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MENTAL HEALTH AND HARMONY IN CONSECRATED LIFE: THE TREASURE CARE MODEL

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Abstract

The theme "Faith as Harmony of Life" invites consecrated life to recover an integrative vision of the human person in which spiritual commitment, psychological wellbeing, relational capacity, and vocational fidelity form a coherent whole. This article argues that mental health is not ancillary to consecrated vocation but constitutive of its theological integrity. Drawing upon Christian theological anthropology, Magisterial teaching, contemporary mental health scholarship, and sustained clinical and pastoral engagement with women religious, the paper adopts a practice-informed theological methodology to examine how unaddressed psychological distress—often obscured by stigma, spiritualisation of suffering, and structural dynamics—disrupts personal integration and communal harmony.

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In response, the article proposes the TREASURE CARE Model, a faith-embedded, community-based mental health framework developed by women religious for women religious. The model integrates five interdependent pillars: mental health literacy and stigma reduction, early identification of distress, relational accompaniment, structured professional referral, and community-level cultural transformation. Situated within global mental health principles and ecclesial anthropology, the model reframes care for psychological wellbeing as an expression of incarnational theology and communal responsibility. By engaging critically with traditional understandings of asceticism, redemptive suffering, and obedience, the paper contends that therapeutic care safeguards vocational freedom and strengthens consecrated life as a credible witness to communion, hope, and harmony. Mental health care thus emerges not merely as pastoral support but as a theological and ecclesial imperative within contemporary religious life.

Keywords: Consecrated life; Harmony of life; Mental health and faith integration; Psychospiritual accompaniment; Community-based care; TREASURE CARE Model.

1. Introduction: Faith as Harmony of Life

Faith as harmony of life refers to the integration of the human person in relationship with God, self, others, and mission. Harmony does not imply the absence of struggle but the presence of integration. The Second Vatican Council affirms that the human person is a unified being in whom "body and soul form a single nature," and whose dignity requires care for the whole person.[1] This affirmation establishes an anthropological foundation for understanding faith as integrative rather than compartmentalised.

Consecrated life represents a distinctive embodiment of this integration. It is a total response to a divine call, involving the offering of one's entire existence in loving service. Pope John Paul II describes consecrated life as a manifestation of transformed existence in which the Gospel permeates every dimension of the human person.[2] This transformation, however, unfolds within human psychological

[1] Second Vatican Council, *Gaudium et Spes* (Pastoral Constitution on the Church in the Modern World), December 7, 1965, no. 14, https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_const_19651207_gaudium-et-spes_en.html.

[2] John Paul II, *Vita Consecrata*, March 25, 1996, no. 65, https://www.vatican.va/content/john-paul-ii/en/apost_exhortations/documents/hf_jp-ii_exh_25031996_vita-consecrata.html.

reality. Consecrated life does not remove emotional vulnerability; rather, it situates vulnerability within grace.

Psychological well-being plays a foundational role in vocational integration. Contemporary mental health research demonstrates that emotional stability supports meaning-making, relational engagement, and resilience.[3] Emotional distress—including depression, anxiety, trauma-related conditions, and burnout—can impair discernment, weaken relational trust, and diminish vocational vitality. When suffering remains unacknowledged, it may manifest as withdrawal, relational fragmentation, and diminished missionary engagement.

Christian theology affirms that grace engages human nature rather than bypassing it. The Incarnation reveals that divine grace enters fully into human psychological and embodied reality. Faith lived in harmony, therefore requires attention to psychological well-being. Care for mental health is not external to faith but intrinsic to its authentic embodiment.

2. Mental Health as a Theological and Anthropological Reality

Mental health must be understood within the framework of theological anthropology. The human person, created in the image of God, possesses inherent dignity, relational capacity, and interior depth. The Church affirms that human dignity requires conditions that enable integral flourishing.[4] Psychological well-being is essential to this flourishing.

George Engel's biopsychosocial model demonstrated that health emerges from the interaction of biological, psychological, and social dimensions rather than biological functioning alone.[5] This insight resonates deeply with Christian anthropology, which affirms the unity of body, mind, and spirit. Human well-being cannot be fragmented into isolated domains.

Psychological well-being supports freedom, discernment, and relational capacity. Emotional regulation enables vocational fidelity. Psychological distress, by contrast, can impair cognitive clarity, relational trust, and spiritual integration.[6] Without appropriate care,

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[3] Thomas R. Insel, *Healing: Our Path from Mental Illness to Mental Health*, New York: Penguin Press, 2022, 52–60.

[4] Second Vatican Council, *Gaudium et Spes*, nos. 12–14.

[5] George L. Engel, "The Need for a New Medical Model: A Challenge for Biomedicine," *Science* 196, 4286 (1977) 129–136, at 131.

[6] Thomas R. Insel, *Healing: Our Path from Mental Illness to Mental Health, 52-60.*

distress may compromise both personal well-being and communal harmony.

Spirituality contributes significantly to resilience. Faith provides meaning, belonging, and hope. However, spirituality cannot substitute clinical care when psychological disorders are present. Research demonstrates that religion enhances coping most effectively when integrated with psychological and medical support.[7] This integration reflects an incarnational approach to care.

Pope Francis emphasises that authentic pastoral care requires accompaniment that recognises human fragility and vulnerability.[8] Mental health care within religious life reflects this pastoral vision by affirming human dignity and supporting integral well-being.

Mental health is therefore both a theological and ecclesial concern. It reflects care for the human person created in God's image and strengthens the integrity of ecclesial life.

3. Consecrated Life as a Context of Integration and Vulnerability

Consecrated life is a prophetic witness to the integration of faith and existence. It embodies relational communion, sacrificial love, and missionary service. Pope John Paul II affirms that consecrated life reflects the Church's call to holiness and communion.[9]

However, consecrated life unfolds within human psychological realities. Religious sisters often serve in emotionally demanding ministries involving sustained exposure to suffering. These caregiving roles require emotional labour, defined as the regulation of emotional expression in caregiving contexts.

Research demonstrates that caregiving professions experience elevated risks of burnout and emotional exhaustion when emotional demands are sustained without adequate support.[9] Compassion fatigue may weaken psychological resilience and vocational vitality.

Leadership roles introduce additional psychological complexity. Leaders carry responsibility for institutional functioning and

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[7] Harold G. Koenig, "Religion, Spirituality, and Health," *ISRN Psychiatry* (2012) 1–33, at 5

[8] Francis, *Evangelii Gaudium*, November 24, 2013, no. 169, https://www.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html

[9] *John Paul II, Vita Consecrata, 65.*

relational harmony. Without adequate support, leaders may experience emotional burden and isolation.

These vulnerabilities do not reflect vocational weakness but human reality. Pope Francis affirms that consecrated persons remain human and require accompaniment, growth, and care.[10] Care for mental health strengthens the capacity to live a consecrated vocation authentically and sustainably.

4. Structural and Psychological Vulnerabilities of Women Religious

Women religious have played a foundational role in the Church's mission, particularly among marginalised populations. Their ministries reflect profound vocational commitment.

However, structural realities often expose women religious to psychological strain. Cultural expectations of self-sacrifice may discourage emotional expression. Emotional distress may be spiritualised rather than addressed clinically.[11]

Stigma surrounding mental illness remains a major barrier to help-seeking. Research demonstrates that stigma delays treatment and deepens suffering.[2] Silence may be misinterpreted as spiritual strength when it reflects psychological distress.

Mental health services often lack familiarity with consecrated life. Religious vocation involves unique relational, spiritual, and communal structures. Mental health care must therefore integrate psychological expertise with contextual understanding.[11]

Addressing these vulnerabilities requires community-based and faith-integrated mental health frameworks.

5. Community as the Context of Mental Health and Healing

Human beings are fundamentally relational, and psychological well-being develops and is sustained within relational environments. Emotional health is not formed in isolation but through experiences of acceptance, belonging, and mutual care. Social belonging strengthens resilience, enhances coping capacity, and promotes healing by

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[10] Francis, *Fratelli Tutti*, October 3, 2020, no. 115, https://www.vatican.va/content /francesco/en/encyclicals/documents/papa-francesco_20201003_enciclica-fratelli-tutti.html.

[11] Patrick W. Corrigan, Benjamin G. Druss, and Deborah A. Perlick, "The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care," *Psychological Science in the Public Interest* 15, 2 (2014) 37–70, at 40.

providing individuals with emotional security and relational stability.[12]

The Church affirms that human fulfilment emerges within communion, reflecting the relational nature of the human person created in the image of a relational God.[13] Consecrated life embodies this relational anthropology in a distinctive way. Community life provides not only structural coexistence but also relational support, shared mission, emotional accompaniment, and spiritual companionship. These relationships create a context in which individuals are seen, understood, and sustained in their vocational journey.

When communities foster emotional safety, openness, and acceptance, they become environments of healing where vulnerability can be expressed without fear of judgement. Such environments enable early recognition of distress and facilitate compassionate support. Conversely, communities characterised by silence, stigma, or emotional distance increase psychological vulnerability, deepen isolation, and delay help-seeking.

Global mental health research consistently emphasises the importance of community-based care, early identification, relational support, and shared responsibility as essential strategies for promoting mental well-being and preventing psychological crises.[14] These principles align naturally with the communal structure of consecrated life, where daily relational contact provides unique opportunities for accompaniment, early support, and healing presence.

Community, therefore, becomes not merely the setting of consecrated life but its therapeutic and formative environment—the primary context in which psychological wellbeing is protected, suffering is recognised, and healing is nurtured.

6. Genesis and Vision of the TREASURE Movement

The TREASURE Movement emerged from sustained clinical and pastoral engagement with women religious experiencing

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[12] Corrigan, Druss, and Perlick, "The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care,"please provide other details of this book…..

[13] Second Vatican Council, *Gaudium et Spes*, nos. 12–14.

[14] Vikram Patel et al., "The Lancet Commission on Global Mental Health," *The Lancet* 392, 10157 (2018) 1553–1598, at 1558.

psychological distress. Over years of psychiatric and psychospiritual accompaniment, a consistent pattern became evident. Many religious sisters struggled silently with emotional distress, anxiety, trauma, burnout, and relational wounds. While clinical care was helpful, it became increasingly clear that clinical intervention alone was insufficient when community awareness and support were lacking.

A particularly painful moment that profoundly shaped the vision of TREASURE was the suicide of a young religious sister. This tragedy revealed the devastating consequences of unrecognised and unsupported psychological suffering. It exposed the limitations of individualised care in the absence of community awareness. It highlighted the urgent need for community-based approaches that foster early identification, accompaniment, and support.

TREASURE emerged as a response to this gap. It was envisioned not merely as a mental health programme but as a movement of care within religious life. Its vision is rooted in the conviction that mental health care is an expression of faith and communal responsibility. TREASURE seeks to foster communities where psychological well-being is recognised as integral to vocation and where care becomes a shared responsibility. TREASURE represents a shift from crisis-based intervention to preventive and community-based care. It recognises that healing often begins not in clinical settings but in relationships of trust, presence, and understanding.

Pope Francis describes the Church as a "field hospital," called to respond to human suffering with compassion.[15] TREASURE embodies this ecclesial vision. Its mission is to foster communities where mental health is recognised as integral to vocation.

7. The TREASURE CARE Model

The TREASURE CARE Model is a structured, community-based mental health framework designed specifically for religious women living in vowed communal settings. It has been developed by the TREASURE network—a collaborative body of religious sisters engaged in professions of care (including psychiatry, psychology, counselling, education, healthcare, and social service) as well as religious formation. The network currently includes more than ninety religious sisters from diverse congregations across India who share a

[15] Pope Francis, Interview, *La Civiltà Cattolica*, September 2013.

commitment to strengthening mental health literacy and pastoral care within consecrated life.

Emerging from sustained clinical engagement, pastoral accompaniment, and formation experience, the model translates principles of global mental health and Christian theological anthropology into a contextually adapted system of care within religious communities. The TREASURE network functions as both a professional and ecclesial consortium, facilitating knowledge exchange, peer collaboration, leadership dialogue, and digital outreach. Its activities and resources are coordinated through its website (www.thetreasuresisters.in), which serves as a hub for educational content, testimonies, and community engagement.

Rather than functioning as a clinical centre, the TREASURE CARE Model operates as a capacity-building and culture-forming framework. Its primary objective is to equip communities themselves with the literacy, relational competence, referral pathways, and structural safeguards necessary to recognise psychological distress early and respond responsibly. In doing so, it shifts mental health from an external, crisis-driven intervention to an embedded communal responsibility.

Operationally, the model functions at three interrelated levels:

Individual Level – strengthening emotional awareness, self-understanding, and help-seeking capacity among sisters.

Community Level – cultivating peer accompaniment, early identification mechanisms, and emotionally safe relational environments.

Institutional Level – engaging leadership, formation structures, and governance processes to embed sustainable systems of care.

The TREASURE CARE Model does not replace professional psychiatric or psychological services. Rather, it establishes a stepped-care pathway in which community-based awareness and accompaniment serve as first-line responses, while structured referral ensures timely access to specialised care when necessary. This integration prevents both over-medicalisation of ordinary vocational struggles and the neglect of clinically significant distress.

A distinctive feature of the model is its origin in consecrated life itself. Developed by women religious for women religious, the framework integrates psychological expertise, formation experience,

and ecclesial sensibility. Mental health care is thus framed not merely as a therapeutic necessity but as an expression of incarnational faith, communal responsibility, and vocational stewardship.

The TREASURE CARE Model is therefore best understood as a preventive, relational, and structurally embedded framework that strengthens vocational sustainability by integrating information, intervention, and infrastructure within the daily life of religious communities. It is structured around six interdependent pillars.

7.1 Mental Health Literacy and Stigma Reduction

Education constitutes the first pillar of the TREASURE CARE Model, addressing one of the most significant barriers to mental health care: stigma. Misunderstanding, fear, and spiritual misinterpretations often prevent individuals from recognising psychological distress and seeking appropriate support. Education restores dignity by replacing stigma with knowledge, fostering informed awareness, and enabling communities to recognise mental health challenges as legitimate human experiences rather than signs of personal or spiritual inadequacy.[16] Through structured training, workshops, and ongoing formation, TREASURE promotes mental health literacy that integrates psychological knowledge with spiritual sensitivity. This educational process transforms community culture, creating environments where emotional vulnerability can be acknowledged without shame and where help-seeking becomes an act of courage and responsible self-care rather than perceived weakness.

7.2 Early Identification

Early identification represents a preventive and protective dimension of the model. Psychological distress often develops gradually, manifesting initially through subtle emotional, behavioural, or relational changes. Without early recognition, such distress may progress into more severe psychological conditions, impairing personal wellbeing and vocational stability. Early identification prevents escalation of distress and promotes timely care by enabling community members, leaders, and peers to recognise early warning signs and respond with sensitivity and care.[17] This approach reflects the principle that communities themselves can serve

[16] Corrigan, Druss, and Perlick, "The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care," other details please….

[17] Vikram Patel et al., "The Lancet Commission on Global Mental Health," 1558.

as primary environments of observation, support, and intervention. Early identification not only reduces suffering but also strengthens resilience, preserves relational harmony, and enhances the sustainability of consecrated vocation.

7.3 Relational Accompaniment

Relational accompaniment forms the heart of the TREASURE CARE Model. Healing begins with compassionate presence. Accompaniment reflects both the pastoral tradition of the Church and contemporary psychological understanding of relational healing. It involves attentive listening, empathetic presence, and non-judgmental support that affirms the dignity and worth of the person. Within consecrated communities, accompaniment reflects the Gospel model of walking with one another in love, compassion, and mutual responsibility. Psychologically, relational accompaniment reduces isolation, fosters emotional safety, and strengthens resilience. It creates spaces where individuals feel seen, heard, and understood, thereby facilitating openness and trust. This relational foundation ensures that care emerges not as clinical intervention alone but as a lived expression of communal love and spiritual solidarity.

7.4 Structured Referral

Structured referral pathways ensure that individuals experiencing psychological distress receive timely and appropriate professional care when needed. TREASURE facilitates access to professional care while maintaining relational continuity and support within the community. This integration prevents fragmentation between clinical care and community life. Professional mental health services provide specialised assessment and treatment, while community accompaniment ensures sustained emotional and spiritual support. Structured referral pathways also reduce delays in care by creating clear, trusted channels for accessing mental health professionals who are sensitive to the spiritual and vocational realities of consecrated life. In this way, TREASURE complements professional mental health care, ensuring that individuals receive holistic support that honours both their psychological needs and vocational identity.

7.5 Community Cultural Transformation

The ultimate goal of the TREASURE CARE Model is community cultural transformation. Mental health care cannot be sustained through individual interventions alone; it requires transformation of communal attitudes, beliefs, and practices. TREASURE fosters

cultures of care by promoting openness, emotional safety, compassion, and shared responsibility. Communities are gradually transformed from environments of silence and stigma into environments of understanding, acceptance, and healing. This transformation strengthens relational trust, enhances communal harmony, and creates conditions where psychological wellbeing can flourish. Mental health care becomes integrated into the ordinary life of the community, reflecting a lived expression of faith, communion, and mutual care. In this transformed culture, care for mental health is no longer seen as an exception but as an integral dimension of consecrated life itself.

7.6 Theological and Pastoral Implications

The integration of mental health into consecrated life does not merely introduce a pastoral strategy; it invites theological discernment. By bringing psychological science into dialogue with spiritual tradition, the TREASURE CARE Model raises critical questions regarding asceticism, redemptive suffering, obedience, and the exercise of authority within vowed community.

7.6.1 Reframing Asceticism Through Integral Anthropology

Classical asceticism aims at freedom for love through disciplined self-gift. *Perfectae Caritatis* affirms that renewal of religious life requires "a continual return to the sources of all Christian life and to the original spirit of the institutes" while also attending to "the changed conditions of our time".[18] This dual fidelity requires discernment regarding how ascetical practices are understood and embodied today.

When detached from psychological insight, ascetical language may unintentionally legitimise emotional suppression, chronic self-denial, or neglect of legitimate human needs. Yet Christian anthropology, as articulated in *Gaudium et Spes*, affirms that the human person is an integrated unity of body and soul (GS, 14). Authentic asceticism therefore presupposes psychological integration. Sacrifice that emerges from unresolved trauma, anxiety, or depressive distortion cannot be equated with evangelical freedom. Mental health awareness

[18] Second Vatican Council, *Perfectae Caritatis* (Decree on the Adaptation and Renewal of Religious Life), October 28, 1965, no. 2, https://www.vatican.va/archive/hist_councils/ii_vatican_council/documents/vat-ii_decree_19651028_perfectae-caritatis_en.html.

reframes asceticism not as the endurance of unmanaged suffering, but as the disciplined integration of the person in truth and charity.

7.6.2 Discernment and the Spiritualisation of Suffering

Consecrated life has long interpreted suffering within the horizon of participation in Christ's redemptive love. *Salvifici Doloris* affirms that suffering united to Christ acquires salvific meaning.[19] However, theological affirmation of redemptive suffering does not eliminate the need for discernment. Psychological disorders—such as major depression, trauma-related conditions, or severe anxiety—are not reducible to spiritual trial. When psychological pathology is prematurely spiritualised, clinical care may be delayed and isolation deepened.

Evangelii Gaudium calls pastors to accompany others with attentiveness to "human fragility" and concrete reality.[20] Such accompaniment requires distinguishing between ordinary vocational struggle and clinically significant distress. A mature theology of suffering neither romanticises nor absolutizes pain; it recognises that seeking therapeutic care can itself be an act of humility and responsible stewardship of vocation. In this light, professional intervention does not contradict participation in Christ's cross but may restore the interior freedom necessary to carry it authentically.

7.6.3 Redemptive Meaning and Therapeutic Responsibility

The integration of psychological care requires holding in tension two truths: suffering may be spiritually meaningful, yet it may also impair freedom and relational capacity. *Vita Consecrata* emphasises that consecrated persons are called to reflect the full humanity of Christ, integrating affective maturity with spiritual commitment.[21] When psychological distress compromises agency, distorts discernment, or erodes relational trust, therapeutic intervention becomes a means of restoring the human foundations upon which grace builds.

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[19] John Paul II, *Salvifici Doloris*, February 11, 1984, no. 19, https://www.vatican.va/content/john-paul-ii/en/apost_letters/documents/hf_jp-ii_apl_11021984_salvifici-doloris.html

[20] Francis, *Evangelii Gaudium*, November 24, 2013, no. 169, https://www.vatican.va/content/ francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html.

[21] John Paul II, *Vita Consecrata,* March 25, 1996, no. 65, https://www.vatican.va/content/john-paul-ii/en/apost_exhortations/documents/hf_jp-ii_exh_25031996_vita-consecrata.html.

Thus, mental health care safeguards vocational freedom. Therapy does not eliminate the cross; rather, it clarifies which burdens belong to the call of discipleship and which arise from untreated psychological conditions. By strengthening emotional regulation and cognitive clarity, therapeutic care enhances the capacity for conscious and generous self-gift.

7.6.4 Obedience, Authority, and Conditions for Help-Seeking

Consecrated life is structured around vowed obedience, ordered toward communion and shared mission. *Lumen Gentium* affirms that obedience is offered in faith and love (LG, 43), while *Vita Consecrata* emphasises that authority must be exercised as service (VC, 43). Yet hierarchical dynamics can unintentionally shape help-seeking behaviour. Fear of being perceived as weak or lacking vocation may inhibit disclosure of psychological distress. Cultural ideals of self-sacrifice may further discourage self-advocacy.

For obedience to remain evangelical, it must be grounded in truth and freedom. Structures of authority therefore bear responsibility for creating psychologically safe environments where vulnerability can be expressed without suspicion. When authority affirms rather than minimises psychological suffering, barriers to care are reduced and communal trust is strengthened.

7.6.5 Toward an Incarnational Ecclesial Praxis

The theological implications of mental health integration converge upon an incarnational vision of the human person. *Gaudium et Spes* insists that "nothing genuinely human fails to raise an echo" in the hearts of Christ's disciples (GS, 1). Psychological suffering, therefore, cannot be treated as peripheral to spiritual life. To attend to mental health is to honour the concrete humanity assumed by Christ.

7.6.6 Religious Formation

Formation constitutes the integrative pillar that ensures long-term sustainability. In continuity with *Vita Consecrata* (no. 65), which emphasises the integration of human and spiritual maturity, TREASURE embeds psychological literacy within both initial and ongoing formation. Emotional regulation, relational skills, and self-awareness are recognised as essential foundations for vocational fidelity.

Formation within the model is not limited to intellectual instruction. It cultivates capacities for discernment, empathetic presence, and responsible self-care. By integrating mental health

awareness into formative processes, communities move from reactive intervention toward preventive culture-building. In this way, formation becomes the structural mechanism through which the other pillars are stabilised and transmitted across generations.

8. Institutional Embedding and Sustainability

Beyond individual and communal awareness, the long-term viability of the TREASURE CARE Model depends upon institutional embedding. Engagement with congregational leadership has emphasised the importance of psychologically safe governance, clear referral protocols, and explicit affirmation of professional consultation when needed.

The integration of mental health literacy within formation structures, leadership training, and digital platforms reflects a movement toward systemic sustainability. TREASURE's online initiatives, peer networks, and leadership conferences further support this structural embedding by creating national and transnational spaces of dialogue and shared discernment.

Such institutional integration ensures that mental health care does not remain an isolated initiative but becomes woven into the formative, administrative, and missionary life of religious communities. Sustainability thus emerges not from periodic programming alone, but from the gradual internalisation of care as a normative dimension of consecrated identity.

9. Impact: Information, Intervention, and Infrastructure

The impact of the TREASURE initiative can be understood through its three interrelated operational arms: Information, Intervention, and Infrastructure. Together, these dimensions reflect a movement from awareness to accompaniment to sustainable structural integration within consecrated life.

9.1 Information: Creating Awareness and Reducing Stigma

The first arm of TREASURE focuses on mental health literacy and cultural transformation. Through workshops, formation programmes, leadership consultations, and digital engagement, the initiative has contributed to a measurable shift in awareness among women religious. Sisters increasingly demonstrate the ability to recognise early signs of psychological distress and to distinguish clinical vulnerability from spiritual struggle.

The TREASURE web platform plays a significant role in this awareness-building process. By regularly featuring reflections and testimonies from sisters on resilience, community life, emotional struggle, and care commitments, the platform fosters open and faith-integrated conversations on mental health. Across its digital handles, cumulative engagement has exceeded 50,000 views globally, indicating that the conversation has extended beyond local congregational contexts into wider ecclesial and transnational spaces.

This informational arm has contributed to the gradual reduction of stigma. Mental health is increasingly discussed not as a private weakness but as a shared human reality within vocation. While long-term evaluative research remains a future goal, qualitative feedback indicates greater openness to dialogue and increased willingness to seek professional consultation when necessary.

9.2 Intervention: Accompaniment and Early Support

The second arm concerns timely relational response and early intervention. TREASURE emphasises peer accompaniment, early identification of distress, and structured referral pathways. Workshops and training initiatives have equipped sisters with foundational competencies in empathetic listening, psychological first response, and responsible referral.

WhatsApp-based peer networks formed under the TREASURE banner function as active communication communities. These groups facilitate listening, shared discernment, and informal guidance. In many instances, they operate as first points of contact for sisters experiencing distress, serving as relational containment spaces that can prevent escalation and encourage appropriate professional support. While not substitutes for clinical services, these networks embody a task-sharing approach consistent with community-based global mental health models.

The TREASURE CARE online course further strengthens this intervention arm. Designed to train over 500 women religious in Mental Health First Aid, the course seeks to build community-level competence in recognising early warning signs, responding compassionately, and facilitating timely referral. By enhancing first-line support within daily community life, the intervention dimension promotes preventive rather than crisis-driven care.

9.3 Infrastructure: Building Sustainable Ecclesial Structures

The third arm of TREASURE addresses structural sustainability. Beyond individual awareness and accompaniment, the initiative seeks to embed mental health care within the formative and governance structures of religious life.

Leadership engagement has been a key component of this effort. Workshops with superiors and formators have emphasised the creation of psychologically safe environments, clear referral pathways, and policies that normalise professional consultation. In communities where leadership explicitly affirms mental health care, barriers to help-seeking decrease and communal trust strengthens.

Looking ahead, the TREASURE sisterhood is planning nationwide conferences to convene religious leadership across India. These gatherings aim to foster collective discernment regarding sustainable formative and missionary frameworks for women religious in contemporary contexts. By engaging leadership at institutional levels, TREASURE seeks to move from isolated initiatives toward systemic integration of mental health within formation, governance, and mission.

10. Conclusion: Care as Faith Lived in Harmony

"Harmony of Life" calls consecrated communities to a renewed integration of spiritual commitment, psychological maturity, relational trust, and vocational freedom. Mental health is not peripheral to this harmony but constitutive of it. When psychological suffering remains unrecognised, spiritualised prematurely, or structurally silenced, both personal integrity and communal communion are weakened. Conversely, when psychological care is embraced within an incarnational theology of the human person, consecrated life is strengthened in authenticity and witness.

Engagement with contemporary mental health scholarship does not dilute the ascetical or sacrificial dimensions of religious life; rather, it purifies and clarifies them. Authentic asceticism presupposes psychological freedom. Redemptive suffering requires discernment so that clinical pathology is not mistaken for sanctity. Obedience, ordered toward truth and communion, must create conditions in which vulnerability can be expressed without fear. In this way, mental health care safeguards the freedom necessary for genuine self-gift.

The TREASURE CARE Model proposes a concrete ecclesial response grounded in theological anthropology and aligned with

global community-based mental health principles. Through its three operational arms—Information, Intervention, and Infrastructure—it seeks to cultivate awareness, strengthen relational accompaniment, and embed sustainable structures of care within consecrated life. Its expansion into digital engagement, peer networks, formation programmes, and leadership collaboration reflects an emerging recognition that psychological wellbeing is integral to vocational sustainability.

This development represents not an accommodation to modern therapeutic culture, but a deepening of the Church's incarnational vision. As Gaudium et Spes reminds us, nothing genuinely human lies outside the concern of Christ's disciples (GS, 1). Psychological suffering, therefore, belongs within the horizon of ecclesial care. To attend responsibly to mental health is to affirm the dignity of the person created in the image of God and called to consecrated life.

The future of consecrated life depends not only on fidelity to charism and mission, but on the cultivation of communities capable of integration—communities where vulnerability is not hidden, accompaniment is intentional, leadership is responsive, and care is embedded in formation and governance. Such communities become credible witnesses to communion and hope.