From February, 1977, I was suffering from periodic unexplained symptoms which were initially diagnosed as the effects of sinusitis. It was not until after my hospitalization that I found I had been suffering from *panic attacks*. The psychiatrist explained that when a *panic attack* occurs the brain becomes confused and prepares the body either to fight, or to flee from, an imagined enemy. The blood flows to the legs and the brain, extra adrenalin is produced and the heart pumps faster to distribute the blood to the vital organs. He further explained that the patient, being unaware of the true nature of his complaint, becomes more and more worried. The attacks become frequent and a vicious circle is built up. The vicious circle has to be broken and the unwanted behaviour unlearned.

In spite of these attacks, I felt that my faith was becoming deeper. I spent part of my daily train journey to work in prayer, followed by a time of Bible reading for my correspondence theology course. In fact, I felt at peace with God, and happy in the fellowship of the local church. In addition, I was successful in my work and deriving considerable satisfaction from it. I was (and still am) respected and held in high esteem by both my superiors and workmates. My family life is stable, and I love and am loved by my wife and two young sons.

The day prior to my hospitalization, my mind began to become confused and I began to have 'unwanted' thoughts. I became afraid of the drugs in the house; I became apprehensive about crossing the local level-crossing to catch the train. As the day progressed things became considerably worse. I did not want to be alone. I kept on checking to ensure that the door from the office to the roof was closed. I felt voices calling me to 'do it'. I felt I could no longer cope and was losing control. The trip home was

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[2] P. Tournier, *The Meaning of Persons*, London: S.C.M. Press, 1957; idem, *A Place for You*, London: S.C.M. Press, 1968.

[3] W. A. Miller, *Why Do Christians Break Down*? London: Coverdale House, 1976.

[4] E. Goffman, *Asylums*, Harmondsworth: Penguin, 1968.

[5] I. G. Little, *Nervous Christians*, Chicago: Moody Press, 1956.

[6] J. Mallison, *The Small Group Book Series*, Sydney: Renewal Publications, 1976, No. 1: *Guidelines for Small Groups in the Christian Community*; No. 2: *Learning and Praying in Small Groups;* No. 3: *Keeping Group Life Vita;* No. 4: *Celling Youth and Adults*.

horrific—would I jump from the moving car? I visited the family doctor who ordered me to take four weeks rest.

The following morning my wife left for work as usual. I suddenly became scared of the knives in the house. I tried to pray and read my Bible, but I could not concentrate. I rang my wife and asked her to come home immediately. I went outside and watered the garden to keep me out of the house. If necessary I would have locked myself out of the house. It was obvious that urgent psychiatric p. 98 help was required. I visited the local doctor and then a psychiatrist who had me admitted to a private psychiatric hospital. I was hospitalized for five and a half weeks, convalesced at home for three weeks, and have been returning to complete health ever since. Since my return to work, recovery has been consistent though at times fraught with difficulty. I have been aided by the loving concern of family, doctor, nursing staff and friends. While my church activities have been restricted, my Bible reading and prayer life have returned to their pre-hospital level, though I have not recommenced my correspondence course.

2) *The relationship between doctor and patient*

Time and again my thoughts returned to a passage of Shakespeare quoted in Tournier's *The Meaning of Persons:*

> All the world's a stage
> And all the men and women merely players:
> They have their exits and their entrances;
> And one man in his time plays many parts….[7]

Tournier considers how a person has many masks, uses different masks for different occasions and shows different masks to different people.

It is relatively easy for a patient to put on a suitable mask and to discuss with the psychiatrist only those facets of his life he wishes to reveal. My approach was that I would discuss all facets of my life, no matter how embarrassing or how personal, with the psychiatrist and hospital staff, so that they could follow up areas that they considered to be important. In addition, I also resolved to undertake any treatment prescribed. For the patient to be able to be responsive, the doctor must build up a relationship of trust with him. In my case this was developed from the time of the first consultation. This was due at least in part to my decision to be as co-operative as possible.

Little considers that Christians who seek psychiatric help fall into two groups: those who seek information about their condition and those who seek confirmation of their way of life.[8] While the response of the Christian should be the former, in practice the p. 99 response is dependent on the patient's mental condition and on the relationship with his counsellor. The reasons for the patient's response may not be understood or even apparent to the outsider, whether he be family or friend. My case was straightforward, and in most situations I am open and frank. My psychiatrist, too, was friendly, frank and open, and this encouraged a positive response. How a patient regards his own role while under treatment is important. In general, he can adopt one of two attitudes:

(a) the patient can say to the psychiatrist, 'What are *you* going to do to help my recovery?', or
(b) the patient can say to the psychiatrist, 'What are *we* going to do to help my recovery?'.

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[7] Tournier, 1957, p 7, quoting *As You Like It*, II, vii, 139ff.

[8] Little, p 60.

It was obvious from remarks made by other patients during group therapy sessions, that some, at least, were responding in what they considered to be a frank and positive manner but which, because of their complaint was neither open nor positive. To some extent, the only person I believed was myself. Often patients misinterpreted statements made by others or read into situations more than they should have. I learned to become somewhat sceptical about what the other patients said. During one of my sessions with the psychiatrist, I asked him about a patient whom I had tried to help in hospital, and who had been subjected to an apparently traumatic experience in the army. I asked him whether what the patient said was true. This question was not meant to be inquisitive, but asked so that I might be more responsive in helping her. The doctor's answer was 'Well, she says it is true'. In other words, Little's comment needs elaboration. While Christians, and others, may be seeking information about their problem, they may not be able to respond positively to it.

Because of the confidential relationship between psychiatrist and patient, it is possible for the patient to discuss areas of his life which he would not discuss with others be they close friends or family. Another reason that such discussion can take place is that the psychiatrist is able to interpret the comments made, whereas the untrained person may respond in a negative or ill-informed manner. This aspect is critical. While my friends and parents were compassionate and loving they really did *not* understand. (My wife, however, understood more than they). The psychiatrist may spend many hours with his patient to improve his understanding p. 100 of the needs and problem of the patient. These sessions are also used to encourage the patient and to allow him to express and rationalize his fears and thoughts.

As part of his treatment, the patient may be required to take drugs. This should not be looked on as a spiritual failing on the part of the patient. Rather, it is using the treatment that is considered most appropriate to the patient's condition. The patient should take medication strictly as prescribed and see this as an aid to complete recovery rather as an end in itself.

There is one other important factor in the doctor-patient relationship. That is the inclusion of the family. In my case, the local doctor pointed out that it was both my wife and I who were consulting the psychiatrist and not I alone. In fact, my condition was not related to the family situation. Nevertheless, each important decision—whether I was to be admitted to hospital, when I might be discharged, and finally the date of discharge—was made by the three of us together, namely, doctor, patient and spouse. The inclusion of my wife in the decision-making was a very important aspect of my counselling. My wife spoke privately with the psychiatrist on at least two occasions and, because of the importance of the doctor-patient relationship in my recovery, he then spoke either to both of us together or to me privately and outlined what had been discussed.

It is quite common for the children to suffer because they cannot understand what has happened. Children often require some counselling, mainly from the parents. In our case, this was aided by the actions of the doctor and nurses who spent a few moments talking with them. These talks were not 'counselling' sessions, but showed the children that the staff recognized them, and gave them the assurance that 'daddy' was being well looked after. If one word were used to describe the relationship between doctor and patient it would be *integrity*—integrity on the part of all persons concerned.

3) *The role of group therapy*

At the hospital, one of the compulsory activities for all patients (except those on bed rest) was attendance at 'group'. There were two groups: a therapy group under the guidance of either a psychiatric-trained sister or the social worker; and a social or discussion group under the guidance of a member of the hospital staff. Attendance at the therapy group was

restricted to those patients whose doctors had advised the staff that they *considered that they could cope with what was often a very threatening and emotion-charged experience*. Staff meetings were held every afternoon, and relevant points raised at the group therapy session were discussed.

Because of my experience in small groups, including sessions run by Mallison based on those described in his Small Group Series of books,[9] I was able to adapt readily to group sessions.

The more obvious role of group therapy is to enable the patient to verbalize his experiences through discussion with other members of the group. Patients at times felt threatened by the group sessions, and sought leave of the group because they could not cope with the situation. The less obvious, yet in many ways more important, aspect of group therapy is one's response to the experiences of another group member. The effect of one's response can be considerable. In this regard, let me quote my own experience. When I first joined the group, I was asked to explain the reasons for my admission to hospital. I was able to explain in detail the circumstances surrounding my admission, to answer all questions asked of me, and to explain my work and home situation. This experience was not particularly threatening. On another day, a group member was discussing her problem, and stated that if her family situation did not improve she would commit suicide—this was no idle threat. In response to this I stated how my own life was affected by the suicides of a close family friend fifteen years ago. This was one of the events that finally led to my hospitalization. The full impact of this experience did not become apparent until this particular group session. Once aware of the effect of this experience, I was able to discuss it with both the doctor and the group.

Group therapy also serves another very important function in the rehabilitation process. On admission to hospital the patient is, among other things, confused. His thoughts wander. How can the doctor really understand my problem? He has not been through what I have been through. The members of the group—well I can put a little more trust in what they say. Maybe they have had similar experiences, and they do try to encourage, but p. 102 probably they do not really understand either! Gradually you become more confident and begin to realize that they really do understand and that you really will overcome what appear to be insurmountable obstacles to recovery.

If group therapy is to be effective, it requires a trained leader and suitable feedback to other hospital and medical staff, so that they can act upon the information and thus aid the patient's recovery.

4) *The need to relate*

One of my real needs, and indeed, the expressed need of many of the people suffering from depression or anxiety with whom I have spoken, is the need to relate. I wanted to show people that I was 'normal' and not 'mad'. This was one of the greatest needs I experienced. Because I did not understand, I was also certain that my family, friends and workmates did not understand my condition. I wanted them to visit me to see for themselves that I was 'normal' and 'rational' with a nervous disorder that was temporarily afflicting me.[10]

Because nervous disorders are not understood by most people, it can be difficult for them to relate to the patient. This immediately creates a communication barrier as the patient attempts to discuss his problem with family and friends. What is said by the patient may distress or even shock them. They probably will not completely understand, but they should at least try to understand and encourage. It is important to the patient

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[9] See above, fn. 6.

[10] At no stage did I lose touch with reality. I recognize, however, that many psychiatric patients do lose touch with reality, and others suffer from chronic ongoing conditions that do not appear curable.

that he be able to discuss his problem with his family and friends on the clear (unstated) understanding that he should initiate the discussion and be able to terminate it when he sees fit. The visitor should not try to change the topic of conversation.

While family, friends and workmates did not fully understand my condition they aided my recovery as they stood by me and encouraged me, both when I was hospitalized and when I returned to work. It must be remembered that, like the surgical patient, the patient suffering from a nervous disorder will probably take many months to recover fully. After all, it took him many years to learn the behaviour he now has to unlearn! p. 103

My wife and I did not try to hide the problem from our two boys, aged five and six. The boys visited me at least twice a week while I was in hospital. My wife and I consider this to have been one of the important factors in my recovery, and it was also very important for them. It is difficult for a child to understand how someone can be in hospital when they do not appear to be suffering from any obvious sickness. At times it was difficult for them, even when I returned home, because I was not able to participate in activities with them or because I required rest and hence quietness. The experience obviously affected the children, but in their own way they have encouraged me and we have tried to be supportive to them.

During my hospitalization the role of the local church was one of a praying, concerned community. Visitation was restricted because of the distance between hospital and church. On my return home, loving concern was expressed by many members of the congregation. Much of the concern was expressed by persons who were members of small groups or the family cluster with which I was associated. The concern did not end there; people whom I hardly knew came up and spoke to me. One lady came up to me and said, 'I know how you feel. I had the same problems three years ago'. After further discussion, she stated that when she was in hospital no one understood and no one really seemed to care. I was able to discuss my problems with both clergy and frends, and they were able to encourage me, and at the same time I was able to aid their understanding of the cause and effects of some nervous conditions.

Regardless of the type of group in which a person is involved, it is important that each member be aware and concerned for the other members of that group. Small groups allow more freedom for self-expression but often a member's problems do not become apparent unless you are perceptive.

5) *How did this experience affect me as a Christian*?

As stated in the introduction, I set out to discuss nervous illness from my own experiences rather than survey the literature on the subject. Nevertheless, during this period two books were drawn to my attention: Little's *Nervous Christians* and Miller's *Why do Christians Break Down*? Little's book is negative, and is based p. 104 on the premise that the psychiatric patient is seeking release from the satanic bondage of fear, anxiety and worry. He considers that the doctor prescribes drugs which do not alter the emotional problem but only dull the mental thinking, so that the patient is not alert to his fears. A Christian believes that evil comes from Satan and that Christ is the final answer. But man is not perfect. I cannot accept Little's comments concerning drugs. Drugs *do* have a place to play, and I doubt if anyone including members of the medical profession would argue that they were *the* solution. Rather, the role of drugs is to help the person through the crisis, and then, through the media of group and individual therapy, the cause (or causes) can be brought to the surface so that they can be further discussed. Once one knows the cause then therapy can be directed at the problems. My general feeling is that Little's book was written for a different era and should not have been reprinted.

Miller, on the other hand, writes in a positive and compassionate manner. He commences with the premise that breakdowns can be caused by a variety of factors, some

obvious, some obscure. He argues that Christians do, in fact, break down, that spiritual faith does not guarantee immunity, and that this fact is statistically verifiable. Miller considers four factors that can cause conflict: what I *am*, what I *want* to be, what I *ought* to be, and what 'they' *expect* me to be. In many cases, the Church has reinforced the conflict and has caused people to suppress their feelings, leading to tension and stress which can lead to a breakdown. Miller does not argue that man should be allowed to express his thoughts by action. Rather, he argues that he should verbalize his fears and discuss them with others. While Miller refers to the church, what he says can be applied to society in general. The individual is taught to behave in certain ways and to suppress his feelings; for example, he is told 'big boys don't cry'; 'you shouldn't say things like that'; 'Christians shouldn't express anger' … the list is endless. Each of these sayings causes the individual to repress such feelings, and in the end he may 'break'. Prior to reading this book, my doctor and I had discussed such topics and felt that my problem was very much related to factors beyond my control. The trauma of the suicide related earlier had had a much greater impact on me than my parents or I could have possibly imagined. Miller's book p. 105 had direct application to my case. I recommend it without reservation.

Although my mind was confused during this period (i.e., I was well aware of what was going on but could not understand the reason for it), at no stage did I question my faith or consider that the 'breakdown' was the result of a lack of faith. Indeed, my faith, and the approach I took to my complaint, combined to make my hospitalization a positive learning experience. I have learned to become more compassionate and understanding, and because of this I feel more able to help others, whether on a personal basis or by making them more aware of the problems faced by those suffering from nervous disorders. I now feel able to offer more informed advice to other people. It is amazing the number of people who have discussed their problems with me because they realize that I will probably understand.

Because of my experience, I can see similar problems beginning to manifest themselves in other people, but until they are at their point of need it is difficult to make them realize that they are on the road to a 'breakdown'. This type of a ministry is a challenge. It involves a greater understanding of nervous disorders and greater perception of people and the stresses that are operating in their lives. Much could be achieved by the development of sharing groups in the church.

Another important aspect is a recognition that Christians are not perfect, even though they are striving for perfection. As well as sharing high points of their lives, Christians should also be willing to discuss their problems. If, however, the cause is external and not conscious to the mind of the person, as was my own situation, little can be done at that stage. Rather, we should be aware of how suppressed feelings can have long-term consequences, and should allow our children to verbalize their feelings and not encourage them to suppress them. In addition we should be aware of the possible effects of trauma on a person's life and discuss the situation with them.

My experience showed me the need to be responsive to the needs of the body and the mind. My return to health was brought about by the use of drugs, group therapy, counselling, learning to relax, physical exercise, encouragement and concern expressed by family p. 106 and friends, my faith, the love for my family and their love for me, and my wife's concern and understanding.

6) *Conclusion*

It must be remembered that everyone's condition is different and therefore that different drugs and treatments may be prescribed for different individuals. The church has a very important place to play in the patient's recovery in its functions as a praying, caring community. It must never be assumed that mental illness signifies spiritual decadence.

With proper understanding and counselling, the experience can be a very positive one. The church must become more involved in understanding nervous disorders and the congregation must encourage and sustain rather than shun the person who suffers in this way.

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Marxism and the Church in Latin America

by J. ANDREW KIRK

INTRODUCTION

BY now the celebrated words of Ernesto "the" Guevara concerning revolutionary Christians have echoed round the world: "When Christians dare to give a total revolutionary witness, the Latin American revolution will be invincible, seeing that until now Christians have allowed their teaching to be manipulated by reactionaries." Echoing the same thoughts Fidel Castro is no less forceful: "A Christian who adheres to Christian preaching in its purest form, will not side with the exploiters, nor with the bourgeoise, nor with those who cause injustice, hunger and misery". (Ernesto Cardenal y Fidel Castro, *Cristianismo y Revolucion*, Buenos Aires, Ed. Quetzal, 1974 p. 36).

These words are not pronounced in a vacuum. They reflect a dramatic change of consciousness which has taken place in certain sectors of the Latin American Church within the last 15 years. It is no longer impossible to imagine that the Church, or at least a large section of it, may one day fulfil the expectations of these two renowned Latin American Communist leaders.

The purpose of this paper will be to try and give a personal account of this change, describing briefly its historical development and attempting to ask a few questions concerning the implications that might be drawn from it for the present and future direction of the Church's mission. Naturally, I hope that the practical and theological fervour which has characterised Latin American Christianity in the last decade and a half may be of some value to p. 108 the Church in Africa (especially in Southern Africa) as it seeks to obey, in the midst of its own contemporary historical circumstances, the call of the same one Lord.

A PERSONAL SLANT

In the preface to his book, *The God of the Oppressed*, James Cone does what I believe every theologian ought to do at some stage in the course of his theological development: give an account of his own cultural and social background and the prime influences which have moulded his thought. If this were conscientiously carried out, theological discourse would