Mental Health Information for Ministers

Untitled Portrait Ozzy, c. 2000

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Feedback

The author is very interested in getting constructive feedback on the information in this document so it can be improved and made it more useful. Contact information is on the cover page.

Introduction

Our pews are filled with people suffering from mental illness. This I have learned from experience leading worship services on the subject of mental health. My usual practice is to use the sermon to tell some of my own story as a person living with a mental illness and to give a hopeful message to the congregants. I have learned that such self-disclosure can help make it safe for others to acknowledge mental illness of their own or in their families. At the end of the sermon I ask for people as an act of "public witness" to stand or raise their hand if they or a loved one is living with a mental illness. Every time I have done this, somewhere between 80% - 100% stand up. Everyone looks around and can't believe so many people are affected. Coffee hour is abuzz with people telling formerly taboo stories.

As part of my ministry I have written a curriculum called *The Caring Congregation Handbook and Training Manual*. I've taught several classes of seminarians at Starr King School for the Ministry using this curriculum, as well as teaching others how to lead it in their congregations. But, I've learned that not every minister and every congregation can have the time and dedication to go through the curriculum workshops. Yet, many times a congregant approaches a minister with a mental health problem before seeking professional help. And many ministers are unprepared to be able to help. Hence, this short guide about mental health designed for ministers to pick up and use, with selected resources. For a more comprehensive treatment of the subject, I recommend my curriculum and also the excellent book *Counseling for The Soul in Distress*, by Richard W. Roukema, M.D.

The Minister's Role

The minister's role is to give important and often ignored spiritual support to a person with a mental disorder. The minister, as adjunct to professional mental health care, can impart:

- A calm reassuring presence
- Knowledge that the person is loved and accepted
- Hope – which is necessary for the beginning of recovery
- Visits when in the psychiatric ward, just as you would visit any other hospitalized congregant
- Encouragement to continue on the road to recovery, especially when a person has had previous failures, maybe even harmful failures
- Help in addressing any spiritual dimension of the person's illness
- Use of spiritual practices consistent with the person's beliefs that you think might be helpful and comforting. For example: prayer, meditation, communion and other rituals.
- Confrontation when needed – when the person is in denial or is disruptive to church life
- A safe place in a church that does not tolerate cruelty, exclusion or jokes at their expense.
- Sermons, classes or literature to educate the congregation and/or lay pastoral care workers about mental illness
- Referrals to appropriate professional treatment, including handling of psychiatric emergencies. A rule of thumb: if a person needs more than 3 counseling sessions, a referral should be given.

For information about religion and mental disorders see: Resources for Religion 27.

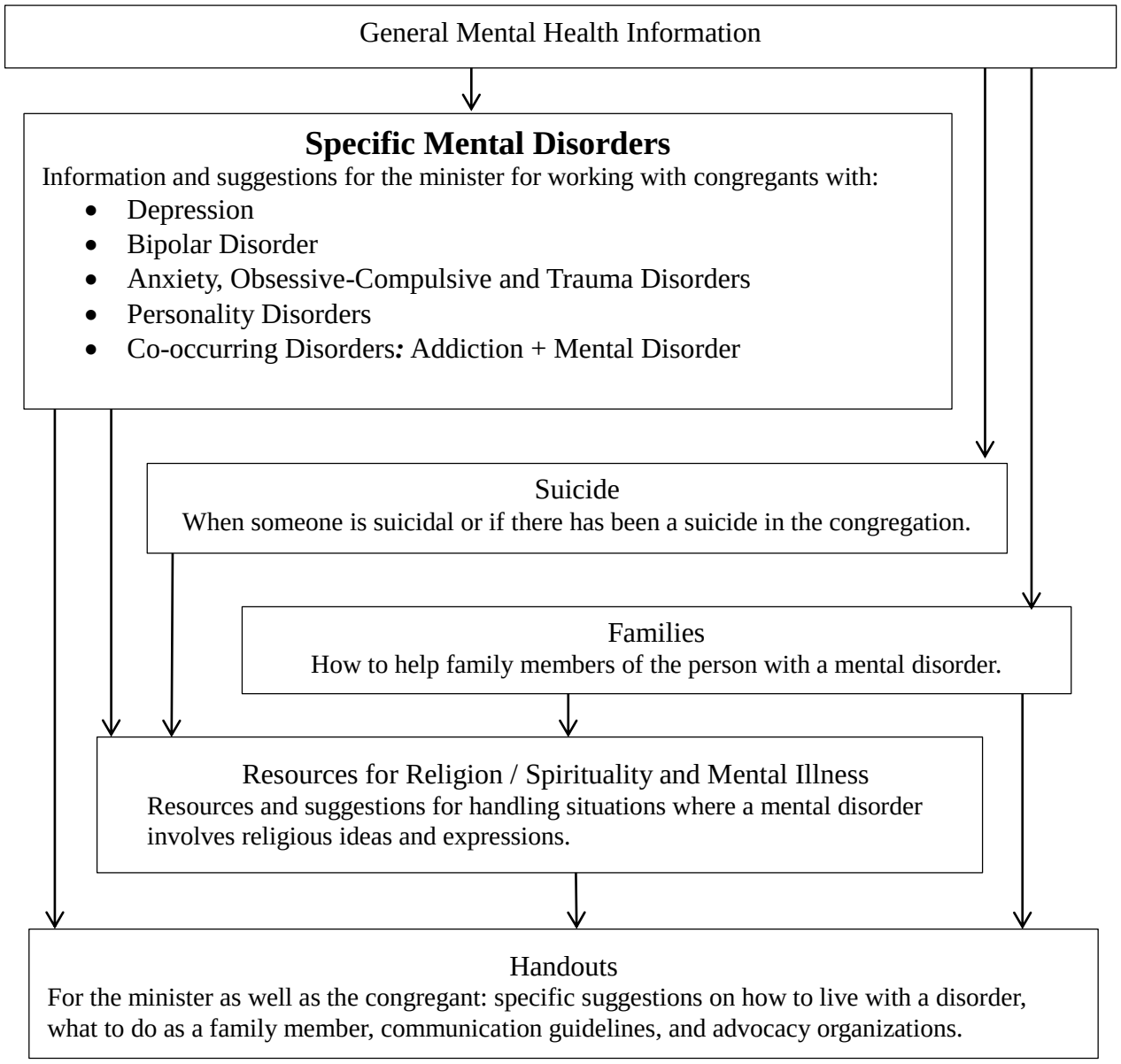
Listening and Giving Advice

As Rev. Doug Kraft explains[1], "There is a difference between supportive listening versus advice. Both can be helpful or irritating depending on what the person wants or needs. If he or she just wants support and you try to give advice, the advice sounds unsupportive ("If you just did what I said you wouldn't feel so bad" kind of diminishes the feelings). On the other hand, if you give purely active listening to someone who wants some advice, it can be maddening ("Ah, I hear you would like someone to help you. That must be frustrating.")." Sometimes the person wants advice and needs to be encouraged to find his or her own solutions. The art is knowing what to do when.

[1] Personal communication between Rev. Barbara Meyers and Rev. Doug Kraft.

How to Use this Document

This document is intended to be one that a minister can pick up and use without reading it its entirety. The following diagram shows the sections of the document and how they are intended to be used.



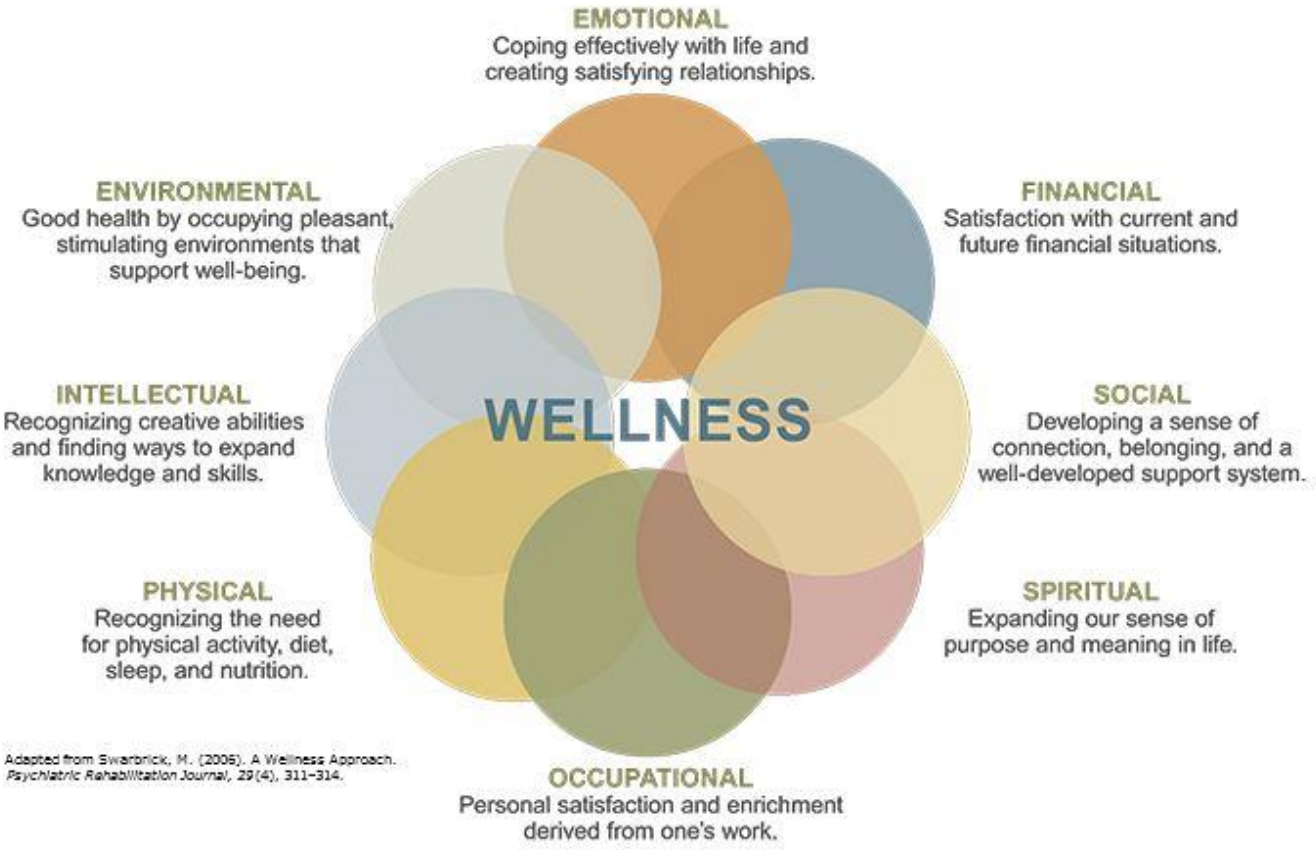
NOTES:

Terminology: The term "***mental disorder***" is used to be consistent with widely recognized definitions of the American Psychiatric Association. The terms *"**mental health client**"* and *"**consumer**"* are often used interchangeably when referring to people who use mental health services. The client-rights movement uses the term *"consumer"* because it implies choice.

We are not diagnosticians: This guide is not intended to make ministers into diagnosticians, but rather to help them understand what the person is going through and when a referral is necessary.

Hyperlinks: This document has hyper links to websites and to places to find some of the most helpful books and resources. You can get a soft copy of this document from Rev. Barbara Meyers, contact info on the title page.

Dimensions to Recovery[2]



A person's life has all of these dimensions; the whole person needs to be considered, not just symptoms

- 'Recovery' means that a person has as much of an autonomous life as possible. It doesn't necessarily mean the elimination of all symptoms, or the need for mental health care.
- Success involves as many of these dimensions as possible
- Each person's balance of these factors is unique.
- When a person is troubled, visualize this diagram and ask "What's missing?"

[2] This diagram and categorization is from SAMHSA's website: http://www.promoteacceptance.samhsa.gov/10by10/dimensions.aspx It also closely resembles the dimensions of well-being defined by Howard Clinebell in *Well Being--A Personal Plan For Exploring & Enriching The 7 Dimensions Of Life--Mind, Body, Spirit, Relationships, Work, Play, Earth*, San Francisco: Harper, 1992.

Mental Health and Mental Disorders

When dealing with mental health and disorders, these definitions[3] I've found most helpful.

Mental Health

The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity

Mental Disorder

Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning.

Points on a Continuum

- People will move back and forth on the continuum as they live their lives.
- Everyone experiences emotional distress during difficult times; thus education helps all.

Recovery from Mental Disorders

'Recovery' from a mental disorder means that a person has as much of an autonomous life as possible. It doesn't necessarily mean the elimination of all symptoms, or the need for mental health care. It just means as much self-determination as possible.

Recovery can be thought of as happening in "stages" similar to the Kubler-Ross stages of death and dying.[4] As with any model, it doesn't predict precisely what will happen, and there can be backsliding and repetition of stages, but it is helpful to understand what people are going through and what might be helpful.

Stage 1. Hope

During times of despair, everyone needs a sense of hope, a sense that things can and will get better. It may be necessary that others hold the hope for the one in despair. People may come to church for hope.

Stage 2. Empowerment

To move forward, a person needs to have a sense of his or her own capability and power. Often a person has to experience success before believing he or she can be successful. Sometimes people need someone else to believe in them in order to be confident enough to believe in themselves.

Stage 3. Self-Responsibility

A person needs to take responsibility for his or her own life. This means learning to take risks, trying new things, and learning from mistakes and failures.

Stage 4. A Meaningful Role in Life

A person needs to find some meaningful role in life that is separate from the mental illness. The person needs to see himself or herself in "normal" roles such as employee, son, mother and neighbor. It is important to join the larger community and interact with people who are unrelated to the mental illness

[3] From the U.S. Department of Health and Human Services, Mental Health: A Report of the Surgeon General, 1999.
[4] This model is based on work by Dr. Mark Ragins discussed in his book *The Road to Recovery*.

Categories of Mental Disorders[5]

CATEGORY	CHARCTERISTICS	EXAMPLE DISORDERS
Neuro-Developmental	Onset is typically in a child's developmental period.	Intellectual Disability Autism Spectrum Attention-deficit/Hyperactivity Disruptive behavior
Schizophrenia & Other Psychotic	Characterized by delusions, hallucinations, disorganized speech or behavior	Schizophrenia, Schizoaffective Delusional disorder Schizotypal Personality
Bipolar	Characterized by episodes of depression and episodes of mania.	Bipolar I Bipolar II Cyclothymic
Depression	Persistence of sad, empty mood with somatic and cognitive changes	Major Depression Dysthymia
Anxiety	Characterized by apprehension usually accompanied by palpitations, and shortness of breath.	Separation Anxiety, Panic attack, Agoraphobia.
Obsessive-Compulsive	Presence of obsessions (persistent unwanted thoughts) and/or compulsions (repetitive behaviors the person feels must be followed)	Obsessive compulsive, Body dysmorphic, Hoarding
Trauma- and Stressor-Related	Disorders in which exposure to a traumatic event causes psychological distress	Post-traumatic stress disorder (PTSD) Adjustment disorder
Feeding & Eating	Severe disturbances in eating behavior.	Anorexia Nervosa Bulimia Nervosa
Personality	An enduring pattern of inner experience and behavior that is pervasive since adolescence is inflexible and leads to distress or impairment.	Paranoid, Antisocial, Borderline, Histrionic, Narcissistic, Schizotypal, Dependent personality disorders

Table 1. Categories of Mental Disorders

While the following mental disorders not often thought of as "mental illness," they are also diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Substance-Related	These disorders result from taking a *substance*: i.e. a drug of abuse, the side effects of a medication, and toxin exposure.	Substance-related disorders Hallucinogen-related disorders Inhalant-related disorders Opioid-related disorders
Neurocognitive	Dysfunctions of the brain caused by neurological problem and/or drug abuse.	Major and Mild disorders caused by: Alzheimer's disease, Traumatic Brain injury, Parkinson's disease

Table 2. Categories of Mental Disorders not often thought of as "mental Illness"

- Diagnosis of more than one mental disorder is possible.
- In general, a general medical condition is ruled out before making a diagnosis of a mental disorder
- Categories of DSM mental disorders **not** included in this chart: Dissociative, Somatic, Elimination, Sleep-Wake, Sexual Dysfunctions, Gender Dysphoria, Disruptive, Impulse-Control and Conduct, and Paraphilic.

[5] Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.*

General Mental Health Resources

These are some reference books, curricula and websites that discuss mental health and religion and their interaction.

Books

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*, Washington, D.C.: American Psychiatric Association, 2013. This is the official manual for diagnosing mental disorders used by psychiatrists and other mental health professionals. The website http://www.dsm5.org/Pages/Default.aspx discusses its development and has a summary of the manual.

- Bramson, Robert M. *Coping with Difficult People*, Dell, 1988. Although not specific to mental illness, many of the suggestions in this book can be helpful.

- Hayes, Larry, *Mental Illness and Your Town – 37 Ways for Communities to Help and Heal*, Ann Arbor: Loving Healing Press, 2009. This is written by a Unitarian Universalist and mental health activist who himself has been hospitalized for depression. This is an excellent resource for how to get involved in advocacy work.

- Meller, William, Albers, Robert and Thurber, Steven, Editors. *Ministry with Persons with Mental Illness and Their Families* , Fortress Press, 2012. A book with chapters about various mental illnesses each written by a different author with mental health and/or theological experience. A good guide.

- Oates, Wayne. *The Care of Troublesome People*, The Alban Institute, 1994. Oates, the grand-daddy of pastoral counseling, on caring for various kinds of troublesome people, mentally ill or not.

- Roukema, Richard W., M.D. *Counseling for The Soul in Distress – What Every Pastoral Counselor Should Know About Emotional and Mental Illness, 2nd Edition*, New York: The Haworth Pastoral Press, 2003. This is an excellent book about mental illness written specifically for ministers. I recommend it highly as a supplement to this guide. Many of his suggestions have been incorporated here.

Religious Mental Health Curricula and Resources

- Meyers, Barbara F., *The Caring Congregation Handbook and Training Manual – Resources for Welcoming and Supporting Those with Mental Disorders and their Families into Our Congregations* , San Francisco: Will To Print Press, 2005. My curriculum.

- Newman, Bobby, *The Inherent Worth and Dignity of ALL Individuals: Encouraging Full Participation in our Unitarian Universalist Congregations*, New York: Dove and Orca, 2008. Written by a Unitarian Universalist who is a psychologist.

- Shifrin, Jennifer. *Pathways to Understanding: Manuals and a Videotape on Ministry and Mental Illness* St. Louis: Pathways to Promise. Helpful information with case study videos.

- Strobel, Shirley. *Creating a Circle of Caring: The Church and the Mentally Ill*, Arlington, VA: National Alliance for the Mentally Ill, 2000. Helpful for starting a mental health ministry.

Websites

Pathways to Promise	**Mental Health Information for Clergy**: Interfaith technical assistance and resource center which offers liturgical and educational materials, program models, and networking information to promote a caring ministry with people with mental illness and their families. I recommend this site highly.

Interfaith Network on Mental Illness	**Interfaith Network on Mental Illness:** An organization with the goal of increasing awareness and understanding of mental illness among clergy, staff, lay leaders and members of faith communities and help them more effectively develop and nurture supportive environments for persons dealing with mental illnesses and their families and friends. Sponsors the Caring Clergy Project Caring Clergy Project which contains resources on mental illness for faith community leaders.
National Alliance for the Mentally Ill (NAMI)	**NAMI is a self-help, support and advocacy organization** of consumers, families, and friends of people with severe mental illnesses. Local affiliates and state organizations identify and work on issues most important to their community.
FaithNetNAMI	**NAMI's information for faith communities.** Facilitates the development within the faith community of a supportive environment for those with mental illness and their families; educates clergy; encourages faith community advocacy to bring about hope and help for all affected by mental illness.
Unitarian Universalist Mental Health Ministry	**Unitarian Universalist Mental Health Ministry.** This website contains: • Fairly comprehensive list of Mental Health Websites • Videos of people telling their stories of recovery from mental illness • Public access TV shows on various mental health problems produced by Rev. Barbara F. Meyers. They can be watched from the web at Mental Health Matters TV Show
UCC Mental Health Network	**United Church of Christ Mental Health Network:** Goal: reduce stigma and promote the inclusion of people with mental illnesses/brain disorders and their families in the life, leadership and work of congregations.
Mental Health Ministries	**Interfaith outreach to enable faith communities** to provide compassionate care to those affected by mental illness. Run by Methodist minister Rev. Susan Gregg-Schroeder, who runs a mental health ministry. Many of her resources can be downloaded for free. Her books and videos are reasonably priced and very well done. The spiritual messages may need "translation" for non-Christian audiences.
National Mental Health Consumers' Self Help Clearing House	**The consumer technical assistance center** has played a major role in the development of the consumer movement, which strives for dignity, respect, and opportunity for those with mental illnesses.
U.S. Department of Veterans Affairs - Mental Health	**The VA**'s goal is to provide excellence in patient care and benefits for veterans of the US armed services. This site has VA Mental Health Consumer Council Newsletters.
Wellness Recovery Action Plan (WRAP)	**Wellness Recovery Action Plan.** A system that a person can use for monitoring and responding to symptoms of his or her mental disorder to achieve the highest possible levels of wellness. It focuses on empowering the client take control of health and wellness, by making decisions when he or she is well for what to do when ill. There are WRAP groups in many localities. Very highly recommended.

Depression

Depression is quite common. Between 10-25% of woman and 5-12% of men develop depression sometime in their life. (These percentages are called the "lifetime prevalence" of an illness.) It takes a toll on the person, family members, the workplace and all of the person's associations, including the church. It keeps one from becoming what one wants to be, and doing what one wants to do with one's life. In suicide, depression is often an underlying condition.

Depression is defined as follows: [6]

Major Depressive Disorder: Five or more of the following symptoms nearly every day over a 2-week period:

1. depressed mood most of the day
2. diminished interest or pleasure in almost all activities
3. significant weight loss when not dieting, or significant weight gain
4. insomnia or hypersomnia
5. psychomotor agitation or retardation
6. fatigue or loss of energy
7. feelings of worthlessness or excessive guilt
8. diminished capacity to think or concentrate
9. recurrent thoughts of death

Postpartum: When a depression occurs after a woman has given birth, it is called Major Depressive Disorder with Postpartum Onset.

Suggestions for the minister:

- Reassure the person that he/she is loved and accepted.
- Sit quietly with the person in a peaceful, secluded place. Calm presence can be very reassuring and healing.
- Try to determine if there are any religious struggles that are playing a part in the depression and discuss these with the person, or make a referral to a pastoral counselor or spiritual director.
- Encourage professional therapy. If it isn't working, encouragement to find one that works.
- Support the person in efforts to find a medication that works as prescribed by a psychiatrist. Sometimes it takes time to work. Individual metabolisms vary a lot, so the person should feel free to consult back with their doctors when starting a new drug as the doctor only knows the average dosages for people in general. It can take a while to get it right with any individual. Sometimes it doesn't work and a new medication must be tried. This process can be agonizing.
- Suggest that the person join a peer support group.
- If the person feels overly guilty about something, suggest this may be an exaggerated feeling.
- Encourage life-style changes that would be helpful: more exercise, better diet, more rest, less stress.
- Share the General Coping Strategies for Mental Health Consumers handout at the end of this document and suggest that the person find something that works for him or her.
- If the person has a supportive family, try and get the family involved. The family needs to understand the person is not just being lazy or uncooperative; compassion and support from his or her loved ones is needed in order for recovery.

[6] Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition,* pages 155 – 188. See this reference for complete criteria.

- If he or she is suicidal, get immediate attention. If there is a suicide plan, hospitalization is necessary to keep the person safe. Call 911 if there's an immediate danger. For more, see "Suicide p.23".
- Encourage attendance at a Wellness Recovery Action Plan (WRAP) group if there is one locally.
- Suggest watching the case studies and suggestions at Mental Health Matters video on depression

Resources for Depression

Books

- Emotions Anonymous. *Emotions Anonymous, Revised Edition,* St. Paul, Minnesota: Emotions Anonymous International Services, 1994. This 12-step program is patterned after Alcoholics Anonymous.

- Solomon, Andrew. *The Noonday Demon: An Atlas of Depression*, New York: Simon & Schuster, 2001. Comprehensive look at strategies Solomon used to overcome depression.

- Real, Terence. *I Don't Want to Talk about It – Overcoming the Secret Legacy of Male Depression*, New York: Scribner Book Co, 1997. Good for men.

- Thorne, Julia and Rothstein, Larry. *You are Not Alone – Words of experience and hope for the journey through depression*, New York: Harper Perennial, 1993. I have purchased multiple copies of this book and loan them out to people living with depression when I think they would be helpful.

Websites

Depression and Bipolar Support Alliance	Organization with many self-help group chapters to improve the lives of people with mood disorders.
National Alliance for Research on Schizophrenia and Depression	Raises funds and gives grants for psychiatric brain disorder research, in an effort to find the causes, better treatments, and eventual cures for these disorders.
Postpartum Support International	The purpose of this website is to increase awareness among public and professional communities about the emotional changes that women experience during pregnancy and postpartum.
Postpartum Education for Parents	PEP offers programs to help parents and families thrive with their new children.

Bipolar Disorder

Bipolar Disorder: sometimes called "manic-depression" typically involves alternating episodes of depression and mania. The lifetime prevalence is 0.4% – 1.6% of the population. There are several forms of bipolar disorder, depending on how frequent and severe the depressive and manic episodes are.

Bipolar Disorder is defined as follows: [7]

Manic Episode: A distinct period of abnormally elevated, expansive mood lasting at least one week, causing impairment in occupational functioning. During that week, three or more of the following symptoms:

1. inflated self-esteem or grandiosity
2. decreased need for sleep
3. more talkative
4. flight of ideas, thoughts are racing
5. distractibility
6. increase in goal-directed activity
7. excessive involvement in high-risk pleasurable activities (ex: spending sprees, sexual indiscretions, foolish business investments)

Bipolar Disorder: One or more Manic Episodes accompanied by Major Depressive Episodes (see information on Depression, p 10). The most common types of Bipolar disorder are Bipolar I and Bipolar II Disorder. Bipolar II Disorder has a less exaggerated manic episode, called a hypomanic episode.

Suggestions for the minister

Since depression is involved, many of the same suggestions that are used for depression are appropriate for bipolar disorder.

- Reassure the person that he/she is loved and accepted.
- Sit quietly with the person in a peaceful, secluded place. Calm presence can be very reassuring.
- Try to determine if there are any religious struggles that are playing a part in the depression and discuss these with the person, or make a referral to a pastoral counselor or spiritual director.
- Encourage professional therapy. If it isn't working, encouragement to find one that works.
- Support efforts to find a medication as prescribed by a psychiatrist that works. It can take time to work. Sometimes it doesn't work and a new medication must be tried. For Bipolar Disorder, sometimes two medications are needed, one for depression and a mood stabilizer for the mania. In addition, individual metabolisms vary a lot, so the person should feel free to consult back with their doctors when starting a new drug as the doctor only knows the average dosages for people in general. It can take a while to get it right with any individual. Finding the right combination of medications can be an agonizing process.
- If the person feels overly guilty about something, suggest this may be an exaggerated feeling.
- Encourage life-style changes that would be helpful: more exercise, better diet, more rest, less stress.
- Suggest that the person keep a time line of mood swings. The Depression and Bipolar Support Alliance has helpful printed charts specifically for this purpose.

[7] Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*, pages 123-154. See this reference for complete criteria.

- Encourage attendance at a Wellness Recovery Action Plan (WRAP) group if there is one locally.
- If the person has a supportive family, try and get the family involved. The family needs to understand the person is not just being lazy or uncooperative; compassion and support from his or her loved ones is needed for recovery.
- If the person is suicidal, get immediate attention. If there is a suicide plan, hospitalization is necessary to keep him or her safe. Call 911 if there's an immediate danger. For more, see "Suicide p. 23".
- Share the General Coping Strategies for Mental Health Consumers handout at the end of this document and suggest that the person find something that works for him or her
- For Bipolar Disorder, the minister can be alert to mood changes in a person who is bipolar, and act by encouraging therapy sooner rather than later.
- If behavior is destructive to congregational life, set boundaries for what is acceptable and what is not acceptable behavior at church and enforce them.
- Suggest watching the two case studies and suggestions at Mental Health Matters videos on bipolar disorder

Resources for Bipolar Disorder

Books

- Fieve, Ronald. *Moodswing*, New York: Bantam Books, 1989. Somewhat dated but excellent overview of Bipolar Disorder recommended to me by my psychiatrist when I received this diagnosis.

- Goodwin, Frederick K. and Jamison, Kay Redfield. *Manic-Depressive Illness*, New York: Oxford University Press, 1990. Definitive textbook on the subject. Jamison has Bipolar.

- Jamison, Kay Redfield. *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*, New York: Free Press Paperbacks, 1994. Fascinating study of what people with Bipolar Disorder have given the world.

- Wootton, Tom, *The Bipolar Advantage*, Bipolar Advantage Publishers, 2005. Wootton has Bipolar Disorder and has recently started a holistic therapy program for it. See his website below for details.

Websites

Bipolar Advantage	Tom Wootton's website and program to holistically help people with mental conditions shift their thinking and behavior to change the paradigm of mental conditions from an illness to an advantage.
Bipolar Disorder Magazine	On-line website for *bp Magazine*, a magazine to create community among and empower people living with bipolar disorder.
Depression and Bipolar Support Alliance	This organization has many excellent self-help group chapters to improve the lives of people with mood disorders.
Lucid Interval	A Self-Management Guide for Bipolar Disorder written by a patient who has "survived numerous manic episodes and consequent hospitalizations." Best bipolar website of 2006.

Anxiety, Obsessive-Compulsive and Trauma Disorders

These taken together are a collection of disorders that together are the most commonly diagnosed. They are characterized by an unpleasant apprehension, dread, or excessive worry usually accompanied by physical discomfort, such as palpitations, shortness of breath and restlessness. People with these disorders usually seek help from a medical doctors for their physical symptoms.

The estimated lifetime prevalence varies with the type of disorder: [8]

Generalized Anxiety	5%
Panic Disorder	1.2% in the general population, 60% in cardiac clinics
Obsessive-Compulsive	2.5%
Post-Traumatic Stress Disorder	8%.

Generalized Anxiety Disorder
People with this disorder have prolonged excessive anxiety and worry that is hard to control.

Panic Disorder
Panic Disorder is recurrent panic attacks which consist of is a period in which there is the sudden onset of intense apprehension or terror. At least four of the following symptoms develop abruptly and reach a peak in 10 minutes:

palpitations	**dizziness**
sweating	nausea
trembling	fear of going crazy
shortness of breath	chills or hot flushes
feeling of choking	fear of dying
chest pain	tingling sensations or numbness
	feeling or unreality or being detached from oneself

Obsessive-Compulsive Disorder
Characterized by recurrent obsessions and compulsions that are severe enough to be time consuming, or cause marked distress or impairment. The person recognizes that these actions are excessive.

Obsessions:
Recurrent and persistent thoughts, impulses or images experienced as intrusive and cause distress that are not simply excessive worries about real-life problems.

Compulsions:
Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rigid self-imposed rules.

Post-Traumatic Stress Disorder (PTSD)
Development of the following symptoms after exposure to an extreme traumatic event that involved actual or threatened death or serious injury. ***Note:*** PTSD has been shown to be a causative factor in other mental disorders.

- The event is persistently re-experienced in recollections or feelings that the event is recurring, that they are reliving them rather than remembering the past like normal memories.
- When a buried post traumatic memory first surfaces, recollections are likely to be feelings not thoughts or images. The person may feel frightened without any memory of the event, and can misinterpret the feeling as coming from some minor current incident.
- The person makes efforts to avoid all stimuli, thoughts, or activities associated with the trauma.

[8] Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition,* p 189-290. See this reference for complete criteria

- The person develops symptoms of increased arousal: ex. hyper-vigilance, angry outbursts, difficulty concentrating, startle response.

Suggestions for the Minister

- Provide understanding and support. Be someone who listens, a calm presence in a quiet place.
- Remind the person that there is effective treatment for anxiety disorders. The treatment can consist of medications, psychotherapy and cognitive behavioral therapy. Cognitive behavioral therapy can be particularly useful for lessening the impact of excessive fears. Many veteran's hospitals have special units for treating Post Traumatic Stress Disorder (PTSD).
- If the person is in therapy, encourage that he or she continues in the program or support efforts in finding another therapy if the current one isn't working.
- Try to determine if there is a religious or mythic dimension to the person's anxiety, and if there is one, help him or her through it or refer to a pastoral counselor or spiritual director.
- Encourage attendance at a Wellness Recovery Action Plan (WRAP) group if there is one locally.
- See the case studies and suggestions at Mental Health Matters video on anxiety and the Mental Health Matters video on PTSD

Resources on Anxiety Disorders

Books

- Anthony, Martin and Norton, Peter. *The Anti-Anxiety Workbook: Proven Strategies to Overcome Worry, Phobias, Panic, and Obsessions,* Guilford Press, 2008.
- Baer, Lee. *Getting Control – Overcoming Your Obsessions and Compulsions, Revised Edition,* New York: Plume Books, 2000.
- Pollard, C. Alec and Zuercher-White, Elke. *The Agoraphobia Workbook: A Comprehensive Program to End Your Fear of Symptom Attacks,* New Harbinger, 2003.
- Ross, Jerilyn. *Triumph over Fear: A Book of Help and Hope for People with Anxiety, Panic Attacks, and Phobias. New York: Bantam Books, 1994.* Excellent therapy and stories.
- Tick, Edward, Ph. D. *War and the Soul: Healing Our Nation's Veterans from Post-traumatic Stress Disorder*, Quest Books, 2005. Unitarian Universalist therapist takes soldiers back to Viet Nam on mythic quests for healing.

Websites

Anxiety Disorders Association of America	Promotes the prevention, treatment and cure of anxiety disorders and to improve the lives of all people who suffer from them.
Obsessive-Compulsive Foundation	Information and resources, for people with obsessive compulsive disorder, their families, friends, professionals and other concerned individuals.
National Center for PTSD in US Dept of Veterans Affairs	This website from the Veteran's Administration has much information about Post Traumatic Stress Disorder (PTSD), and a Guide for families
National Alliance on Mental Illness (NAMI) Veterans Resource Center	Access to a wide range of resources on veterans and mental illness. Designed for veterans and active duty military members, as well as their families, friends, and advocates.
Treatments for post-traumatic stress disorder	This website gives a lot of practical information about PTSD and the many kinds of treatments which are used.

Psychotic Disorders

These disorders are among the most debilitating illnesses and among the most difficult for families to deal with. They are characterized by the presence of psychotic symptoms as listed below. The lifetime prevalence is 0.5-1.5%.

Schizophrenia [9]
Characteristic symptoms: Two or more of the following symptoms are present for a 1-month period

1. delusions – erroneous beliefs held despite clear contradictory evidence
2. hallucinations in any of the senses – hearing voices is the most common
3. disorganized speech – derailment or incoherence
4. grossly disorganized or catatonic behavior– unable to perform activities of daily living
5. negative symptoms:
    a. affective flattening – person's face appearing immobile and unresponsive
    b. alogia– poverty of speech, brief, empty replies
    c. avolition– inability to initiate and persist in goal-directed actions

In addition to the symptoms, there is significant social / occupational dysfunction at home or at work. An episode must last at least 6 months to be diagnosed, with at least 1 month of symptoms above.

Like anyone else, people with schizophrenia can have moods, but when there is a clinically significant mood disorder with schizophrenic symptoms, it is diagnosed as schizoaffective disorder:

Schizoaffective Disorder
An uninterrupted period of illness in which:

- There is either a Major Depressive Episode or a Manic Episode ***concurrent with*** characteristic symptoms of Schizophrenia.
- There is a period of at least 2 weeks of delusions or hallucinations *without* mood symptoms.

Suggestions for the Minister

- See the section on Communication Guidelines in the appendix of this document. Follow these guidelines and urge the family members to also follow the guidelines, especially encourage them to keep the emotional intensity in the house subdued.
- Call or talk to the schizophrenic congregant regularly because he or she may become isolated if you do not. If you can't do this, have a member of your pastoral care team do this.
- Encourage the person's efforts at autonomy and seeking out programs that will teach them life skills. Suggest a Wellness Recovery Action Plan (WRAP) group, if there is one locally.
- Don't encourage meditating in silence or with guided imagery because meditation can be disturbing for people who are psychotic. Voices can come back in full force.
- Find an "angel" in the congregation willing to sit with the person on Sunday mornings, leaving to sit quietly with him or her outside if the person can't remain in the service.
- Realize that delusions and hallucinations may not be real to anyone else, but they are real to the one experiencing them. You can let the person know that you don't buy into this view, but that you understand that the experience is something as real to him or her. It is important to have compassion for this experience, especially if the delusions or hallucinations are disturbing.
- If voices are tormenting the person, suggest using earplugs and a music CD.

[9] Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition,* pages 87- 122. See this reference for complete criteria.

- Determine if there is a religious component in the experience. Remember that many religious patriarchs and prophets had visions and heard voices, and respect the person's experience. Its value should be judged by the meaning to the person and effect it has on his or her life. Counsel the person on this, or make a referral to a pastoral counselor. Pray with the person if he or she would like to do so.
- Encourage the family to attend a NAMI Family to Family class if they are held in your area. See the section below on Families.
- If behavior is destructive to congregational life, set boundaries for what is acceptable and what is not acceptable behavior at church and enforce them.
- See the case studies and suggestions at Mental Health Matters video on schizophrenia
- See the information and discussion at Mental Health Matters video on first psychotic break

Resources for Schizophrenia

Books

- Carter, Rosalynn, with Susan K. Golant. *Helping Someone with Mental Illness – A Compassionate Guide for Family, Friends, and Caregivers*, New York: Times Books, 1998. Good information for families about psychosis written by the former First Lady.
- DeLisi, Lynn. *100 Questions & Answers About Schizophrenia: Painful Minds*, Jones and Bartlett, 2006. Basic up-to-date facts about the illness.
- Kingdon, David and Turkington, Douglas. *Cognitive Therapy of Schizophrenia*, Guilford Press, 2008.
- Mueser, Kim and Gingerich, Susan. *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life*, Guilford Press, 2006.
- Saks, Elyn R. *The Center Cannot Hold – My Journey through Madness*, New York: Hyperion, 2007. One of the few autobiographical books by people living with schizophrenia. Very well written.
- Torrey, E. Fuller. *Surviving Schizophrenia: A Manual for Families, Consumers and Providers, 5th edition*, Perennial, 2006. Standard reference updated.

Websites where you will find the most current information on schizophrenia and its treatment:

National Alliance for Research on Schizophrenia and Depression	Raises funds and gives grants for psychiatric brain disorder research, in an effort to find the causes, better treatments, and eventual cures for these disorders.
Prevention and Recovery of Early Psychosis	A program at UCSF whose goal is to provide comprehensive, conscientious and evidence-based services to people suffering from signs and symptoms of serious mental illness. It aims at early intervention.
Schizophrenia	Non-profit web community dedicated to providing high quality information, support and education to the family members, caregivers and individuals whose lives have been impacted by schizophrenia.

Personality Disorders

Personality disorders can be among the most frustrating for ministers to work with. In many cases, the person is highly intelligent and functional, but has a maladaptive pattern of behavior that has been part of his or her personality since adolescence. Some people with these disorders can cause havoc in a congregation, particularly if they have positions of responsibility, because of problems they create in interactions with other congregants and with the minister.

A central conflict of many of these people is that they have failed to develop a solid sense of themselves and their significance and worth. Unconsciously they feel empty, inadequate, or unlovable. Consequently, they are constantly turning to others for affirmation, attention, and rewards. When they can see their behavior as a problem in their lives, they will be motivated to change it. For most personality disorders, psychotherapy is the treatment of choice, with drugs being prescribed for another mental disorder which may be present.

General criteria for Personality Disorders: [10]

An enduring pattern of inner experience and behavior that:

- deviates markedly from the expectations of the person's culture in two or more of:
  1. cognition (ways of perceiving self and others)
  2. affectivity (range of emotional response)
  3. interpersonal functioning
  4. impulse control
- is inflexible and pervasive across a broad range of social situations
- has an onset in adolescence or early adulthood
- is stable over time
- leads to distress or impairment

Borderline Personality Disorder:

This disorder involves a pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity. The lifetime prevalence is 2 %.

1. unbearable feeling of abandonment and frantic attempts to avoid it
2. unstable interpersonal relationships, unstable self-image, altering between extremes of idealization and devaluation
3. impulsivity in self-damaging ways (ex: substance abuse, recurrent suicidal behavior)
4. inappropriate or intense anger or difficulty controlling anger

As a result of these symptoms, some people with Borderline Personality Disorder may:

- stress the importance of something one day only to deny the significance of it the next
- consider people to be all bad or all good
- split groups by taking sides and alienating one side against the other
- be impulsive and have unpredictable mood shifts
- have angry outbursts out of proportion to the situation

Histrionic Personality Disorder

Histrionic personality disorder is characterized by a person who:

- Must be the center of attention.
- Displays inappropriate sexually provocative behavior.
- Great emphasis on physical appearance to attract attention.

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[10] Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition*, pages 645-684.

- Theatrical, exaggerates, and uses speech that is vague and lacking in detail.
- Considers friendships and relationships to be far more intimate than they are.

They can be excessively sensitive to criticism or disapproval, self-centered and rarely show concern for others.

Narcissistic Personality Disorder

Narcissistic personality disorder is a condition characterized by an inflated sense of self-importance, need for admiration, extreme self-involvement, and lack of empathy for others. Individuals with this disorder differ from those with Histrionic personality disorder by needing to be *superior*. They:

- Expect to be noticed as superior and have domineering behavior. Need to be admired.
- Are selfishly greedy, feeling they are entitled to receive more than they need or deserve.
- Are very sensitive to criticism or defeat. They may react with disdain, rage, or defiant counterattack.
- Are inter-personally exploitative, taking advantage of others
- Are usually arrogantly self-assured and confident.

They often have their social life impaired due to problems derived from entitlement, the need for admiration, and the relative disregard for the sensitivities of others.

Paranoid Personality Disorder

Paranoid personality disorder is characterized by excessive distrust and suspiciousness of others, so that their motives are interpreted as malevolent. People with this disorder are generally:

- Mistrustful of others, doubting without sufficient basis their loyalty or trustworthiness.
- Bearers of grudges, seldom forgiving others' mistakes
- Feel exploited or victimized; seldom expressing gratitude

People with this disorder tend to need to have a high degree of control over those around them. Often rigid, critical of others, they are unable to collaborate, and can't readily accept criticism themselves. They can be difficult to get along with and often have problems with close relationships because of their excessive suspiciousness and hostility. They can become involved in legal disputes.

Suggestions for the Minister

- Realize that the person's behavior is not your fault. You cannot change the personality of your congregant, but you can try and work with him or her in ways that are consistent with the particular personality traits being expressed.
- Realize that because the behavior pattern has been present since adolescence, it is going to be very difficult to change, even if the person is working hard to do so. If the person is making a good faith effort to change, try to have patience with the person in his or her struggle.
- Realize that the person may not share the same view of reality that you have, and thus may not interpret events in the same way, or share sets of limits and boundaries you experience with others.
- Realize that as much as you are suffering in trying to deal with the behavior, the individual and his or her family are suffering as much or more. Try to have compassion. Many of these people behave as they do because they were emotionally if not physically abandoned and/or abused as children, and are still frantically seeking love in any way they can. Try to understand how it must feel to be so insecure that one puts up such disturbing defenses.
- Try to ensure that the person is not in a position of responsibility where the maladaptive behavior could affect the congregation.
- Support the individual's family

- Don't take everything that is said as being meant seriously
- If the person is not getting adequate therapy, encourage him or her to do so. This may be difficult because many people with personality disorders have poor insight into their problems.
- Be on your guard if the congregant sees you as "the best clergyperson ever." Tomorrow he or she may discover all your faults and bring them to the attention of other congregants.
- Learn how to set boundaries for what is acceptable and what is not acceptable behavior at church and enforce them. This might even mean getting the board, or good offices people involved, and may result in asking the person to leave the church, if the behavior is destructive. If the person is destructive to the congregation, and won't change, there is no easy way out; the person needs to go.
- Talk to minister colleagues who have handled similar situations for emotional support and for advice.

Resources for Personality Disorders

Books

- Haugk, Kenneth C. *Antagonists in the Church – How to Identify and Deal with Destructive Conflict*, Minneapolis: Augsburg, 1988. Not about personality disorders *per se*, but good practical hard-nosed advice for dealing with people who might destroy a church.
- Horowitz, Mardi, ed. *Hysterical Personality Style and Histrionic Personality Disorder*, Jason Aronson, 1991. Updated version of classic work on histrionic personality disorder.
- Kantor, Martin. *Understanding Paranoia: A Guide for Professionals, Families, and Sufferers*, Praeger Paperback, 2008. Combines good insight into paranoid thinking with practical advice.
- Kraeger, Randi, and Mason, Paul T. *Stop Walking on Eggshells – Taking your life back when someone you care about has borderline personality disorder*, Oakland, CA: New Harbinger Publications, Inc, 1998. This book has excellent advice about setting boundaries, and about what helps for the families of those with Borderline personality disorder. Randi Kraeger also has a website BPD Central that has been helpful to many families and friends.
- Kreisman, Jerold and Straus, Hal. *I Hate You, Don't Leave Me – Understanding Borderline Personality Disorder,* New York: Avon, 1991. Describes how the person with Borderline personality disorder sees the world.
- Millon, Millon, Meagher, Grossman and Ramnath, *Personality Disorders in Modern Life*, New York: Wiley, 2004. Update of the leading textbook on personality disorders.
- Vaknin, Sam. *Malignant Self Love: Narcissism Revisited*, Czech Republic: Narcissus Publications, 2001. Highly rated, practical look at how narcissists think and behave.

Websites

Borderline Personality Disorder Resources	Geared for friends/family/loved ones of those with Borderline personality disorder.
The Truth Behind Borderline Personality Disorder	An article with a good overview with resources that is actually in line with current research about BPD.
Personality Disorders	Mayo Clinic information about personality disorders, their symptoms, treatments, coping, and prevention.
TARA	Treatment and Research Advancements Association for Personality Disorders. Supports research, education, and advocacy for personality disorders.

Co-occurring Disorders

A co-occurring disorder is a diagnosis of a substance abuse disorder in addition to a mental disorder. It was formerly called "dual diagnosis." As many as half of people with mental disorders also have some form of substance related disorder. Despite this, until recently, these people had great deal of trouble getting treated for both. Fortunately, this is changing.

Substance Related Disorders [11]

These disorders related to taking a ***substance***: i.e. a drug of abuse (including alcohol), to the side effects of a medication, and to toxin exposure.

Substance classes:	**Lifetime Prevalence of Dependence**
1. alcohol	15%
2. amphetamine (speed, diet pills)	1.5%
3. caffeine (coffee, tea, cold remedies)	Unknown
4. cannabis (marijuana, hashish)	5%
5. cocaine (crack)	0.2%
6. hallucinogens (LSD, mescaline)	0.6%
7. inhalants (gasoline, glue, paint thinners, spray paints)	Unknown
8. nicotine	25%
9. opioids (morphine, heroine, codeine, methadone)	0.7%
10. phencyclidine (PCP, sernylan)	Unknown
11. sedatives, hypnotics and anxiolytics	3-6%

Substance Disorder Characteristics

The person continues use of the substance despite significant substance-related problems.

1. ***Tolerance*:** need for increasing amounts of the substance to achieve same effect
2. ***Withdrawal:*** withdrawal symptoms when using substance is stopped. Each substance has its own unique set of intoxication and withdrawal symptoms.
3. ***Repeated attempts to quit or control use.***
4. ***Compulsive pattern of use***:
    a. taking in larger amounts and over longer period than intended
    b. spending more and more time activities necessary to obtain the substance
    c. giving up formerly important activities
    d. continuing to use the substance despite persistent physical and psychological problems related to use
5. **Neglect major roles:** Recurrent substance use resulting in a failure to fulfill major role obligations
6. ***Hazardous use:*** Recurrent substance use in situations in which it is physically hazardous
7. ***Continued substance use*** despite having persistent problems related to the substance

Suggestions for the Minister

- Refer to Unitarian Universalist Addiction Ministry resources for how to help people who are addicted.
- If a person has a substance related disorder, suggest that he or she also be screened for mental disorder. Sometimes the need for the substance can go away if the mental disorder is treated.

[11] Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* pages 481-590.

- If a person has a mental illness, suggest that he or she also be screened for substance related disorders. After all, half of all such people do. Sometimes people try to self-medicate with a substance if the mental illness is not being adequately addressed.
- If the person has a co-occurring disorder strongly suggest a therapy program that treats both in an integrated way, because these programs give the person a much better chance of recovery.
- Recognize that a person's motivation level may be at a different points in dealing with each disorder. He or she may be willing to admit addiction, but not mental illness, or vice versa.
- Don't be an enabler for substance abuse through your forgiving and helpful behavior. Clearly and repeatedly confront the person until he or she gets over denial. Confront family members as necessary if they are enablers.
- Direct the person and his or her family to appropriate sources of help, such as 12-step programs or other effective addiction resources in addition to mental health care.
- Understand that relapses happen, sometimes more than once before the person becomes stable.
- If the person's behavior is destructive to congregational life, set boundaries for what is acceptable and what is not acceptable behavior at church and enforce them.
- Encourage attendance at a Wellness Recovery Action Plan (WRAP) group if there is one locally.
- See the case study and suggestions at Mental Health Matters video on co-occurring disorders

Resources for Co-occurring disorders

Books

- Alcoholics Anonymous. *Twelve Steps and Twelve Traditions*, New York: Alcoholics Anonymous World Services, 1996. The classic manual for AA.
- Evans, Katie, and Sullivan, J. Michael. *Dual Diagnosis – Counseling the Mentally Ill Substance Abuser*, New York: Guilford Press, 2000. A book for counselors with helpful information for all.
- Meacham, Denis G. *The Addiction Ministry Handbook: A Guide for Faith Communities*. Boston: Beacon Press, 2004. Unitarian Universalist Minister who leads the Unitarian Universalist Addictions Ministry.
- Narcotics Anonymous. *It Works: How and Why*: *Twelve Steps and Twelve Traditions of Narcotics Anonymous*.
- Washton, David. *Cocaine Addiction: Treatment, Recovery, and Relapse Prevention*. New York: W.W. Norton, 1989.

Websites for Substance Abuse and Co-occurring Disorders

Co-Occurring Disorders: Integrated Dual Disorders Treatment	US Dept of Health and Human Services: Substance Abuse and Mental Health Services Administration Report on treating co-occurring disorders.
Double Trouble in Recovery Dual Diagnosis Anonymous	12-step groups specifically designed for co-occurring disorders
Al-Anon / Alateen Alcoholics Anonymous Cocaine Anonymous Emotions Anonymous Narcotics Anonymous	12-Step Addiction Programs For families and teen-age children of alcoholics For addicts
Unitarian Universalist Addiction Ministry	Unitarian Universalist Addiction Ministry website.

Suicide

Suicide is a tragedy not only for the person who died, but also for the family members and friends. A suicide of a member can bring up hidden wounds for many in the congregation and color the atmosphere for years. Some people may feel that the family has been disgraced, including family members themselves. It may become a family secret they try to cover up.

Suicide – The Warning Signs: 80% of people who contemplate suicide give out signs that they are thinking about it. Notify the family, caregiver and/or doctor if appropriate. The following are some indications that a person may commit this act:[12]

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

Suicide Risk The risk that someone will make a suicide attempt has been calculated for a number of different conditions as shown in this table.

Condition	Risk of Suicide as compared to the average person
Previous Suicide Attempt	38 i.e. A person who has made a previous suicide attempt is 38 times more likely to die of suicide than an average person
Depression	20
Bipolar Disorder	15
Opiate Abuse	13
Alcohol Abuse	6
Schizophrenia	9
Personality Disorders	8
Anxiety Disorders	6

Suggestions for the Minister

- If a person says that he or she is contemplating suicide, professional mental health care should be consulted. It is better to be safe than sorry. Ask the person if he or she is getting professional care and if so, whether suicidal ideation has been discussed in that context. If not, they need a referral. The QPR Model[13] for helping someone who is suicidal can be helpful in making a determination and getting help.
  Q: Question a person about whether he or she is suicidal
  P: Persuade the person to get help
  R: Refer the person to the appropriate resource

[12] Information from Pathways to Promise website
[13] *Question Persuade Refer – Ask a Question Save a Life*, a booklet used for training for Certified QPR Gatekeeper Instructors by the QPR Institute, 1995

- Questions for judging suicide intent: Is anyone nearby? Is intervention possible? Has a suicide plan been made, have treasured possessions been given away? Has extensive preparation been made? Is the method highly lethal?
- If a person has actually made a plan for committing suicide, he or she needs to be in a hospital. Having an amateur trying to deal with a person in this much despair is not a good idea. Call 911 or take the person to the hospital emergency room for immediate treatment. Upon release from the hospital, there needs to be in an intensive after-care program in place.
- While it is true that a person who really wants to die by suicide can do it, it is also true that many times suicides are impulsive, and can be triggered by anniversaries of traumatic events, or by places with special association with suicide, ex: the Golden Gate Bridge. One study I heard about asked people who had intended to kill themselves but didn't why they didn't do it. One answer I remember is, "Someone smiled at me."
- After a suicide, suggest the family get involved in a suicide survivor's support group, and determine if anyone in the congregation is troubled so much that he or she needs special attention. Special attention should be paid to other youth after a young person dies by suicide.
- See the case studies and suggestions at Mental Health Matters two videos on suicide

Resources for Suicide

Books – for heading off suicide, or dealing with the situation in its aftermath

- 1-800 SUICIDE is the national suicide hot line, which is automatically routed to a local provider.
- Bolton, Iris, *My Son...My Son: A Guide to Healing After Death, Loss, or Suicide*, Atlanta: Bolton Press, 1983. Written by a mother whose son died of suicide.
- Ellis, Thomas and Newman, Cory. *Choosing to Live – How to Defeat Suicide* through Cognitive Therapy, Oakland, California: New Harbinger Publications, 1996. A self-help guide for those considering suicide and their families.
- Fine, Carla, *No Time to Say Goodbye – Surviving the Suicide of a Loved One*, New York: Broadway Books,1997. Excellent book by a survivor of family suicide.
- Jamison, Kay Redfield. *Night Falls Fast – Understanding Suicide*, New York: Alfred A. Knopf, 1999. *Tour de force* by Jamison who herself has been seriously suicidal at times.
- Litts, David, ed. *After a Suicide – Recommendations for Religious Services & Other Public Memorial Observances*, Suicide Prevention Resource Center, 2004. I am grateful for this excellent on-line guide that I have used for helping prepare memorial services after a suicide.

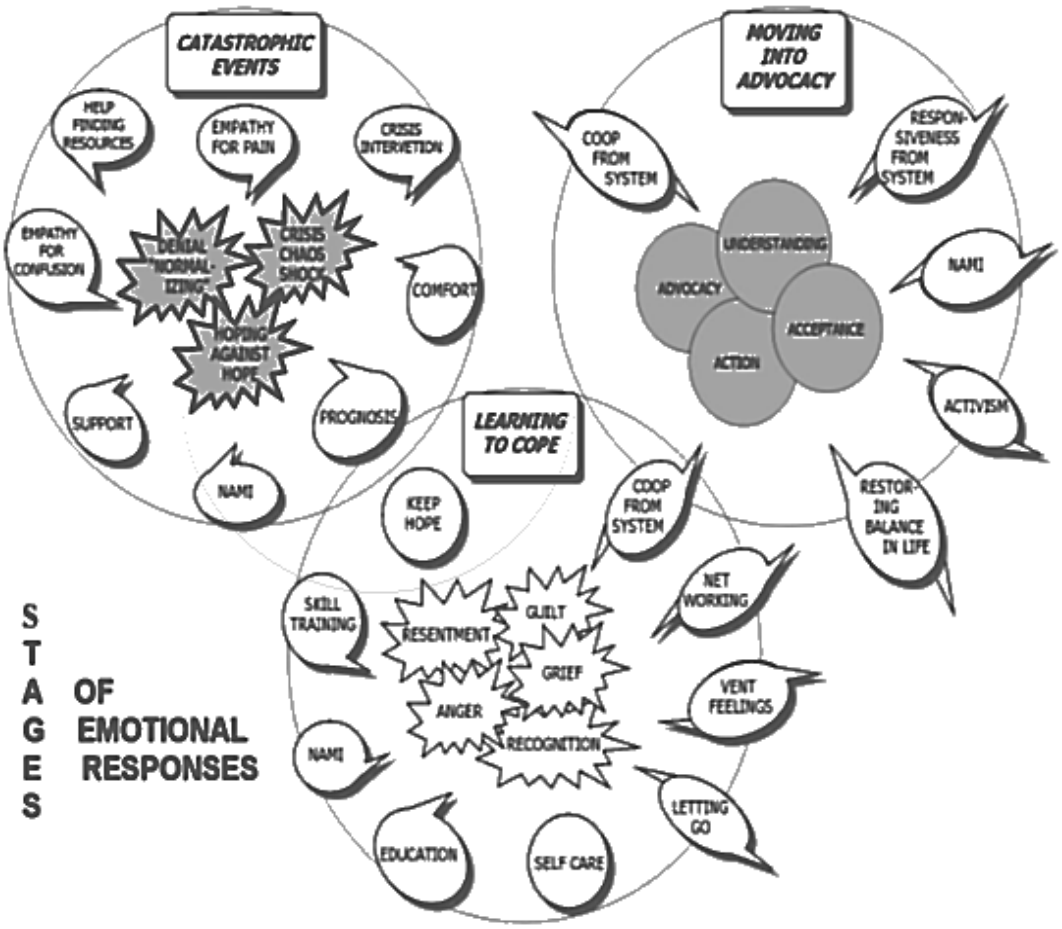
Websites

American Association of Suicidology	Dedicated to the understanding and prevention of suicide. Links to suicide support groups nation-wide.
Compassionate Friends	Grief support after the death of a child
International Association for Suicide Prevention	Dedicated to preventing suicidal behavior, to alleviate its effects, and to provide a forum for academicians, mental health professionals, crisis workers, volunteers and suicide survivors.
National Council for Suicide Prevention	An organization with a mission to further effective suicide prevention through collaborative activities and information sharing in order to save lives. It is a collaboration of many suicide prevention groups.
Caring Clergy Project	Excellent short videos that were prepared for clergy in addressing suicide: prevention, intervention and response

Families

When a loved one is diagnosed with a serious mental illness, families suffer, too, albeit in a different way. The following figure from the National Alliance on Mental Illness (NAMI) [14] depicts what happens in a family when a mental health crisis happens, giving the characteristics and needs for each stage.

Starting at the top left, when a catastrophic event happens, the family feels shock, sometimes denial and sometimes hoping against hope that it will just go away. The needs that the family has are in the surrounding circles: comfort, empathy, crisis intervention, and help finding resources.



In the second stage, the family is learning to cope. Family members may be feeling guilt, grief, resentment, resentment and anger. They need to keep their hope, self-care, to vent their feelings, to let go of what they can't change, education, networking, and cooperation from the system.

In the third stage, which not everyone reaches, families move into becoming advocates. They may reach a point of understanding, acceptance and feeling like they can take action. Their needs are cooperation and responsiveness from the system, learning how to advocate and restoring balance to their lives.

[14] Stages of Emotional Reactions among Family Members NAMI Family-to-Family Education Course

Remember:

- None of these states are wrong; they are normal reactions of people to serious illness.
- The process is ongoing. It can take years, and it can recycle with setbacks
- Notice that the National Alliance on Mental Illness (NAMI) plays an important role at each stage.

Suggestions for the Minister

- In the catastrophic stage, provide comfort and empathy to the family members for what they are going through. If you can, you may refer them to resources or groups in the community.
- Suggest that the family contact NAMI, especially the Family to Family Program
- In the coping stage, help the family members to deal with any grief, guilt or strong feelings they have. And help them to let go of what they cannot change.
- In the advocacy stage, cheer them on, connecting them with any advocacy resources you may have. You may want to make this work part of the social justice program of your congregation.
- Give them a copy of the General Strategies for Coping with a Loved One's Mental Disorder.
- Review the Communication Guidelines in the appendix and share them with family members.
- See the case study and suggestions at Mental Health Matters video on first psychotic break

Resources for Families

Books – *Including a number of guides for families written by people who've been there*

- Amador, Xavier F. with Anna-Lica Johanson. *I Am Not Sick I Don't Need Help!*, Vida Pr, 2000. Help for getting people over denial.
- Bernheim, Kayla, Lewine, Richard, and Beale, Caroline. *The Caring Family – Living with Chronic Mental Illness,* Chicago: Contemporary Books, 1982.
- Carter, Rosalynn, with Susan K. Golant. *Helping Someone with Mental Illness – A Compassionate Guide for Family, Friends, and Caregivers*, New York: Times Books, 1998. Comprehensive and helpful information for families by the former First Lady.
- Johnson, Julie T. *Hidden Victims – An Eight Stage Healing Process for Families and Friends of the Mentally Ill, 2nd Edition,* Edina, Minnesota: PEMA Publications, 1994.
- Hatfield, Agnes B. *Coping with Mental Illness in the Family – A Family Guide,* Arlington, Va.: National Alliance for the Mentally Ill, 1992.
- Mueser, Kim T. and Gingerich, Susan. *The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life*, Guilford Press, 2006.
- Patton, Sally. *Welcoming Children With Special Needs: A Guidebook for Faith Communities*, Boston: Skinner House, 2004. Guide for integrating special needs children into congregations.
- Rosen, Laura Epstein, and Amador, Xavier F. *When Someone You Love Is Depressed- How To Help Your Loved One without Losing Yourself*, New York: Free Press, 1997.
- Waterhouse, Stephen. *Strength for His People: A Ministry for Families of the Mentally Ill*, Amarillo, TX: Westcliff Bible Press, 1994.
- Woolis, Rebecca. *When Someone You Love Has a Mental Illness*, New York: Tarcher, 1992.

Website

NAMI Family-to-Family Education Program	A 12-week course for family caregivers of individuals with severe brain disorders.

Resources for Religion / Spirituality and Mental Illness

The symptoms of some mental disorders can resemble experiences involved in spiritual awakening. These experiences have helped shape the religious landscape throughout human history; the prophets and patriarchs of most religious traditions saw visions and heard voices, and shaman in native cultures have these experiences as a central role in initiation and practice. When helpful to the person and the church, they are experiences of the holy and need to be respected and honored.

Suggestions for the Minister

- To try and distinguish between mental health issues and spiritual awakening, ask yourself:
  - Does the person describe the experience as mystical, as near death, as a revelation of a universal religious truth, as finding who he or she really is?
  - Does the person have a curiosity about the experience and want to explore it?
- If the person reports that he or she believes there is a religious or spiritual dimension to the illness, try and determine the religious meaning that the person attributes this experience. If the experience it is a negative one, you may want to empathize and if possible suggest another meaning that is more positive.
- I find the following lists from *Religion and Mental Health*, edited by John F. Schumaker[15], a book of articles reviewing recent research into the relationship between religiosity and mental health, interesting and helpful. They may help you to counsel someone whose mental illness has religious overtones.

  Relationship of Religion and Mental Health – Two Sets of Views

  There have been different views of the way that religion and mental health relate to one another. Reasons given by those making the argument that religion is generally beneficial to mental health are that religion:

  1. reduces existential anxiety by offering a structure in a chaotic world
  2. offers a sense of hope, meaning, and purpose, and thus emotional well-being
  3. provides reassuring fatalism enabling one to deal better with pain
  4. affords solutions to many kinds of emotional and situational conflicts
  5. offers afterlife beliefs, helping one to deal with one's own mortality
  6. gives a sense of power through association with an omnipotent force
  7. establishes moral guidelines to serve self and others
  8. promotes social cohesion
  9. offers a social identity and a place to belong
  10. provides a foundation for cathartic collectively enacted ritual

  Reasons given by those who feel that religion doesn't help, and may harm mental health are that religion has the potential to:

  1. generate unhealthy levels of guilt
  2. promote self-denigration and low self-esteem by devaluing human nature
  3. establish a foundation for unhealthy repression of anger
  4. create anxiety and fear by beliefs in punishment in hell for 'evil' ways
  5. impede self-direction and a sense of internal control
  6. foster dependency and conformity with an over-reliance on external forces
  7. inhibit expression of sexual feelings
  8. encourage black and white views of the world: all are 'saints' or 'sinners'

[15] Schumaker, J.F., editor. *Religion and Mental Health*, New York: Oxford University Press, 1992.

9. instill ill-founded paranoia concerning evil forces threatening one's integrity
10. interfere with rational and critical thought

- If you feel that you can't adequately serve the person's spiritual needs, you can make a referral to a therapist who will respect the healing nature of the spiritual transformation process. You can create a referral list by consulting with your peers or with spiritual guides you know and respect.

- See the case studies and suggestions at Mental Health Matters video on spirituality and mental health. In this video, Dr. David Lukoff (see website below) talks about what he sees as the difference between authentic holy experience and schizophrenic psychosis.

Selected Books on Religion and Mental Health

- Boisen, Anton. *The Exploration of the Inner World – A Study of Mental Disorder and the Religious Experience,* Philadelphia: University of Pennsylvania Press, 1936. This is a classic in the field.

- Carlson, Dwight L. *Why Do Christians Shoot Their Wounded?: Helping (Not Hurting) Those with Emotional Difficulties,* Downers Grove, IL: InterVarsity Press, 1994.

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Website

Spiritual Competency Resource Center	Psychologist David Lukoff's website with on line resources that enhance the cultural sensitivity of mental health professionals regarding spiritual matters. Spirituality is now accepted as an important component of cultural competence for mental health professionals.

When the Minister Needs Help

Dealing with Self

A minister, like any other human being, operates his or her life on the continuum between mental health and mental disorder. Being a minister can be a stressful job and generally speaking, ministers are prone to overwork. Because of these stresses, a time might come when you as a minister feel that you may need professional mental health assistance. This is a time when you can practice good self-care, just as you are advising your parishioners to do. In particular:

- If you think you need help, be evaluated by a mental health professional, and follow treatment recommendations.
- Look at the self-care recommendations in General Coping Strategies for Mental Health Consumers *p. 31* in the appendix of this document and discover which of them would be helpful to you.
- Guard against burnout by learning to monitor yourself. Involve your loved ones and trusted colleagues in this assessment and listen to them when they say that you might be overdoing it and need a rest.
- Consider ongoing spiritual direction or therapy to stay on top of the issues that might be important in your functioning as a minister.
- If you find yourself unable to cope with a member of your congregation who has mental health problems, ask for help from a colleague or from a trusted mental health professional.
- If you receive professional mental health services, at some point you might want to consider "coming out" and telling your parishioners that you have gotten this care and that it has helped you. In my experience, such news as this is often very helpful and healing for the congregation, and people feel safe to talk about their issues when a respected person is open. This, however, is clearly a highly personal decision that you have to make in your own unique situation.

Dealing with Other Congregants

Because people with some of the more serious mental health difficulties can do things which can alarm, or disgust other members of the congregation, sometimes the minister needs to be able to cope with these reactions along with the reactions of the person with the mental disorder. Here are some suggestions:

- Consider making this a teachable moment, when you can model how one can behave with another person who is behaving quite differently from "expected" behavior. Have them see you talk to the person and accept the person as the precious human being that he or she is.
- After such a situation has passed, speak with other congregants who might have witnessed it and explain your understanding of what has happened and how it is being resolved. If you think it would be helpful, enlist their support in working with the person in the future, as a person of inherent worth and dignity.
- Identify other congregants who understand mental health situations and have them help you.
- Consider offering a class on mental health at your congregation to educate members and perhaps to begin advocacy. The Caring Congregation Program is one such curriculum.

Handouts

The following pages are handouts which may be useful to you and also which can be copied and given to congregants as you feel they would be helpful.

- General Coping Strategies for Mental Health Consumers is a list of suggestions that have worked for other people.
- General Strategies for Coping with a Loved One's Mental Disorder has a list of suggestions for the families of a person living with a mental disorder.
- Communication Guidelines gives ways for communicating with a person who is in the depths of a mental disorder
- NAMI is the National Alliance on Mental Illness – the preeminent advocacy organization for mental health.
- The Consumer Movement tells about the civil rights movement by and for mental health consumers.

General Coping Strategies for Mental Health Consumers

Here are some suggestions for coping with their mental illnesses collected from people who are living with them. As with any list, not every suggestion will work with every person.

Professional / Peer Help

- Psychotherapy with a therapist trained to know how to discover and deal with psychological problem areas.
- Effective medication in an effective dosage prescribed by a psychiatrist. If a medication isn't working for you, work with your doctor to find another medication or therapy that does work.
- Join a peer support group.
- Consider adding alternative therapies to your treatment plan. Ex: Acupuncture, Acupressure, Homeopathy, Dance therapy, Art therapy, Music therapy, Tai Chi, Yoga...
- Help someone else, especially someone with problems similar to yours.
- Work with a counselor to identify and make progress toward career goals

Personal Care

- Eat a good solid balanced diet.
- Little or no caffeine
- No alcohol. Alcohol is a depressant and often interferes with medication.
- Get plenty of rest. If you can't sleep, ask your doctor for something to help you sleep.

Stress Management

- Exercise. Elevate the heart rate for 15-30 minutes a day, with your doctor's permission. Examples: walking, jogging, aerobics, swimming …
- Avoid getting over-committed in time to any activities, so that you feel overwhelmed.

Emotional Self Awareness

- Learn how to recognize warning signs of a coming episode of mental illness and take immediate action to head it off or minimize it. Involve your family so they can help you.
- Do something to make you laugh, cry, or get angry in a safe place. Ex: watch a sad movie and cry.

Life Enrichment

- Indulge in some creative activity. Ex: music, drawing, painting, crafts, creative writing, weaving
- Take an adult school class: swimming, art, history …
- Engage in volunteer work
- Continue to be active with friends and make efforts to develop friendships
- Seek out helpful relatives

Spirituality

- Learn how to love yourself as an individual, spiritually and creatively. There is no one else on Earth quite like you.
- Meditation. 15-60 minutes of quiet listening to your heartbeat and breathing. Caveat: This can be disturbing for people who are psychotic. If so, don't use meditation, guided or silent.

General Strategies for Coping with a Loved One's Mental Disorder

Here are some suggestions collected from people who have loved ones with a mental disorder:

Professional / Peer Help
- If someone is suicidal, get immediate attention for him or her. Call 911 if there's an immediate danger.
- Make sure that the person gets the help needed, for example, a therapist or a hospital stay. You may have to help make the appointment and go with him or her.
- Get professional help for yourself to learn what your own responsibilities and capabilities are.
- Join your own support group, formal or informal.

Learn about Mental Health and Mental Illness
- Read and learn all you can about the mental disorder that your loved one has.
- Be flexible and patient. Cures are rarely instantaneous.
- Learn to recognize the signs of the mental disorder.

Communicate with your loved one
- Tell the person that you love and care about him or her.
- Visit him or her, especially if hospitalized. A smile, a flower, a picture or a short hug can make all the difference.
- Avoid doing things that trigger the person's disorder, ex: if the person become anxious or depressed when he or she is pressured to hurry, don't try and rush things.

Help your loved one live with the illness
- Help the person to keep his or her days structured.
- Support efforts to find the medicines and therapies that work best.
- Monitor medicine intake.
- Encourage physical exercise, good diet, plenty of sleep, creative activities, and sunlight.
- Learn to recognize the warning signs that an episode is going to happen, and help your loved one to take action to head it off or minimize it.
- Plan future activities for both of you to look forward to.
- Maintain some kind of social activity with your loved one, such as going to the movies.
- Make the best of the person's good days. Drop the housework to enjoy time with your loved one.
- Keep guns out of the house.

Have a life of your own.
- If the depressed person needs monitoring or assistance, get help.
- Plan future activities for yourself alone.
- Live one day at a time.

Communication Guidelines[16]

Expression of Empathy and Compassion

A person with mental disorders can get discouraged with the illness and the negative prejudice it engenders. It is important to have and show compassion. Examples of things that you can say are:

- "I know it must be difficult for you right now."
- "It must be terrible to feel that way."

Listen to the person and remember that feelings are real even if not based on reality.

Not all people with mental disorders will have these problems, but when they do, here are some guidelines to communicate effectively:

When a mentally ill person …	You need to …
has trouble with 'reality'	be simple, truthful.
is fearful	stay calm
is insecure	be accepting
has trouble concentrating	be brief, repeat, clarify what you are hearing
is over stimulated	limit input, not force discussion
is easily agitated	recognize agitation, allow escape
has poor judgment	not expect rational discussion
is preoccupied	get attention first
is withdrawn	initiate relevant conversation
has little empathy for you	recognize this as a symptom
believes delusions	empathize, don't argue;
has low self-esteem and motivation	stay positive
is in crisis, speaking loudly and fast	match the person's volume and rate, then slowly lower your voice and rate of speech. This will encourage the other person to do the same.

How to make positive requests: in a direct, pleasant and honest way:

1. Look at the person
2. Say exactly what you would like the person to do
3. Say how it would make you feel

Example: "I would like you to dry the dishes. That would help me and brighten my day."

How to express negative feelings: in an effective, non-threatening way

1. Look at the person. Speak firmly.
2. Say exactly what the person did to upset you.
3. Say how it made you feel.
4. Suggest how the person might prevent this from happening in the future

Example: "I feel angry that you shouted at me. I'd like it if you spoke quieter next time."

Giving praise:

Use praise to encourage any progress, no matter how small, ignoring flaws. Be specific. Praise can be attention, physical affection, expression of interest, and/or commendation.

What to avoid: Research shows these can lead to relapses.

Blaming	Threats
Highly emotional responses	Ignoring him/her or expressions of distress
Perpetuating negative stereotypes	Telling him/her to "buck up"
Character assassination	Setting too many demanding limits

[16] Summarized from Family Guidelines by Dr. Christopher Amenson and "Tips for Crisis Prevention" from Crisis Prevention Institute, Inc., adapted.

NAMI [17]

The National Alliance on Mental Illness (NAMI) is the preeminent mental health advocacy organization. Founded in 1979, it is a nonprofit, grassroots, self-help, support and advocacy organization of mental health consumers, families, and friends of people with severe mental illnesses. NAMI works to achieve equitable services and treatment for more than 15 million Americans living with severe mental illnesses and their families. It provides:

- Over 1000 local affiliates and 50 state organizations
- Education and support on mental illness. One of NAMI's programs is Family-to-Family (see below)
- Combat negative stereotypes
- Support increased funding for research
- Advocate for adequate health insurance, housing, rehabilitation, and jobs for people with mental illnesses and their families.

NAMI's Family-to-Family 12-week education program for families of mentally ill people
This program is taught by facilitators who are family members and have previously been through the program themselves. The following are examples of subjects addressed in the weekly classes.

- Symptoms of serious mental disorders: Schizophrenia, Bipolar Disorder, Depression, Panic Attacks
- The causes of mental disorders
- Understanding psychiatric medications
- Empathy: Learn how it feels to be mentally ill, and how to develop effective communication skills
- The Recovery model. Developing a plan with your loved one
- Dealing with mental health prejudice and self-care

The Consumer Movement [18]

This is a civil rights movement for mental health clients, many of whom have had bad experiences with traditional mental health care in the past and want to reform the system. Some of its ideas, such as the concept of "recovery," have become accepted by the mainstream mental health system.

Some mental health consumer views of the "medical model" of mental health care

- The concept of "mental illness" is a form of social control for people who are "different"
- The medical model defines the problem in the individual instead of an oppressive society
- Some emotional crises are a reaction to difficult, oppressive circumstances and are not permanent "chemical imbalances" of the brain that will require medication for life
- Over-reliance on medication and ECT which sometimes has serious, irreversible side effects
- Use of forced treatment for mental illnesses is counterproductive
- Significant differences between Europe and US in how schizophrenia and bipolar disorder are diagnosed suggesting subjectivity of mental illness definition and treatment

Consumer Movement Stresses:

- Mental health consumer rights
- Self Determination, Self-Advocacy, Self Help and Peer Support
- Lobbying and advocacy for rights of mental health consumers
- Some mental health consumers reject some or all medical intervention for mental disorders:
  - Psychiatric Medication, especially forced medication ← **Key disagreement with NAMI**
  - Psychiatric Hospitalization
  - Electroconvulsive Therapy (ECT) i.e. "shock therapy"

[17] Sources: NAMI and NAMI Family-to-family Education Course;

[18] See: National Mental Health Consumers' Self Help Clearing House and the National Empowerment Center

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