



Mental Illness & Families of Faith

How Congregations Can Respond

Resource/Study Guide for Clergy and Communities of Faith

Rev. Susan Gregg-Schroeder
Coordinator of Mental Health Ministries
www.MentalHealthMinistries.net
sgschroed@cox.net

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Mental Illness and Families of Faith: How Congregations Can Respond

Resource/Study Guide for Clergy and Communities of Faith

Introduction

Background

Surveys show that over forty percent of Americans seeking help with mental health issues turn first to ministers, priests and rabbis. This is twice as many as those who went first to a psychiatrist, psychologist or family physician. Unfortunately, the response of clergy and congregations falls significantly short of what parishioners expect of their faith leaders. Individuals struggling with mental illness are significantly less likely to receive the same level of pastoral care as persons in the hospital with physical illnesses, persons who are dying or those who have long-term illnesses. People often visit others with physical illness, bring them meals and provide other helpful services. Mental illness has been called the “no casserole disease.”

There are a number of reasons why these needs are not being met. Clergy do not receive adequate education about mental illnesses in seminaries. Some faith groups see mental illness as a moral or spiritual failure. Congregations are made up of individuals who mirror the stigma and fear we find in society as a whole. Even if people are aware that someone is struggling with mental illness, they may not know what to do or say.

The needs of families coping with mental illness are documented in the book, *Families and Mental Illness: New Directions in Professional Practice*. (Marsh, New York: Praeger. 1992) The needs fall into eight categories:

- A comprehensive system of mental health care
- Support
- Information
- Coping Skills
- Involvement in the treatment, rehabilitation, and recovery process
- Contact with other families impacted by mental illness
- Managing the process of family adaptation to illness
- Assistance in handling problems in society at large (e.g. ignorance, fear, stigma)

Audience

This resource/study guide is designed to be used with clergy, members of congregations, family members and anyone desiring to learn more about mental illness and how to respond with compassion and care. In breaking the silence about mental illness, you are giving permission for people to share their own stories. Group leaders need to be ready to provide support and/or appropriate referrals, if necessary. It is always important to provide a safe and confidential setting for participants to share openly.

How to Use this Resource

Because of the amount of information and the emotional nature of some of the content, it is recommended that this material be used in a small study group.

Group leaders can choose what material to cover and what study questions would be most helpful in their particular setting.

Leaders may want to adapt this resource to use as an extended class or seminar with a recommended minimal time of one and a half hours.

An optional assessment tool is provided to help participants identify their beliefs about mental illness.

Faith leaders can use this resource to quickly find information on a specific topic when the need arises.

SECTION ONE Understanding Mental Illness

Meditation

People with mental problems are our neighbors. They are members of our congregations, members of our families; they are everywhere in this country. If we ignore their cries for help, we will be continuing to participate in the anguish from which those cries of help come. A problem of this magnitude will not go away. Because it will not go away, and because of our spiritual commitments, we are compelled to take action.

Rosalynn Carter¹

Attitudes about Mental Illness

Before starting the group, the tool below will help assess the participants' beliefs and attitudes about mental illnesses. It can help begin the discussion by determining the knowledge and attitudes of the group about mental illness. This assessment tool is available in the Appendix.

1. What are your beliefs about the cause of mental illnesses such as depression, schizophrenia, addictions, etc.?



Circle all that best relate to the way you feel.

- a. Suffering can give you the opportunity to grow spiritually
- b. If a person prays more, they will be cured.
- c. Persons with a mental illness are more violent.
- d. God never abandons those who suffer
- e. Persons with mental illness in their families need the support of the faith community.
- f. Suicide is a sin and shows a lack of faith in God.
- g. Persons with a mental illness could just snap out of it, but they are too lazy.

2. Persons with mental illness are better off going elsewhere to worship. They have difficult behaviors that can disrupt worship.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

3. Spirituality and religion are not that helpful for persons with a mental illness and their families.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

4. I feel comfortable talking with my pastor or other church leaders about mental health issues.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

5. Persons with a mental illness and their families are treated like any other parishioner.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Background for Group Facilitator

The magnitude of mental illness in this country is staggering. According to the Surgeon General, one in every five Americans experiences a mental disorder in any given year and half of all Americans have such disorders at some time in their lives. These illnesses of the brain affect all of us, regardless of age, gender, economic status or ethnicity. Nearly every person sitting in our congregations has been touched in some way by mental illness. And yet individuals and families continue to suffer in silence or stop coming to worship because they are not receiving the support they so desperately need. They become detached from their faith community and their spirituality, which can be an important source of healing, wholeness and hope in times of personal darkness.

Persons with a mental illness or concerned family members are more likely to seek help from their faith leader than from mental health professionals. Yet studies have shown that clergy are least effective in providing appropriate support, care and referral information. Too often the seminary training for clergy is inadequate. Clergy have their own fears. Many faith leaders are hiding their own mental illness or that of a family member. Serious mental illness has been called the modern day leprosy.

Our Spiritual Imperative to Care for Those Who Suffer

Hospitality is a core value of all major religions...Muslim, Jewish and Christian. The words hospital, hospice and host are derived from hospitality. Hospitality means literally extending our hand to another, touching another and getting close enough to recognize our mutual vulnerability to things in this life.

Major religions also share the conviction that we are called to care for those who suffer in this world. Both the Hebrew Scriptures and the New Testament contain many stories of people being called to care for others. The great prophets share a similar message. God asks us to be faithful, to love one another, to reach out to those who are broken and to seek justice for all God's people.

What Causes Mental Illness?

Mental illness seldom has one single cause. As humans, our minds, body and spirit are interconnected in complex and wondrous ways. The word "mental illness" can be confusing since it is used to describe a continuum of emotional issues from mild depression to serious brain disorders that affect one's ability to function.

Neuroscientists are in awe of the magnificence of the human brain. The human brain has billions of nerve cells (neurons), thousands of connections by each neuron to other neurons and trillions of possible pathways for nerve impulses to travel. Researches continue to uncover the mysteries of this complex organ. Enough is known at present, however, to say that serious mental illness has a biological component and is not the result of poor parenting or a lack of character on the part of the person afflicted with one of these "no fault disorders." Statistical studies have also shown that heredity likely plays a significant role in the development of serious mental illness.

Because mental illness involves a biochemical change in the brain chemistry, certain medical conditions can contribute to mental illness. For example, persons who have medical conditions like thyroid conditions, heart attacks, strokes, cancer and other many other physical illnesses can develop symptoms. Since these disorders can be related to a medical condition, most symptoms respond well when treated as part of the illness. Women have a higher risk of having depression after childbirth and during menopause.

There are many other factors that can contribute to the development of emotional disorders that are often time limited. Persons who lack social support, who feel isolated or have low self esteem are at a higher risk for developing a mood disorders. Other risk factors include poverty, lack of access to medical care and being socially marginalized.

Such things as traumatic events in life, losses of all kinds, environmental trauma and the perceived absence of purpose or meaning in one's life can contribute to the onset of a mood disorder. While emotionally disturbing events are not felt to be the cause of more serious mental illness, they often trigger an initial psychotic break particularly for persons with schizophrenia or bipolar depression.

While scientist continue to learn more about the causes of a wide variety of physical and mental illnesses, a diagnosis does not define the whole person. People with mental illness are unique individuals created by a loving God and have their own skills, gifts, talents and abilities.

Fear and Stigma

There is a great deal of stigma associated with mental illness. Persons with mental illness are often feared, mistrusted and marginalized. This was even more evident in Biblical times. Persons who had physical or mental illnesses that were not understood were isolated from the community. Afflictions of all kinds were seen as the result of a person's sin, the sin of a family member or the person was said to be possessed by demons.

One example of how a town dealt with a man with a mental illness is the story of the so-called Gerasene demoniac recorded in Luke 8: 28-34. Many clergy use this passage to talk about Jesus' curing the man. But this story is a good example of the social context of the community. The population of the town kept the man chained, fed and cared for in the cemetery outside the town. By keeping him separate from the "normal" population, they felt secure. But it prevented them from interacting with this man and seeing him as a whole person.

Due to scientific advances, most of the illnesses described in the Bible have been identified and effective treatments are now available. While we accept these scientific advances as blessings for those who suffer, too often the stigma and shame surrounding illnesses of the brain continues.

Many people still believe that mental health problems, psychological problems, emotional problems, psychiatric disorders, etc., are a sign of personal or moral weakness or failure. If communities of faith do not talk openly about these brain disorders, they perpetuate the stigma that the person or his or her family is at fault. The symptoms of severe mental illness can be so disturbing and misunderstood that one can understand why people are unwilling to openly admit that they have an illness of the brain.

Too often mental health is an afterthought to medical care for physical problems. There will be less stigma and discrimination surrounding mental illnesses as people become educated about their causes and treatment options and as people advocate for health parity in dealing with physical and emotional illnesses. Then we can put more attention into early diagnosis and treatment for all ages instead of spending money on the effects of untreated mental illness such as addiction, homelessness, unemployment, domestic violence, and problems with the legal or school systems.

It is, therefore, important to understand the various forms of mental illnesses recognize the symptoms and gain understanding of how mental illness affects different groups of people.

Mental Illness: Types and Symptoms

There are many types of illnesses that affect the brain. Some of these include anxiety disorders, addictions, obsessive compulsive disorder (OCD), postpartum depression (PPD), post-traumatic stress disorder (PTSD), eating disorders, major depression, bipolar disorder and schizophrenia.

Many of these illnesses can occur together making an accurate diagnosis difficult. Symptoms can change over time resulting in a new or additional diagnosis. These changes also impact treatment options. This is why it is important to be under the care of a mental health professional to adjust medications based on an individual's response to the medication and/or a change in diagnosis.

Major Depression

A depressive illness is a "whole-body" illness, involving the body, mood, thoughts, and behavior. It is not just a passing blue mood. It is also not a sign of personal weakness or a condition that can be wished away. Depressive illnesses may be associated with an imbalance of chemicals in the brain, negative life experiences, other medical illnesses, medications, certain personality traits and genetic factors. With the effective medications and therapies available today, most people, including those with the most severe forms, can improve significantly.

The economic and social costs of untreated depression are staggering. Mental health conditions are the second leading cause of workplace absenteeism. Untreated and mistreated mental illness costs the United States \$150 billion in lost productivity each year.

Yet early diagnosis and appropriate treatment reduces overall costs by reducing hospitalizations, medical expenses, and disability. There are several different types of depressive illnesses including **major depression**, **dysthymia** (a milder, chronic form of depression) and **bipolar disorder**. Depression can often co-occur with other illnesses. Symptoms of depression can include:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities once enjoyed, including sex
- Insomnia, early-morning awakenings, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue

- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Difficulty concentrating, remembering, making decisions
- Persistent physical symptoms that do not respond to treatments, such as headaches, digestive disorders, and chronic pain

Bipolar Disorder

Bipolar disorder is a treatable illness marked by extreme changes in mood, thoughts, energy and behavior. It is also known as manic depression because a person's mood can alternate between mania (highs) and depression (lows). Bipolar affects more than two million adult Americans and often begins in late adolescence.

There are different types of bipolar disorder determined by the patterns and severity of the symptoms. **Bipolar I** is the most severe form of this illness and is marked by extreme manic episodes. **Bipolar II** disorder is not as severe as bipolar I and is characterized by a less severe form of mania known as hypomania. **Cyclothymic disorder** is characterized by chronic fluctuating moods with periods of hypomania and depression. With cyclothymic disorder, the symptoms of both depressive and hypomanic symptoms are shorter and less severe. Symptoms of mania in bipolar disorder can include:

- Excessively "high" mood
- Irritability
- Decreased need for sleep
- Increased energy and activity
- Increased talking, moving, and sexual activity
- Racing thoughts
- Disturbed ability to make decisions
- Grandiose notions
- Being easily distracted

A mild to moderate level of mania associated with bipolar II disorder is called hypomania. People have increased energy and tend to become more active than usual. They are often more optimistic, have increased speech and activity and have a decreased need for sleep. Some people have increased creativity while others demonstrate poor judgment and irritability. People with this disorder do not have delusions or hallucinations and do not lose touch with reality. For these reasons, hypomania can be difficult to diagnose and can masquerade as mere happiness.

Schizophrenia

Signs of schizophrenia vary from person to person and many early signs are not cause enough to suspect schizophrenia. Unusual behavior can stem from a number of causes, but behavior that is repeatedly out of the ordinary and persistent might be a sign of chemical imbalance in the brain. Some of the common warning signs include sleep problems, social isolation, hyperactivity or inactivity, inability to concentrate, hostility, paranoia, unusual emotional reactions, deterioration in personal hygiene and unusual sensitivity.

Not every person with schizophrenia will have all symptoms. A combination of the symptoms below, accompanied by a decline in functioning for at least six months, is needed to diagnose schizophrenia:

- **Delusions:** false ideas that a person has about him or herself or surroundings (such as receiving special messages from the TV or radio, having unusual powers that no one else has, or being singled out for persecution)
- **Hallucinations:** sensations that are heard, seen, smelled, or felt that a person experiences while others do not. The most common hallucination is auditory – hearing voices talking negatively about the person or sometimes giving commands for dangerous behavior; however, not everyone with schizophrenia hears voices
- **Disrupted thoughts and behavior:** trouble concentrating and maintaining a train of thought (conversation might not make sense – may respond to queries with a seemingly completely unrelated answer; or sentences that start with one topic and end somewhere completely different); unpredictable or erratic behavior, including pacing or rocking, depersonalization, or behavior inappropriate to the situation
- **Grossly disorganized behavior:** inability to perform goal-directed tasks often resulting in daily living challenges; unpredictable agitation or silliness; behaviors that appear bizarre and lack purpose; social disinhibition, or the inability to suppress impulsive behaviors and emotions
- **Flattened or blunted affect:** reduction of, or lack of emotional expression, including flat voice, lack of eye contact, and restricted facial expression
- **Lack of interest** or enthusiasm for previously enjoyable activities, difficulty in creating goal-directed behavior, social withdrawal
- **Catatonic behavior:** apparent unawareness of the environment, decreased motion or excess and aimless motions, bizarre postures, lack of self-care
- **Difficulties with speech,** inability to carry a conversation, short and sometimes disconnected replies to questions, lessening of fluency

Schizoaffective Disorder

Schizoaffective disorder is a condition in which a person meets the criteria for both schizophrenia and a mood disorder. As with all mental illness, the symptoms vary from person to person and an accurate diagnosis can be difficult. People with schizoaffective disorder generally experience psychotic symptoms such as hallucinations, disorganized thinking and paranoid thoughts. They also experience mood disturbances associated with depression or bipolar disorder. These persons tend to be antisocial and are often shunned by people around them.

Post Traumatic Stress Disorder (PTSD)

Anyone can experience PTSD symptoms after being exposed to a traumatic event. It is a normal reaction to a horrific situation. There is no way to predict who will and will not develop PTSD symptoms from experiencing a traumatic event...whether in their past or in the present. Some people may be more affected than others based on their perceptions and learned views of the world. Current research shows that there may also be genetic and biological factors that influence how a person will react to extreme stress.

Recent studies estimate that one in five military service members who served in Iraq or Afghanistan suffer from what many are calling "combat operation stress injury." The emotional and spiritual wounding of persons who served in the military can affect all aspects of a person's life.

Symptoms of PTSD include, but are not limited to:

- Recurrent, intrusive and distressing thoughts about the event
- Recurrent dreams, nightmares about the event
- Flashbacks or a sense of reliving the event
- Distress caused by reminders of the event such as sights, sounds and smells
- Alienation, isolation and avoidance of people and places
- Emotional numbing
- No sense of future
- Survivor's guilt for having survived when others did not
- Difficulty falling or staying asleep
- Difficulty concentrating or remembering
- Hyper-vigilant or survivalist behavior
- Exaggerated startle response – usually to loud noises

Mental Illness Can Happen to Anyone

Children and Adolescents

Just like adults, children and adolescents can have mental health problems that interfere with the way they think, feel and act. Studies show that one in every five young people is affected by mental health issues at any given time and one in ten has a serious emotional disorder. Suicide is the second leading cause of death among college students and the third leading cause of death among all youth 15-24 years old. In the United States only accidents and homicides claim more lives.

Because these years can be a confusing and difficult time for many young people, parents, teachers and even health care professionals often do not recognize the life-threatening consequences of untreated mental illness. Some severe mental illnesses begin during the teenage years or in the 20's. Lack of education about the symptoms, denial and stigma keeps many young people from asking for help, resulting in an alarming increase in the rate of suicide and suicide attempts in this age group. Fortunately, there is increased public awareness of mental health issues affecting adolescents and young adults that can help persons get the treatment they need before the symptoms become severe.

Women

Studies reveal that mental illness, especially different types of depression, appear to be twice as common for women as for men. Approximately 12 million women in the United States experience clinical depression each year and it occurs mostly in women aged 25 to 44. These higher numbers may be because women are more likely to talk about their emotions and feelings. Men often cover or repress their emotions and self medicate with various forms of addictive behaviors.

Women may be more susceptible to brain disorders because of the hormonal changes associated with premenstrual syndrome, childbirth, infertility and menopause. There are also social factors such as the stress of combining work and family responsibilities, the roles and expectations society places on women, sexual abuse and poverty. There is also a strong relationship between eating disorders (anorexia and bulimia nervosa) and depression in women.

The occurrences of bipolar disorder and other forms of serious mental illness are about the same for both men and women.

Men

More than 6 million men in the United States have at least one episode of major depression each year. Mental illness with men is not as widely

recognized and diagnosed as with women. There are a number of reasons for this. Men often deny having a problem because they are supposed to be "strong." Men are taught to be tough. They are more likely to rein in their emotions and deal with their symptoms in a "macho" way. This makes it harder for doctors and other medical professionals to recognize symptoms.

Men may be fearful of the negative social prejudice and how a diagnosis of mental illness might affect their career or their respect from family and friends. Studies show that suppression of emotions can lead to complications such as escalating anger, aggressiveness and addictive behaviors. These coping strategies may be superficially effective at first, but they can also have devastating consequences. The Centers for Disease Control (CDC) reports that men in the United States are about four times more likely to commit suicide than women. Men are also more likely to use methods that are more lethal, such as guns, they tend to be more impulsive with suicidal thoughts, and they show fewer warning signs.

Older Adults

Depression is the most common emotional disorder in older adults, occurring in about one in seven people over 65. Depression is not an inevitable consequence of aging, but is a common symptom of Parkinson's disease, stroke, arthritis thyroid disorders and cancer. It is often difficult to sort out whether a person is depressed because of a physical illness or because the illness has triggered a chemical change in the brain. Loneliness, isolation and physical limitations can also contribute to depression. Medical intervention is often very effective.

The suicide rate for older adults is 50% higher than the than the national rate as a whole. In fact, the population over 65 accounts for about 20 percent of the nation's suicides.

African Americans and Other Ethnic Groups

The prevalence of mental disorders among non-white populations, especially African American, is often underestimated. Studies have shown that African Americans will go to their clergy with both physical and emotional illnesses before seeking help from professionals.

Societal factors such as socioeconomic issues, educational inequities, access to medical care and other environmental constraints can hinder persons from getting appropriate referrals and care. The shame and stigma associated with mental illness is also a major factor that affects a person's willingness to reach out for help. These factors make it even more imperative that we have trained clergy and lay persons who can recognize the early warning signs of various mental illnesses. With appropriate, culturally sensitive interventions, many people can be spared the suffering brought on by these illnesses.

Treatment Options

The good news is that most mental illnesses can be successfully treated with a combination of drug therapy and various types of talk therapy or counseling. Yet only one third of those suffering from mental illness seek treatment. This is due in part to the lack of awareness about the illness and treatment options. Even when symptoms are brought to the attention of professionals, misdiagnosis or the lack of an accurate diagnosis results in persons not getting proper treatment.

Because of the complex interaction of brain chemistry, life experiences, and a person's physiology and emotional states, no one form of treatment is appropriate for everyone. New and more effective medications are being developed to treat the chemical imbalances in the brain. Some of the brain chemicals thought to be out of balance include serotonin, norepinephrine, dopamine and cortisol. Individuals respond differently to medications and finding the right medications can take some time. One problem is that persons stop taking medications when they feel better or because of the side effects. Persons can easily get caught in the "revolving door" of the public health care system.

For many persons who suffer from a mental illness, psychotherapy (also known as "talk therapy") allows the individuals to converse with a trained therapist to address issues such as low self-esteem, difficult childhood experiences, environmental trauma, losses of all kinds, relationship issues and the lack of any positive meaning for one's life. The most common forms of psychotherapy are cognitive therapy, psychodynamic therapy, interpersonal therapy, group therapy and marriage and family counseling. Pastoral counseling that addresses emotional issues while respecting a person's faith tradition is also very effective.

Studies are increasingly demonstrating the relationship between the physical, mental, emotional and spiritual dimensions of our lives. We know that support from family members, friends and a person's community of faith are a very important part of a person's treatment and recovery. People are more likely to comply with their medication therapy or participate in psychotherapy if they can envision hope for the future.

Because of a renewed interest in treating the whole person, more persons are seeking out mental health professionals who will incorporate their spirituality in the treatment process. Professionals like those from the American Association of Pastoral Counselors (www.aapc.org) receive training in both psychology and theology. These counselors can add a spiritual perspective to the professional counseling relationship by incorporating a person's spirituality with sensitivity to cross-cultural traditions. Mental health professionals who are sensitive to and respectful of the spiritual dimension can "walk with" persons as they seek their own path to personal growth and healing

Come along with me
as a sojourner in faith.
Bring along
a sense of expectancy
a vision of high hopes
a glimpse of future possibility
a vivid imagination
For God's creation is not done.
We are called to pioneer forth
toward a future yet unnamed.
As we venture forward,
we leave behind our desires for
a no-risk life
worldly accumulations
certainty of answers.
Let us travel light
in the spirit of faith and expectation
toward the God of our hopes and dreams.
Let us be a witness
to God's future breaking in.
Come along with me
as a sojourner in faith
secure in the knowledge
that we never travel alone.
Rev. Susan Gregg-Schroeder²

Discussion Questions

1. What are our beliefs about persons with mental illness and how were they formed?
2. How does the media perpetuate these stereotypes?
3. What are some of the reasons why persons do not seek treatment?

Section Two The Unique Role of Faith Communities

Meditation

In the Kingdom of God there is neither Jew nor Greek, not schizophrenic, nor dementia victim, only people loved equally by god and called to live humanly.³

John Swinton

Background Information for Facilitator

The religious community has much work to do to address the shame, guilt and stigma associated with mental illness. Because of a lack of information or theological beliefs, some religious groups do not understand mental illness as an illness unlike any physical illness. Sometimes a person is encouraged to stop taking medication and rely on prayer. Some continue to put blame on the family at a time when the family members are most in need of support. This is especially true with suicide. If the suicide is seen as a sin or an unfaithful act, the family has to deal with their grief as well as the guilt, shame and isolation from their community of faith at a time when the family most needs the support of their community.

There are no good words to describe the utter despair and hopelessness associated with depression. As more research is done on the brain, new medications and new therapies are rapidly being developed to address the physical and emotional stress associated with brain disorders. But, unfortunately, there is a split in treating mental illness using the medical model that makes little allowance for addressing issues of spirituality. Yet a person's spirituality or religious views can be of great benefit in the treatment and healing of many illnesses, including mental illness.

A Brief History of Beliefs and Treatment of Mental Illness

It may be helpful to look at how we got in this predicament. Mental illness goes back as far as recorded history and has been known by many names over time. Most ancient societies regarded mental illness as a religious problem involving the health of one's soul. There were elements of magic and mysticism in the rituals performed to cure persons with a mental illness.

With monotheism, as articulated by ancient Judaism, there was a shift in how mental illness was understood. While still almost completely religious in nature, mental illness became a problem in the relationship between an individual and God...a condition associated with the soul. The Hebrew and Christian scriptures are full of stories and laments of persons suffering from so called demon possession, visions or hallucinations, depression and other forms of mental illness.

In the year 370, the Eastern Orthodox Church established the first hospital. Over the next 1200 years, the church built hospitals throughout Europe to

treat physical illnesses. Many physicians were monks and priests. Nuns served as nurses. The physical and spiritual care of patients went hand in hand.

Islam began to spread across Asia, Africa and southern Europe about a thousand years later. Like Judaism, the *Qur'an* frequently talks about the spirit or the soul. But there was not the conception that mental illness was a punishment from God. Those suffering from mental illness were thought to be possessed by supernatural spirits, but these *jinn* (genies) were not seen as good or bad.

Since mental illness was not seen as wrongdoing, Islamic scholars and physicians in the 10th century were the first to move toward a more scientific look at the causes and symptoms of mental illness. During this time a hospital was established in Baghdad with a psychiatric ward.

Such treatment did not exist in Europe during the late Middle Ages and the Renaissance because mental illness was seen as witchcraft or demonic possession. Those found acting irrationally or suffering hallucinations were thought to be possessed and were often tortured and killed. Others were sent away on "ships of fools" and excluded from the community. Persons with a mental illness endured horrific treatment like bloodletting and the drilling of holes in the head to allow the "evil spirits" to escape.

With the age of Enlightenment in about 1750 and the introduction of the science of psychology, attention was directed to the mind. Psychoanalysis looked at such things as unhappy childhood experiences or other conflicts arising from the unconscious mind. Followers of Freud viewed spirituality as superstition and the church's influence all but disappeared. The split with the church was complete. Mental illness was no longer a spiritual issue associated with the health of a person's soul. It was a problem with the mind or one's thinking.

Insane asylums were opened and an era of so-called moral treatment began. From 1750 to about 1950 persons with a serious mental illness were put in an asylum or other locked facility. Treatment in the early asylums was very poor, often secondary to prisons. Some early forms of treatment included lobotomies and a primitive form of electro convulsive therapy or ECT.

Some persons from pacifist faith traditions, like the Mennonites, did their alternative service during World War II in hospitals that included mental hospitals. Appalled at the deplorable conditions in the psychiatric hospitals, these faith groups were among the first to bring compassionate care to persons. Some of these religious groups established psychiatric hospitals.

With the advent of anti-psychotic medications around 1950, the focus was on symptom reduction. A shift occurred that de-emphasizes both the spirit and the mind with the focus on biological changes in brain chemistry. New

technologies such as brain-imaging devices, medications affecting brain chemistry and behavior modification therapies, like cognitive therapy, have become the treatments of choice. This new medical model, however, put the emphasis on the illness and not on the many other needs of the individual.

A crisis that exists to this day began when patients in mental hospitals were moved back to their communities. This "deinstitutionalization" resulted in persons with severe mental illness being released from hospitals into a community that was ill prepared to serve them. Instead of money being used for community support services, many persons ended up homeless.

Psychiatric hospitals continue to operate today with much stricter admission standards. With the rise of managed care, little money is allocated for access to mental health professionals, appropriate medication, low cost housing, day treatment programs, crisis services, job training and other essential support services. Our prisons today have become the largest mental institutions in our society. And the responsibility for the care of persons with a severe mental illness has fallen on families who are mostly untrained and unprepared to deal with a loved one in crisis.

Differences between Spirituality and Religion

Spirituality has become a popular and often misused word in our time. Spirituality is different from organized religion. Spirituality springs from a belief system. It is what gives meaning to our lives, and it grows out of life experiences rather than doctrine. Paul Tillich talked about the divine as the "ground of our being." Spirituality is a universal truth but a highly individual journey.

Religion, on the other hand, refers to the beliefs and practices associated with organized groups such as churches, synagogues, mosques, etc. It provides a hierarchy for some faith groups and guidelines for finding meaning. Today a new phenomenon is taking place. It is called "interfaith spirituality." It is an integrative approach because it focuses on the common threads of all faiths such as love and mercy.

The search for meaning is a timeless pursuit. The question of why there is suffering in this world and what God has to do with suffering is one of the focuses of the spiritual journey. There are many Biblical accounts of God's people struggling with intense emotional pain. Some of the most profound descriptions of emotional and faith struggles are found in Job and Ecclesiastes.

Psalm 88 portrays the experiences of a depressed person from an emotional spiritual perspective. The words of the psalmist describe many of the symptoms of depression; sadness, isolation, anger, abandonment, mistrust, spiritual emptiness and hopelessness.

You have put me in the depths of the Pit, in the regions dark and deep.

Lord, why do you cast me off? Why do you hide your face from me?

Mental illness affects all aspects of our life including our spiritual well being. It strikes at the very soul of our being making us feel cut off or separated from God's love and acceptance. It is like a thief in the night. It steals a person's sense of self worth, their hopes and dreams for the future and it feels like it will always be this way. Mental illness challenges our core beliefs and values, and we often feel unworthy of God's love and acceptance. We feel alienated from God. We feel alone, helpless and hopeless in the dark despair of our illness.

Today many are espousing a more holistic approach that is being supported by scientific studies. This perspective gives credence to modern biological discoveries and compliments them with an understanding of a person's emotional and spiritual makeup. It is the mind/body/spirit approach.

Integrating Spirituality into the Treatment Process

We still face the long standing conflict between faith and science. The scientific medical model looks for a cure. The emphasis is on finding answers and the relief of symptoms. As we know, many times there is not a cure.

Healing is the peace that comes from knowing that God is working in our lives to bring about the best possible outcome, which is healing mind, body and spirit. This sense of peace and wholeness are gifts from a loving and compassionate God even as we learn to live with mental illness. The challenge we face today is not the choice between faith and science.

We need both. Medications may stabilize symptoms. But it is relationships, connections to others and love that heal the soul.

Mental health providers and faith leaders are increasingly working to find an integrative approach to mental illness. This is a philosophy of treatment that acknowledges the physical, emotional and spiritual components of these illnesses. Many medical schools are now including courses on spirituality. We need to continue to find ways to encourage collaboration and partnership that includes a myriad of support systems.

Too often these simple goals are out of reach, because as the *President's New Freedom Report on Mental Healthcare in America*⁴ illustrated, our current delivery system for mental health services is in shambles and only a total "transformation" of the system will benefit consumers. From a theological perspective, transformation refers to a spiritual process of growth and change. The Commission, which was made up of some of the most respected mental health professionals in America, asks for more coordination of services and providing treatment through community-based groups rather

than institutions. It also calls for assisting persons to re-integrate into being successful and productive members of society through such means as job training and community support. Our faith communities can be an integral part of this process.

The goal is recovery! Recovery is a process rather than a completed goal. Instead of using our resources to focus on the results of mental illnesses, the *New Freedom Report* encourages using resources on lifelong assessment and treatment.

Spiritual Themes Surrounding Mental Illness

Stories, whether they are told through oral narrative, books, or films, have tremendous power to heal by transforming the viewer during their experience of listening. This is especially true for stories that tell about the human condition and true/sincere human experiences. Good stories not only entertain us but also inform our lives in some way. Somehow we feel enriched by having heard or watched a story well told.

The scriptures are full of stories and often these stories are used by clergy to teach and inform congregations about spiritual themes that transcend time.

Love

The love that existed before any human love touched us is the love of God. God's love for each person is evident throughout all sacred texts. It is an unconditional love and is offered with no strings attached. Knowing that we are accepted by a loving God just as we are can heal our brokenness and free us to live more fully.

Persons living with mental illness are so caught up in the symptoms of their illness, especially guilt and shame, that they often feel unworthy or cut off from the empowering love of God. Family members, friends and a supportive faith community can model God's unconditional love by assuring the person that he or she is not alone in the midst of personal darkness.

God promises to be with us in all the times of our life. God says, "I have called you by name, you are mine...You are precious in my sight, and honored, and I love you.

Isaiah 43: 1,4

Where can I go from your spirit? Or where can I flee from your presence? If I ascend to heaven, you are there; if I make my bed in Sheol, you are there. If I take the wings of the morning and settle at the farthest limits of the sea, even there your hand shall lead me, and your right hand shall hold me fast. If I say, 'Surely the darkness shall overcome me, and the light around me become night,' even the darkness is not dark to you; the night is as bright as the day, for darkness is light to you.

God is love, and those who abide in love abide in God, and God abides in them. There is no fear in love, but perfect love casts out fear.

1 John 4: 16b, 18a

Suffering

Do not now seek the answers, which cannot be given you because you would not be able to live them. And the point is, to live everything. Live the questions now. Perhaps you will then gradually, without knowing it, live along some distant day into the answers.

Rainer Maria Rilke⁵

To live is to know suffering. One of the mysteries of faith is why people suffer. The biblical account of Job shows one man's struggle to find the cause for his pain. Job is a man of faith and does not understand why so many terrible things happen to him. Three friends come to offer advice and reasons for his plight. But in the end, Job found peace of mind in the assurance of God's presence with him despite his suffering. In accepting what he could not change, Job was open to living with the unanswered questions of life. He finds solace in his relationship with God and a strength that allows him to move on with his life.

For some faith traditions like Buddhism, the meaning of suffering is central to its teachings. The study of suffering of oneself and that of other people is encouraged by all the Buddhist traditions. The belief is that we are born into suffering. The concept of pleasure is not denied, but it is acknowledged as fleeting. The Four Noble Truths of Buddhism offer a way to deal with the reality of suffering, both physical and mental. The goal is a state where one is in a transcendent state free from suffering and from the worldly cycles of birth and rebirth. This spiritually enlightened state is referred to as Nirvana. The Buddhist practices of meditation and mindfulness are very similar to spiritual disciplines found in many cultures and faith traditions.

Part of the spiritual journey is seeking out the meaning of suffering and where God is in the midst of our suffering. Theologians have struggled with these questions for hundreds of years. Faith offers no easy answers but calls us to live with the unanswered questions, with paradox, with ambiguity and with mystery. Being truly present with a person in the midst of suffering is a gift of God's grace.

Forgiveness

To forgive is to make a conscious choice to release the person who has wounded us from the sentence of our judgment, however justified that judgment may be. It represents a choice to leave behind our resentment and desire for retribution, however fair such punishment might seem. It is in this

sense that one may speak of "forgetting", not that the actual wound is ever completely forgotten, but that its power to hold us trapped in continual replay of the event, with all the resentment each remembrance makes fresh, is broken.

Marjorie J. Thompson⁶

Part of forgiveness is accepting people for who they are and understanding that each person did the best they could in dealing with a difficult situation. Despite all the challenging situations faced by family and members and friends of a person with a mental illness, we are empowered to move beyond our own pain, to persevere and to not give up.

Family members need to be able to feel and express their anger. Many of us feel guilty about anger. We hear so much about love, reconciliation and forgiveness, that we are often reluctant to express anger. Yet scripture is full of references to God's anger at injustice and oppression of all kinds. Anger is an emotional energy deep within us that signals a warning that all is not right and is an important aspect of the spiritual journey. Healthy anger is healing and can serve as a catalyst for change. It is also the ground from which forgiveness and reconciliation can take root.

There are two parts to forgiveness. Because God forgives us, we are first called to forgive ourselves. We all have past regrets and many of us beat ourselves up for the mistakes we have made. Our guilt prevents us from being the whole persons God intends for us to be.

The second part of forgiveness is forgiving others. Forgiveness does not mean denying our hurt or excusing unjust behavior. To forgive is to make a conscious choice to release the person who has wounded us from our judgment and anger. It is a choice to let go of our resentment. Forgiveness is part of the spiritual journey that allows us to open ourselves to a freedom that enables us to love fully. Forgiveness may or may not lead to reconciliation. But it is the first step that we can take to bring about reconciliation and the full restoration of a whole relationship.

Redemption

You may encounter many defeats, but you must not be defeated. In fact, it may be necessary to encounter the defeats, so you can know who you are, what you can rise from, how you can still come out of it.

Maya Angelou

God comes to us to redeem the present. God accepts and understands our circumstances whatever they may be. Even though we are accepted as we are, God calls us to be more. God also works through persons and communities of faith to bring positive change. God can take our despair and transfer our suffering into finding new possibilities for life. With support, persons with a mental illness can find some degree of release of the past and rediscover themselves as whole persons of mind, body and spirit.

Hope

Though you have made me see troubles, many and bitter, You will restore my life again; From the depths of the earth you will again bring me up. You will increase my honor and comfort me once again.

Psalm 71:20-21

The world breaks everyone and afterward many are strong at the broken places.

Ernest Hemingway

The Letter to the Hebrews says, "We have this hope, a sure and steadfast anchor of the soul." (Heb. 6:19) Hope is not linear...something we can only expect in the future. Hope is not simply positive or wishful thinking that everything will turn out all right. Hope is not escapism. It is not tied to religious doctrines or dogmas but emerges from a deep place inside.

Listening to the stories of our faith tradition or the stories of persons who have persevered through their personal darkness can bring hope. We can look back at our own dark times and realize that we persevered. This can give us hope when we face those dark times again. Louisa May Alcott puts it this way. "I am not afraid of storms, for I am learning how to sail my ship."

One of the unique roles of communities of faith is to be a vessel of hope for all who feel despair. Faith communities can remind us that God does not give up on us. It is other persons standing with us in our despair that empower us by their love not to give up even when the future looks bleak.

Hope is grounded in the steadfastness of God who has acted in our past, is acting in our present and will continue to act in our future. God works in our lives in the midst of our pain to bring about a personal transformation. A belief in hope for the future can be a conscious decision of faith to live each day in expectation and anticipation of what is yet to come.

Spirit God, you know our needs
our wounds
our hurts
our fears
even before we can form them
into words of prayer.

You are patient with us.
You are protective of us.
You are present with us
until such time that we are able
to ask for what we need.

Thank you, Spirit God,
for your healing taking place within
before we are even aware
of how broken we have become.
Susan Gregg-Schroeder⁷

Discussion Questions

1. What are the reasons that mental health professionals are reluctant to include a person's faith in the treatment plan?
2. How do you deal with life questions that have no easy answers?
3. Redemption is a gift of grace when other people do not give up on us no matter what we do. How can the faith community model God's acceptance of us and that God loves us just as we are?
4. When you are going through difficult times in your life, where do you find hope to persevere?
5. What is your understanding of suffering? Where is God in the midst of your daily struggles?
6. Part of recovery is finding purpose and hope for the future. What is your view of hope?

Section Three Creating Caring Congregations

Meditation

Those in a position to make a decision about these caregivers sometimes respond by pretending that a crisis doesn't exist. Other times they believe that the caregiver's move to another locale will resolve all the problems. Too often churches (I would add synagogues, mosques and other organized religious groups) have sought to ignore a simple reality: that mental illness can come even to those who are providing care.

Rosalynn Carter⁸

Background Information for Facilitator

The Substance Abuse and Mental Health Services Administration (SAMSHA) has provided recommendations to address the challenge of lifting up the role that faith and spirituality can provide in recovery for many mental health consumers.⁹

Factors that promote recovery include:

- (1) a sense of community,
- (2) the rituals of a person's faith tradition and
- (3) other spiritual practices such as informal or formal prayer, personal testimony and meditation.

Factors that hinder recovery include:

- (1) discrimination and stigma,
- (2) lack of outreach to persons with mental illnesses,
- (3) an authoritarian perspective and/or lack of openness, and
- (4) the historical schism between religion and the mental health community.

An awareness and understanding of a consumer's cultural background, including language and a culture's understanding of mental health, are important in accommodating their needs in recovery. Some of the recommendations for faith leaders include:

- 1) creating a welcoming, supportive environment for mental health consumers,
- 2) introduce instruction on mental health and mental illnesses as required topics in seminary education, and
- 3) address issues of discrimination and stigma, including dealing openly, positively, and compassionately with clergy who have their own mental health issues.

Creating Caring Congregations - Five Step Program

There are many ways that congregations can begin or expand a ministry to and with persons with a mental illness and their families. While the journey to become a caring congregation can be described in many different ways, this Caring Congregations model uses a five step approach. These five steps include education, covenant or commitment, welcome, support and advocacy.

These steps are not linear. Rather the process of becoming a caring congregation is dynamic and unique to each community. Some congregations have developed models of ministry unique to the needs of their community. Hopefully our faith communities will become involved in an ongoing process of education, commitment, welcome, and support. We all need to be advocates for a just mental health delivery system.

1. Education

The first step in creating caring congregations is education. This begins with the leadership of the church. If the ministers, priests, imams and rabbis do not educate themselves, they will not be able to recognize the symptoms and make appropriate referrals to counselors and psychiatrists. This is often made more difficult because many religious leaders are hiding their own struggle with mental illness from the hierarchy of their religious organization. As clergy leave the ministry in record numbers, we can no longer ignore the mental health needs of our clergy and their families.

There are many ways to begin an education program with a congregation. Here are a few examples:

- Invite a speaker or offer a workshop to teach people that mental illnesses are brain disorders.
- Get educational material and referral information from groups like the National Alliance on Mental Illness (NAMI), the Depression Bipolar Support Alliance (DBSA), Mental Health America (MHA) and SAMHSA.
- Use bulletin inserts and newsletters to educate about serious mental illness especially during Mental Health Month in May and Mental Illness Awareness Week in October.
- Offer a health fair and include education about different mental illnesses.

2. Commitment (Covenant)

The second step in becoming a caring congregation is covenant or commitment. This means that the church leadership commits to be intentional in seeking ways to become a caring congregation. It is often a

concerned lay person who initiates this process because pastors are so overwhelmed with other responsibilities.

Most successful programs have come from “the bottom up.” Because of the many demands on our clergy, few will initiate such a ministry. But lay persons can collaborate with the church leadership to form a task force to look at ways that particular community can provide education about mental illness.

When mental health provider groups establish programs for persons with mental illness, the church is often left out. Part of covenant involves networking, collaborating and partnering with community based groups to educate them about what the faith communities have to offer in support of persons and families living with mental illness.

- Involve the clergy and other leadership groups in developing a task force to assess the needs of your congregation.
- Adopt a statement stating our congregation's commitment to this ministry.

3. Welcome

The third step of welcome involves seeking ways to integrate persons with a mental illness into the faith community. Often we distance ourselves from those persons most in need of a welcoming community. We send money to survivors of the tsunami, Katrina, AIDS in Africa and other global problems...which is very much needed.

But welcoming and hospitality require us to reach out to persons in a way that allows for the mutual exchange of joys and concerns. When we take the time to really get to know another person, the barriers between “us” and “them” break down.

Welcoming persons with a mental illness involves seeking ways to integrate them into the faith community. When we practice hospitality, God can use our faithfulness in surprising ways.

- Provide training for ushers and greeters to be welcoming and supportive of all persons. Some communities have trained persons to act as "companions" to accompany a person to worship, to talk or simply to help them find a quiet place to rest.
- Invite persons with a mental illness to participate as they are willing and able...acting as a liturgist, being part of a group.
- Include persons with a mental illness in prayers, liturgies and sermon illustrations
- Partner with organizations in your area like the Ecumenical or Interfaith Council to identify persons who would need a ride to a faith

community of their choice. This often results in congregations helping the person with housing, employment, transportation to medical appointments and practicing important social skills.

4. Support

We are brought up to be strong, self-sufficient and independent people. It is hard to ask for help and so often keep our struggles hidden. But God wants us to care for one another – and allow others to care for us in our time of need. We are called to “bear one another’s burdens.” (Galatians 6:2)

There are many ways to provide support to persons with a mental illness and their families.

- Train mentors through programs like Stephen Ministry, parish nurses and other volunteers.
- Have a referral list of mental health services in your community
- Offer a support group or invite outside groups like your local NAMI affiliates "Family to Family" program to use your facilities.
- Provide counseling services through a sliding scale or voucher program.
- Involve members in programs to provide meals or housing.
- Make prayer quilts, comfort pillows or care baskets to take to persons who are in the hospital, residential facility or who do not come to worship due to their illness to let them know they are not forgotten.
- Find ways to reach out and support family members.

5. Advocacy

The spirit of the Lord God is upon me, because the Lord has anointed me to bring good tidings to the afflicted; He has sent me to bind up the brokenhearted, to proclaim liberty to the captives, and the opening of the prison to those who are bound.

Isaiah 61:1

The mental health delivery system in this country is broken. There is a lack of resources and a lack of continuity in treating mental illness. People with a mental illness too often get caught in a “revolving door” health care system. This is especially true for persons who use the public health system for treatment.

Mental illness is a justice issue involving such basic human rights as access to medical care, stable and supportive housing, and job training. Once a congregation has developed a mental health ministry, a natural next step is to be involved in advocacy.

Here are some ways in which you can make a difference:

- Keep informed on pending legislation about mental illness.
- Attend workshops and conferences
- Contact your elected representatives or visit them as a group
- Support candidates working on mental health issues
- Keep in contact with advocacy groups like NAMI, DBSA, and the MHA.
- Participate in community events such as NAMI Walks.
- Partner with other organizations for community events about mental illness. The community needs to be educated about the important role a person's faith can play in the treatment and recovery process.

Models of Ministry through Partnership

Faith communities have used these steps or similar guidelines to develop their own unique models of ministry. Most of these ministries begin small, perhaps led by one or two persons. Seeds are sown, some take root and some even reach out to the meet the needs of the larger community.

Effective partnerships with community provider groups have been developed to provide transitional housing, help with legal issues, programs for addiction and other medical problems, peer counseling, family advocacy, training in daily living skills and employment referrals. Faith communities are in a unique position to address the spiritual needs by being intentional about inviting persons with mental illness to worship, offering prayer groups and opening the doors to a variety of small support groups.

Barriers of fear, ignorance and stigma are broken down when people take the risk to break the silence and speak out by sharing their struggles of living with a mental illness or by sharing the struggles of loving and caring for a family member.

Providing Support for Family Members

In the shadow of your wings, I will take refuge, until the destroying storms pass by.
Psalm 57:1

The family is a system. When one member needs special care and attention of any kind, the family system becomes unbalanced. Family members of a healthy family are connected to each other. Yet someone with a serious mental illness may be disconnected from his or her family. Emotional and social isolation on the part of the person with a mental illness often accompany their sense of shame and hopelessness. Individuals in a family may also experience disconnection from other family members as they try to cope with a loved one's illness.

Before family members can provide support, it is important that they educate themselves about these brain disorders. In learning about the causes and

treatment of mental illness, family members can hopefully come to understand that these illnesses are no one's fault. Keeping a loved one separate from the illness allows you to better accept the person AND his or her illness, with its accompanying symptoms and limitations. Coming to this place of acceptance is difficult and can take time, but it is an integral part of the recovery process for the whole family.

Recovery and healing is ultimately the responsibility of the person with the illness. Family members and friends cannot force a person to take medication or show up at a job. Most persons who have a mental illness respond well to appropriate treatment, and families can play an important role in helping a person recover or learn to live with their mental illness.

Research indicates that the attitudes and communication skills of specific family members can reduce relapse and promote recovery. These are skills that require time and practice to acquire. This can be challenging when dealing with a person with a mental illness because negativity and stress can spread, and guilt and resentment can fester.

Part of learning about a loved one's illness is developing patience, and stamina. Medication, psychosocial supports and improvements in the lives of people with a serious mental illness can take time. An ill person's ability to understand, cope and function in the world may be severely impaired. It is normal to feel great sadness, grief, anger, frustration and a multitude of other emotions.

Issues for Families When a Loved One has a Mental Illness

Treatment is costly and family resources can be drained. Coping with a person's symptoms can make family life chaotic and unpredictable. Siblings often feel ignored and family members become emotionally drained. The following are some of the emotions family members can experience when dealing with a loved one's mental illness.

1. **Guilt and Shame** – It is not just the person with the illness that experiences guilt and shame. Families are also victims of stigma. They wonder what they have done wrong. If they are part of a faith community that understands mental illness as a moral or spiritual failure, they may hide their loved one's illness from family, friends and their faith community. Family members need to be reminded that mental illness is NOT their fault. It is an illness like any other illness.
2. **Anger** – This is a difficult emotion because our faith tells us there is something wrong when we feel angry. Families can be angry at their family member because it is often difficult for families to separate their loved one from the illness. They may also be angry with a mental health delivery system that can be very difficult to navigate in order to get help for their loved one.

3. **Loneliness and Isolation** – Because mental illness is often misunderstood and treated differently than a physical illness, families can feel isolated and alone. This may be especially true if they are active in a faith community and feel that they cannot share their struggles.
4. **Fear** – Fear is a powerful emotion. Families are afraid because mental illness can be unpredictable. They don't know why their loved one is acting differently or what is going to happen next.
5. **Anxiety** – Even when a loved one is doing well...perhaps after a major crisis...families never know when there might be a relapse or what that next phone call will be. If there is the possibility of suicide, there is a tortuous anxiety whenever your loved one leaves that you may never see that person again.
6. **Denial** – This is a very common as one spouse, parent or sibling will say, "Why can't he just get his act together." Men tend to be problem solvers. Often the father or husband has the "pull up your boot straps" attitude. If the wife or another family member is out there trying to get help, it can lead to relationship issues.
7. **Despair and Hopelessness** – This is the most difficult emotion as the despair of the family members can be just as deep as that of the person with the illness.
8. **Overwhelmed** – Trying to deal with a person's illness, meeting the needs of siblings and a spouse on top of the normal stress of life, jobs, and other responsibilities can leave family members feeling overwhelmed. Very often self care is not addressed. The constant worry, lack of sleep, poor eating habits and the inability to pursue enjoyable activities or hobbies can lead to the feeling of being trapped and overwhelmed.

Other Issues That Families Deal With

1. **Finding Appropriate Care** – This is difficult even if you have medical insurance. It is compounded when dealing with the public health system. Families need to be proactive in seeking out mental health providers who will hopefully work with the family. HIPPA and confidentiality laws prevent providers from providing medical information for adult persons with an illness unless the ill person signs a release. But this does not prevent you from contacting the doctor and providing information about your family member to the provider.
2. **Learning About the Mental Health Laws** – Each state has different legal requirements for things such as applying for disability income

and the legal requirements for involuntary hospitalization if a person is perceived to be in danger of hurting him or herself or others. If the ill person is arrested, many questions surface. Do you bail them out? Do you hire a lawyer? If convicted of a crime, is there an alternative program than prison?

3. **Housing issues** – Where does the ill family member live? If living at home, what happens when the family can no longer handle the ill person...especially when there is the possibility of violent behavior, safety issues, hygiene, substance abuse and other health and safety issues?

Many families don't know what to do with a seriously ill adult child. Do you use the public health system knowing that your family member will likely end up on the street? Do you strain the family resources by trying to provide appropriate residential treatment programs or other housing options? How do you set up a conservatorship to ensure that your loved one is taken care of after you are gone?

4. **Boundary Issues** – What do you do when you can no longer handle the loved one at home? Families are forced with impossible choices when they have tried everything and nothing has worked. The loved one leaves the drug treatment program or transitional housing arrangement. They get arrested over and over again. They are out of control. How often do you take the person back into the home? Sometimes families are forced to take a "tough love" approach and change the locks on the house or file a restraining order. How do you deal with the reality of knowing your son or lovely young daughter is going to end up on the street?
5. **Getting on the Same Page** – It is important that all family members work together and not give the ill person conflicting messages. This may mean sitting down together and breaking it down to decide what the most important issue is to deal with NOW. It is easy to get a laundry list of issues. It works best to pick one issue and get agreement from everyone on what action to take.

Ways Families Can Support Their Loved One

The most productive ways families can help their sick loved one is to try to obtain the best available treatment for him/her. It is vital that family members be part of a supportive team with doctors, therapists, teachers, co-workers and others who may be involved with your mentally ill loved one. They can give voice to symptoms and concerns that the relative may have difficulty communicating to professionals. Very often they need to advocate, and be proactive in assuring that your loved one receives appropriate care. As part of a support network, there are ways families can encourage their loved one to follow the treatment plan that is developed.

Part of caring for each other is having open communication. Families need to learn about and accept the varied emotions that come with any serious illness...guilt, fear, anger, sadness and helplessness. If a family member accepts and understands his or her illness, it can be very helpful to talk about its patterns and symptoms and engage them in helping to recognize the signs before a crisis occur. A plan can be put in place to alert a person's support team when a crisis emerges. This kind of communication empowers family members and gives them a way of feeling less helpless when a situation occurs that is beyond their control.

There is a fine line between respecting the individuality of the person and knowing when you need to step in to protect that person. Even when the person appears symptom free, it can be difficult to return to a "normal" routine. Families live with uncertainty as they wait for the "next shoe to drop."

Someone said people commit suicide because they get so tired. When a person is in the depths of despair, it feels like it will never end, like it will never get any better and there is no hope for the future. Family members are in the best position to recognize and monitor warning signs that may require intervention. Create a crisis plan. If a loved one alludes to ending it all through suicide, take it seriously! 80% of those who commit suicide give some indication of their intentions. This is not a time to argue or leave the person alone. Ask them if they have a specific plan and accompany them to an appointment or to a hospital, if necessary.

Caring for yourself and other family members is critical. Don't ignore your needs or the needs of the family. It is best if routines can be maintained as much as possible. Encourage all family members to pursue work, social and personal goals and to remain involved with activities and friends. If there is child abuse or domestic violence that is occurring, families must reach out and let others know.

When families can no longer handle taking care of the ill family member at home, a placement outside the home may be necessary. If the person with the illness is an adult and lacks insight or refuses treatment, the family may need to find an outside placement or release the person to the public health care system.

Emotional support for the family is essential to deal with the natural feelings of guilt, anger, fear and confusion. Clergy can help by referring the family to a mental health professional or support groups offered in the community to help make a plan that is best for everyone. The faith community can be a source of spiritual and inner strength for the family. Families need to know that someone understands their pain and that they will have on-going support and care.

Break into my confusion, God.
help me to know who I am
and what I am meant to be.

Guide, uphold, and strengthen me,
as I leave behind
the world of limits and labels.

Guide, uphold and strengthen me,
as together we create
a world of infinite possibility.

Susan Gregg-Schroeder¹⁰

Discussion Questions

1. What strengths does your congregation have as a group that can help you develop and implement a mental health ministry?
2. What are the major obstacles and challenges that would keep your congregation from beginning or expanding an outreach to persons with a mental illness and their families?
3. What strategies could you employ to overcome these obstacles?
4. What steps can you take to begin to establish a mental illness ministry that is appropriate for you community?
5. How could a caring faith community be supportive of family members?

Chapter Four Help for Faith Leaders

Meditation

Thus says the Lord, he who created you, O Jacob, he who formed you, O Israel: Do not fear for I have redeemed you; I have called you by name, you are mine. When you pass through the waters, I will be with you; and through the rivers, they shall not overwhelm you; when you walk through fire, you shall not be burned, and the flame shall not consume you.

Isaiah 42: 1-2

Background Material for Group Facilitator

Clergy and faith leaders are in a unique position to not only support persons and families dealing with mental illness, but also to save lives. Since people often come to their faith leader first with medical, interpersonal, emotional and spiritual issues, clergy need to educate themselves about the symptoms of mental illness, have training in pastor counseling and be aware of resources in the community when a referral is needed.

While most people living with a brain disorder respond well to treatment, severe mental illness is a chronic illness requiring lifelong care. This can feel overwhelming to a faith leader who lacks the training and skills to provide supportive care. Clergy need to practice self care and be aware of setting healthy boundaries.

Spiritual Care

If there is one word to describe the emotional pain of mental illness it would be disconnection. People with a serious mental illness often lack insight into their illness, or experience confusion regarding their symptoms and treatment. Clergy with pastoral skills can address the spiritual and religious dimensions of persons dealing with different forms of life experiences.

Persons with a mental illness often struggle with issues like the inability to experience God's love and acceptance, the inability to accept oneself, the need to confess one's sins and know God's forgiveness, the need to be reconciled with others and the lack of hope that things will get better. Pastors, rabbis, imams, priests and other faith leaders can provide the "ministry of presence." In listening carefully to a person's struggle, faith leaders can explore the cause of one's separation from God, share the biblical stories of persons struggling with similar issues and share stories of God's forgiveness and acceptance.

The rituals and sacraments of one's faith tradition can be of great comfort during times of distress. Clergy can hear a person's confession and offer the assurance of forgiveness. Sacraments like communion and anointing in the

Christian tradition can help the person reunite with his or her faith community. Praying with the person and the family also helps offers assurance that they are not alone in their struggle and builds a relationship of trust and confidence.

Because faith leaders are respected by their congregations, they can model an acceptance that will help diminish the stigma associated with mental illness. This is easier if mental illness in sermon has been treated like any other physical illness in sermon illustrations and in small group educational settings. By including persons with mental illness in pastoral prayers and liturgies, clergy are helping to educate the congregation that mental illness is not caused by lack of faith or spiritual commitment.

Pastoral care needs to include visitation to persons and families struggling with mental illness as with any other physical illness. Devotional material from your faith tradition can be given to individuals in a counseling setting. Scripture and other resources from your faith tradition can bring comfort to persons in a psychiatric hospital, group home or other setting.

May is Mental Health Month. The first week in October is designated as Mental Illness Awareness Week. The Tuesday of that week is the National Day of Prayer for Mental Illness Recovery and Understanding. Worship can be an opportunity to educate about mental illness at these designated times of the year to coincide with community groups and activities.

Recognizing Symptoms of Mental Illness

Education about the various forms of mental illnesses and their symptoms is crucial to providing appropriate support and care. An overview of symptoms is included in Section One. Organizations listed in the Resource section will help you find out more about specific illnesses of the brain.

But the best way to assess the need for further intervention and possible referral is in the normal course of pastoral care. When you suspect a person may be suffering from a mental illness, it is important to ask a series of questions that incorporate the symptoms of mental illness. If the person is receptive, you can offer the opportunity to complete a questionnaire. There are several self-rating diagnostic tools that can be used to help determine if a member of your congregations is at risk. One such assessment tool, the *Zung Depression Self-Rating Scale*, is available in the Appendix.

Another helpful assessment tool in the Appendix is called *FICA*. *FICA* is an acronym for Faith, Importance/Influence, Community and Address, with a set of questions to explore each of these areas. But before you can address the issue of faith with the persons you work with, it is essential that to understand where you are in your own spiritual beliefs. This is important because the issues that a client brings up may trigger certain feelings and responses from your own.

Some useful questions to ask yourself are:

What gives meaning to my life? Have I come to terms with my own mortality? How do I react to crises and situations beyond my control? Am I willing to risk to be open to the unanswered and difficult questions of my own life? What things in my past experiences might be triggered as I listen and become involved in another's story?

Grief and Depression

There is a difference between grief and depression. Following a major loss of any kind, persons may exhibit symptoms of despair, anger, lethargy, insomnia, changes in appetite and/or weight, guilt and obsessive thoughts. All of these emotional and physical responses are normal and people will grieve in their own way. These symptoms gradually subside over time depending on the severity of the loss. If the grief response is unusually severe and debilitating, or persists over a long period of time, it may be considered as a mood disorder that requires additional attention. A chart outlining the difference between grief and depression is included in the Appendix.

Suicide Risk

Immediate action needs to be taken if you determine that a parishioner is at risk for hurting him or herself or others. Faith leaders should be aware of the laws regarding psychiatric hospitalization. Clergy need to take appropriate action when you sense that a person is a danger to themselves or others even if the disclosure is made in the context of a pastoral discussion. Confidentiality may need to be compromised in order to save a person's life. 80% of persons who contemplate suicide will give out warning signs. The following is a list of some indications that a person might be at risk for suicide.

- a. A preoccupation with and/or writing about death or suicide
- b. Making final arrangements and giving away special possessions
- c. Avoiding commitments
- d. Sudden loss of interest in something that was once quite important
- e. Insomnia or sudden changes in sleep or eating patterns
- f. Dependence on alcohol and/or drugs
- g. Deep depression
- h. A recently experienced loss
- i. A sudden upturn in energy following a depression. Committing suicide takes energy, which people lack when they are severely depressed.

Any of the above indications should be treated as a cry for help. Persons are more likely to be open about their feelings if there is a relationship of trust.

It is important to listen to what the person is saying without judgment and to assess the person's circumstances and stressors. Remain calm and do not argue with the person. Ask the person about suicide, what it means to them and if they have a plan.

Clergy need to have emergency phone numbers readily accessible. There are times when it is appropriate to take the person to a local emergency room for evaluation. If the person is combative or becomes violent, you need to keep your distance and remain calm. Call emergency services and report a previous suicide attempt, a suicide plan, if the person has a weapon or is intoxicated or if you feel personally threatened.

Dealing with a Difficult Parishioner

Faith leaders learn quickly to expect the unexpected during worship. Ushers and others should be trained to deal with those situations. Hopefully a plan is in place in case a parishioner faints, has a heart attack or other medical emergency.

Congregations also need to have a plan for disruptive, inappropriate or threatening behavior. It is important not to judge a person because of appearance. A homeless person that looks unkept may be a stranger to the community. Just as with any newcomer, that person should be welcomed.

One model that has been successful is to have lay persons trained as "companions" or support persons if a person coming to worship appears to be in crisis for any reason. Many congregations have trained mentors through programs like Stephen Ministry. A Parish Nurse can be invaluable. A warm and calm demeanor will help put the person at ease. If the person becomes disruptive with inappropriate language or behavior, the companion can accompany that person to a quiet person away from the sanctuary. Offer the person a drink or snack and take the time to sit with the person and listen to his or her story. Often a time aside, perhaps some food or drink and a listening ear will be enough for the crisis to pass.

But as with any medical emergency, lay persons need to have emergency numbers available if the situation continues or escalates. Persons providing support need to protect themselves and others by keeping a safe distance. Speaking calmly and softly, try to identify the problem. Is the person having delusions or hallucinations? Is the person angry at someone and threatening to act on that anger? Is the person intoxicated or have a weapon?

Once the companion knows the situation, he or she can sit quietly with the person or discuss what is happening in a calm and matter-of-fact way. The person should be informed of the consequences if the inappropriate behavior escalates. If a threat is made, the person in danger should be notified. If the person is known to the community, a family member or caregiver should be contacted. An emergency call to police may be necessary if the situation

is not diffused. The lay person will need to provide any information gathered from the discussion to the emergency personnel.

Understanding Religious Experiences

Some persons with schizophrenia and other serious mental illnesses exhibit religious delusions and hallucinations. They may believe that they are a biblical prophet, saint or even God. Excessive fear or paranoia can be a symptom of mental illness. People may try to warn others of the end of the world or other impending doom. They may also feel personally responsible for leading or preventing some religiously-oriented event.

Some delusional behavior is easily identifiable. But it is not always easy to differentiate between a true spiritual experience or calling and a delusion. Clergy can help make this determination by asking questions to assess if the person's delusions are realistic, if the person is in touch with his or her limitations and if this is accepted as part of the person's religious upbringing, cultural heritage or religious history.

Some people believe they have exceptional spiritual gifts. If they are from a charismatic or Pentecostal background, they may claim to "speak in tongues" or feel that God has given them prophetic words to speak. These situations can seem strange. But faith leaders should not assume this behavior is a sign of mental illness. Again, an understanding of the person's faith history and current status is essential in assessing the situation.

If a person is clearly delusional, this is their reality. No theological arguments or other attempts to talk them out of their thinking will change their minds. It is best to acknowledge that this is their belief. This helps the person know that someone has listened to them. It shows respect for their beliefs and validates them as a person.

A helpful approach is to say something to the effect, "I see that you believe this and that it is very real to you. It must be very exciting, empowering, frightening...whatever is appropriate..." Then you can then very simply state what you believe.

Most delusions are not dangerous. If you feel the situation is escalating, it may also be necessary to describe what actions may be necessary for you to take, especially if the delusion has something to do with harming themselves or others.

If a person receives treatment from a trained mental health professional, the faith leader can be an important part of the wellness team by offering insight from their spiritual expertise and training.

Appropriate Language When Referring to Mental Illness

Faith leaders have the opportunity, and responsibility, to model appropriate language when speaking about persons with a mental illness. The language we use can compound the stigma and misconceptions about mental illness or it can educate persons and help reduce the stigma and shame associated with these illnesses of the brain. We've all heard stigmatizing language from other people and from the media. Words like "crazy", "psycho", "looney", "nuts" or other demeaning terms are not only hurtful, they are not accurate.

The language we use should reflect our belief in the dignity of each individual and that we are all created in the image and likeness of a loving God. It is important to use "people first language." We need to refer to people as the person they are and not the illness they have. Instead of referring to people as "the mentally ill," we need to say, "A person who has a mental illness." Just as we don't refer to someone as "the cancer person," appropriate language helps to dispel misinformation about various forms of mental illness.

Many persons living with a mental illness are very productive and have much to offer in all arenas of life. We often leave these persons out when speaking about "ministry **to** persons with a mental illness." We can acknowledge the contribution of this group by saying, "ministry to and **with** persons with a mental illness."

Schizophrenia is an illness that has symptoms of delusions and hearing voices. It is not having a split personality. There are also differences in the severity of mental illnesses. It is helpful to be more specific and use the terms "serious mental illness" or "major mental illness" to describe severe disorders.

Support for the Family

As we have seen, families in crisis in dealing with mental illness need support and care. Be supportive of the entire family, including those family members who infrequently come to worship, as they may feel isolated. Just as the person dealing with the illness many need to be referred, clergy also need to be prepared to refer family members to community resources depending on the need.

It is important to have first-hand knowledge of good, trustworthy psychotherapists and psychiatrists in your community so you can refer a person with confidence and peace-of-mind. It is especially important to link up with professional counselors and other professionals if you are new to the area.

Clergy and faith communities can provide ongoing support to the person with the mental illness and the family during treatment. Assure the family of a continued relationship as the referral process itself can result in a crisis of faith. When appropriate, the rituals of your faith tradition can bring comfort and an assurance that persons are not alone in their pain.

Coming Home

O God, the journey has been so long.
I've taken every side road along the way.
I've explored all the hidden places.
As your prodigal daughter,
I've felt that I could find the way myself.

Even so, You, as loving parent, were beside me
picking me up when I fell
sustaining me when my strength was gone
nurturing me when I was helpless.

And when I was exhausted
floundering
ready to give up ,
You touched me with Your grace,
And I felt Your abundant love.

We walked back home together...
hand in hand.¹²

Discussion Questions

1. What action would you take if you recognized the symptoms of mental illness with a person in your congregation?
2. What resources can you utilize in your extended community?
3. What are some ways to educate and train your faith community about the mental illness?
4. In what ways can the faith community become part of the treatment team?
5. How can your faith community be welcoming of persons with a mental illness and provide a nurturing community where their spiritual needs can be met?

End Notes

Section One

1. Rosalynn Carter, *A Voice for the Voiceless - The Church and the Mentally Ill, Second Opinion: The Church's Challenge in Health Care*. Park Ridge Center for the Study of Health, Faith and Ethics, Chicago. 1990, p.45,46.
2. Gregg-Schroeder, Susan. *In the Shadow of God's Wings: Grace in the Midst of Depression*. Upper Room Books, Nashville, TN. 1997. p.14.

Section Two

3. Swinton, John Ph.D, *Spirituality in Mental Health Care Practices*. From a paper delivered originally to the Wheaton Annual Conference on Theology, Wheaton College, Illinois, 1999.
4. President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America*, 2003.
5. Rainer Maria Rilke. *Letters to a Young Poet*. W.W. Norton & Company, New York, 1993. p. 35.
6. Thompson, Marjorie J. "Moving Toward Forgiveness," *Weavings*. The Upper Room, Nashville, TN. March/April 1992. p.19.
7. Gregg-Schroeder, Susan. *In the Shadow of God's Wings: Grace in the Midst of Depression*. Upper Room Books, Nashville, TN. 1997. p.116.

Section Three

8. Rosalynn Carter, *A Voice for the Voiceless - The Church and the Mentally Ill, Second Opinion: The Church's Challenge in Health Care*. Park Ridge Center for the Study of Health, Faith and Ethics, Chicago. 1990, p.45,46.
9. *Building Bridges: Mental Health Consumers and Members of Faith-Based and Community Organizations in Dialogue*. DHHS Pub. No. 3868. Rockville, MD. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2004.
10. Gregg-Schroeder, Susan. *In the Shadow of God's Wings: Grace in the Midst of Depression*. Upper Room Books, Nashville, TN. 1997. p.47

Section Four

11. Lipman, Rabbi Kennard. *Mental Illness through the Prism of Jewish Texts, Caring for the Soul – R'fuat HaNefesh: A Mental Health Resource and Study Guide*. Union of Hebrew Congregations Press, New York, NY, 2003, p. 3.
12. Gregg-Schroeder, Susan. *In the Shadow of God's Wings: Grace in the Midst of Depression*. Upper Room Books, Nashville, TN. 1997. p.97

Resources

Media and print resources continue to be developed by national organizations and the many faith traditions. The most comprehensive listing and review of these resources is the Congregational Resource Guide.

www.congregationalresources.org/mentalhealth.asp

Books – These are just a few of the many books on spirituality and mental illness

Address, Rabbi Richard F. (ed), *Caring for the Soul – R'fuat HaNefesh: A Mental Health Resource and Study Guide*. Union of Hebrew Congregations Press, New York, NY.

Gregg-Schroeder, Susan, *In the Shadow of God's Wings: Grace in the Midst of Depression*. Upper Room Books, Nashville, TN. 1997.

Gregg-Schroeder, Susan, *In the Shadow of God's Wings: Group Study Guide*. Upper Room Books, Nashville, TN. 1998.

Kehoe, Nancy, *Wrestling With Our Inner Angels; Faith, Mental Illness, and the Journey to Wholeness*. Jossey-Bass, San Francisco, CA. 2009.

Koenig, Harold G., M.D., *Spirituality in Patient Care: Why, How, When and What*. Templeton Foundation Press. Radnor, Pennsylvania. 2002.

Koenig, Harold G., M.D., *Faith in the Future: Healthcare, Aging and the Role of Religion*. Templeton Foundation Press. Radnor, Pennsylvania. 2004.

Koenig, Harold G., M.D., *Faith & Mental Health: Religious Resources for Healing*. Templeton Foundation Press. Radnor, Pennsylvania. 2005.

May, Gerald G., M.D., *The Dark Night of the Soul: A Psychiatrist Explores the Connection Between Darkness and Spiritual Growth*. HarperCollins, San Francisco. 2004.

Moore, Thomas, *Care of the Soul*. HarperCollins, New York. 1994.

Nelson, John E., M.D., and Nelson, Andrea, Psy.D.,(ed). *Sacred Sorrows: Embracing and Transforming Depression*. Penguin Putnam Inc., New York. 1996.

Rennebohm, Craig. *Souls in the Hands of a Tender God: Stories for the Search for Home and Healing on the Streets*. Beacon Press, Boston. 2008.

Rosen, David, M.D. (ed), *Transforming Depression: Healing the Soul through Creativity*. Nicolas-Hays, Inc. York Beach, Maine. 2002.

Sanford, John A., *Healing Body and Soul: The Meaning of Illness in the New Testament and in Psychotherapy*. Westminster John Knox Press, Louisville, KY. 1992.

Vickers, Angela D., JD, *Brain Bondage: The Delay in Mental Illness Recovery*. Angela Vickers, Jacksonville, FL. 2006.

Media

DVD's from Mental Health Ministries

www.MentalHealthMinistries.net

Mental Illness and Families of Faith: How Congregations Can Respond.

Mental Illness and Families of Faith: How Congregations Can Respond is a two DVD set to help educate faith communities about various mental health issues. These eight shows cover a variety of mental health issues. Professionals provide important information about each illness. You will hear from real people who live with these brain disorders. Each segment presents an issue related to the experience of mental illness, puts a face to the issue and offers a message of hope. Each segment has a discussion guide with background information, questions for discussion and where to find additional resources.

LIST OF SHOWS

Disc 1

Coming Out of the Dark -- Interfaith Introduction (*Length: 53 seconds*)

Mental Illness in Different Age Groups (*Length: 17:39 minutes*)

Mental Illness and Families of Faith (*Length: 20:50 minutes*)

Understanding Depression (*Length: 16:31 minutes*)

Overcoming Stigma: Finding Hope (*Length: 13:13 minutes*)

Disc 2

Addiction and Depression (*Length: 16:42 minutes*)

Anxiety: Overcoming the Fear (*Length: 18:49 minutes*)

Teenage Depression and Suicide (*Length: 14:39 minutes*)

Eating Disorders: Wasting Away (*Length: 12:58 minutes*)

Creating Caring Congregations (*Length: 10:39 minutes*)

- *Mental Health Mission Moments*
- *Creating Caring Congregations*
- *Breaking the Silence: Postpartum Depression and Families of Faith*

DVD's from Third Way Media

www.thirdwaymedia.org

Third Way Media has produced documentaries that have aired on ABC, NBC, Hallmark Channel and cable networks. The documentaries are created from interviews with people who have told their stories and with experts and religious leaders who address the address.

- *Shadow Voices: Finding Hope in Mental Illness*
- *Fierce Goodbye: Living in the Shadows of Suicide*
- *Finding Hope in Recovery: Families Living with Addiction*

Links to Websites for More Information on Mental Illness

American Association of Pastoral Counselors
www.aapc.org

Anabaptist Disabilities Network
www.adnetonline.org

Association of Brethren Caregivers
www.brethren-caregivers.org

Congregational Resources
www.congregationalresources.org/mentalhealth.asp

Depression and Bipolar Support Alliance (DBSA)
www.DBSAAlliance.org

Episcopal Mental Illness Network
www.eminnews.org

Jewish Mental Health
www.JewishMentalHealth.info

Mental Health America
www.mentalhealthamerica.net

Mental Health Chaplaincy
www.mentalhealthchaplain.org

Mental Health Ministries
www.MentalHealthMinistries.net

Muslim Mental Health
www.muslimmentalhealth.com

National Alliance on Mental Illness (NAMI)
www.nami.org

FaithNet NAMI
www.nami.org/namifaithnet

National Catholic Partnership on Disability
<http://www.ncpd.org>

Pathways to Promise
www.Pathways2Promise.org

Presbyterian Serious Mental Illness Network
www.pcusa.org/phewa/psmin.htm

SAMHSA: Substance Abuse and Mental Health Services Administration
www.samhsa.gov

United Church of Christ Mental Illness Network
www.min-ucc.org



What is NAMI FaithNet?

...an interfaith informational resource network of NAMI members and friends established to:

1. Equip and educate clergy, congregations and NAMI members with ministry tools and resources about mental illness
2. Encourage supportive congregations for individuals and families who live with mental illness
3. Promote the role of spirituality in recovery
4. Foster engagement of faith communities in mental health advocacy in partnership with NAMI

NAMI FaithNet is an information resource for NAMI members, clergy and congregations of all faith traditions working together to create welcoming and supportive faith communities for individuals and families living with mental illness.

NAMI FaithNet provides a wide variety of resources, including an e-newsletter, articles, referrals, handouts and other Web pages at www.nami.org/namifaithnet

What is NAMI?

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country who engage in advocacy, research, support and education. Members of NAMI are families, friends and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder.

Many NAMI affiliates offer an array of support and education programs for families and individuals. For information about what is available in your community, contact your local affiliate directly, or call the NAMI HelpLine at 1 (800) 950-NAMI (6264), or *visit* www.nami.org.



Appendix

- Attitudes about Mental Illness Assessment Tool
- Zung Self-Rating Depression Scale
- FICA Spiritual Assessment Tool
- FICA: Taking a Spiritual History
- Distinctions Between Depressive Grief and Clinical Depression
- National Day of Prayer for Mental Illness Recovery and Understanding (English and Spanish)

Other downloadable resources available at www.MentalHealthMinistries.net

- Mental Illness and Families of Faith: Creating Caring Congregations brochure with 5 step program (English and Spanish)
- Coping with a Loved One's Depression (English and Spanish)
- 1 in 4 Households in Your Church is Afraid to Tell You This Secret`
- Comfort from the Scriptures for Persons with a Mental Illness (English and Spanish)
- Mental Illness: Coping with the Holidays (English and Spanish)
- May is Mental Health Month Bulletin Insert (English and Spanish)
- Mental Illness in Children and Adolescents Bulletin Insert (English and Spanish)
- Children's Mental Health Week bulletin insert
- Breaking the Silence: Postpartum Depression and Families of Faith
- Mental Illness in Older Adults: An Opportunity for Spiritual Growth
- Guidelines for Organizing a Successful Conference
- Mental Health in Challenging Times
- Famous People With Mental Illness
- Faith Group Resolutions on Mental Illness
- Veteran's Day – A Time to Remember and Support (PTSD)
- How Congregations Can Support Veteran's and Their Families
- Self Care Tips for the Clergy Family
- Guidelines for Clergy: Providing Pastoral Care to Persons with Mental Illness and Their Family
- Sample Blue Christmas services

Attitude Assessment Tool

1. What are your beliefs about the cause of mental illnesses such as depression, schizophrenia, addictions, etc.?

Circle all that best relate to the way you feel.

- a. Suffering can give you the opportunity to grow spiritually
 - b. If a person prays more, they will be cured.
 - c. Persons with a mental illness are more violent.
 - d. God never abandons those who suffer
 - e. Persons with mental illness in their families need the support of the faith community.
 - f. Suicide is a sin and shows a lack of faith in God.
 - g. Persons with a mental illness could just snap out of it, but they are too lazy.
2. Persons with mental illness are better off going elsewhere to worship. They have difficult behaviors that can disrupt worship.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

3. Spirituality and religion are not that helpful for persons with a mental illness and their families.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

4. I feel comfortable talking with my pastor or other church leaders about mental health issues.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

5. Persons with a mental illness and their families are treated like any other parishioner.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Zung Self-Rating Depression Scale (SDS)

For each item below, please place a check mark (✓) in the column which best describes how often you felt or behaved this way during the past several days

Place check mark (✓) in correct column.	A little of the time	Some of the time	Good part of the time	Most of the time
1. I feel down-hearted and blue.				
2. Morning is when I feel the best.				
3. I have crying spells or feel like it.				
4. I have trouble sleeping at night.				
5. I eat as much as I used to.				
6. I still enjoy sex.				
7. I notice that I am losing weight.				
8. I have trouble with constipation.				
9. My heart beats faster than usual.				
10. I get tired for no reason.				
11. My mind is as clear as it used to be.				
12. I find it easy to do the things I used to.				
13. I am restless and can't keep still.				
14. I feel hopeful about the future.				
15. I am more irritable than usual.				
16. I find it easy to make decisions.				
17. I feel that I am useful and needed.				
18. My life is pretty full.				
19. I feel that others would be better off if I were dead.				
20. I still enjoy the things I used to do.				

Zung Self-Rating Depression Scale

The **Zung Self-Rating Depression Scale** was designed by W.W. Zung to assess the level of [depression](#) for patients diagnosed with depressive disorder.

The Zung Self-Rating Depression Scale is a short self-administered survey to quantify the depressed status of a patient. There are 20 items on the scale that rate the four common characteristics of depression: the pervasive effect, the physiological equivalents, other disturbances, and psychomotor activities.

There are ten positively worded and ten negatively worded questions. Each question is scored on a scale of 1-4 (a little of the time, some of the time, good part of the time, most of the time).

The scores range from 25-100.

- 25-49 Normal Range
- 50-59 Mildly Depressed
- 60-69 Moderately Depressed
- 70 and above Severely Depressed

Zung, WW (1965) A self-rating depression scale. Arch Gen Psychiatry 12, 63-70.

FICA: Personal Spiritual Assessment Tool

The acronym FICA can help structure questions in taking a personal spiritual history.

F –Faith, Belief, Meaning

Do I have a spiritual belief that helps me cope with stress? With illness? What gives my life meaning?

I –Importance and Influence

Is this belief important to me? Does it influence how I think about my health and illness: Does it influence my healthcare decisions?

C –Community

Do I belong to a spiritual community (church, temple, mosque or other group)? Am I happy there? Do I need to do more with the community? Do I need to search for another community? If I don't have a community, would it help me if I found one?

A –Address/Action in Care

What should be my action plan? What changes do I need to make? Are there spiritual practices I want to develop? Would it help for me to see a chaplain, spiritual director or pastoral counselor?

Christina Pulchalski has developed an acronym, FICA, which can be used in performing a spiritual assessment. (Puchalski C, Romer AL. Journal of Palliative Medicine. 3(1): 129-137, 2000.)

FICA: Taking a Spiritual History

The acronym FICA can help structure questions in taking a personal spiritual history.

F – Faith, Belief and Meaning

“Do you consider yourself spiritual or religious?” or “Do you have spiritual beliefs that help you cope with stress?” If the patient responds, “no,” the physician might ask, “What gives your life meaning?” Sometimes patients respond with answers such as family, career or nature.

I – Importance and Influence

“What importance does your faith or belief have in your life? Have your beliefs influenced how you take care of yourself in this illness? What role do your beliefs play in regaining your health?”

C – Community

“Are you part of a spiritual or religious community? Is this of support to you and how? Is there a group of people you really love or who are important to you?” Communities such as churches, temples, and mosques, or a group of like-minded friends, can serve as a strong support system for some patients.

A – Address/Action in Care

“How would you like me, your healthcare provider, to address these issues in your healthcare?” Often it is not necessary to ask this question but to think about what spiritual issues need to be addressed in the treatment plan. Examples include referral to chaplains, pastoral counselors, or spiritual directors, journaling, and music or art therapy. Sometimes the plan may be simply to listen and support the person in their journey.

Christina Pulchalski has developed an acronym, FICA, which can be used in performing a spiritual assessment. (Puchalski C, Romer AL. Journal of Palliative Medicine. 3(1): 129-137, 2000.)

Possible Distinctions Between Depressive Grief and Clinical Depression

Normal Grief	Clinical Depression
Responds to comfort and support	Does not accept support
Often openly angry.	Irritable and may complain but does not directly express anger
Relates depressed feelings to loss experienced	Does not relate experiences to a particular life event
Can still experience moments of enjoyment in life	Exhibits an all pervading sense of doom
Exhibits feelings of sadness and emptiness	Projects a sense of hopelessness and chronic emptiness
May have transient physical complaints	Has chronic physical complaints
Expresses guilt over some specific aspect of the loss	Has generalized feelings of guilt
Has temporary impact upon self-esteem	Loss of self-esteem is of greater duration

Source: Wolfelt, A.D., (1988) *Death and Grief: A Guide For Clergy*, Accelerated Development, Inc. Publishers, 3400 Kilgore Avenue, Muncie, Indiana 47304 (317-284-7511).
(Permission to use granted by author).

NATIONAL DAY OF PRAYER FOR MENTAL ILLNESS RECOVERY AND UNDERSTANDING

Tuesday of Mental Illness Awareness Week - First full week in October

The National Day of Prayer for Mental Illness Recovery and Understanding has been designated as the Tuesday of Mental Illness Awareness Week which is first week in October of each year. Mental illness networks and faith leaders are urged to work together so that they may recognize and prepare for this day in a way that works best for each faith community. The prayers and actions of both faith communities and secular organizations (e.g. NAMI, NMHA, DBSA, OCF, ADAA, etc.) are needed to restore mental wellness in America. In seeking God's guidance, we can recommit ourselves to replacing misinformation, blame, fear and prejudice with truth and love in order to offer hope to all who are touched by mental illness.

This flyer includes some resources you may find helpful.



PRAYER OF CONFESSION

Leader: We confess that we are still uninformed about mental illness and how it impacts persons and their families.

Response: **At times, because of our lack of knowledge and understanding we find ourselves separated from our sisters and brothers with mental illness, their families and ourselves.**

Leader: There are lines drawn between us because we may define wholeness and normality with different words, but not a different spirit.

Response: **Because of our lack of knowledge we live cut off from sources of strength and power that would help us be present to people with mental illness. This lack often makes us feel that we cannot act.**

Leader: So many events, meetings and needs call to us, grabbing for our attention, that we find ourselves stretched to a fine, thin line.

Response: **In the face of all this, we continue to seek knowledge and understanding of mental illness that will bring liberation and shalom to us and those we serve and unite us to action.**

All: **O God, our liberation and shalom, we seek the power of your Spirit, that we may live in fuller union with you, ourselves and our sisters and brothers with mental illness. Also grant that we may gain courage to love and understand each other. Amen.**

PASTORAL PRAYER

Loving Creator, we come to you on this National Day of Prayer for Mental Illness Recovery and Understanding because we know that you are a God of love and compassion. We come as people of all creeds and all nations seeking your presence, comfort and guidance. We come as consumers, family members, friends, co-workers and mental health professionals. We come this day because we believe that you, Divine One, love each one of us just as we are and you walk with us on our individual journeys through life. You see the ignorance and injustice that divides and separates persons struggling with mental illness and you weep with us.

Give us courage to face our challenges and open us today to the many ways you are already working in our midst. Help us to identify mental illness as the disease it is, that we might have courage and wisdom in the face of ignorance and stigma. Inspire us as we seek to overcome fear, acquire knowledge, and advocate for compassionate and enlightened treatment and services.

Lead us as we open our hearts and homes, our communities and job opportunities, our houses of worship and communities of faith. Enable us to find ways to be inclusive of persons living with mental illness in our everyday lives. Be with doctors, therapists, researchers, social workers, and all those in the helping professions as they seek to overcome ignorance and injustice with care and compassion.

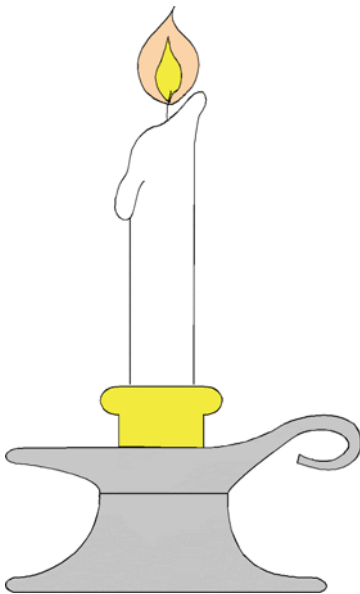
Sometimes, Divine Spirit, we feel discouraged and hopeless in the face of so many challenges. Help us to see ourselves as you see us...persons of value and worth...persons of creativity and potential. May we come to understand the interconnectedness of mind, body and spirit in bringing about health and wholeness. And may we go forward into our communities with a renewed sense of vision, hope and possibility for the future. Amen.

Reverend Susan Gregg-Schroeder

CANDLELIGHTING SERVICE

We light the candle of **Truth** that God will help us dispel ignorance and misinformation about major depression, bipolar disorder, schizophrenia, severe anxiety and obsessive compulsive disorder. (Silent prayer)

We light the candle of **Healing** that troubled minds and hearts, broken lives and relationships might be healed. (Silent prayer)



We light the candle of **Understanding** that the darkness of stigma, labels, exclusion and marginalization might be dispelled for the sake of those touched by mental illness. (Silent prayer)

We light the candle of **Hope** for persons and families living with mental illness, for better treatment, for steadier recovery, for greater opportunity to work and serve. (Silent prayer)

We light the candle of **Thankfulness** for compassionate, dedicated caregivers and mental health professionals; for new discoveries in brain research and better medications. (Silent prayer)

We light the candle of **Faith** to dispel doubt and despair for those who have lost hope and are discouraged. (Silent prayer)

We light the candle of **Steadfast Love** to remind us of God's love and faithfulness, and to remind us to share the light of love and service for those living with mental illness. (Silent prayer)

Carole J. Wills

Other Options

After lighting the candles, participants can be invited to come forward and light a votive candle speaking the name of someone they wish to pray for aloud or in their heart. Other types of candles can be used and a song can be sung.

Another option is to have a fountain or bowl of water in the center of the candles. Participants can come forward and take a stone, colored marble or shell from the water and take it with them as a reminder of their personal prayer.

Websites for More Resources

NAMI FaithNet

www.NAMI.org/NAMIFaithNet

Mental Health Ministries

www.MentalHealthMinistries.net

Pathways to Promise

www.pathways2promise.org

FaithCEP NAMI Indianapolis

www.congregationalresources.org/mentalhealth.asp

About the Author

Rev. Susan Gregg-Schroeder founded Mental Health Ministries to provide educational resources to help erase the stigma of mental illness in our faith communities. As a consumer, she also educates doctors, therapists and other mental health care providers to understand the important role a person's spirituality can play in the recovery and healing process. She encourages collaborative relationships between communities of faith, mental health professionals, community based providers and national organizations involved in education, service and advocacy.

As Coordinator of Mental Health Ministries, Susan has produced broadcast-quality DVD resources addressing various mental health issues from a spiritual perspective. The two DVD set, *Mental Illness and Families of Faith: How Congregations Can Respond*, puts a face to different mental health issues and offers a message of hope. All of her DVD resources and downloadable print resources are available on the Mental Health Ministries website, www.MentalHealthMinistries.net.

Susan is also an author. Her best known book is *In the Shadow of God's Wings: Grace in the Midst of Depression*, published by The Upper Room. This book shares her very personal story as she has struggled with severe depression.

Susan has been active with NAMI and NAMI FaithNet for many years. She was awarded NAMI California's Clergy person of the Year award in 2003. Susan is also a member of the Pathways to Promise Board of Directors and a member of the American Association of Pastoral Counselors (AAPC).

Susan is married and lives in San Diego with her husband. She has two grown children and two grandchildren.