

Dear Friends,

Thank you for your interest in **Serious Mental Illness Awareness Sunday, May 16, 2004!** This packet contains resources

designed to assist you to plan a Serious Mental Illness Awareness Sunday. Worship celebrations on alternate dates throughout the year are also encouraged. A worship service could focus on the gifts that persons with mental illness bring to the church, the barriers that often keep people with mental illness from being fully accepted and integrated into the life of the church and society, and/or education about mental illness.



Making your congregation more aware of serious mental illness is important. Mental illness touches many lives. According to the landmark "Global Burden of Disease" study, commissioned by the World Health Organization and the World Bank, mental illness represents four of the ten leading causes of disability for persons age 5 and older. Among "developed" nations, including the United States, major depression is the leading cause of disability.

Health Ministries, USA has an Extra Commitment Opportunity for Mental Illness Awareness. If you would like to support the development of resources to make Presbyterian congregations, governing bodies and the public more aware of the issues surrounding mental illness, consider giving to Mental Illness Awareness (ECO #051411).

Thank you for your interest in Serious Mental Illness Awareness Sunday. As a church, we need to respond to mental illness effectively, compassionately, and together. If we can be of further assistance, please contact Health Ministries, USA at 888.728.7228, ext 8011; e-mail at [health@ctr.pcusa.org](mailto:health@ctr.pcusa.org) or visit our website at [www.pcusa.org/health/usa](http://www.pcusa.org/health/usa). Please share your experiences and other useful resources with us and we will pass them on to others.

Blessings of Health and Wholeness!

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**Health Ministries is:**

Caring For One Another

Promoting Health & Wholeness

**Working for Equity & Access**



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## **Suggestions for Observing Presbyterian Mental Illness Awareness Week:**

Establish a special Sunday morning worship service around mental illness. Have the minister or someone from the congregation speak about the impact of mental illness in their life or the life of a loved one or friend.

Order “The Congregation: A Community of Care and Healing (Mental Illness Awareness Resource)” for worship, study and sermon ideas. This resource looks at the response of the congregation to this issue of mental illness.

Start a study group for youth. Use the video “Honest Talk About Serious Mental Illness (for Older Youth)” to assist adults as well as youth in becoming aware about the facts and challenges of serious mental illness. Use the companion book, “Honest Talk About Serious Mental Illness: A Four-Session Curriculum for Youth,” as a study guide to assist in the structure of the group. Have a facilitator that is both knowledgeable and comfortable with this topic. If a church member doesn’t feel comfortable leading these sessions, then contact community based organizations dealing with this topic or a hospital that specializes in this area of care, to find a person who is comfortable

Provide presentations by persons and/or families affected by mental illness. The stigma surrounding mental illness is based on fear, discomfort and lack of information. -Presentations will put a personal face on mental illness and help dispel the myths.

Provide a series of classes/educational sessions on mental illness. Include facts, types, and treatment of mental illness and resources. Also, include personal stories about people living with mental illness. Focus on education and dispelling the myths.

Encourage your congregation or presbytery to form a Mental Illness Task Force to assist members in understanding mental illness.

Create a mental health and mental illness section in your church library. Include church resources and community-based resources. It is important to know where people can get help.

Write an article about mental illness for your church newsletter. Include facts and personal accounts of people dealing with mental illness. Provide resources and a list of how people can respond to a person with mental illness and/or support their family.

Establish a bulletin board with current mental health information. For information on mental health issues visit our website at [www.pcusa.org/health/usa](http://www.pcusa.org/health/usa). Also, check out the resources at the end of this document to gather information for the bulletin board.

Discuss starting a Congregational Care Team program in your congregation for a person with mental illness or for the family. Download the Exploration Guide for Presbyterian Care Teams to explore the idea of developing Presbyterian Care Teams within your church. The packet can be used for educational programming ideas, church school lessons and worship. For more information go to <http://www.pcusa.org/health/usa/careteams/index.htm>. Small grants are available to help you get started.

## **Presbyterian Church (U.S.A.) Policy Statement on Serious Mental Illness**

The Church and Serious Mental Illness: A Report and Resolution Approved by the 200<sup>th</sup> General Assembly (1988)

The need to address chronic mental illness is urgent. The 1988 General Assembly of the Presbyterian Church (U.S.A.) adopted a report and resolution, which called the church to ministry and mission with those persons affected by serious mental illness including family, friends and professionals. The report:

acknowledged that the religious community is in a unique position to be the bridge between clinical settings and life in the home community and to offer support to the diversity of persons whose lives are touched by mental illness

urged pastors and congregations to develop ways of inclusion

urged that congregations cherish the presence of all in the community of faith as it worships, studies, gives, grows and heals together

encouraged the church to learn more about mental illness, and

encouraged the church to seek new ways to respond to those with severe mental illness and their families.

The Church and Mental Illness, report and resolution from the 200<sup>th</sup> General Assembly (1988) about the church's call to ministry and mission with those affected by serious mental illness.

### **General Assembly Referral**

The 210<sup>th</sup> General Assembly (1999) took an action calling for a comprehensive serious mental illness statement:

25.039. Direct the Advisory Committee on Social Witness Policy, in consultation with appropriate entities, to develop a comprehensive serious mental illness policy, including justice issues and full participation in the life of the church, and report to the 217<sup>th</sup> General Assembly (2005). (Minutes, 1999, Part I, pp. 41, 309).

The Advisory Committee on Social Witness Policy has received a slate of nominees to consider for this work. The members of the team will be selected during the course of the next couple of months. After they have been confirmed, the first meeting will take place in the Fall to begin their work on the referral. For more information, go to <http://www.pcusa.org/acswp/wwd/wwd-seriousmentalillness.htm>.

## **The Lord's Day**

### **Minute for Mission: University of Dubuque Theological Seminary**

The command of Jesus to love one another is easy to embrace in the abstract, but difficult and complicated in the particulars. How does one show love to a business competitor? A drug addict? A church leader whose teaching appears questionable? Oppressed and impoverished people in faraway lands? A loved one at the end of life? An implacable enemy? A hardened criminal?

St. Theresa of Lisieux found a deep communion with Christ in the recognition that her calling was not to show love but to become the love of Christ in the midst of her world. How do churches, congregations, and individual believers become the love of Christ in the midst of a complex world? What difference does it make to be Christ's follower in the context of service as a business person? A medical worker? A homemaker? A lawyer? A military officer? A teacher? A parent?

The University of Dubuque Theological Seminary has added an ethics requirement to its curriculum to ensure that every new pastor going out from its halls will have wrestled deeply and seriously with the demands of love. Our goal with this requirement is not just to foster skills in puzzling our quandary situations and ethical dilemmas. More than that we are seeking to equip pastors with analytical skills, theological vision, and leadership qualities for shaping and nurturing faithful Christian congregations. Our goal is for the church to exert a transformative influence not only in the lives of individual Christians but also in the wider community.

*--Rev. Dr. Mark Achtemeier, associate professor of Systematic Theology and Ethics,  
University of Dubuque Theological Seminary*



# Health Ministries USA

*Beloved, I pray that all may go well with you and that you may be in good health, just as it is well with your soul. - 3 John 2*

## **Suggestions for prayers and readings during the Serious Mental Illness Sunday Service**

### **Moving Toward Wholeness for Those with Mental Illness**

#### **Call to Worship**

Greeting

All may stand as the minister(s) and other worship leaders enter.

The minister greets the people, saying one of the following:

The grace of the Lord Jesus Christ be with you all.

or

The Lord be with you.

**And also with you.**

or

Our Lord Jesus Christ brought grace to those who were sick and suffering,

May the grace of the same Jesus Christ be with you.

**And also with you.**

or

Let us ask ourselves why we are gathered here.

**Why are we gathered here?**

We come to this place and holy time as people of faith.

**We come because the Spirit of God invites us here.**

We gather today, especially to think about those who feel the pain of mental illness and those who walk with them as they struggle to live with their disease.

**Help us to support and sustain them.**

We gather to learn about the needs of those who are feared or maligned by their neighbors and those whose energies are sapped by dealing with an uncaring, closed community.

**Keep us from compounding the pain that is inflicted on your people by illness, ignorance and stigma.**

We gather to remember our calling as singers of life.

**We gather to offer to God a commitment that our work is to be a way of rendering service to another human being and thus an opportunity to give glory to God.**

We gather to acknowledge that we have been called to be God's co-workers, partners in the continuing acts of creation.

**Through our speaking, listening, singing, and learning we offer now our praise to God who creates and redeems and sustains.**

## **Confession and Pardon**

### Call to Confession

In God's image we have been created, with gifts and needs. At times we fail to recognize our own limitations and abilities, but we can ask God to forgive us. Too often we do not accept as sisters and brothers people with mental illness and their families. Let us ask God to forgive us for the times we see people through the lens of a label and not for who they are.

(A pause for silent reflection follows.)

### Confession of Sin

**God, help us to break down barriers that separate us from others; our insensitivity; our failure to listen to the yearnings of the heart; our failure to offer support; our failure to invite people with mental illness to be part of our lives and our Lord congregation. Hear our prayer, Lord. Amen.**

*"Lord Have Mercy", Holy God, Holy and Mighty" or "Lamb of God" may be sung.*



## **Suggested Scripture Sentences and Readings**

### **Old Testament**

Leviticus 19:33-34  
Deuteronomy 10:12-22  
Deuteronomy 15:7-11  
Deuteronomy 26:10-13  
1 Samuel 16:14-23  
Isaiah 11:1-5  
Isaiah 56:1-8  
Isaiah 58:6-10  
Lamentations 3:33  
Nahum 1:7

### **Psalms**

Psalm 9:9-20  
Psalm 18:2-6, 16-17, 19  
Psalm 22:23-24  
Psalm 23  
Psalm 27  
Psalm 30  
Psalm 38:8-11, 15-16, 21-22  
Psalm 40  
Psalm 46:1-7

### **New Testament**

Matthew 5:1-12  
Matthew 11:28-29  
Matthew 25:31-46  
Mark 5:2-20  
Luke 6:20-23  
Luke 8:27-39  
John 5:2-9  
John 14:27  
John 16:33  
Acts 3:1-16  
1 Corinthians 12:12-26  
Galatians 4:14  
Hebrews 10:19-25  
Hebrews 11:1  
Hebrews 13:1-15  
“Mental Illness Worship Resource”  
Compiled and Edited by Christopher L.  
Smith  
Item #7266099015

**Health Ministries, USA** ~ [health@ctr.pcusa.org](mailto:health@ctr.pcusa.org) ~ Visit us at  
[www.pcusa.org/health/usa](http://www.pcusa.org/health/usa)  
PCUSA ~ 100 Witherspoon St. ~ Louisville, KY

## **Facts about Mental Illness**

Mental illnesses include schizophrenia, schizo-affective illness, bipolar illness, major depressive illness, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, borderline personality disorder, dementia and other severe and persistent mental illnesses that affect the brain.

These illnesses can profoundly disrupt a person's thinking, feeling, moods, ability to relate to others and capacity for coping with the demands of life.

Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weakness, lack of character, or poor upbringing.

Mental illnesses are treatable. Many people with serious mental illness need medication to help control symptoms, but also rely on supportive counseling, self-help groups, assistance with housing, vocational rehabilitation, income assistance and other community services in order to achieve their highest level of recovery.

People who have been diagnosed with a mental illness are often stigmatized. A stigma is commonly defined as the use of stereotypes and labels when defining someone. Stigma is Greek for "sign" and it has come to refer to a characteristic or set of characteristics that bring shame to an individual or group who bear this "sign" or stereotyped label.

Here are some important facts about mental illness and recovery:

Mental illnesses are biologically based brain illnesses. They cannot be overcome through "will power" and are not related to a person's "character" or intelligence.

Mental illnesses fall along a continuum of severity. The most serious and disabling conditions affect five to ten million adults (2.6 – 5.4%) and three to five million children ages five to seventeen (5 – 9%) in the United States.

Mental illnesses are the leading cause of disability (lost years of productive life) in the North America, Europe and, increasingly, in the world. By 2020, Major Depressive illness will be the leading cause of disability in the world for women and children.

Mental illnesses strike individuals in the prime of their lives, often during adolescence and young adulthood. All ages are susceptible, but the young and the old are especially vulnerable.

Without treatment the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives; The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States.

The best treatments for serious mental illnesses today are highly effective; between 70 and 90 percent of individuals have significant reduction of symptoms and improved quality of life with a combination of pharmacological and psychosocial treatments and supports;

Early identification and treatment is of vital importance; by getting people the treatment they need early, recovery is accelerated and the brain is protected from further harm related to the course of illness.

Stigma erodes confidence that mental illnesses are real, treatable health conditions. We have allowed stigma and a now unwarranted sense of hopelessness to erect attitudinal, structural and financial barriers to effective treatment and recovery. It is time to take these barriers down.

**Facts from The Nation's Voice on Mental Illness (NAMI) <http://www.nami.org/>**

## **The Personal Side of Mental Illness**

### ***Misconceptions about Mental Illness***

Have you ever thought that people with a mental illness are violent? Have you ever had concerns about your own mental well being, but felt too ashamed or embarrassed to tell anyone? Answer yes to any one of these, and you are one of the millions of people who reinforce myths and misconceptions around mental illness, every day, without even really knowing it.

### **What is Stigma?**

Stigma is a term used to describe a process where a person is denied full and equal

social standing with another person. The process often begins with the application of a label that distinguishes "normal" or "well" people from "sick" or "abnormal" people. Stigma takes many forms and occurs at many different levels. We can see evidence of the stigma surrounding mental illness at an individual, interpersonal and institutional level. Stigma around mental illness is everywhere.

### **How does the stigma of mental illness Affect Us?**

One does not have to have a mental illness to be affected by the stigma surrounding it. The misconceptions and stereotypes that you have been taught from the day you were born generate so much fear and misunderstanding, that when you might actually need help, you may not even recognize that you need it. It can make you feel too afraid to ask for help.

Stigma can prevent you from offering time, support or friendship to someone you know who is experiencing mental illness. Fear of someone's illness can deprive you of new perspectives and ways of understanding what it means to have a mental illness.

Stigma can also make you believe that people with a mental illness are violent, brain damaged, intellectually disabled, unimportant, untrustworthy or inconsequential. Believing these things may make you feel powerful, different and better than others. These feelings of superiority, however, are based on myths and stereotypes, not realities. Stigma can make you feel convinced that you know the truth, when it is clear to those around you that you do not.

### **Stereotypes**

If you have a mental illness, you have probably internalized many of the misconceptions surrounding mental illness without even knowing it. When you have been taught myths and stereotypes for long enough, you can internalize them and begin to believe the stereotypes to be true. This internalized stigma, combined with the external discrimination you may be experiencing, can make you feel rejected, lonely, depressed, dismissed and less than human.

Whether you have or have had a mental illness or not, stigma and the stereotypes can affect you. If it has not affected you directly, then it surely has had an impact on someone you know. One of the key effects of stigma is the development and reinforcement of myths and stereotypes. Some examples follow:

**MYTH:** People with a mental illness are violent

**FACT:** 90-95% of people with a mental illness are no more inclined to violence than the general population

**MYTH:** People with a mental illness should be kept in isolation, away from the community

**FACT:** One in five of us will experience a mental illness at some stage in our lives. It would be extremely costly, both socially and economically, to isolate 20% of the population. Part of recovering from mental illness is being able to interact in everyday living situations.

**MYTH:** People with a mental illness have an intellectual disability or a type of brain injury

**FACT:** Mental illnesses are just like other forms of illness, such as diabetes or asthma, it wouldn't enter our mind to think that someone with asthma is brain damaged or intellectually disabled, so why would we think of someone with a mental illness in this way?

**MYTH:** People with a mental illness have a flawed or weak character.

**FACT:** People are not to blame for becoming mentally ill. Having a mental illness has nothing to do with a lack of will power. People do not choose to be mentally ill, any more than people choose to have heart disease.

Through this kind of stereotyping, people with a mental illness are reduced to being a symptom of their illness, rather than a person in their own right. It is far easier to hate or ignore someone when you see them as an illness, rather than as a person.

The stigma surrounding mental illness has not occurred overnight. Stereotypes, myths and misconceptions can take years to develop into what we mistakenly believe is reality. It will take time to deconstruct much of the stigma in our society, especially because we don't identify it as anything other than reality. There is much we can do to actively challenge stigma, and everyone can play a role.

*Adapted from Territory Health Services and the Top End Association for Mental Health (Team Health)*

## **Description and Statistics of Mental Illness**

The most effective way of demystifying mental illness is to actually get to know people who have mental illness, as individuals – as people with full and regular lives.

Another method – sometimes helpful before reaching out to an individual - is to become more aware of the ways that mental illness may affect people. The information following is provided as a background resource.

**The descriptions used here are, at times, given in clinical terms. Mental illness is not a monolithic entity and as with all types of illness, affects each individual - each person - uniquely and differently.**

### **Mental Illnesses in the US**

Mental illnesses are common in the United States and internationally.

An estimated 22.1 percent of Americans ages 18 and older—about 1 in 5 adults—suffer from a diagnosable mental illness in a given year.

44.3 million people are affected by a mental illness.

4 of the 10 leading causes of disability in the U.S. and other developed countries are mental illness—major depression, bipolar illness, schizophrenia, and obsessive-compulsive illness. Many people suffer from more than one mental illness at a given time.

In the U.S., mental illness are diagnosed based on evaluation against criteria included in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)*.

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### **Depressive Illness**

Depression encompass major depressive illness and bipolar illness. Bipolar illness is included because people with this illness have depressive episodes as well as manic episodes.

Approximately 18.8 million American adults, or about 9.5 percent of the U.S. population age 18 and older in a given year, have a depressive illness.

Nearly twice as many women (12.0 percent) as men (6.6 percent) are affected by a depressive illness each year. These figures translate to 12.4 million women and 6.4 million men in the U.S.

Depressive illness may be appearing earlier in life in people born in recent decades compared to the past.

Depressive illness often co-occur with anxiety illness and substance abuse.

### **Major Depression**

Major depression, unlike normal experiences of sadness, loss or passing mood states, is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity and physical health. Among all medical illnesses, major depression is the leading cause of disability in the United States and many other developed countries.

Major depressive illness is the leading cause of disability in the U.S. and established market economies worldwide.

Major depressive illness affects approximately 9.9 million American adults, or about 5.0 percent of the U.S. population age 18 and older in a given year.

Nearly twice as many women (6.5 percent) as men (3.3 percent) suffer from major depressive illness each year. These figures translate to 6.7 million women and 3.2 million men.

While major depressive illness can develop at any age, the average age at onset is the mid-20s.

### **Symptoms of Depression**

The onset of the first episode of major depression may not be obvious if it is gradual or mild.

Persistently sad or irritable mood

Pronounced changes in sleep, appetite, and energy

Difficulty thinking, concentration, and remembering

Physical slowing or agitation

Lack of interest in or pleasure from activities that ere once enjoyed

Feeling of guilt, worthlessness, hopelessness, and emptiness

Recurrent thoughts of death or suicide

Persistent physical symptoms that do not respond to treatment, such as headaches, digestive illness, and chronic pain

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## **Bipolar Disorder**

Bipolar illness, or manic depression, is a serious brain that causes extreme in mood, energy, and functioning. Bipolar illness is characterized by episodes of mania and depression that can last from days to months. It generally requires lifelong treatment, and recovery between episodes is often poor. Generally those who suffer from bipolar illness have symptoms of both mania and depression (sometimes at the same time).

Bipolar illness affects approximately 2.3 million American adults, or about 1.2 percent of the U.S. population age 18 and older in a given year.

Men and women are equally likely to develop bipolar illness.

The average age at onset for a first manic episode is the early 20s.

## **Symptoms of Bipolar Illness**

### Symptoms of Mania

Mania is the word that describes the activated phase of bipolar illness. The symptoms of mania may include:

Either an elated, happy mood or an irritable, angry, unpleasant mood

Increased activity or energy

More thoughts and faster thinking than normal

Increased talking, more rapid speech than normal

Ambitious, often grandiose, plans

Poor judgment

Increased sexual interest and activity

Decreased sleep and decreased need for sleep



## **Symptoms of Depression**

Depression is the other phase of bipolar illness. The symptoms of depression may include:

- Depressed or apathetic mood
- Decreased activity and energy
- Restlessness and irritability
- Fewer thoughts than usual and slowed thinking
- Less talking and slowed speech
- Less interest or participation in, and less enjoyment of activities normally enjoyed
- Decreased sexual interest and activity
- Hopeless and helpless feelings
- Feelings of guilt and worthlessness
- Pessimistic outlook
- Thoughts of suicide
- Change in appetite (either eating more or eating less)
- Change in sleep patterns (either sleeping more or sleeping less)

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## **Dementia**

Dementia is a progressive, degenerative disease that attacks the brain and results in problems with memory, thinking and behavior and becomes severe enough to interfere with a person's ability to work and to take care of everyday tasks such as bathing, cooking, dressing and grooming. Dementia is not a normal part of aging.

## **Symptoms of Dementia**

The symptoms of dementia include trouble learning new things; trouble remembering things that were known in the past; trouble with abstract thinking; poor judgment; trouble speaking well; trouble carrying out motor tasks; trouble recognizing or naming objects; personality change; trouble being able to work or carry on a normal social life. Sometimes people with dementia also develop anxiety, depression, suspiciousness, assaultiveness, agitation, wandering, confusion, or verbal abuse.

## **Causes of Dementia**

Dementia always has a physical cause. The most common dementia, Alzheimer's Disease, is caused by changes in the structure of the brain that may develop because of genetic inheritance, a chemical imbalance, a viral infection, environmental toxins, or for other reasons. Research is being carried out to learn more about its cause, prevention and treatment. Another common dementia is Vascular Dementia, which is caused by blood vessel disease or small strokes in the brain. Still other dementias are caused by AIDS, metabolic disease, diseases of the brain, lack of oxygen or sugar to the brain, or a buildup of pressure in the brain.

## **How does Dementia impact people?**

Alzheimer's Disease, the most common dementia, develops slowly and gradually becomes more severe over a period of several years. Vascular Dementia also becomes gradually more severe, although it may begin more suddenly and there may be longer stable periods than there are in Alzheimer's Disease. With other dementias, the way the symptoms develop depends on the cause. Dementia can occur at any age, but is more common after age 65.

## **Dementia Treatment**

There is no cure for Alzheimer's Disease or Vascular Dementia, but many of the symptoms can be treated or managed so the patient can remain comfortable and function independently for as long as possible. Good medical care is very important so the patient's general health can be maintained. There are several medications called cholinesterase inhibitors that can slow the progression of the disease. Medicines can also be prescribed when they are needed for agitation, anxiety, depression, impulsive behaviors, or insomnia.

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**Some of the things that can be done to help a person with dementia are:**

Stick to a regular daily routine. Make sure there are lots of familiar objects around to be seen and enjoyed.

Check on the patient's safety regularly. One method some families use to prevent wandering is to attach bells to all the doors that lead outside.

Make sure the patient eats well and drinks plenty of liquids

Help the patient stay as independent as possible for as long as possible.

Provide for regular exercise and recreation.

Keep in touch with friends and family.

Use written memory aids such as large calendars and clocks, written lists of daily routines, reminders about safety measures, and name tags placed on important objects.

See that the patient gets regular medical checkups.

Plan ahead for future needs such as respite care or nursing home placement.

Give lots of emotional support to the patient and all the caregivers.

If medicines are prescribed, see that the patient takes them regularly.

Join a support group of other people who care for people with dementia.

Ask for help with money problems, legal problems, day-to-day advice, emotional issues, respite care or nursing home placement when they are needed.

Check the home for safety features, such as bars on the wall near the toilet and bathtub, night lights in hallways and on the stairs, non-slip rugs, lowering the height of the bed to prevent falls, etc.

Make sure all health care providers have a complete list of all the patient's prescription and over-the-counter medicines.

If incontinence is a problem, remind the patient to use the toilet every two hours.

Enroll the patient in a dementia day program to provide stimulation for the patient and respite for the caregiver.

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## **Schizophrenia**

Schizophrenia is a devastating brain illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others. The first signs of schizophrenia typically emerge in the teen-age years or early twenties. Most people with schizophrenia suffer chronically or episodically throughout their lives. A person with schizophrenia does not have a "split personality," and almost all people with schizophrenia are not dangerous or violent towards others when they are receiving treatment.

Approximately 2.2 million American adults, or about 1.1 percent of the population age 18 and older in a given year, have schizophrenia.

Schizophrenia affects men and women with equal frequency.

Schizophrenia often first appears earlier in men, usually in their late teens or early 20s, than in women, who are generally affected in their 20s or early 30s.

**Symptoms of Schizophrenia** - are classified into two broad classes: positive symptoms and negative symptoms.

### **Positive Symptoms**

Positive symptoms, or "psychotic" symptoms, refer to overt symptoms that should not be there.

Hallucinations

Delusions

Disorganized thoughts and behaviors

Loose or illogical thoughts

Agitation

### **Negative Symptoms**

Negative symptoms reflect the absence of thoughts and behaviors that would otherwise be expected.

Flat or blunted affect

Concrete thoughts

Anhedonia (inability to experience pleasure)

Poor motivation, spontaneity, and initiative

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## **Anxiety**

Anxiety illness includes panic illness, obsessive-compulsive illness, post-traumatic stress illness, generalized anxiety illness, and phobias (social phobia, agoraphobia, and specific phobia).

Approximately 19.1 million American adults ages 18 to 54, or about 13.3 percent of people in this age group in a given year, have an anxiety illness.

Anxiety illness frequently co-occurs with depressive illness, eating illness, or substance abuse.

Many people have more than one anxiety illness.

Women are more likely than men to have an anxiety illness. Approximately twice as many women as men suffer from panic illness, post-traumatic stress illness, generalized anxiety illness, agoraphobia, and specific phobia, though about equal numbers of women and men have obsessive-compulsive illness and social phobia.

### **Symptoms of Anxiety Illness**

Feelings of fear or dread

Trembling, restlessness, and muscle tension

Rapid heart rate

Lightheadedness or dizziness

Perspiration

Cold hands/feet

Shortness of breath

### **Panic**

A person who experience recurrent panic attacks, at least one of which leads to at least a month of increased anxiety or avoidant behavior, is said to have panic illness. Panic illness may also be indicated if a person experiences fewer than four panic episodes but has recurrent or constant fears of having another panic attack. Panic attacks typically last about 10 minutes, but may be a few minutes shorter or longer.

Approximately 2.4 million American adults ages 18 to 54, or about 1.7 percent of people in this age group in a given year, have panic illness.

Panic illness typically develops in late adolescence or early adulthood.

About 1 in 3 people with panic illness develop *agoraphobia*, a condition in which they become afraid of being in any place or situation where escape might be difficult or help unavailable in the event of a panic attack.

**Symptoms of Panic Illness** (To be diagnosed as having panic illness, a person must experience at least four of the following symptoms during a panic attack).

Sweating

Hot or cold flashes

Choking or smothering sensations

Racing heart

Labored breathing

Trembling

Chest pains

Faintness

Numbness

Nausea

Disorientation

Feelings of dying

Losing control

Losing one's mind

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### **Obsessive-Compulsive Disorder (OCD)**

Obsessive-compulsive disorder (OCD) is often described as “a disease of doubt.” Sufferers experience “pathological doubt” because they are unable to distinguish between what is possible, what is probably, and what is unlikely to happen.

Obsessions – are intrusive, irrational thoughts – unwanted ideas or impulses that repeatedly well up in a person's mind. On one level the person knows these obsessive

thoughts are irrational. Nevertheless, on another level, he or she fears these thoughts might be true. Trying to avoid such thoughts creates great anxiety.

Compulsions – are repetitive rituals such as hand washing, counting, checking, hoarding, or arranging. An individual repeats these actions, perhaps feeling momentary relief, but without feeling satisfaction or a sense of completion. People with OCD feel they must perform these compulsive rituals or something bad will happen

Approximately 3.3 million American adults ages 18 to 54, or about 2.3 percent of people in this age group in a given year, have OCD.

The first symptoms of OCD often begin during childhood or adolescence.

### **Symptoms of Obsessive-Compulsive (OCD)**

OCD occurs when an individual experiences obsessions and compulsions for more than an hour each day, in a way that interferes with his or her life.

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### **Post-Traumatic Stress Disorder (PTSD)**

Post-traumatic stress disorder (PTSD) is an anxiety illness that can occur after someone experiences a traumatic event that caused intense fear, helplessness, or horror. PTSD can result from personally experienced traumas (e.g., rape, war, natural disasters, abuse, serious accidents, and captivity) or from the witnessing or learning of a violent or tragic event.

Approximately 5.2 million American adults ages 18 to 54, or about 3.6 percent of people in this age group in a given year, have PTSD.

PTSD can develop at any age, including childhood.

About 30 percent of Vietnam veterans experienced PTSD at some point after the war. The illness also frequently occurs after violent personal assaults such as rape, mugging, or domestic violence; terrorism; natural or human-caused disasters; and accidents.

### **Symptoms of Post-traumatic Stress Disorder**

Although the symptoms for individuals with PTSD can vary considerably, they generally fall into three categories:

Re-experience – Individuals with PTSD often experience recurrent and intrusive recollections of and/or nightmares about the stressful event. Some may experience flashbacks, hallucinations, or other vivid feelings of the event happening again. Others experience great psychological or physiological distress when certain things (objects, situations, etc.) remind them of the event.

Avoidance – Many with PTSD will persistently avoid things that remind them of the traumatic event. This can result in avoiding everything from thoughts, feelings, or conversations associated with the incident to activities, places, or people that caused them to recall the event. In others, there may be a general lack of responsiveness signaled by an inability to recall aspects of the trauma, a decreased interest in formerly important activities, a feeling of detachment from others, a limited range of emotion, and/or feelings of hopelessness about the future.

Increased arousal – Symptoms in this area may include difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, becoming very alert or watchful, and/or jumpiness or being easily startled.

It is important to note that those with PTSD often use alcohol or other drugs in an attempt to self-medicate. Individuals with this illness may also be at an increased risk for suicide.



## Treatment

People with Mental Illness can receive effective treatment that enables them to lead very typical lives. They have jobs and professional careers, they have families, own homes and take vacation.

Current treatment includes medications, services, and programs that are vital to recovery. Newer classes of medications can better treat individuals with severe mental illnesses and with far fewer side effects. Assertive community treatment, a proven model treatment program that provides round-the-clock support to individuals with the most severe and persistent mental illnesses, significantly reduces hospitalizations, incarceration, homelessness, and increases employment, decent housing and quality of life.

The involvement of congregations and family members in all aspects of planning, organizing, financing, and implementing service-delivery systems results in more responsiveness and accountability, and far fewer grievances. For more information on specific treatments go to <http://www.nimh.nih.gov/HealthInformation/index.cfm> or [http://www.nami.org/Template.cfm?Section=By\\_Illness](http://www.nami.org/Template.cfm?Section=By_Illness).

Information in this section came from the National Institute of Mental Health (NIMH), National Institute of Health <http://www.nimh.nih.gov/publicat/numbers.cfm> , The Nation's Voice on Mental Illness (NAMI) <http://www.nami.org/>, Mental Health: A Report of the Surgeon General <http://www.surgeongeneral.gov/library/mentalhealth/home.html>, and The Surgeon General's Call to Action To Prevent Suicide 1999 <http://www.surgeongeneral.gov/library/calltoaction/calltoaction.htm>

## **A Word about Suicide Awareness**

**Suicide is not a Serious Mental Illness, but can be a component. The majority of people who commit suicide have a diagnosable mental disorder, however, people who commit suicide do not always exhibit symptoms that would have called them to the attention of a mental health professional. Suicidal thoughts or ideations could be the first indication that there is a problem. It is an issue to be taken seriously.**

Suicide is a tragic and potentially preventable health problem. Suicidal behavior is complex. Some risk factors vary with age, gender, and ethnic group and may even change over time. Research indicates that alterations in neurotransmitters such as serotonin are associated with the risk for suicide.

- ?? In 2000, 29,350 people died by suicide in the U.S.
- ?? More than 90 percent of people who kill themselves have a diagnosable mental disorder, commonly a depressive disorder or a substance abuse disorder.
- ?? The highest suicide rates in the U.S. are found in white men over age 85.
- ?? In 2000, suicide was the 3rd leading cause of death among 15 to 24 year olds.
- ?? Four times as many men as women die by suicide; however, women attempt suicide 2-3 times as often as men.
- ?? Suicide by firearm is the most common method for both men and women, accounting for 57 percent of all suicides in 2000.
- ?? There are between 8 and 25 attempted suicides for every suicide death; the ratio is higher for women and youth and lower in men.

### **Risk Factors for Suicide**

- ?? Previous suicide attempt
- ?? Mental disorders – particularly mood disorders such as depression and bipolar disorder
- ?? Co-occurring mental and alcohol and substance abuse disorders
- ?? Family history of suicide
- ?? Hopelessness
- ?? Impulsive and/or aggressive tendencies
- ?? Barriers to accessing mental health treatment
- ?? Relational, social, work, or financial loss
- ?? Physical illness
- ?? Easy access to lethal methods, especially guns
- ?? Unwillingness to seek help because of stigma attached to mental and substance abuse disorders and/or suicidal thoughts
- ?? Influence of significant people – family members, celebrities, peers who have died by suicide – both through direct personal contact or inappropriate media representations
- ?? Cultural and religious beliefs – for instance, the belief that suicide is a noble resolution of a personal dilemma
- ?? Local epidemics of suicide that have a contagious influence
- ?? Isolation, a feeling of being cut off from other people

### **Observable Behaviors**

A person who is severely depressed and contemplating suicide often markedly changes his or her behavior. Someone might:

- no longer care about this/her appearance and stop taking showers or baths or wearing make-up
- not change clothing or refuse to get dressed without prodding
- miss work or school
- no longer appear to take responsibility for family and children
- articulate suicidal thoughts or a preoccupation with death
- purchase a deadly weapon
- refuse to make plans for the future
- indicate that he/she might not be "around" much longer
- begin giving away personal belongings because he/she no longer needs them

### **Suicide Prevention Steps:**

If someone shares suicidal thoughts or life threatening information never, never, never promise confidentiality, and **do not try to manage this situation alone.**

If there are no care decision makers available and you feel the person is in imminent danger, contact his or her therapist (if one is being seen) or get him/her to an emergency room. It is always better to err on the side of the living!

### **Stay Calm and Listen.**

A person in crisis needs someone who will listen and really hear what he/she is saying. Maintain eye contact with the person as they are talking. Every effort should be made to understand the feelings behind the words.

### **Be Accepting, Do Not Judge.**

Let the person talk about his/her feelings, but do not relieve the person of the responsibility for his/her actions.

### **Do not be afraid to ask directly if the person has entertained thoughts of suicide.**

Suicide may be suggested but not specifically mentioned. Experience shows that inquiring directly about a person's intentions is generally the best approach. In fact, the individual welcomes it and is glad someone enables him/her to open up and bring it out.

### **Take Threats Seriously.**

All suicidal talk should be taken seriously. If the person has made definite plans, the problem is apt to be more acute than when his/her thinking is less definite. Once a person has made up their mind, get her/him to a place where they can get help.

**Do not be misled by the suicidal person's comments that he/she is alright and is past the crisis.**

Often the suicidal person will feel initial relief after talking of suicide, but many times on second thought he/she will try to cover it up. The same thinking may come back later, however. Follow up is crucial to insure a good treatment program.

**Reassure the Person.**

Let her/him know that help is available and that you will help her/him find the help they need.

**Don't do it Alone.**

Do not leave the person alone until you are sure they are in the hands of competent professionals. If you have to leave, make sure another friend or family member can stay with the person until they can receive help. Take the person to the hospital emergency room, police, mental health service or call 911 for emergency assistance or your local crisis services (listed inside the phone book). The National Crisis Help line is 1-888-284-2433 (1-888-SUICIDE).

(Emergency Court Orders can be activated - for care and 24 hour observation in a medical facility - for a person who is of danger to himself/herself or to others. The procedure will vary from state to state. Check with the emergency room staff for the procedures in your state or check with the Court).

**How a Congregation Can Respond**

Clergy and congregations are asked to respond to a variety of community needs. These needs often focus on persons living in 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.**

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 to 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.

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 board 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, bulleting 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 Presbyteries and Synods to encourage congregations (and help resource congregations to be responsive to the needs of persons with a mental illness and their friends.

### **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 statement 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.

### **Personal Coping**

Serious Mental Illness can be a pervasive condition, however, traumatic situations can challenge even long used coping mechanisms. Some advice (from the American Psychological Association) for getting through difficult situations and challenging times:

Make connections. Good relationships with close family members, friends, or others are important. Accepting help and support from those who care about you and will listen to you strengthens resilience. Some people find that being active in civic groups, church, or other local groups provides social support and can help with reclaiming hope. Assisting others in their time of need also can benefit the helper.

Avoid seeing crises as insurmountable problems. You can't change the fact that highly stressful events happen, but you can change how you interpret and respond to these events. Try looking beyond the present to how future circumstances may be a little better. Note any subtle ways in which you might already feel somewhat better as you deal with difficult situations.

Accept that change is a part of living. Certain goals may no longer be attainable as a result of adverse situations. Accepting circumstances that cannot be changed can help you focus on circumstances that you can alter.

Move toward your goals. Develop some realistic goals. Do something regularly — even if it seems like a small accomplishment — that enables you to move toward your goals. Instead of focusing on tasks that seem unachievable, ask yourself, "What's one thing I know I can accomplish today that helps me move in the direction I want to go?"

Take decisive actions. Act on adverse situations as much as you can. Take decisive actions, rather than detaching completely from problems and stresses and wishing they would just go away.

Look for opportunities for self-discovery. People often learn something about themselves and may find that they have grown in some respect as a result of their struggle with loss. Many people who have experienced tragedies and hardship have reported better relationships, greater sense of strength even while feeling vulnerable, increased sense of self-worth, a more developed spirituality, and heightened appreciation for life.

Nurture a positive view of yourself. Developing confidence in your ability to solve problems and trusting your instincts helps build resilience.

Keep things in perspective. Even when facing very painful events, try to consider the stressful situation in a broader context and keep a long-term perspective. Avoid blowing the event out of proportion.

Maintain a hopeful outlook. An optimistic outlook enables you to expect that good things will happen in your life. Try visualizing what you want, rather than worrying about what you fear.

Take care of yourself. Pay attention to your own needs and feelings. Engage in activities that you enjoy and find relaxing. Exercise regularly. Taking care of yourself helps to keep your mind and body primed to deal with situations that require resilience.

Additional ways of strengthening resilience may be helpful. For example, some people write about their deepest thoughts and feelings related to trauma or other stressful events in their life. Meditation and spiritual practices help some people build connections and restore hope. The key is to identify ways that are likely to work well for you as part of your own personal strategy for fostering resilience.

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### **For Congregations - Messages from Individuals With Long Term Illness**

*Be friendly, be genuine, listen*  
*Do not gossip about me and do not ignore me*  
*Be concerned about me; be more helpful and caring*  
*Check to see why I am not in church*  
*Show me the same respect you do those with other illnesses*  
*Do not put me down; do not make fun of me*  
*Be nice to me; offer fellowship and hospitality*  
*Pick me up for church*  
*Check on me to see if I am okay*  
*Be supportive and have fellowship with me*  
*Socialize, have a drink at a café*  
*Invite me back to church - visit with me*  
*Be more caring like Jesus*  
*Visit me in the hospital/at home*  
*Ask me to participate in church activities*  
*Treat me as a fellow member*  
*Support my achievements, accomplishments, and strengths*  
*Treat me as an equal*  
*Help me find a place to stay/a job*  
*Donate food*  
*Accept me as I am; love me*

### **Messages From Family Members Of Individuals With Long Term Illness**

*Call and give support*  
*Continue relationships*  
*Visit*  
*Write child/send cards*  
*Welcome at church*  
*Include in activities*  
*Support in finding constructive work*  
*Show interest*  
*Be more out going and friendly*

### **Messages From Family Members - What They Need**



*Visit me; pray for me  
Ask about my child/mention my child to me  
Do not ignore me  
Try to understand the illnesses  
Do not put us down  
Refrain from offering simple solutions  
Be supportive of other family members*

### **For ministers - from individuals with long term illness**

*Be friendly  
Have compassion  
Care; listen  
Be more understanding  
Get to know me  
Talk/visit/let me know I am not alone  
Visit me at home or in the hospital  
Provide rides to church  
Make me feel at home  
Preach the gospel  
Do NOT connect my illness with demons  
Do not push religion on me  
Be a resource for appropriate referrals  
Give money, support, and encouragement  
Buy a meal/donate food  
Help me find a place to stay  
Help me find a job  
Do not turn aside when I am hospitalized and in my time of greatest need  
Do not look down on me  
Pray with me  
Accept me as I am*

### **Messages From Family Members For Individuals With Long Term Illness**

*Visit child at hospital/home  
Send cards and letters  
Be supportive; be available  
Give more time  
Urge professional care  
Make my loved - one in prayer in church*

### **Messages From Family Members For Themselves**

*Give moral support*  
*Express concern*  
*Do not be judgmental*  
*Show interest; listen*  
*Understand the financial drain*  
*Have knowledge of the illnesses*  
*Don't be a therapist - be a minister*  
*Call even when things are okay*  
*Refrain from offering simple solutions*  
*Let me talk about my child*  
*Pray*

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## **How to Show Someone You Care**

by Jacob Zimmer\*

We all care about our friends, family and partners, but caring about them and showing them that we care are two different things.

When someone has a broken leg, you know what to do. Help them up, get them food, push their wheelchair and so on. But when someone is depressed, how to show them we care does not come naturally to us. We are often quick to try and cheer them up with a quick upper, but that is usually not effective.

Having been on both sides of this (depressed and living with ones who suffer from depression) I feel confident enough to offer some valuable insight and practical tips.

Here is what you can do:

\* Write them a note. E-mail is easy and fast -- and fast is often necessary. Depression comes in waves and so it is important to act at the time that the depression is at its worst. However, a hand-written note demonstrates a much higher level of personal involvement. The fact that you take the time to find paper, write it out, find a stamp, go to the mailbox and so on. It's the "It's the thought that counts" idea. And making a card with drawing, stickers and personal designs is even more personal than a store bought card. The fact that you went to all that work demonstrates that you care.

\* Call them. When you talk, listen. Sometimes people suffering from depression needs to talk and get it out of their system, sometimes they need

to be talked to about something else in order to think about something else. So call and find out how you can help. The mere fact that you call will allow them to know that you care.

\* Visit and hang out with them. I will not lie to you, being around depressed people sucks. They are boring, sad and tend to bring others around them down too. But hopefully you can be happy and lift them up. Take them out to dinner, to a movie, or treat them to something fun. People suffering from depression have little motivation of their own and need others to take initiative. In addition, make them do fun activities. Taking that initiative will allow them to see that you care.

What to say and write:

\* It is absolutely imperative that you truly understand and empathize. A friend of mine has repeatedly told me that she understands, but I was not convinced until she told me what I was feeling. Many times people are looking for pity and that is not good for them or you. But you can listen to and understand someone's situation and feelings without having pity on them.

\* Advising is NOT listening. Replying is NOT understanding. To show someone you care, repeat back to them their feelings. Put yourself in their shoes. Don't think about what you would do in their shoes, think about what they are feeling. Don't just say that you understand, show them that you understand. One sure-fire trick is to start a sentence with the words: "You feel..." or "Sounds like you..."

\* Affirm the past; encourage the future. Be positive. Compliment them. People who are depressed have tunnel vision and they only see the negative. They need to be reminded of the positive. There are two main groups: Internal and External. Internal positive characteristics are traits that the person who is depressed has. Remind them that they are smart, creative, funny, good looking and so on. Don't make stuff up. If the person sucks at athletics don't tell them that they are great at basketball. It may seem silly to tell a chess whiz that he or she is good at chess, but you have to. External are positive things outside of the person. Remind them that they have a loving sibling or

parent, name off some friends, remind them of an upcoming activity or a nice possession they enjoy. Remember, depression erases memory of the positive and you have to remind them.

\* Focus on specifics. If your depressed friend is a photographer, find something positive to say about one of their recent pieces. And then comment that you look forward to seeing their next great work. That sort of a statement emphasizes that there will be something positive and productive in the future. I had someone tell me that I was a good writer and they always look forward to reading my email stories. That affirmed what I had done in the past and encouraged me to repeat the positive work in the future.

\*Jacob Zimmer is 30 years' old and lives in New Orleans, LA. He works as an Audio-visual production manager and is active in the peace movement.

## **Congregational Resource Guide**

**The following may be helpful as your congregation responds to people with Serious mental illness.**

### **HEALTH MINISTRIES USA**

Health Ministries USA makes tangible to all Presbyterians, our responsibility for the stewardship of our own health, as well as the health of others. Health Ministries promotes a health, healing and wholeness in body, mind and spirit. These ideas are carried out through caring for one another, promoting health and wholeness and mission and programs. For more information visit our website at [www.pcusa.org/health/org](http://www.pcusa.org/health/org).

### **PRESBYTERIAN SERIOUS MENTAL ILLNESS NETWORK**

The Presbyterian Serious Mental Illness Network (PSMIN) welcomes those who advocate in the church and greater community for those who have been touched by mental illness. They seek equity, justice, human dignity and full acceptance into the life of the church. For more information about PSMIN or how to join the network go to <http://www.pcusa.org/phewa/psmin.htm>.

### **ORGANIZATIONAL RESOURCES**

**Pathways to Promise <http://www.pathways2promise.org/>**

An interfaith resource center promoting a caring ministry for people with mental illness and their families. Pathways to Promise offers liturgical and educational resources, program models, and networking information.

**National Alliance for the Mentally Ill (NAMI) <http://www.nami.org/>**

NAMI is the nation's leading grass roots advocacy non-profit organization solely dedicated to improving the lives of persons with severe mental illness.

**National Alliance for Research on Schizophrenia and Depression  
[www.narsad.org](http://www.narsad.org)**

The National Alliance for Research on Schizophrenia and Depression provides up-to-the-minute press releases, newsletter articles, grant information, brochures and fact sheets along with frequently asked questions and coming events pages.

**National Institute of Mental Health (NIMH) <http://www.nimh.nih.gov>**

NIMH offers a wide range of free brochures, fact sheets, reports, press releases and other educational materials on mental health issues, learning disabilities, eating disorders, suicide, medications, etc.

**National Mental Health Association <http://www.nmha.org/>**

The National Mental Health Association is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness.

With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans through advocacy, education, research and service.

**Reports**

Mental Health: A Report of the Surgeon General

<http://www.surgeongeneral.gov/library/mentalhealth/home.html>

The Surgeon General's Call to Action To Prevent Suicide 1999

<http://www.surgeongeneral.gov/library/calltoaction/calltoaction.htm>

**Books**

Amador, Xavierm PhD & Anna-Lisa Johanson, PhD. ***I'm Not Sick; I Don't Need Help;*** 2000, Vida Press.

Denial of illness, refusal of treatment, and quitting medications too soon are common laments of family members or anyone who works with individuals overcome by mental illness. This quick, easy-to-read book provides insight into feelings and impressions of the person with SMI. The premise is that we cannot control the symptoms of mental illness but we can better control our responses when we understand.

Govig, Stewart D. ***In the Shadows of our Steeples: Pastoral Presence for Families Coping***

**with *Mental Illness***, 1998, Haworth Pastoral Press, Binghamton, NY  
(Phone: 800-342-9678)

Identifies deinstitutionalization as “the largest failed social experiment of 20<sup>th</sup> century America.” In which the ideal of liberating persons from confinement has led to isolated, discarded, sad and lonely individuals for whom safety, shelter and a proportion of friendship have given way to nothing.

Toews, John & Loewen, Eleanor. ***No Longer Alone: Mental Health and the Church***; 1995,  
Herald Press, Scottsdale, PA (Phone 412-887-8500)

In a simple yet careful way, Toews and Loewen differentiate between mental illness and mental ill health. Addresses the interrelation of social, emotional, physical, and spiritual selves. Reflects on depression, addictions, schizophrenia, grief and suicide. For congregations who want to learn to walk with persons with mental illness.

### **Video Tapes**

**Honest Talk About Serious Mental Illness** (for older youth) (1998; 35min.) A truthful look at the facts and challenges of serious mental illness, produced by PC(USA) Office of Health Ministries. Explores depression, anxiety, bipolar illness and schizophrenia through stories of youth their own age. A leader’s guide is included with the video and a four session booklet of the same title is also available. Both can be purchased through Presbyterian Distribution Service at 1-800-524-2612. Video, \$9.95; Booklet, \$7.95

**Honest Talk About Serious Mental Illness** (companion booklet)

Whether you choose to use this curriculum alone or in conjunction with the video resource, Item #095301(see above), this booklet will help older youth think about and understand various serious mental illnesses such as bipolar, clinical depression and schizophrenia. Ideal for Sunday school classes, or youth group session.  
Item #095302 \$7.95. Shipping and handling charges apply.

**Schizophrenia: Stolen Minds, Stolen Lives** (2001; 1 hour) Excellent documentary tells the stories of several families, including Nobel Prize winning mathematician John F. Nash, Jr. and his son Johnny, who both have this brain illness. Presents recent research on schizophrenia and profiles top scientists. Available for \$19.95 + s/h through the Discovery Channel (1-800-475-6636) or online at Discovery.com.

## **Health Ministries Resources**

### **The Congregation: A Community Of Care and Healing (Mental Illness Awareness Resource)**

Basic guide to understanding and doing ministry with persons affected by serious mental illness. Part of the series, "The Congregation: A Community of Care and Healing." This resource focuses on serious mental illness and how your church might be better able to raise awareness about and confront the realities of mental illness as it affects church members' lives.

Item #25790002

\$2.50. Shipping and handling charges apply

### **Mental Illness Worship Resource**

This resource is a nice array of Presbyterian worship services designed to incorporate concerns of mental illness during worship. Using the services in this booklet (or parts of these services) is a wonderful way to embrace those in your congregation who are dealing with mental illness and those who support them (as family members, friends or professionals). This resource also is a way to raise awareness of the issue from the pulpit. Step-by-step services are arranged, or the prayers, meditations, suggested hymns and scripture readings may be used to create an individualized worship service. From a morning prayer service to an evening prayer service to a service for a Mental Illness Awareness Day, this resource has a variety of ways to incorporate the concerns of mental illness into worship.

Item #7266099015

\$2.50. Shipping and handling charges apply.

### **Setting Us Free from the Stigma of Mental Illness**

This mental illness poster has the image of a butterfly against a yellow triangle on a background of purple sky. The butterfly is often used as a symbol in the mental health field. On the back of the poster are ideas for celebrating Presbyterian Mental Illness Awareness day and week during the Year of the Child. The 11" by 17" poster is an attractive awareness tool. The bulletin inserts' backside features a litany of response and are a great way to raise awareness in the pews on Sunday mornings.

**Poster** -- Item #7266000001

\$0.50 each



**Seasonal Affective Disorder and Depression** – “My Christmas Tree is down and so am I: Post-Holiday Blahs, Winter Blues, Seasonal Affective Disorder (SAD) and Depression <http://www.pcusa.org/health/usa/healthinfo/sad.htm>.

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[www.pcusa.org/health/usa](http://www.pcusa.org/health/usa)  
**Tips for Finding Information on this Website  
& Using it With Your Congregation**



**Much of the information and many of the resources posted on the Health Ministries USA website have been suggested, requested and at times supplied by folks who are actively involved in congregational health ministry or parish nursing throughout the Presbyterian Church (USA).**

Following is a list of the types of information typically posted on the website - categorized according to the **navigational button** where it can be found.

Also included are suggested ways the information and resources might be used. We would welcome any additional ideas for using the information and resources and will gladly add them to this list.

### **Health Advisories**

**Timely & Important Health Information** – typically posted under the “alerts” box is designed to provide additional detail about health topics that are currently in the news. The intent is to go beyond the sensationalism often driving the media reporting and to both more fully explain the health risks and provide links to additional and reliable sources. You might:

- use the information (or parts of it) in newsletter or bulletins
- develop a brief presentation and share the information with Sunday School Classes or other groups that meet
- use the information to recognize which groups or individuals in your congregation might be most vulnerable (for example, the information predicting a particularly virulent flu season this year included a warning about the vulnerability of frail elderly and very young children)

use the portions of the information on “risk reduction” to educate and promote preventive activities

### **News & Announcements**

Information about related conferences and other relevant educational opportunities is typically provided in both web based information and in downloadable files. By using the downloadable files you can make copies of brochures, bulletin information and even posters. The newest resources will routinely be listed here, as well. This useful information can be:

distributed  
posted or  
otherwise circulated

### **Advocacy**

This section contains timely issues on which the PC (USA) has specific policy statements requesting “action” on the part of Presbyterians. In addition to the actual policy statements, suggestions for ways that individuals, congregations or other groups with in the church may get involved are listed. Contact information fro other organizations – both within and outside the church are also listed. This website section can be used as:

A call to action for your congregation  
The basis for a current events program  
The basis for a program on the positions of the PC(USA) related to health and justice issues  
Training materials for those who which to do advocacy work

### **Congregational Health Ministries**

**Ministry Models, Training Aids and Educational Information** - Often congregational health ministry works through volunteers who care about the health of their fellow congregation members and come to this ministry from a variety of educational backgrounds and experiences. A great deal of the more recently created materials on the website are designed to support the preparation of the volunteers who will be the hands and feet of health ministry. Here are some of the ways these materials might be utilized.

Introductory materials for assessing the need and support for “Congregational Care Teams” can be downloaded and used for exploratory activities in order to find out if a congregational care team is the right fit for your particular situation.

Topic specific resources like – Don't Sit on the Bed – hints for successful hospital visitation can be used for training or as a “read and heed” piece for individuals who are about to embark on a new and perhaps less than comfortable.

Resources like the “Parish Nurse Primer” can be very helpful if your congregation is exploring a new ministry and more information is needed.

### **Health Information**

**Addressing the Needs and Concerns of Individual Presbyterians** – Information related to specific health issues, prevention and wellness information, practical suggestions like “How to Talk to Your Doctor” and many others, are typically provided on the website after repeated requests have come to the office.

While this information is geared for individual needs, almost any piece can be used as the basis of a health centered program. If you do not have someone in your congregation who would be able to easily facilitate a health program, finding a nurse or pharmacist to help is usually not difficult.

### **Family Care Giving**

**Supporting those who are giving care** – Although the information contained in this sections specifically addresses issues of family care givers, it can also be used for:

- assistance for caregivers
- training materials for congregational care teams
- educational programs
- support groups for care givers

### **Resources**

**Everything You Ever Wanted to Know** about health ministry (well almost) is listed typically in this section. Your publication, poster, brochures or other material may be ordered with the click of a button. These resources will supplement any health related activity you might be planning.

## **Health Ministries Community Connections**

**Three on-line discussion groups are hosted by the website.** Often when people are seeking particular information or solutions to problems that have already been experienced by someone else, the on-line forums allow a single request for assistance to reach a group of people simultaneously.

In addition to responses that often include a variety of suggestions, the discussion around and adaptation of replies usually provides a veritable plethora of suggestions and ideas.

At times people who are involved in health ministry may feel they have no local “colleagues.” The on-line discussion groups enable us to support and assist one another.

The e-list “sign on” is the link to the health ministries data base and e-update mechanism. This allows you to receive an e-mail when new information is posted to the website.

Congregational Liaison enrollment allows you to become an official point of contact for your congregation - on health related issues. You will be the first to know!

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**This is your opportunity to let us know what you think of the website. If you have suggestions for additional resources, different types of information, etc., let us know. We do read and heed comments and suggestions and use them as we add pieces to our website.**



## **May is Mental Health Awareness Month**

May marks the 53<sup>rd</sup> anniversary of the creation of Mental Health Month by the National Health Association. During May, there are several observances focusing on mental health. Below is a listing of the observances. Check out their websites for more information.

### **May 1 - 31**

#### **Mental Health Month**

National Mental Health Association and National Council for Community Behavioral Healthcare

2001 North Beauregard Street, 12th Floor

Alexandria, VA 22311

(800) 969-6642

none available

[www.nmha.org](http://www.nmha.org)

### **May 2 - 8**

#### **National Mental Health Counseling Week**

American Mental Health Counselors Association

801 North Fairfax Street, Suite 304

Alexandria, VA 22314

(800) 326-2642

[vmoore@amhca.org](mailto:vmoore@amhca.org)

[www.amhca.org](http://www.amhca.org)

### **May 23 - 29**

#### **Older Americans' Mental Health Week**

Older Women's League

1750 New York Avenue, NW, Suite 350

Washington, DC 20006

(800) 825-3695

[owlinfo@owl-national.org](mailto:owlinfo@owl-national.org)

[www.owl-national.org](http://www.owl-national.org)

**May 4**

**Childhood Depression Awareness Day**

National Mental Health Association  
2001 North Beauregard Street, 12th Floor  
Alexandria, VA 22311  
(800) 969-6642 x4787  
none available  
[www.nmha.org](http://www.nmha.org)

**May 24**

**National Schizophrenia Awareness Day**

National Schizophrenia Foundation  
403 Seymour Street, Suite 202  
Lansing, MI 48933  
(517) 485-7168 x105  
(517) 485-7180 Fax  
[harwin@NSFoundation.org](mailto:harwin@NSFoundation.org)  
[www.NSFoundation.org](http://www.NSFoundation.org)

**Health Ministries, USA~ [health@ctr.pcusa.org](mailto:health@ctr.pcusa.org) ~**

**Visit us at [www.pcusa.org/health/usa](http://www.pcusa.org/health/usa)**

**Presbyterian Church (USA) ~ 100 Witherspoon St. ~ Louisville, KY ~ 40202**