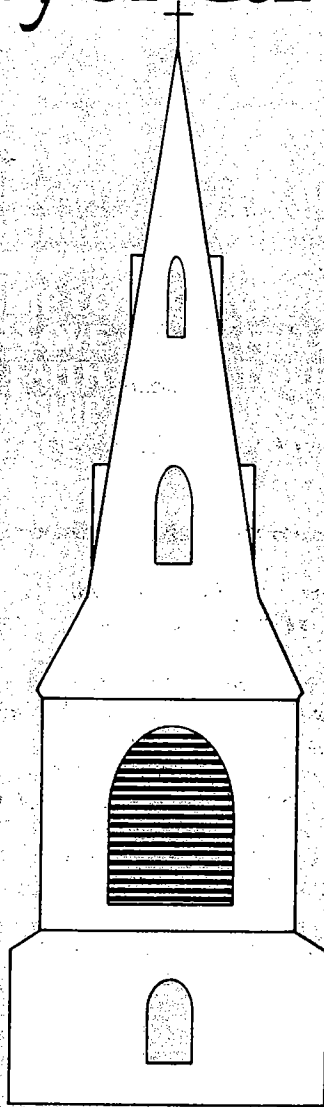


THE CONGREGATION:

A Community of Care and Healing



MENTAL ILLNESS AWARENESS RESOURCES



*Presbyterian Church (U.S.A.) / Presbyterian Serious
Mental Illness Network*

Social Justice and Peacemaking Unit, Office of Human
Service, 100 Witherspoon Street ■ Louisville, KY 40202-1396 ■ (502) 569-5793



Dear Friends in Christ:

Fourteen and a half million Americans - 210,000 Presbyterians are counting on the church for a change.

...counting on the church, because the much heralded "care in community" promised three decades ago has, for many, turned out to be a cruel deception;
...counting on the church, because fear and stigma have blunted their welcome and left them isolated in the community at large;
...counting on the church, which has traditionally played a role of moral leadership in society;
...counting on the church for kinship which embodies gentle, respectful support without compromising confidentiality or autonomy.

Two hundred ten thousand Presbyterians are counting on the church for a change...

- in the way we view mental illness;*
- in our strategies for inclusion within the community of faith;*
- in our level of advocacy within the community at large.*

The numbers are staggering. Mental and emotional disorders afflict more Americans than any other category of disabling illness. Diseases which ravage the mind cause as much pain for those who are ill and their families as any disease which destroys the body. Recognizing a growing need to address issues of care for persons with prolonged mental illnesses, the 200th General Assembly, meeting in St. Louis in 1988, adopted a resolution (reprinted inside back cover) affirming the ministry and mission of the church with those affected by mental illnesses.

...those 14.5 million Americans and our 210,000 Presbyterians;
...the one-in-five families in each of our 11,600 congregations who know the devastating effect of mental illness;
...virtually all of our 20,000 clergy whose ministry will inevitably bring them in contact with persons who have mental illness and an abundance of mental health professionals from our congregations who deal daily with frustrations of working with persons who have acute, prolonged, intractable illnesses;
...our 200,000 deacons and elders in their ministries of care and decision making;
...ultimately. . . each of us!

This book aims at disarming fear and enabling dialogue - first steps across the secrecy that has surrounded the presence of mental illness in our midst. We hope you find it useful in your congregation.

Sincerely,

David L. Zuverink

David L. Zuverink,
Associate for Human Services
Social Justice and Peacemaking Unit

Florence Kraft

Florence I. Kraft
Chair, Education Committee
Presbyterian Serious Mental Illness Network

100 Witherspoon Street - Louisville, KY 40202-1396 - (502) 569-5793

THE CONGREGATION:

A COMMUNITY OF CARE AND HEALING

MENTAL ILLNESS AWARENESS RESOURCES

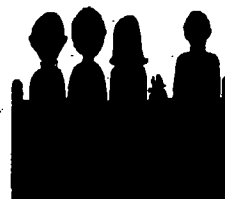
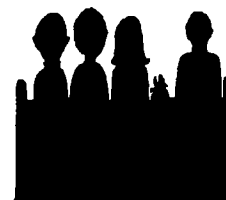
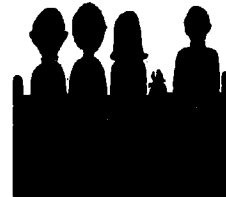
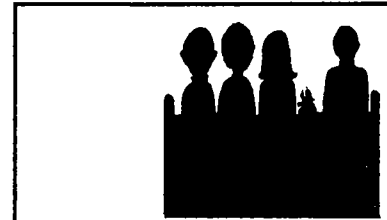
We are your brother...

your sister...

the man across the street...

or...

the woman next to you in the pew.



A resource guide of the Presbyterian Church (U.S.A.), prepared in cooperation with the Presbyterian Serious Mental Illness Network and Pathways to Promise: Interfaith Ministries and Prolonged Mental Illnesses, Jennifer Shifrin, Executive Director.

This is the second in a series of sourcebooks for ministry of caring within the congregation. It is published in response to directives of the 200th General Assembly by the Social Justice and Peacemaking Ministry Unit, Presbyterian Church (U.S.A.): Belle Miller McMaster, Director; Donald J. Wilson, Human Services Group Director and Associate Director.

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PRESBYTERIAN SERIOUS MENTAL ILLNESS NETWORK (PSMIN)

WHO ARE WE?

We are Presbyterian consumers of mental health services, family members, parish clergy and chaplains, medical and human service professionals and concerned lay people. The PSMIN is a constituency group within the Presbyterian Health Education and Welfare Association (PHEWA) which operates out of the Social Justice and Peacemaking Ministry Unit of the Presbyterian Church (U.S.A.).

WHAT IS OUR PURPOSE?

The 200th General Assembly (1988) adopted a resolution, "The Church and Serious Mental Illness" which affirmed "anew the ministry and mission of the church and all its people and parts with those suffering from or affected by severe mental illnesses." Our purpose is to assist our denomination, our churches, fellow members and ourselves in carrying out the mandate of that resolution.

To accomplish this, we have established the following goals:

1. To develop an information, referral and support system operating at synod, presbytery and congregational levels which is related to other denominations and to independent consumer, family and advocacy organizations.
2. To initiate and review denominational health policy formation and implementation with respect to serious mental illnesses, focusing on supporting and empowering persons with serious mental illnesses and their families, and to promote our denomination's advocacy of enlightened and consumer-sensitive public policy.
3. To provide education and training for congregations, church professionals and volunteers, in dialogue with consumers, families and mental health service providers, concerning serious mental illness and the response of the religious community.

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This book may be ordered through the Presbyterian Distribution Management Service at 1-800-524-2612.
The order number is DMS 257-90-002.

THE CHURCH AND SERIOUS MENTAL ILLNESS

Although care and treatment of persons who have mental illnesses has improved dramatically with the introduction and development of new drugs, medical practice has outpaced practicality. In too many instances, citizens who have had the misfortune to suffer mental illness - even those who approach society's definition of normal - daily face an unsympathetic, unfair, and hostile society.

For example, research studies have found that most Americans think the two worst things that can happen to a person are leprosy and insanity. In American society, ex-convicts stand higher on the ladder of acceptance than former mental patients. Asked to rank 21 categories of disability from the least offensive to the most, respondents place mental illness at the bottom of the list. . . People continue to discriminate against the mentally ill, although it may be less socially acceptable to admit it openly. Discrimination crosses all boundaries of society and exists among people of all ages, socioeconomic levels, intelligence, education, and places. Nearly everyone, it seems, regards victims of mental disorders as "fundamentally tainted and degraded." (U.S. Department of Health and Human Services, Publication #ADM 86-1407)

Those who shy away are in comfortable company. Mental illness is clearly a least-popular cause among many worthy causes. Thankfully, the Presbyterian Church (U.S.A.) has recognized, spoken to, and continues to support efforts to better the lives of families affected by mental illnesses.

SUGGESTIONS FOR USING THIS BOOK

1. Designate a Sunday as mental illness awareness day, perhaps during May which is National Mental Health Month or the first week in October which Congress has set aside as Mental Illness Awareness Week. Use ideas from this book and help from information and support groups within your community in planning a sermon, church school lessons for all ages, and perhaps a church wide event.
2. Plan an adult education series using ideas found in Section V or the Study and Action Guide on page 17.
3. There are likely to be several members in your congregation who have personal or professional concerns about mental illness. Use this book as a catalyst for bringing them together informally and offer support for further study and strategy development.

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Section I

MENTAL ILLNESS

MYTH AND REALITY

- MYTH:** Mental illness does not affect the average person.
- REALITY:** No one is immune to mental illness. The National Institute of Mental Health's statistics show 35 million Americans have some form of mental illness in any given six months.
- MYTH:** Most people who struggle with mental illness live on the streets or are in mental hospitals.
- REALITY:** About two thirds of Americans who have a mental illness live in the community, either with their family or in various types of community living settings.
- MYTH:** Children do not get mental illness.
- REALITY:** Twelve million children and adolescents do suffer diagnosable mental disorders including depression, attention deficit disorder, and conduct disorder.
- MYTH:** A person can recover from a mental illness by turning his or her thoughts positively and with prayer.
- REALITY:** Recovery is possible when the person receives the necessary treatment and supportive services.
- MYTH:** People who have a mental illness are dangerous.
- REALITY:** People who have a mental illness are no more violent than someone suffering from cancer, diabetes, or any other serious disease. More often, they are the victims of violence.
- MYTH:** If you have a mental illness, you are "crazy" all the time.
- REALITY:** People suffering from even the most severe mental illnesses are in touch with reality as often as they are actively psychotic. Many quietly bear the pain of mental illness without ever acting "crazy."
- MYTH:** If people with other handicaps can cope on their own, people who have a mental illness should be able to do so as well.
- REALITY:** Most people who have been through a disabling illness need help, or rehabilitation, to return to normal functioning. Physical therapy often fills this role after physical illness. Similarly, following mental illness, social rehabilitation is often needed.

THE REALITY OF MENTAL ILLNESS

*"The future?
I can't look too far ahead.
I won't look too far ahead.
I like to be in control of my life.
With this illness
you can't be in control.
What I do, instead, is
take control over what I do
when I get sick.
I can't control
when it's going to happen
or how intense it's going to be.
I can control how I handle it
and what I do." Vicki*

*"Mental illness is biochemical.
It comes in many different ways.
You can hear voices,
be totally paranoid,
be afraid to talk to somebody.
You can be so scared
to walk outside your door
that you want to die." Carrie*

*"When you talk about
falls from grace,
maybe for us who are
psychiatrically ill,
the word is 'breaks.'
We go through 'breaks.'
They are horrible.
I have been through four.
I went through three in
successive years.
One right after the other.
I didn't even know what hit me."
Bill*

*"It is not demon possession.
It is just a chemical imbalance
you can't control without
getting the right help for it." Gail*

What is mental illness? Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and/or relating. The result is a substantially diminished capacity for coping with the ordinary demands of life. In America, today, 35 million people suffer from some form of mental illness. One in four American families is affected by mental illness. No segment of society is immune. Mental illness can affect persons at any age and can occur in any family.

How prevalent is mental illness? Mental illness is twice as prevalent as Alzheimer's disease, six times as prevalent as diabetes, and five times as prevalent as multiple sclerosis. In fact more hospital beds in America are occupied by people who have a mental illness than those who have cancer, heart, and lung disease *combined*.

Is it possible to recover? People can and do recover from mental illness. There are some famous examples, including President Abraham Lincoln, philosopher William James, U.S. Senator Thomas Eagleton, popular singer Rosemary Clooney, actress Patti Duke, and professional golfer Bert Yancy. With proper treatment, two out of three people who have a mental illness can expect to get better and lead productive lives. In the United States, at least two million people who have been hospitalized with a mental illness are currently a part of the community.

Does mental illness have different forms? Mental illness has various forms. In America over 9 million people suffer from depression, 2.8 million from schizophrenia and more than 13 million from anxiety disorder.

Is there a difference between mental illness and mental retardation? Yes. People with mental retardation have diminished intellectual capacities, but people who have a mental illness have normal intellectual capacities. However, some may have difficulty performing at a normal level due to their illness, their medication or lack of a supportive environment.

Is mental illness due to "poor parenting?" Mental illness is NOT caused by dysfunctional families nor is it evidence of weakness of character.

What causes mental illness? Its causes are not fully understood. It is thought the brain's neurotransmitters do not function properly due to a biochemical imbalance in the brain. This sort of imbalance is comparable to imbalances in other areas of the body that cause illnesses such as diabetes and cancer. And, just as with diabetes, many symptoms of mental illness can be controlled with medication.

Other factors may contribute. Heredity may be a factor in mental illness, as it is in diabetes and cancer. Stress may contribute to the onset of mental illness in vulnerable persons. "Recreational" drugs may also contribute to onset but are unlikely to be the primary cause. Family interaction and early childhood training were once dominant as theories of causation, but research no longer supports these theories.

"Patients have told me they are frightened of doing the wrong thing or eliciting some response from someone in public that will hurt them. I think they have very low self esteem and are very vulnerable to being overwhelmed by people in authority. Overwhelmed by routine interactions that would not bother you or me." Roy Wilson, M.D.

"My grandfather committed suicide when my mother was seven. It was not until my first breakdown when I asked for a family history that I found out about it. He had been in the state hospital for a year before he committed suicide. I realized then that this is the living experience that has no name. The 'untalked' about shadow that can follow any person." Ruth

What treatments are available? An expanding range of medications is currently available. While they do not cure these illnesses, they reduce symptoms markedly for most people. In addition, most persons can profit from supportive therapy and from a community program to help them rebuild self-confidence and learn independent living skills. With quality comprehensive treatment, symptoms may substantially subside and many people experience periods of remission. Others may require on-going support programs designed specifically for people who have these illnesses. The goal is to enable them to achieve the highest degree of independence, productivity, and satisfaction in their lives.

Can mental illness be prevented or cured? Since the causes of mental illnesses are not fully known, there is little effective prevention. However, research to determine causes and to plan strategies for prevention and rehabilitation is progressing. Similarly, there are no identified cures for mental illnesses, but proper treatment may substantially improve the functioning of persons with these illnesses, and in some cases they may completely recover.

Does research offer hope? The key to finding cures for people who have mental illnesses is in scientific research on the brain and in genetics. Recent developments in research technology point to the decade of the 1990's as the pivotal decade in the understanding of all diseases of the brain.

Can a person who has had a mental illness ever be normal? Mental illness is often temporary. A previously well-adjusted individual may have an episode of illness lasting weeks or months, and then may go for years, or even a lifetime, without another. To label such a recovered person as "abnormal" is both unfair and unrealistic. Others may become ill periodically. Between episodes, they may be perfectly well. At these times they understandably resent being treated as other than normal. Like any of us, people who have had a mental illness deserve to be judged on their own merits. Too often, they are thought of only in terms that unfairly label them.

(Statistics used throughout this publication are taken from research made available by the National Institute of Mental Health.)



DEFINITIONS OF MENTAL ILLNESSES

AFFECTIVE DISORDERS

Under the umbrella term of "affective disorders" are the most common groupings of psychiatric disorders. The primary symptom is that of changed affect or mood. These mood disorders may be manic-depressive illness (bipolar), in which the person swings between extreme high and low moods, or severe depression (unipolar) in which the person has persistent low moods.

*"It started with real functioning.
A very productive, energetic time.
I felt I could do nothing wrong.
To the people around me, it was
obvious something was wrong.
But to me life could not be better.
Then it all escalated to the point
where I was not rational.
The things I did were bizarre.
I spent money like it was water!
I would think of ten or twelve
different things I should be doing
that day and just not go to work.*

*"And then, just as fast as
I went up, I went down.
I was so tired, being burned out
from the manic high.
I would sleep constantly,
not want to go out at all.
I wouldn't want to see people.
Everything seemed hopeless.
I could never find a good reason
why I was here any more." Vicki*

Manic-depression - Persons diagnosed as having manic-depression or bipolar illness usually have several of the following symptoms:

- boundless energy, enthusiasm, and need for activity
- decreased need for sleep
- grandiose ideas and poor judgement
- rapid, loud, disorganized speech
- short temper and argumentativeness
- impulsive and erratic behavior
- possible delusional thinking
- rapid switch to severe depression
- suicidal thoughts

Severe depression - Persons diagnosed as having severe depression or unipolar illness (or the depressive phase of a bipolar disorder) usually have several of the following symptoms:

- difficulty in sleeping
- loss of interest in daily activities
- inability to concentrate
- psychotic symptoms (delusions, hallucinations)
- suicidal thoughts and actions
- feelings of worthlessness, guilt, hopelessness

Who Gets This Illness?

At any given time, 6 in 100 Americans (over 14 million people) are diagnosed as having depression. For those having a single episode of depression, 20 to 30% will have a complete remission.

2 in 100 Americans (5 million people) will have a long term, severe depression.

Depression is most apt to strike people in the prime of life - ages 25 to 44.

With appropriate treatment, 80 percent of people with depression improve.

Cost of depression

In the United States, the economic cost of depressive disorders is \$16 billion per year. The cost results from loss of time on the job, stress, divorce, hospitalization, suicide, and secondary alcoholism.

SCHIZOPHRENIA

Schizophrenia is due to a chemical imbalance in the brain. It is a complex disease. Few generalizations hold true for everyone who has it. People with schizophrenia do not have a "split personality," or an idiosyncratic way of thinking which is correctable through psychoanalysis. People experiencing an acute episode of schizophrenia have a sudden onset of severe psychotic symptoms. To be "psychotic" means to be out of touch with reality, or unable to separate real from unreal experience. People with this disease can experience periods of a distorted sense of reality or ability to think and also hallucinations and delusions. People with schizophrenia sometimes exhibit an emotion which is inconsistent with his or her speech or thoughts. Or they may show "blunted" or "flat" affect, which refers to a severe inability to express any emotion. While medications can usually control the most flamboyant symptoms of schizophrenia, none can cure it.

"When I was acutely ill, it was like being in a car with the accelerator and the brakes on at the same time - full bore. It was like being in a rapidly moving vehicle for which there was no driver. I felt trapped in a world of hallucinations that went on without my control and compelled me to act in certain ways.

"It's like being forced to be in a movie you don't like. It's like being tied to the chair in a movie theater for weeks on end listening to something that you really don't want to be there to see." Ruth

"I first thought there was something wrong with Henry in his last year of high school. Henry didn't want to go to school. He would sleep and he would eat. He would not do anything else in the house. He would not take a bath. He would not communicate with the family. He said he could hear voices and see things. He would say someone was after him, chasing him. He said many things I knew were not normal. Something was awfully wrong with Henry." Veronica

Schizophrenia - Persons diagnosed as having schizophrenia may exhibit the following symptoms:

- disconnected and confusing language
- believing his or her thoughts are controlled by others
- poor reasoning, memory, and judgement
- eating and sleeping disorders
- hallucinations
- delusions
- deterioration of personal appearance and hygiene
- loss of motivation
- poor concentration
- withdrawal
- sense of body boundaries deteriorating

Who Gets This Illness?

1 in 100 Americans (2.8 million).

There are as many people with schizophrenia in the United States as the combined population of the states of Oregon, Mississippi and Kansas.

Each year 100,000 Americans are newly diagnosed.

One third of all people diagnosed and hospitalized with schizophrenia will recover completely. One third, will improve, needing only occasional hospitalization. One third have long term, recurring schizophrenic episodes requiring hospitalization.

Schizophrenia generally occurs between the ages of 17 and 30, and rarely after age 45.

Cost of Schizophrenia

In the United States, the annual cost of schizophrenia is \$20 billion per year. This results from hospitalization, disability benefits such as Social Security, welfare payments, and lost wages.

OTHER DISABLING MENTAL ILLNESSES

Anxiety disorders, when totally disabling, may also be considered mental illness. As a group, anxiety disorder afflict 8.3% of Americans. This group of illnesses includes phobias, panic disorders, post-traumatic stress disorder and obsessive-compulsive disorders. Probably no single situation or condition causes anxiety disorders. Rather, physical and environmental triggers often combine to create a particular anxiety illness. Other conditions such as **personality disorders** and the **abuse of alcohol and drugs** may be so disabling as to be labeled mental illness.

POSSIBLE SIGNS AND SYMPTOMS OF MENTAL ILLNESS

Not all symptoms occur in every person with a mental illness. Each of them indicates excessive and/or EXAGGERATED patterns of perceptions, behaviors and feelings. Although, individuals and societies vary as to what is "normal," a person with a mental illness should be evaluated if there is a change to extremely unusual behavior. Never hesitate to call a physician to share these concerns, just as you would for any illness.

SEEK MEDICAL EVALUATION IF SOME OF THESE EXAGGERATED BEHAVIORS BEGIN TO APPEAR.

"He would get on a pace and he would pace up and down the hall. He would laugh sometimes and cry sometimes. I would go to the door many nights and ask him what was wrong. He would say nothing and be crying." Ida Mae

"She doesn't come down to dinner with the family anymore. Sometimes she takes a tray in her room. Sometimes she doesn't eat anything at all. Her table manners, when she does eat with us, are atrocious. She never combs her hair or washes her hands before coming to the table. Her clothes are all over her room in piles. Six equal piles of dirty clothes. She doesn't like me to touch that." Marian

"If you go in the kitchen, as soon as you leave, he rushes in to see what you may have done. If something is left on the counter, a plate, a bowl, whatever, he washes it and dries it two or three times. He also has to have the kitchen floor and the hall floor mopped twice a day in a certain way. Always left to right, left to right." Sue

SYMPTOMS

- withdrawal or distrust of friends and family.
- decline in academic, athletic, or job performance.
- slovenliness or decline in personal hygiene.
- inappropriate dressing for weather or occasion.
- self destructive actions.
- glazed or faraway stare and/or bizarre posturing.
- excessive changes in sleeping or wakefulness.
- excessive changes in appetite - too little or too much.
- excessive seeking of approval.
- excessive writing of nonsensical or disconnected thoughts and words.
- abuse of alcohol or other drugs.

PERCEPTIONS

- extreme or unusual sensitivity to LIGHT/COLORS/NOISE.
- fear of touching or being touched by others or things.
- changed sense of self (body parts diseased, detached, hanging, etc.).
- hallucinations: either auditory (hearing voices) and/or visual (seeing something that is non-existent).
- certain clothing having unusual meaning.

EMOTIONS/FEELINGS/THOUGHTS

- extreme anxiety over the smallest things.
- extreme guilt over "past sins" or bad conduct.
- extreme pessimism and/or unceasing depression.
- extremely low self esteem.
- suicidal thoughts.
- paranoia towards everyone and everything.
- delusions of power/wealth/knowledge.
- exaggerated, blunted, or inappropriate emotional response (laugh/cry).
- inability to express or feel any emotion.

REACHING OUT TO SOMEONE WHO HAS A MENTAL ILLNESS

As you do with other friends, treat someone who has a mental illness as you would want to be treated, with understanding and respect.

When a person with a mental illness:

is withdrawn,
is overstimulated,
becomes insecure,
is fearful,

You need to:

initiate relevant conversation.
limit input, do not force discussion.
be accepting.
stay calm.

When symptoms or medications cause behaviors such as:

disorientation or preoccupation,
difficulty with concentration,
stress in ordinary situations,
trouble remembering,
unsound judgement,

You need to:

keep to a known, structured routine.
slow down, and perhaps repeat; use simple, short sentences.
create an uncomplicated, predictable environment.
help the person record information.
remain rational and reinforce common sense.

Some symptoms of mental illness are unlike anything you will encounter elsewhere. *YOU* can't change that, but you can refrain from further destroying the person's integrity.

When a person with a mental illness:

is not grounded in reality,
believes delusions,
displays little empathy,
has difficulty making contact,
seems totally lacking self-esteem and motivation,

You need to:

listen for kernels of truth, or wait for a better time.
avoid arguing.
recognize this as a symptom; try not to respond in kind.
make direct contact and keep the initiative.
affirm the person's value; treat accomplishments positively.

Fine inner qualities often remain and develop in spite of mental illness. Do not do "for" persons with a mental illness, do "with them", as you do with other persons with other disabilities.

When a person with a mental illness:

shows a talent such as music, writing or art;

retains an inborn generosity,

expresses an interest in his or her illness and its consequences,

wants to have a serious discussion,

wants to help,

You can:

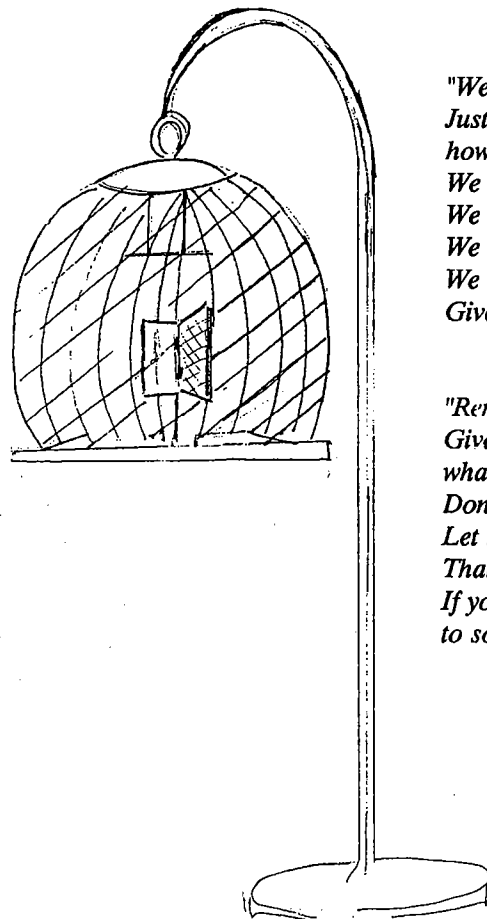
be open to the person sharing this with you.

acknowledge the gifts (which may not always be monetary).

learn together.

remember, even the most severely ill are rational as much of time as they are psychotic.

give them a task and let them do it.



"We are in your congregations, your churches. Just think about how many of us there are and how many more of us there are with our families. We want to make friends with you. We want to talk to you. We want to work with you. We have capacities to help. Give us that opportunity." Jay

"Remember us when you are trying to help us. Give us a chance to use what we have, what our capabilities are. Don't stop us. Let us fail. Let us try again. Let us reach as far as we can. That is the love and compassion we seek from you. If you love us, help us to fly, to soar toward our highest goals." Terry

THE FAMILY AND MENTAL ILLNESS

Mental illness of a loved one affects everyone in the family. Reactions are varied. Some families have trouble dealing with the reality of the illness or feel a tremendous sense of shame and isolation. Some may become overly preoccupied with what has happened. In reaching out to a family in this situation it is important to remember that living with the disease can be bewildering and taxing. It is important for everyone to know that the family did not cause the illness; the family is not responsible for it. Self-blame and blame leveled by others is destructive for all concerned.

What families need to do is plan for the future. Many families who work together to deal with the often harsh effects of mental illness may discover a wealth of abilities and assets they possess as individuals and as a unit. The family's discovery of these strengths and skills often gives rise to changes that improve the quality of life for everyone in the family (including the ill member). As time goes by the family may find itself the first line of defense for their loved one. They must keep themselves physically and mentally healthy so they are able to best help their ill family member.

Anyone living and/or working with a person who has a mental illness should:

- place no blame or guilt;
- look for support;
- seek relief from stress;
- continue outside interests;
- don't try to be "super parent," "super sibling," "super spouse," or "super friend."

The following are some **tips to help in coping** with a family member who is mentally ill. Families have sometimes used these techniques successfully. They are to be used to help develop coping strategies that complement professional treatment.

- Learn all you can about the illness and educate other family members and friends about it.
- Know resources for help and support before a crisis occurs.
- Designate someone in the ill person's immediate circle (family member, friend) to be there when help is needed.
- Anticipate vulnerable situations (difficult relationships, job stresses, anniversary and holiday dates), and space them out. If Aunt Tess can't handle the relationship, don't have her to dinner when the ill family member is present.
- Space out stressful events. Remember, what is stressful for your ill family member may not be stressful for you.
- Realize a person with a mental illness can suffer from memory loss or poor concentration. This is frustrating and frightening, but do not be judgmental.
- Break down tasks into small units so they do not overwhelm the ill person. Focus on **SUCCESSSES** not failures.
- Avoid pampering. Set reasonable rules and limits and stick to them. If you find this difficult to do, ask the doctor or counselor for suggestions.
- Avoid expecting that all peculiar behaviors and habits can be corrected.
- Learn about medications - what they are and do, side effects and residual effects they may have, how and how long they take to work.
- Pay attention to medications (are they being taken, do they seem to be working, etc.).
- Realize common substances (coffee, tea, sugar, alcohol, over-the-counter medications) may adversely affect the ill person.
- Be sure other doctors (eye doctor, internist, dentist, foot doctor, skin doctor, etc.) know what medications the person is taking.
- Realize another breakdown can be temporary. The person has recovered before and is likely to do so again.

Section II

THE RELIGIOUS COMMUNITY AND MENTAL ILLNESS

HOW A CONGREGATION CAN RESPOND

"People are hurting with mental illness. One must believe that God is a loving God and a God of action, who responds to their cry." The Reverend Chester W. Keene

"The Church is not a house for saints, shielded from human suffering. Rather, the Church is a hospital where broken lives can be healed." The Reverend Duane Bruce

Clergy and congregations are asked to respond to a variety of community needs. These needs often focus on persons living within the neighborhood of the congregation. In many cases an effective response can be made. This is as true for the needs of those who have a mental illness as it is for others in need. The following are some suggested ways to respond.

Members of the congregation can be a friend.

Long term mental illness tends to isolate people. Be a friend to those who may have no other friends or support systems.

Be accepting, friendly, understanding, and genuine.

Write, send a card.

Telephone to keep in contact.

Talk with the person, listen to the person.

Make visitations.

Encourage the person to work with their strengths, with their gifts.

Help set realistic goals.

Be a resource for information and referral.

Avoid implying that if the person can "get things right with God" or "confess" that the person will be cured.

Members of the congregation can let the person know *he/she is not alone*.

Welcome the person into the church community.

Recognize the need for spiritual healing, without focusing on the "cure" for the illness.

Always reassure the person that God loves and cares for him/her.

Remember that this is not a punishment from God or caused by demons or the devil.

Encourage the person to join a support group, social club and/or advocacy group.

The congregation can offer opportunities to *integrate the person* into the church community.

Holiday programs are nice. More important is including the person in the church's year round activities, outings, interest groups, etc.

Encourage the person to volunteer at the church. Make tasks you ask of the person constructive and meaningful. These could include doing a reading, preparing the place of worship, helping with the coffee hour, helping with the bulletin or newsletter.

The congregation can open the church to:

- Hosting a group of people who have a mental illness from a community facility.
- Sponsoring a support group for persons who are ill or family members.
- Sponsoring a social club or drop-in center.
- Offering employment such as secretarial, using artistic talents, janitorial, maintenance, food preparation, etc.
- Initiating a visitation program.

Members of a congregation can educate themselves and others by:

- Encouraging clergy, lay staff and congregations to learn about mental illness.
- Raising awareness in the congregation about mental illness in a sermon, bulletin or newsletter.
- Adding materials about mental illness to the congregation's library.
- Encouraging heightened awareness about mental illness beyond its congregation by writing a letter to the editor or an article for a regional or national denominational publication.
- Encouraging the denomination's area wide, regional or national structure to be responsive to the needs of persons with a mental illness and their families.

Members of a congregation can advocate for persons with a mental illness in the community by:

- Being willing to work with other congregations in the community to improve the quality of life for persons with a mental illness and their families.
- Supporting efforts to obtain appropriate housing and jobs.
- Not letting false, stigmatizing statements about mental illness go unchallenged.
- Objecting in writing or by telephone when media and public events stigmatize people who have a mental illness.
- Encouraging the denomination's legislative and advocacy groups to support increased budgets for research, creation of appropriate housing, and community services.

(adapted from material written by Cheryl Runyan, Horizons Mental Health Center, Hutchinson, Kansas)

*"We are human beings.
Treat us as human beings.
We want to talk about what
you want to talk about.
We want to be involved in what you do.
We want you to be involved in what we do.
Support us. Love us." Ro*

*"The beginning of my journey back
began when people stopped treating me
as being disabled and incompetent and
started treating me as being welcome at the table." Jay*

*"The church can help.
There is this church that donates its services.
They open the hall so we can have a meeting hall.
We can have a get together.
That is all we ask of you.
Just open your door." Gail*

*"I don't see enough outreach from church groups to
people. When you leave the hospital, you can be
discharged from a hospital on Friday and not be placed
in a community program until Monday.
What are you supposed to do from Friday until
Monday?" Gail*

*"As a parent of a son with schizophrenia, I know it is
a great deal easier when you educate yourself about it.
There is no reason for anybody who can read or pick
up a telephone to call for a referral, to sit in the dark
wondering about this illness. We all need to
educate ourselves so we can advocate effectively for the
programs and services people with a mental
illness desperately need." Ann*

*"We are in the same position as any civil rights
group just starting out. We need friends. We need
support in our local communities. We need friends in
the legislature. We need your help." Jay*

HOW A CONGREGATION CAN RESPOND TO A FAMILY

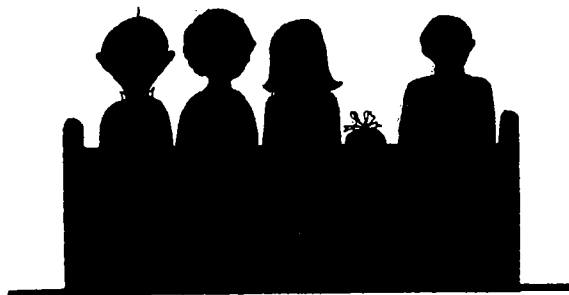
Clergy and congregations often struggle to find an appropriate response to families who are living with mental illness. The following are some suggestions, some of which are similar to those one would use in reaching out to someone who has a mental illness.

*"I'm so very tired.
At times I want a way out
of this dreadful situation.
Just close the door and leave.
Take the car and drive off to
anywhere. But I don't.
I still love her.
I want to help.
But, I sure could use some
'caring' myself from others
sometimes." Terry*

*"He talks about
not having any friends.
His old friends seem
to have forgotten him,
or don't know what to do.
It seems the same
with his mother and me.
No one seems to keep in touch.
No fellowship.
This illness doesn't just
isolate the ill person,
the family is isolated, too." Jim*

Clergy and the congregation should:

- recognize the need for spiritual healing without focusing on the "cure" of the illness;
- listen, give moral support;
- be an information and referral source;
- let the family know they are not alone;
- visit the family;
- avoid being judgmental;
- sponsor family support groups;
- offer help, offer prayers;
- refrain from offering simplistic solutions to complex problems;
- encourage sharing;
- be supportive of the entire family, including those members who infrequently come to worship as these are the people who may feel the most isolated;
- encourage the family to continue as apart of congregational life;
- encourage networking with a support group in the community;
- designate individuals within the congregation to be there for the family when help is needed;
- realize another breakdown or a relapse is often temporary;
- avoid expecting that all peculiar behaviors and habits can be corrected.



One in four families is touched by severe mental illness.

Section III

PASTORAL RESOURCES

The following are ways in which others have developed pastoral resources. Adapt them for your own use.

A PRAYER BY JOHN BAGGETT

O God, who cares about the suffering of your children, grant us the gift of acceptance that we might find serenity and courage this day faithfully to cope with the mental illness in our midst. Teach us the patience and understanding our mentally ill brothers and sisters need from us. Help us not to victimize with uninformed and uncaring attitudes those who suffer, but strengthen us with the love and understanding we receive from you to care and nurture. Enable us with wisdom and guidance to do your will in all our opportunities to serve those who suffer. Amen

(The Reverend John Baggett, M. Div., M.A., is Executive Director of the North Carolina Alliance for the Mentally Ill and has a son who suffers from schizophrenia.)

A RESPONSIVE READING BY WALTER S. HILL

O God, we pray for all who suffer in mind or spirit. Grant them your peace and love.

Hear our prayer, O Lord.

As David ministered to Saul with kindness and understanding, enable us to care for our brothers and sisters who have a mental illness.

Hear our prayer, O Lord.

Grant that we may identify mental illness as the disease it is and, without fear, reach out with compassion to be instruments of your grace and peace for those who suffer from mental illness.

Hear our prayer, O Lord.

Grant us courage and wisdom to remove the stigma of mental illness from those who suffer. Open our eyes to the need all around us. Enable us to recognize those who hurt and welcome them with the open arms of your love into the fellowship of faith, that all might find a place in the midst of your congregation.

Hear our prayer, O Lord.

Strengthen us with wisdom and guidance, empower us with love, patience, and understanding to accept and faithfully serve our brothers and sisters who have a mental illness, through us and all who serve their needs, that they and we might be drawn closer to your Kingdom of grace and peace.

Hear our prayer, O Lord. Grant us this ministry of service, nurture and witness in Your Holy Name. Amen

(The Reverend Walter Hill, M.Div., is a Methodist minister who wrote the above section for the American Psychiatric Association's clergy packet.)

SERMON STARTERS

Genesis 18: 2-3. When we find God in meeting the stranger.

So often we think about finding God's message and presence solely in "religious" places. We are surprised to find it in the unexpected. (Also see Genesis 18:1-16; Matthew 24:31-46 and 25:35,45.)

In the Abraham story, Abraham invites the stranger in, offers hospitality, never asks what is wanted. He is "selfless."

Jesus calls *all* the children to him: "Let the little children come to me and forbid them not, for such is the Kingdom of Heaven."

I Samuel 16:14-23. King Saul's troubled spirit is soothed by David.

Saul is said to be tormented by "an evil spirit from the Lord." Young David is introduced to the troubled king who finds relief in David's presence and music.

That which mystifies us, frightens us, the inexplicable, even today, we sometimes explain as an evil spirit of divine punishment. Medical science, which is a true gift of God, might have helped Saul. Modern researchers have theorized that Saul suffered from either manic depression or schizophrenia. (See R. K. Harrison, "Madness, The Interpreter's Dictionary of the Bible," Vol. 3, Nashville: Abingdon Press, 1962, p. 220). Both these mental illnesses have physical causes and are treatable. More than music, David's willingness to befriend the king, his compassion and care, even in the face of Saul's terrible rages brought Saul peace and comfort.

People of faith have always shared God's love in appropriate ways with people who are hurting. As we learn more about what mental illness is, destigmatize it, and accept persons who are mentally ill as persons in need of our compassion and care, we go far in bringing God's healing and comforting grace into trouble lives.

Mark 5:1-20. The Gerasene Demoniac

Jesus approaches a man cast out by society because of his "demons." Jesus, unafraid, identifies the demon, "My name is Legions." Once named, the demon loses its power to cause fear. It become a knowable, understandable, thus treatable entity.

By identifying the man's demon for what it is, Jesus is able to exercise authority over it, heal the man and restore him to this community.

Modern men and women rarely think in terms of demons. Yet, we are still afraid of what we do not understand. Once mental illness is understood, we no longer need fear it or shun those who suffer. Our compassion and understanding, our recognition that the person and the disease are separate, are powerful indications of God's loving grace, and are instrumental in the treatment of persons suffering from mental illness.

John 10:7-10. Jesus the Good Shepherd

Karl Menninger observed, "religion has been the world's psychiatrist throughout the centuries." (See *Man Against Himself*, Harcourt, Brace & World, Inc., 1938, p. 449). Mental illness is not a sin, nor is it a spiritual weakness, nor is it something a person will "get over" if he or she just puts his or her mind to it. It is a serious problem affecting millions of people.

Jesus, the good shepherd, "came that they may have life, and have it abundantly." Our Lord's ministry was often directed to those cast out by society. He sought to bring them into his fold, and to heal their bodies, minds, and spirits. Those whom others shunned, Jesus welcomed with open, loving arms into his fold.

Many people turn initially to the clergy for help with mental health problems. The fellowship, acceptance, care, and friendship of their faith family are vitally important to them and to their families. By making a place for them, by reaching out to them in Christ's name, by removing stigma and guilt, we go far in shepherding our brothers and sisters who have a mental illness toward the abundant life Jesus offers to all.

(This section is the combined work of Rabbi Jeffrey Cohen and the Reverend Walter Hill.)

Two books that are useful in this context are:

Strong At The Broken Places: Persons with Disabilities and the Church, Stewart D. Govig, Westminster/John Knox Press, Louisville, KY, 1989.

Creating The Caring Congregation, Harold H. Wilkie, Abingdon Press, Nashville, TN, 1983.

HYMN SUGGESTIONS

All hymns are not in all hymn books. Use whichever ones are appropriate for your faith group. The following are some hymns some groups have used in their worship services.

"Praise to the Lord, the Almighty," especially verse 2

"Oh Love That Will Not Let Me Go"

"O God, Our Help in Ages Past"

"Be Thou My Vision"

"Lord, Whose Love Through Humble Service"

"O God Whose Will Is Life"

"Jesus, United by Thy Grace"

"Now, Thank We All Our God"

STATEMENTS AND RESOLUTIONS ON MENTAL ILLNESS

The following denominations and religious bodies have statements and/or resolutions specifically focused on mental illness.

American Baptist Conference; Christian Reformed Church in America, Committee on Disability Concerns; Lutheran Church-Missouri Synod, Board of Social Ministries; The Mennonite Central Committee and the Church of the Brethren Mental Health Awareness and Education Committee; The Presbyterian Church (U.S.A.); The United Church of Christ, Board for Homeland Ministries; The United Methodist Church, General Board of Church and Society; The United Synagogues of America.

Section IV

CONGREGATIONAL RESOURCES

SUGGESTIONS FOR GETTING STARTED AT THE CONGREGATIONAL LEVEL

1. Organize a leadership group

Identify and convene members of the congregation who have personal or professional concern and knowledge about mental illness. Include persons recovered or recovering from mental illness, their friends and families, clergy, mental health professionals, and other direct service providers. Wait until later for a general announcement asking for volunteers.

2. Establish the group's identity

Agree on terminology, basic theological perspectives, and focus. Bring in outside resource persons, when necessary.

3. Assess needs and catalogue strengths of your congregation

A. Have clergy and lay staff had the opportunity to develop the knowledge and skills necessary to implement congregational efforts to respond pastorally to issues raised by mental illness? Have they:

1. learned about the nature, severity and scope of mental illness and its effects on individuals, their families, and the community?
2. developed skills necessary to identify behaviors which may indicate mental illness in an individual or family?
3. developed skills necessary to become involved in the spiritual journeys of those members who must cope with mental illness in themselves or in their families?

B. Does a caring community exist within the congregation where acceptance is possible?

C. Has a support system been established for members, including families, who are returning to the congregation after treatment for mental illness or remaining in the congregation while receiving therapy?

D. Has a survey been made of available community resources, treatment programs and self-help organizations?

4. Establish connections and begin building relationships with:

community agencies, self-help organizations, religious outreach networks, interfaith coalitions, denominational resource persons, other congregations.

5. Formulate long-term goals and objectives

A. Determine strategies, such as:

1. continuing education for pastors, elders, deacons, church school classes, and others in the congregation.
2. integrating advocacy for persons with mental illness into the overall mission program of the congregation.
3. establishing programs of direct service for persons with mental illness and their families.

B. Establish a time-line for action, including a timetable for securing the support of the pastor(s) and all committees and/or boards.

C. Designate spokesperson(s) for public relations; assign other tasks, such as:

1. selecting literature for displays;
2. developing a budget;
3. identifying possible speakers for congregational events;
4. locating sample curriculum materials from your own or another denomination;
5. identifying and interpreting public policy issues.

6. Decide what is "do-able" this year

Plan and present to your congregation's governing board a start-up proposal (including background, time-line, budget implications and action wanted).

7. Continue implementation of long-term strategies

Give particular attention to recommendations in policy statement(s) of your denomination;

1. form coalitions with other interested congregations and organizations;
2. provide public forums and public service announcements;
3. organize education and training events;
4. include the program in your congregation's annual budget;
5. provide for on-going evaluation and reporting to the congregation.

STUDY AND ACTION GUIDE

The following is a guide for study and strategy development by committees, task forces and other concerned groups in congregations, local congregational clusters, or ecumenical coalitions.

STEP I: Background, History, Theology

A. Material in background papers, resolutions, and policy statements of your denomination(s) provides a basis for study and discussion. Adequate time should be allowed for the leader to develop a theological foundation for implementing the recommendations at a local or regional level.

B. Provide common experience and focus, perhaps through a videotape or personal presentations, from clients and their families. Depending on the level of knowledge and specific focus, consider:

"When The Music Stops," an introductory videotape which comes with its own educational booklet, 20 minutes, VHS only, \$20.00. Available from the National Alliance for the Mentally Ill.

"A Place To Come Back To," an introduction to the role of a caring congregation in the lives of people who are mentally ill and their families, 30 minutes, VHS only, \$15.00. Available from Pathways to Promise.

- C. Hear reports on specific aspects of the topic, such as:
 1. the population of concern and types of services required;
 2. family and consumer perspectives;
 3. the legal and criminal justice systems as they relate to mental illness;
 4. the impact of deinstitutionalization;
 5. building support systems for people who have a long-term mental illness.
- D. Assignment: Before moving to STEP II, assign individuals or teams to collect data on the local situation, such as: demographics; treatment facilities; community resources for housing, vocational rehabilitation, legal aid, financial support, and jobs.

STEP II: Our Situation: Present Realities and Our Vision of the Future

- A. IDENTIFY local issues that can be addressed by the church. Hear reports on the local situation from those who have been collecting this data.
- B. IDENTIFY local/regional judicatory policies/strategies/programs which are already in place and are being implemented.
- C. DISCUSS parallels that exist between the finding in STEP I and STEP II.
 1. How is the church in our area responding to those needs?
 2. How do the programs/budgets of the local judicatories reflect our concerns and needs?
 3. How do the local situation and current programs/strategies reflect the recommendations of the denominations(s)?

STEP III: Building Strategies

- A. IDENTIFY the next steps.
 1. What can our church DO? What do we already have going for us?
 2. Identify existing obstacles/barriers. How will we involve those who are most affected by the situation locally (including professional care givers as well as clients) in our strategy and planning?
 3. What observable outcomes do we wish for in the next year? What outcomes will be satisfactory?
 4. LIST action steps based on the above questions.
 - a. Identify who will be responsible
 - b. Develop a time line, i.e., "starting by ____ date, we will have ____."
 5. Develop a budget and decide how it will be presented to the responsible officials.
- B. BUILD coalitions.
 1. Identify possible ecumenical and political allies. Decide when, how and by whom they will be contacted.
 2. Clarify the role of the local, regional and national governing bodies of each denomination represented.
 3. Clarify the role of local, regional, state, and national governments.
- C. BUILD ownership.
 1. Clarify the existing means of communications among the congregation and governing bodies and those who will be served. What possible new means of communication will be needed?
 2. Develop a list of what is to be done, by whom, and when.
 3. Be sure that all other appropriate groups and offices are kept fully informed and involved.

Section V

EDUCATION MODELS FOR THE CONGREGATION

The following are some suggestions for a sermon topic, newsletter article or adult education session. Adapt them to fit your situation. A more extensive adult continuing education curriculum and training manual is, *A Stranger In Our Midst: A Congregational Study on Prolonged Mental Illnesses* by Ruth Fowler available from Pathways to Promise.

ADULT EDUCATION

Section I: **Persons with Mental Illness - Old Testament Laws of Hospitality** (see also Matthew 25).

A. Thought Provokers:

1. the strangest of the "strangers . . . you received . . . in your home."
2. The least of "the least" (doubly damned).
 - a. "We'll take the homeless, but don't send us any who are mentally ill."
 - b. "We'll deal with alcohol and substance abuse, but not those also diagnosed as mentally ill."
 - c. "Our vocational program is for those whose handicap is mental retardation; there's no space for those who have a dual diagnosis."
 - d. "Our disability caucus doesn't include mental illness; we have enough trouble trying to convince people our minds are okay."

B. Resources:

1. Case Studies:
 - a. *A Family Affair: Helping Families Cope with Mental Illness*, Bruner/Mazel Publishers, 1986, \$9.95, is written in response to "Dear Abby" letters. Writer after writer tells of the failure of hospitals, community service systems, and therapists to recognize the need for professionals to give support.
 - b. *Experiences of Patients and Families: First Person Accounts*, National Alliance for the Mentally Ill, \$4.50. These accounts illustrate the range and complexity of mental illness and enhance the understanding of patients, family members, and professionals.
2. Biography:
 - a. *The Voices of Bobby Wilde*, by Elizabeth Kytte, Seven Locks Press, 1987, \$17.95. Provides insight into the experience of mental illness and records the disheartening failure of the mental health system to help a sensitive and intelligent sufferer.
 - b. *Is There No Place On Earth For Me?* by Susan Sheehan, Random House, 1983, \$5.90. A journalist gives both a detailed account of a woman with schizophrenia and a general description of mental illness and its treatment.
 - c. *Call Me Anna* by Patty Duke and Kenneth Turan, Doubleday, 1987, \$4.95. Patty Duke's autobiography which traces her childhood, her career, the mood swings that were diagnosed recently as manic depression, and the therapy that stabilized her.
3. Videotapes
 - a. "When The Music Stops," an introductory videotape which comes with its own educational booklet, 20 minutes, VHS only, \$20.00. Available from the National Alliance for the Mentally Ill.
 - b. "A Place To Come Back To," an introduction to the role of a caring congregation in the lives of people who are mentally ill and their families, 30 minutes, VHS only, \$15.00. Available from Pathways to Promise.

Section II: Mental Illness - as Part of Disabilities Awareness

A. Thought Provokers:

1. Passover: the parting of the Red Sea; for God's people all barriers were removed.
2. Advent and Christmas: God came into the world as a baby; vulnerable, subject to human ills, difficulties, disabilities and yet embodying full human potential.
3. Epiphany: God's showing forth of the divine to all people, excluding no one.
4. Easter: rolling away the stone; overcoming all barriers.
5. Pentecost: God's overcoming the language barriers (as we do with audio aids, sign language, Braille, large-print Bibles) but also rising above, clearing away incoherence to find the essential human unity.
6. Trinity: the season for doing the job; congregation will study and act through classes, committees, study groups, task forces, and advocacy.

B. Resources:

Creating the Caring Congregation: Guidelines for Ministering with the Handicapped, by Harold Wilke, Abingdon Press, 1983 and "Program Suggestions for Accessibility for the Local Congregation Following the Holy Days of the Religious Year," both by the Reverend Harold Wilke, or the United Church of Christ. Born without arms, Reverend Wilke has become one of the religious community's primary advocates for persons with handicaps and other marginalized people.

Section III: Persons with Mental Illness and the Inclusive Community (Psalm 55:14; Deut. 16:10-14; I John 1:7).

A. Thought Provokers: The line of division between those considered mentally ill and those not so labeled is, of course, not the only line which divides humanity. However, it is a very real line and it is found in each local situation. Despite much progress over the past several decades for many other disabilities, the line separating those whose disability results from mental illness remains largely unchanged.

B. Resources: *Strong at the Broken Places: Persons with Disabilities and the Church*, Stewart D. Govig, Westminster/John Knox Press, 1989. Govig, a professor of religion at Pacific Lutheran University and a Lutheran minister, is himself disabled. He offers a practical resource which enables congregations to achieve a balance of realism and hope; examines attitudinal barriers; and links biblical teachings.

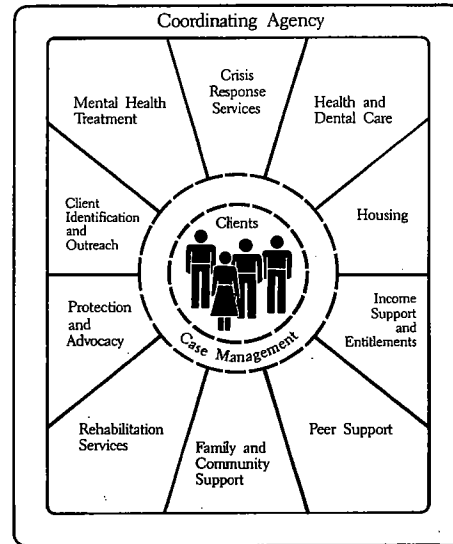


IV. Persons with Mental Illness - Our Social Conscience

- A. Thought Provokers: It's not that deinstitutionalization has failed, but that it has never really been tried.

"When we think of deinstitutionalization, we must realize that when a chronically mentally ill person leaves a psychiatric hospital, the community becomes, in effect, that person's hospital. That is, the community must then provide, in some fashion, all those aspects of hospital care . . . financial support, low cost housing, employment or vocational rehabilitation, socialization, recreation, a degree of protection and supervision, advocacy and case management, medication, crisis intervention, and psychotherapy." Bert Pepper, M.D.

COMMUNITY SUPPORT SYSTEM



B. Resources:

1. *Community Support Systems for Persons with Long-term Mental Illness*, National Institute of Mental Health, Community Support Program, 1988. Presents, in 27 pages of a question and answer format, the current knowledge about community support programs after ten years of demonstration programs, evaluation, and research.
2. *Developing A Service Project for Persons with Prolonged Mental Illness*, Pathways to Promise. A workbook to assist congregations in a step by step approach to developing a program and involving the congregation in working with persons who have a mental illness.

V. Persons with Mental Illness and Other Members of the Congregation

- A. Thought Provokers: Attitude is the greatest barrier. To a large extent, persons with mental illness are emotionally rejected people. Other people do not quite know how to deal with them. They shy away in a reaction of fear. Attitudes are deeply interwoven with our self-identity and connected with our sense of physical and mental well-being. Change in attitude does not come about by confrontation, argument, or trying to convince people they are wrong. It cannot be forced.

B. Resources:

1. "Mental Illness: the Double Scarlet Letter," by Dr. Robert S. Maseroni. A thirty minute, one-act play about a person recovering from mental illness which focuses around the consequences of Andie's encounter with her family, friends, herself, and the public. The play is available in Christian, Jewish or secular versions. In churches it may be performed as the "sermon," in worship, based on Luke 8:26-39, or in synagogues based on one of the Psalms. It may be presented as religious education, a special program, an ecumenical outreach or denominational social concern. For further information contact: Dr. Robert S. Maseroni, Center for Community Development or Prince George's County, 5120 Frolich Lane, Cherverly, MD 20781; (301) 341-4640.
2. "Blindspots and Breakthrough," by Rita Cuhman and Hugh Halverstadt, Presbyterian Church (U.S.A.), 100 Witherspoon St., Louisville, KY 40202-1296, 1985. A workshop on reconciliation cooperatively developed by the Presbyterian Church (U.S.A.), the United Methodist Church, and the National Council of Churches for use in overcoming racial and ethnic prejudice. Adapt for use as a weekend retreat or an on-going series of five three-hour sessions designed to provide participants with occasion, stimulus, support and resources aimed at attitudinal change.

LESSONS FOR CHILDREN AND YOUTH

These lessons could be used in church school, youth groups, or Bible classes. Adapt them for your students.

Introduction to children's lessons: as children in God's kingdom, each of us is given the power to pass along God's love to others. You are needed to be a part of the caring congregation in our church to show God's love to those who need healing. Among those who need our love are people who have unusual illnesses. Let's see if we can learn to understand them and ourselves in relation to them. Let's share our love and caring.

Lesson I: People with Mental Illnesses in Our Community

Background: some of us are confronted with mental illness in our families or in our community. We want to understand and to help. Often, we don't know what to do. The following are several suggestions for how to begin.

Scripture: See the stories of Job, Saul, Sampson, etc. Mark 12:31, II Corinthians 1:3-4, John 15:12. Dueteronomy 15:7-8, Proverbs 3:14 (for grades 6-8). Zachariah 7:9-10, Ephesians 5 (for grades 9-12).

Note: for young children (grades 1 and 2) do not separate mental illness from other disabling conditions. Questioning should be further developed with older children.

Closure: will come at varying points with different age groups and will be more simple or complex depending on the interest and needs of the children. As you reach closure, bring the discussion back to the questions: (1) What would Jesus do? Or, (2) What are some examples of God loving all kinds of people healthy or sick?

Hints: Healing in the biblical sense, means not simply fixed or repaired, but made whole, eased in body, mind and spirit, with relationships restored.

Grades 1 - 5

ACTIVITY I

Questions:

1. Do you remember when you were sick? What did your friends do for you? What would you have liked them to do?
2. Name a physical problem you can see (broken leg in a cast, eye glasses, hearing aid, cerebral palsy, etc.).
3. Name a sicknesses you have had that you can see (such as measles, mumps, poison ivy, etc.).

Method:

Teacher writes on a flip chart for young children, have older children compile individual lists to compare.

Activity:

Draw a picture of yourself having a physical problem or illness we can all see.

ACTIVITY II

Questions:

1. Name a sickness you have had or someone you know has had, but you can not see (flu, upset stomach, diabetes, heart disease, cancer, etc.).
2. Which of these problems do we get over quickly?
3. What understanding would you like from your friends if any of these illnesses happened to you?
4. What about the brain? It, too, can be attacked by illness, a mental illness.
5. What kind of understanding would you want if you had a mental illness?

Method:

Teacher lists on a flip-chart.

ACTIVITY III

Questions:

1. For which of these problems might we need to go to the hospital?
2. Have you ever had a sickness which kept you away from your family?
3. What feelings did you have then?
4. What feelings would you have if the person in the hospital were you or someone in your family?
5. If you could visit that person, what would you do or say?
6. Who else might visit you if you were in the hospital?

Method:

1. Teacher writes on a flip-chart.
2. Role play visiting a friend in the hospital; emphasize that it is more important just to be there than to have a "script" ready.

Hint:

1. Relative, pastor, friend, etc.
2. Fear is a normal feeling when we or someone we love is hospitalized. It should be acknowledged and discussed along with feelings of sadness, loneliness, etc.

Grades 6 - 8

ACTIVITY I

Questions:

1. Have you ever had or known someone who had an illness that lasted a long time? How long?
2. Tell what you would like from your friends if this happened to you.
3. What might your family need?
4. What kinds of understanding and help could you give if this happened to a friend?
5. What kinds of understanding would you want, and what needs would you have, if you had a mental illness?

Method:

List on a flip-chart special problems there might be with an illness that lasted:

- a year
- a month
- ten years

Hint:

Needs differ over different time spans; needs remain even after ten years; people don't want to be forgotten.

ACTIVITY II

Questions:

1. We speak of people as having mental illnesses. What do we mean?
2. We call some people "crazy," or "psycho." What are we saying when we use words like this?
3. What do doctors say about those we call "loonies?"

Method:

You could distribute copies of the sheet "Learn to See the Sickness" which is available from the American Mental Health Fund (address listed on page 25).

Hint:

1. They act differently, we don't understand them; we're afraid of them; we don't respect them.
2. They have a medical illness that can be treated.

nuts

deranged

mad

insane

beserk

loony

out of her mind

psycho

odd

gone bonkers

schiz

bizarre

crazy

wierdo

demented

lost his marbles

peculiar

ACTIVITY III

Questions:

1. Have you or has someone in your family ever had an illness or injury which frightened you?
2. What helped you get over that fear? Did it help to learn about and understand the illness or injury? How did it feel when you, your family and your friends all understood what was wrong?
3. Can you imagine how frightening it must be to the person or to the family when an illness affects the mind?
4. How might you give the kind of help in this case that you learned helped you with your illness or injury?

Questions:

How can this class alleviate fears and spread truth about helping and understanding persons who have mental illnesses?

Hint:

Expect students in high school to have first hand knowledge of other students who have been hit by mental illness which often begins in the late teens. Case studies and resources in Lesson II may help to bring this out.

Lesson II: What Are Friends For?

Background: Feelings associated with mental illness are often based on false information or irrationality. In a family where someone is mentally ill, denial is common, as is a sense of guilt-laden responsibility. Informed friends can offer understanding, support and objective feedback.

Help students become aware of resources in the community. A representative from the Alliance for the Mentally Ill, the Manic Depressive Association, the Mental Health Association, the American Psychiatric Association or other such informational groups could be asked to come to a class session.

Method: Distribute copies of the examples listed below to the class. Use them as the basis for discussion, focus on what a friend would FEEL, what a friend could DO, and what the problem really IS.

EXAMPLES

1. Susan and Gloria had finished school for the day. They both had afternoon jobs at the mall. Susan suggested they walk together. Gloria said Susan should go on and that she would catch up with her later because she had to stop home. But, Susan stopped after school to pick up a book in the library and then decided to stop at Gloria's to pick her up. Susan heard the stereo turned up very high. She could hear it half way down the block. When she went to ring the door bell she heard Gloria's mother talking very angrily and loudly. When Gloria answered the door she told Susan to stay on the porch while she ran upstairs to get her purse. However, with the door ajar, Susan could see Gloria's mother was talking to someone or something that did not exist. On their way to work, Gloria changed the subject when Susan asked her what was going on.
2. Bill and Seth had been friends since Bill's older brother had coached them both in a Little League program. Bill's older brother, Lee had been a star of the baseball team in high school before he went away to college. He had often given the boys tickets to the games. Bill and Seth are now members of the high school team. Seth asked Bill if he would like to give Lee a ticket to the game when he came home from college, that way Lee could see how they are following in his footsteps. After the game they could go out after the game to get a pizza and some pointers. Bill said Lee wasn't in college anymore. That he had dropped out. That he had a "chemical imbalance" and just stayed at home all day, sitting in his room in front of the T.V. Bill said Lee did not care about him, or anyone else anymore. Then he mumbled something about the whole family suffering because of Lee.

Two books that are useful in this context are:

Dinner, Shirley H., Ph.D. *Nothing To Be Ashamed Of: Growing Up With Mental Illness in Your Family*, Lothrop, Lee & Shepard Books, New York, 1989.

Hyland, Betty. *The Girl with the Crazy Brother*, Franklin Watts, New York, 1987.

Section VI

SOURCES FOR INFORMATION AND SUPPORT

ORGANIZATIONS

The following are information and/or support organizations that have local offices throughout the country. Write or call them or contact your local United Way for a listing of how to get in touch with these groups in your community.

American Academy of Child and Adolescent Psychiatry

Public Information, Box 60, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016; (202) 966-7300
Publishes "Facts for Families," a pamphlet series on child and adolescent mental health issues.

American Mental Health Fund

P.O. Box 17389, Washington, DC 20042; (703) 573-2200
Informative literature concerning mental illness, videotape, posters, public service announcements.

American Psychiatric Association

1400 K St., N.W., Washington, DC 20005; (202) 682-6000
Informative literature including the "Let's Talk About . . ." series, an informational packet for clergy, public service announcements, and videotapes.

COMPEER, Inc.

Monroe Square, Suite B-1, 259 Monroe Avenue, Rochester, NY 14607; 546-8280
Matches caring, sensitive, trained volunteers with mental health patients in a one-to-one friendship relationship. Training materials and resources available.

NAMI, (National Alliance for the Mentally Ill)

2101 Wilson Blvd., Suite 302, Arlington, VA 22201; (703) 524-7600
A self-help organization of families of mentally ill persons, of mentally ill persons, and of friends. It provides support groups, referrals, education and advocacy. Informative literature, videotapes, posters and newsletter. It has a Religious Outreach Network throughout the United States.

National Depressive and Manic Depressive Association

Merchandise Mart, Box 3395, Chicago, IL 60654; (312) 939-2442
A self-help organization of people with depression and manic depression and their families. Referral, support groups, informative literature and newsletter.

National Institute for Mental Health

Division of Communications, 5600 Fishers Lane, Rockville, MD 20857; (301) 443-3783
Informative literature, videotapes, posters and public service announcements.

National Mental Health Association

1021 Prince Street, Alexandria, VA 22314-2971; (703) 684-7722
Informative literature on mental illnesses, mental health topics and research. Advocates and provides groups for persons with mental illness.

National Mental Health Consumers' Association

311 Juniper Street, Suite 902, Philadelphia, PA 19107; (215) 735-6367
An advocacy and self-help organization founded by and for consumers of mental health services.

Obsessive Compulsive Disorder Foundation

P.O. Box 9573, New Haven, CT 06066; (203) 772-0565 or (203) 772-0575

Referrals, support groups and informative literature, buttons, posters and newsletter.

Pathways to Promise: Interfaith Ministries & Prolonged Mental Illnesses

5400 Arsenal Street, St. Louis, MO 63139; (314) 644-8400

Founded by fourteen denominations and mental health organizations to facilitate the religious community's work in reaching out to those who have a mental illness and their families. Informative literature (including pamphlets, church bulletin inserts, booklets and a videotape) designed for use by the religious community at a national, regional, local and congregational level.

BIBLIOGRAPHY

In addition to those listed throughout this booklet, the following may be useful to you.

Science and Research

Andreasen, Nancy. *The Broken Brain: The Biological Revolution in Psychiatry*, Harper & Row, 1984

Snyder, Solomon. *Drugs and the Brain*. W. H. Freeman, New York, 1986.

Depression

Griest, John & Jefferson, James. *Depression and Its Treatment: Help for the Nation's No. 1 Mental Problem*, American Psychiatric Press, Washington, D.C., 1984.

Papolos, D., & Papolos, Janice. *Overcoming Depression*, Harper & Row, New York, 1987.

Schizophrenia

Torrey, E. Fuller. *Surviving Schizophrenia: A Family Manual*, Harper & Row, New York, 1988.

Walsh, Maryellen. *Schizophrenia: Straight Talk for Families and Friends*, Warner Books, New York, 1986.

Children & Adolescents

McElroy, Evelyn, PhD. *Children & Adolescents With Mental Illness: A Parents Guide*, Woodbine House, Kensington, MD, 1987.

Congregational Life

Fowler, Ruth. *A Stranger In Our Midst: A Congregational Study On Prolonged Mental Illness*, Pathways To Promise, 5400 Arsenal St., MS 223, St. Louis, MO 63139, 1988.

Harris, Martha L., Engster, Diane & Dornan, Paul B. *New Models for Ministry: Serious Mental Illness & the Faith Community*, New York Ave. Presbyterian Church, 1300 New York Ave., N.W., Washington, D.C. 20005, 1989.

Kingsley, Mitchell L. & Ruth-Heffelbower, Duane. *After We're Gone: Estate and Life Planning for a Disabled Person's Family*, A Christian Perspective. Mennonite Central Committee, 21 South 12th St., Box M., Akron, PA 17501.

Lane, Melodee. *Models of Care*, Pathways To Promise, 1988.

Malony, H. Newton & Ponton, Marcel O. *Religion & Mental Illness: A Directory of Programs*, Integration Press, Pasadena, CA 1989.

Prenheim-Bartel, Dean A. & Neufeldt, Alfred H. *Supportive Care in the Congregation*, Mennonite Central Committee.

Shifrin, Jennifer. *Developing a Service Project For Persons With Prolonged Mental Illness: A Workbook for Congregations*, Pathways To Promise, 1988.

For Professional Service Providers

Bernheim, Kayla & Lehman, Anthony F. *Working with Families of the Mentally Ill*, W. W. Norton, New York, 1985.

Menninger, W. Walter, M.D. et. al. *The Chronic Mental Patient II*, American Psychiatric Press, Washington, DC 1987.

THE CHURCH'S MANDATE:

[Full text of this document is found in Reports to the 1988 General Assembly 37.113-37.141]

Theological Base

Laws of social responsibility and hospitality are clearly stated in the Old Testament and relate to those whose illnesses have made them strangers within our gates. Our Judaeo-Christian understanding sees that "God's holy purpose is for humankind to be of worth and be well; to be in health and nurturing health for one another. The witness of the Christian faith is that through Jesus Christ, God heals and makes whole a hurting and broken world. All stand in need of healing...Though the biblical understanding of life unites body, mind, and spirit, it is often easier for us to see and accept afflictions of the body than of the mind and to support, nourish and heal those whose illness is physical rather than mental. Our thoughts, language and actions serve to define these persons by their disability, thus denying their dignity and identity as persons created and loved by God. Rather than healers of isolation, we often become part of the barrier experienced by those struggling to live with mental illness insofar as we continue to accept their social isolation as inevitable. We often thus miss the possibilities of being ministered to by the gifts which they bring to the community.

The Church's Role

The religious community is in a unique position to be the bridge between the clinical setting and life in the home community. Congregations exist in every American county and urban neighborhood. Together they reach 70 percent of the American population every month and are involved more intimately in the lives of Americans than any other institution...Pastors and congregations are urged to develop ways of inclusion which assure that each person, whether or not labeled "normal", knows that who he or she is and who we all are becoming is important...that we cherish the presence of all as the community of faith worships, studies, gives, grows and heals together. Seminaries are called to re-examine the whole concept of training, to legitimize the role of Christian community in wholistic care, to engage mental health professionals in the attempt to come together in unified directions consistent with our theological underpinnings. Theology and mental health professions should be natural allies, but there are often barriers of territoriality and adversarial relationships to overcome before focus on common interest is possible.

Resolution

The 200th General Assembly (1988) of the Presbyterian Church (U.S.A.) affirms anew the ministry and mission of the church and all its people...with those suffering from or affected by severe mental illnesses. The General Assembly further:

1. Recognizes and extends prayerful support to the diversity of persons whose lives are touched and affected by mental illness: to persons who experience mental illness and to their families; to professionals who are trained and called to the healing arts; to clergy whose ministry will inevitably include people affected by mental illness; to lay persons who in many diverse ways maintain a community of healing and support.
2. Requests sessions and appropriate...committees to review their current response...
3. Encourages clergy and lay staff of congregations, governing bodies and church-related institutions to learn about mental illness...
4. Directs the appropriate ministry units or committees...to:
 - a. Continue...to focus on ministry with persons who are chronically mentally ill and their families, in cooperation with any existing denominational or ecumenical efforts;
 - b. Inform sessions and appropriate governing body committees as to the availability of educational and program resources...
 - c. Develop patterns of relationship and support for the Presbyterian chaplains who work with the mentally ill and their families...