Religious Communities:
Are They Centers for Enabling or Centers for Healing?

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"Do you want to be well again?"

John 5:1-9

Introduction

The healing of the man with an illness was accomplished when Jesus said, "Get up, pick up your sleeping-mat and walk." With others, rushing to get to the healing waters of the Sheep Pool at Bethzatha the sick man was neglected and abandoned for thirty-eight years. No one was willing to take the time to help him also get into the healing waters of the Sheep Pool. Jesus came, saw the sick man lying near the pool water, and asked him directly, "Do you want to be well again?" The man replied, "I have no one to help me into the pool; and while I try to get to the pool, others get there before me". Mindful of his long journey of suffering and desire for healing, Jesus cured him.

In religious life today, our brothers, sisters, and congregational leaders are faced with new challenges in caring for one another that, if not addressed, can lead to illness and death not only of the person but also of the mission and charism of religious community in the life of the Church. As noted in the Rules and Constitutions of religious congregation, the mission, charism and its distinctive ministries, are the responsibilities of the entire community. When a brother or sister becomes ill, for whatever reason, the health of the community and its ministries can also suffer. This paper will provide an overview of some of the characteristics that portray a religious community as a center for enabling addictive behaviors that prevent the community from bringing healing and hope to its members. I will then offer several strategies that can be

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[1] Adapted from a presentation given at the Guest House Institute's Sixth Annual Summer Conference on Addiction and Community Life, Minneapolis, MN, July 9-11, 2007.

employed in assuring the community's role as a center for healing for brothers and sisters suffering from addictive behaviors.

Centers of Enabling

The existence of addictive behaviors in religious communities is not a new phenomenon. However, the times in which we live and work brings new forms of addictions and many challenges to care for priests, brothers and sisters. Addictive behavior is defined as:

> any activity, object, or behavior that has become the major focus of the life of a person (or community) to the exclusion of other activities, or that has begun to harm individuals, communities or others physically, mentally, socially or spiritually.[2]

Addictive behaviors assume many forms, e.g. alcohol; medications; internet; telephone; gambling; sexual abuse of minors and adults; work; running; spending; eating; hording; along with a host of psychological disorders that have addictive features. Addictive behaviors are distinguished from compulsive behaviors in that they inevitably escalate unless there are appropriate and timely interventions.

What are some of the characteristics that exist in religious communities that might contribute to enabling addictive patterns among its members and continue to place the life of the community and its ministries at risk?

Wilson and Fassel[3], in their classic work The Addictive Organization, provide an insightful approach to describing the characteristics of a religious community as an addictive system. The addictive system, described as a closed system fueled by the classic defense mechanism of denial, enables the progressive development of addictive behaviors much like

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[2] Ruth C. Engs, "Alcohol and Other Drugs: Self Responsibility" (Bloomington, IN: Tichenor Publishing Company, 1987): 1.

[3] Ann.W. Schaef and Diane Fassel, "The Addictive Organization" (San Francisco, CA: Harper & Row, 1988): 57-68.

those identified in the person who manifests these behaviors. Addictive systems in religious communities frequently hold these characteristics:

a. *Confusion*: the culture of the religious community is manifested in the inability or unwillingness to engage in any form of productive self-analysis of its life or ministry in order to identify the needs or problems of members who manifest inappropriate behaviors; the addictive system in a community in manifested in frenetic behaviors and an inability to assume responsibility for its members in need of care;
b. *Self-Centeredness*: the culture of a religious community is internally-focused and seen as the center of the universe; it engages in selfish and self-protective behaviors leaving no room for the enthusiasm and articulation of new ideas from current or future members or collaborating with others in its mission in the universal Church;
c. *Dishonesty*: the culture of a religious community that promotes duplicity through lying to itself, to others, and to the larger world about its mission and charism. Such behavior is a contradiction between its mission and charism and actual behaviors in community and in mission.
d. *Denial*: the culture of a religious community that denies the existence of any concerns or needs that must change in order to promote the growth and development of the community and its members for ministry in the Church;
e. *Perfectionism*: the culture of a religious community that claims to know the answers, expects every member to be perfect, never makes mistakes and is unable to tolerate mistakes, failures or infractions of the Rule or Constitutions of its members;
f. *Scarcity*: the culture of the religious community where there is unrelenting searching for more quantitative resources to do its work; not more human problems;

g. *Illusion of Control*: the culture of the religious community that maximizes it resources to control every aspect of its mission, charism and especially the lives of its members. It is obsessed with universal control of all the elements of the life of the religious community and its members and fear and an inability to acknowledge its strengths as well as its limitations among its most vulnerable sisters and brothers;

h. *Frozen Feelings*: the culture of a religious community that refuses, is unable or is fearful about acknowledging and naming its frustrations, anxieties, vulnerabilities and normal human feelings of hope, anger, fear, frustration, anxieties;

i. *Ethical Deterioration*: the culture of a religious community evidenced in the moral collapse of the community and its members where the dignity and freedom of the human person and affirmation of the consecrated life in mission to the universal Church has been seriously weakened or has nearly disappeared.

j. *Spiritual Bankruptcy*: the summit of all the characteristics of an addictive system that leads to the death of a religious community, its mission and its members as well.

The confluence of these ten characteristics of an addictive system portends the death of a religious community as a human organization. The collective effects of these characteristics negatively impact on the mission and charism of the religious community and on dignity and freedom of each of its members and all those served in their ministries. Seldom are all ten characteristics present in one religious community at the same time. However, the interdependent relationships among these characteristics have the potential to develop into a full-blown addictive system. In light of the catastrophic impact of these characteristics on the dignity of the consecrated person and on the mission and charism of the religious community, no single characteristic of an addictive system must ever be left unattended.

Centers for Healing

Reviewing the ten characteristics of an additive system in religious communities reveals a common thread linking each of them. This linkage is the human person, the consecrated brother or sister, who is in need of care and healing and where the experience of human dignity and freedom that comes through Baptism and Religious Profession are once again seen as the foundation for authentic renewal of the community and all of its members.

The process for reaffirming human dignity and freedom is not complicated. It is a process that requires an authentic commitment to renewal in every member of the religious community in order to provide the culture where every brother and sister, not just those with a definitive diagnosis of addiction, will experience human, psychological and spiritual awakening and a re-commitment to their lives and ministers of the Gospel to people in need as exemplified in the mission and charism of the Congregation.

This renewal can be accomplished in several ways: by re-affirming the dignity of the human person through the development of caring behaviors; formation of authentic and sustained healing relationships; by implementing strategies that help the religious communities to become centers of healing, hope and human flourishing where every member of the community, regardless of their illness or circumstances of their lives, is affirmed and respected as a human person with incalculable dignity and worth, the summit of all of creation.

Human Dignity: The Central Moral Principle for Healing

Refounding religious communities as centers of healing can occur only if there is renewed commitment to the intrinsic value of the human person within the context of the mission and charism of the Congregation in service to the church. This commitment can only be realized and sustained through the doctrine of human dignity and how caring and healing affects both the

one who is sick and the community who is committed to help and to heal.

The German philosopher, Immanuel Kant, has been credited with providing rich insight it the understanding of human dignity. In his *Metaphysics of Morals,* Kant[4] states:

> A human being is regarded as a person, that is, as the subject of a morally practical reason, is exalted above any price; for as a person he is not to be valued merely as a means to the ends of others or even to his own ends, but as an end in himself, that is, he possesses a dignity (an absolute inner worth) by which he exacts respect for himself from all other rational beings in the world.

This absolute inner worth is intrinsic dignity; that exalted level of value that is present simply because the person is human. No authority of any kind, of any nation, of any laws, or any illness, or station in life can ever obliterate intrinsic dignity from character of the human person. However, we know from human history and from our own lived experiences that human dignity has been and continues to be violated.

We have only to look back into the early days of this country to see systemic violations of human dignity – slavery – oppression of women and persons of color – child labor – poverty – inequities in health care. We also need to never forget the moral atrocities in Germany in the late 1800 that set the stage for the Nazi exterminations and the T-4 experiments. In the last century we have on our moral consciences in the United States the Tuskegee Syphilis Study, the Marshall Islands research and the human experiments conducted at the Holmsburg Prison.

The application of the doctrine of human dignity requires that religious communities and its members as well, to continually re-examine the direction of their moral compass and focus on the question *"who do we really care about*?" How this challenge is embraced and applied in

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[4] Mary Gregor (Ed). *Immanuel Kant-The Metaphysics of Morals*. (Cambridge, MA: Press Syndicate of University of Cambridge, 1996), 186.

light of caring for persons diminished in any way because of illness, will speak loudly about how we are willing to care for one another in community.

Habits for Healing Communities

Brothers and sisters committed to one another in community are called to care the needs of the whole person. This commitment must not be assigned only to the religious superiors. Entering the total experience of responding to the needs of the sick requires that we possess four habits, namely, (a) affirmation and respect for the intrinsic human dignity in every person, (b) compassion, (c) freedom to acknowledge one's vulnerability in this relationship, and (d) to be willing to be present, physically, emotionally and spiritually, to the one who is suffering.

Offered as a new dynamic paradigm for caring and healing in communities, the habits are described as follows:

Intrinsic Human Dignity: is the unqualified value and worth of every person who has ever been born regardless of the reason for his/her illness, the circumstances of life, age, color, gender, ethnicity, religious persuasion, or station in life. Intrinsic human dignity belongs by right to every person simply because he is human.[5]

Compassion: is the capacity to feel, and suffer with, the sick person - to experience something of the predicament of illness, its fears, anxieties, temptations, its assault on the whole person, the loss of freedom and dignity, the utter vulnerability, and the alienation every illness produces or portends.[6]

Vulnerability: the inevitable consequence of caring and healing and is integral to

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[5] Immanuel Kant. Metaphysics of Morals, 1796; Daniel P. Sulmasy. *Dignity and Vulnerability,* (St. Louis, MO: The Catholic Health Association of the United States, 2003), CD Rom.
[6] David C. Thomasma and Thomasine Kuschner. "A Dialogue on Compassion and Supererogation in Medicine". *Cambridge Quarterly in Healthcare Ethics*, 1995, 4(2), 415-425.

the community's call to compassion in caring for the sick. To acknowledge the call of the sick in the healing relationship is to become aware of one's journey into selfhood; to bring into question one's traditions, previous understanding and beliefs; to become comfortable with doubt and uncertainty and to acknowledge the inevitable risk that comes when one is invited to rethink personal values and meanings associated with the role of a healer.[7] and

Presence: the conscious willingness to risk coming to know the one who is sick, first, as a person, to be with her, in joy and pain, and failure; to risk becoming vulnerable in the person's suffering. In caring for one another in community, presence takes place only at the invitation of the one suffering. It is always a privilege, never a right. It can only be requested, never assumed or demanded. Nothing apart from the permission or invitation of the one who is seeking to be healed ever gives the healer the right to enter another's pain, or another's faith experience, whether it is physical, emotional, relational, or spiritual. The invitation to be present with the sick brother or sister is to be allowed to see, to share, to touch, to hear the brokenness, to bear the burdens of the sick, to provide forgiveness for past hurts, to suffer with, and indeed share the hope and faith of another. Exposing one's suffering, woundedness, grief, and faith are deeply personal. Personal in the lives of the sick person is always regarded and approached with dignity, humility, compassion, and as a gift, and a privilege.[8]

Human dignity, compassion, vulnerability and presence places in unique perspective the preeminent importance of the community as healer, and the person of the one who is sick, in the healing relationship. Entering into this relationship is endowed with both rewards and

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[7] Joyce Travelbee. *Interpersonal Aspects of Nursing* (Philadelphia, PA: F.A.Davis, 1966); Henri J.M. Nouwen. *The Wounded Healer*. New York, NY: Image Books, 1979)

[8] Joyce Pettigrew. "Intensive Nursing Care: The Ministry of Presence". *Critical Care Nursing Clinics of North America*. 1990, 2(3), 503-508.

heartaches. It means being open to experiencing the pain of others. Pellegrino[9] notes that to enter this experience is exquisitely difficult. Each person's experience of suffering is unique and is shaped by all those particularities of individual existence that give persons their unique and unrepeatable personal identity. While we as healers can never fully enter into another's experience, compassion cannot help in the healing relationship unless we do enter to some discernable degree.

Affirming and protecting human dignity, caring with compassion, having courage to become vulnerable in the experience of suffering and dying, and being physically, emotionally, psychologically and spiritually present to the sick person throughout this journey, asks each of us to enter the healing relationship with a most extraordinary gift. This gift is the incredible richness and uniqueness of our own person, own intrinsic human dignity and the commitment brothers and sisters made to one another through their religious profession.

The Healing Relationship Model

A holistic approach to healing those suffering from addictions, both individual brother and sisters and the religious community as well, is essential in order to identify and implement appropriate interventions and to promote the dignity and integrity of all those searching for relief from the experience of pain and suffering.

To accomplish the task, Pellegrino[10] frames this experience in what he defines as the healing relationship - a dynamic interaction between two persons: one person, who is vulnerable, suffering and seeking help, and the second person, the religious community, who promises to care and to heal. The outcome of the healing relationship is a good healing action

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[9] Edmund D. Pellegrino. "Living with AIDS: The Voices of Suffering". In Miriam E. Cameron Living *With AIDS: Experiencing Ethical Problems* (Newbury Park, CA: Sage Publucations, 1993), x-xiv.
[10] Edmund D. Pellegrino. "The Healing Relationship", in Edmund E. Shelp (ed). *The Clinical Encounter.* (Boston: MA: D. Reidel Publishing Co., 1983), 153-172.

that restores health and wholeness to sisters and brothers and to the religious community as well.

The healing relationship in the religious community occurs within three interrelated events. In the first event, the fact of illness occurs when the person or religious community begins to perceive negative change in the holistic health status of individuals or in the culture of the community. Normal activities become difficult to pursue. Changes are experienced and there is a conscious awareness that help is needed. This change in the life of the person and the religious community is both experiential and existential and places them in a position of vulnerability, exploitability and potential assault on the integrity of the person or the religious community. It is at the time of the study of the fact of illness where and addictive system in the community is often first recognized.

The *fact of illness* is often described with these characteristics:

a. disorganization and confusion of the person's or community's whole world;
b. a radical transformation from an active, energized person or community into roles that are chaotic and disorganized, passive, self-centered, vulnerable, defensive and where feelings and beliefs are frozen;
c. there is a deficit in one's humanity
d. the individual or community becomes transformed into something alien, foreign, and no longer integrated;
e. there is a four-fold loss or a diminution of autonomy: of action; of freedom to make choices; of freedom from the power of others; of integrity and self-image;

The second event, *the act of profession – the promise to care*, the moral center of the healing relationship -- is the commitment of the community to care for the sick brothers and sisters and to journey with them through this experience. This event identifies and affirms the

personhood of the one who is suffering and in need of healing and help as well as the role of the religious community as healer. During this encounter between the one who is sick and the community who promises to care, the healing relationship is established often by the simple phrase "how can we help you?" By stating this simple, yet profound question, the community, as healer, freely enters into a helping relationship with the person who is sick. The community as healer assures the sick person that it is committed to help and to heal; that through the charism of the community, it will use this knowledge and skills to bring healing and hope to the sick person. The community as healer establishes and re-affirms a covenant of trust, promised through the religious profession, and assures the sick that they will not be abandoned during the course of their journey.

The *act of profession or the promise to care* holds these characteristics:

a. a promise made to the one who is sick and in need;
b. the declaration "how can we help you" is an active, conscious declaration, voluntarily entered into which signifies willingness to assume the obligation to make the declaration authentic;
c. the promise occurs every time healers present themselves to persons in need – it is both implicit and undeniable;
d. the act of profession and the concern for the person must be above that of the healing community;
e. the act of profession must be true and authentic, built on a covenant of trust, not a contract, that arises from religious profession;

The third event, *the act of healing,* fully engages the sick person and the community in the specific activities of caring and healing. Within this event, the commitment of the healer to

actively engage in the act of healing, further helps achieve the ends of the healing relationship, that is, restoration to health and when this is not possible, restoration to wholeness and the reunification of the wholeness of the human person. The act of healing more concretely unites the community as healer with the sick person in the healing relationship through the use of appropriate therapeutic interventions to restore health, or when this is not possible, to relieve pain and suffering.

This event, *the act of healing*, includes these characteristics:

a. right (technical) and good (ethical) decisions and action;
b. use of appropriate interventions to restore health, to relieve pain and suffering;
c. the decisions and actions are carried out in a compassionate, competent, safe and efficient manner; and
d. activities that attempt to achieve healing and conversion for the community and for all of its members.

These dynamic and interactive events of the healing relationship require a calculus of the values of both the sick person and the religious community, who promises to help and to heal. Of special importance in this relationship is the moral responsibility of the community to affirm the full personhood of the one who is sick particularly in light of the degree of vulnerability and exploitability during illness. Through this experience the personhood of the one who is sick and the religious community who promised to care or to heal, is enriched, renewed and made whole, as well.

The critical outcome of the healing relationship is the physical, emotional, psychological and spiritual good of the person who has asked for healing as well as for the religious community as healers of its members. In this relationship, the community, bound to the sick brother and

sister in a trusting and compassionate way, can also experience affirmation leading to re-founding and renewal of the religious community. Not to have some experience with the pain and suffering of the sick or to be unwilling to encounter them in the fact of their illness limits the development of the healing relationship, fractures the relationship, and restricts the encounters to a series of tasks, activities and technical maneuvers. Preserving the unity of the whole person and the renewal of the religious community through the healing relationship must be a major initiative to bring healing to addictive systems in religious communities.

Strategies for Interventions

Responding to the needs of a religious community, as an addictive system, and in caring for its members is a daunting challenge. Earlier discussions on the principles and guidelines for assuring human dignity, the description of habits for healing communities, and the healing relationship model identified frameworks for interventions. These frameworks provide direction and focus for the more difficult steps of identifying, implementing, and evaluating strategies for the prevention, education, assessment, treatment, supervision and continuing care of the community and its members based on the underlying and multivariate causes for the presence of an addictive system in religious communities. For strategic interventions to have immediate and enduring success in healing religious communities and its sisters and brothers there must be sustained cooperation, collaboration, commitment and accountability from the entire religious community, not just from the leadership of the Congregation.

Agreement and cooperation in implementing systems of support and accountability can help further assure that interventions directed toward creating and maintaining healthy brothers and sisters and their communities are effective. The following are offered as examples:

Systems of support include:

a. living together in a community with limited access by others,
b. participating in a common schedule for prayer, liturgy, meals, recreation, retreats, community meetings and chapters,
c. the presence and availability of a local superior,
d. periodic conversations with the local superior/pastor and major superior,
e. providing professional resources to facilitate communications, conflict resolution, planning and for clinical interventions,
f. participation in visitations and Congregation-wide programs , celebrations and gatherings,
g. developing supportive relationships with other members of the community;
h. participating in programs and services that promote holistic health,
i. caring for one another especially those who are experiencing difficulties, and
j. engaging the help of a spiritual director and counselor.

Systems of accountability include:

a. being physically present and actively participating in the rhythm and prayer life of the community;
b. fulfilling the responsibilities assigned, in a timely manner, and seeking help when needed,
c. seeking permission for any variances or exceptions from approved community policies and procedures,
d. being faithful in complying with policies and procedures approved by the local community regarding absences, overnight excursions, vacations, use of community resources, finances, boundaries, and ethics in ministry to minors and an annual retreat,
e. periodic performance assessments, and
f. providing reports in a timely manner as requested and as appropriate.

The Journey of Conversion and Human Flourishing

The Telos of Caring Community

Since the days of the Greek philosophers, the question of human flourishing has been thoroughly examined. Though centuries of study and discourse on this question and how it can be explained have elapsed, the understanding of the meaning of human flourishing continues to be explored. It evolves as does every person who has ever been born.

Fundamental to the understanding of human flourishing is an awareness and appreciation of the uniqueness, defined in multiple domains (biologically; psychologically, spiritually; culturally) of the individual, human dignity, diversity, freedom, happiness, and holistic well being all of which lead to the telos or a desired outcome of human nature, that is human flourishing, the maximization of the nature of the human person seen as the good for this person.

The process of achieving human flourishing, that is to achieve the good for the person (Aristotle's eudemonia), is a life-long existential journey of self-actualization and self-fulfillment that continues to evolve and develop until the moment of death. The trajectory to achieve human flourishing is a life-long sometimes tortured journey of hopes, regrets, losses, illness, unrelenting suffering and achievements as well. It is an essential part being fully human, a noble good to be achieved because this good is inherent in the very nature of what it means to be human, and a process we all experience. Human flourishing is the telos of the healer's promise to care, to heal, and to help the sick person reclaim his personhood that may have been fractured in the experience of illness. Among religious communities human flourishing occurs both in the person of the brothers and sisters as well as in the culture of the community as a whole.

In the process of caring in community we can clear away the debris that riddles those many life's landscapes that threaten the collapse of even meager attempts to promote human

flourishing, e.g. addictions; illness and discrimination; health inequities; poverty; and to help members of the community reclaim their dignity, their confidence and self-esteem - that regardless of their diagnosis, why they became ill, the circumstances of their lives, or their station in life, they have a moral claim on human flourishing. As caregivers of the whole person, the religious community has the responsibility to enable our sisters and brothers to regain or develop new pathways toward human flourishing.

The authentic telos of the care of the sick, through the healing relationship, re-establishes the wholeness of the person. In this event the dignity and freedom of the human person, both the sick person and the community are affirmed, protected and provide the opportunities and pathways to re-capture the goal of human flourishing, a right that belongs to every person without conditions or limitations. Kass[11] describes this understanding of human dignity as the flourishing of human possibility, in each of its many admirable forms, that depends on active human vitality, that is, on the goodness, worth and dignity of life of every person who has ever been born.

As we read in the Gospel of Luke (5:17-26) the journey of healing and conversion, the telos of a caring community, requires an authentic commitment of the whole community to carry its ill brothers and sisters and place them before Jesus and to the pools and into the healing waters of security, rest, hope and a renewed life in Christ (cf. John 5:1-9). Religious life is one that is completely and perpetually joined to the life and mission of Christ. Women and men

[11] Leon Kass. "Defending Human Dignity", *Human Dignity and Bioethics*, Edmund D. Pellegrino, Adam Schulman and Thomas W. Merrill (Eds). (Notre Dame, IN: University of Notre Dame Press, 2009)

religious, as prophetic witness of the consecrated life, then, are the means whereby they experience the healing ministry of Jesus Christ. May[12] emphasizes this point when he writes:

> God's grace through community involves something far greater than other people's support and perspective. The power of grace is nowhere as brilliant nor a mystical as in communities of faith. Its power includes not just love that comes from people and through people, but love that pours forth among people, as if through the very spaces between one person and the next.

Caring for those who are sick in body and mind and in need of healing, those who are unable to return to good health or for those who are limited in their ministries because of age or illness are a special privilege, an extraordinary grace-filled moment for expressing the bonds of religious life. Caring in community, then, becomes a visible witness of the love for each other. In the words of Henri Nouwen [13]

> Caring together is the basis of community life. We don=t come together simply to console each other or even to support each other. Important as those things may be, long-term community life is directed in other ways. Together we reach out to others. Together we look at those who need our care. Together we carry out our suffering brothers and sisters to the place of rest, healing and safety.

Religious communities should assume the pre-eminent role as primary centers of care where together with love and compassion, Jesus' healing ministry is extended to one another. Caring for one another in community is the first act of preaching – the first act of evangelization and the first and enduring act of healing. Because of this tremendous privilege and as a prophetic witness to the world, religious communities ought not to easily give the care of their sisters and brothers to others. It is in this assurance to each other that the community is the first and primary center for care and healing.

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[12] Gerald G. May. *Addiction and Grace: Love and Spirituality in the Healing of Addictions*. (San Francisco: Harper Collins Publishers,1988), 173.
[13] Henri J.M. Nouwen. *Our Greatest Gift: A Meditation on Dying and Caring*. (New York: Harper Collins Publishers, 1974), 64.

As I have written elsewhere, how, then, do we minister to our sisters and brothers during these times? Are our communities healthy and vibrant, possessive of the faith, courage and commitment to walk with the sick, the elderly and the dying along their journeys; to encourage them to raise their concerns to a level of consciousness; to listen and to care for them with compassion; to simply be present to them? Are we willing to take the time to listen to their life stories; their dreams forgone and unfilled; their achievements of how they brought the healing of Jesus to the disenfranchised and despised of the earth; to their trials and painful days, and still reverence them for whom they are rather than for what they have accomplished? In the spirit and grace of poverty how can we help them let go of their possessions, especially their pain and disappointments, their independence and responsibilities and so they can be free to embrace a greater awareness of the Divine Mysteries in their lives? Can we help them continue to journey to a different place in their relationship with God and those with whom they live? Are we willing to help bring them to Jesus?[14]

For a community to be a center of healing and hope it must be a healing Pool of Bethzatha where the presence of Jesus is strikingly evident in the heart and prayer life of the community and in each of its members. It must promote and defend the dignity and freedom of every person within its care.

In speaking about personal experiences of healing in a religious community, one member wrote:[15]

> I have discovered over the past several years that there are a number of essential ingredients necessary for a successful journey from an addictive behavior to a point where I truthfully can say, "I am on the way in being healed and restored to health". Obviously, a change in certain thought processes and behaviors have to be evident to support such a claim. These necessary ingredients include the abundance of God grace

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[14] Ignatius Perkins. "Caring Communities," *Religious Life Review* 41:213 (March-April, 2002): pp. 66-79.
[15] Ignatius Perkins. Unpublished Correspondence, 2007.

(that He will bring to perfection what He has begun); the openness and co-operation of myself to acknowledge the existence of an addictive behavior; the ability of gifted people who are guiding me on the way to healing; the understanding , support and love of significant others in my life.

The addictive process harbors lots of secrets and hidings within the self and from everyone else. Healing has a lot to do with acknowledging the secrets and isolation, not only within myself but to significant others, since these are the very people who have been directly or indirectly harmed by my negative choices and behaviors. Initially this "revealing" was done with shame and emotional pain akin to debriding necrotic tissue from a serious burn. The ouches are eventually supplanted by freedom and a restoration of self-worth.

I cannot prioritize the above factors in my journey to healing. I will just say the loudest and most effective and essential factor was the acceptance of whom I am, warts and all, by people who love me and have loved me all along, even during those times I perceived myself as not important enough to be loved by others. This understanding and reflection of my own worth mirrored back to me by others were the lynchpins for the other factors to operate. If it were not for an accepting and forgiving community and four of my superiors along with some close friends, I would still be choosing to hide within the darkened and twisted labyrinths of my mind.

Religious Communities: Centers of Healing

As sensitively illustrated in the preceding narrative, the mission of a healthy religious community, caring for one another with compassion is clear: it is a challenge to be embraced and accepted, never a problem or a burden to be endured. Through caring with compassion in community, the community brings the healing ministry of Jesus Christ to all of its brothers and sisters. A religious community that is an authentic center of healing, regardless of obstacles, unsuccessfully interventions, or the reasons for illnesses or failures, continues to carry its sick brothers and sisters to the healing waters of the Pool of Bethzatha. It must never abandon these ministers of God's Word in their personal journeys toward healing and renewal nor leave them to find their own way. Held in earthen vessels, they are the great treasure of the gift of God.[16] A

[16] Congregation for Institutes of Consecrated Life and Societies of Apostolic Life. *Starting Afresh From Christ: A Renewed Commitment To Consecrated Life in the Third Millennium* (May 19, 2002), II, p. 9.

religious community, healed of its own addictive behaviors, can never again allow a brother or sister of the community to ever be left alone or alienated from the healing of Jesus.

To fulfill the community mission of caring brothers and sisters must call one another to the generous and courageous acceptance of all the demands which community life makes of them: caring for those who are suffering in any way, physically, psychologically, socially and spiritually, and especially the alienated and the marginalized; affirmation and reverence of our elderly sisters and brothers for their gifts to the Church in times and places of great suffering and turmoil; compassionate care for those suffering with addictions, chronic diseases and intractable pain; the terminally ill, and the dying; good stewardship of our personal health; and accountability for the use of the community's resources.

Preaching and caring with compassion is the healing ministry of Jesus Christ. As vowed religious preaching and caring with compassion must also be our ministry to one another and to all we serve. When Jesus' question is raised to religious communities and to its brothers and sisters, "Do you want to be well again?" he assures them that healing will be theirs.