

# **The Caring Congregation Handbook And Training Manual**

**Resources for Welcoming and Supporting  
Those with Mental Disorders and their Families  
Into Our Congregations**

**by: The Rev. Barbara F. Meyers**

**Children's lessons co-authored by Peggy Rahman and The Rev. Barbara F. Meyers**



Will To Print Press  
San Francisco, CA  
2005

Copyright © 2005 Barbara F. Meyers. All Rights Reserved.

ISBN 0-9772985-0-7

Second Printing

Direct all inquiries to the publisher:

**WILL TO PRINT PRESS**

234 Hyde Street

San Francisco, CA 94102

**Note:** The information in this document is up to date as of the date of its printing: 2005.

## Acknowledgements

I gratefully acknowledge the help of Peggy Rahman who co-authored the children's lessons with me, and Bonnie McClish Dlott who advised me on the training manual lessons.

I also wish to acknowledge the help from people who reviewed early versions of this curriculum. Their careful review and helpful comments helped to significantly improve the quality of the program. These people are: Elizabeth M. Schaefer, Ph.D., Holly Ito, Rev. Dr. Chris Schriener, Karen Ilkka, James "Scotty" Scott, R.N., Lucy Scott, Rev. Keith Kron, Rev. Dr. Devorah Greenstein, Margaret Bobalek King, Linda Millar, Peggy Rahman, and Milton Reynolds. In addition, a number of people looked at the curriculum and gave me brief encouraging words, for which I am very grateful.

I wish to express gratitude to the Faithful Fools Street Ministry, The Faithful Fools Copy Shop and the staff of Will to Print Press, in particular Sr. Carmen Barsody, Keith Walker, and Richard Nichols.

## Credits

Bellamy, Lauralyn, Reading #692 *If You Have Found Comfort* © Lauralyn Bellamy, from *Singing the Living Tradition*, Beacon Press, 1993. Adaptation with permission.

Chamberlin, Judi for an excerpt from her book *On Our Own*, available from the National Empowerment Center, © 1977 Judi Chamberlin. Used by permission.

Copeland, Mary Ellen, *Wellness Recovery Action Plan*, Brattleboro, VT: Peach Press, 1997, rev. 2002, © Mary Ellen Copeland. Also author of other recovery resources. For a description of the Wellness Recovery Action Plan™. Used by permission.

Gregg-Schroeder, Susan, *In the Shadow of God's Wings – Grace in the Midst of Depression* for poem "Come along with me," p 14, and for the case study of her personal story of depression pp 23-24. © 1997 Susan Gregg-Schroeder. Used and adapted by permission.

Ilkka, Karen, *The Urge to Cut*, © 2004 Karen Ilkka. Used by permission.

Black, Donald with C. Lindon Larson, *Bad Boys, Bad Men – Confronting Antisocial Personality Disorder*, copyright © 1999 by Oxford University Press, Inc., pp 2-4, for a case study of antisocial personality disorder. Used by permission of Oxford University Press, Inc.

Cole, T.L., *Case study of Borderline Personality Disorder*. © 2004 T. L. Cole. Used by permission.

Fleischman, Paul R., *The Healing Spirit – Explorations in Religion and Psychotherapy*, for closing reading. Bonne Chance Press © 1989 Paul R. Fleischman. Used by permission.

Hanson, Gary D., *Histrionic Personality Disorder (formerly known as Hysteria)*. Copyright 2003 © Narramore Christian Foundation, 250 W. Colorado Blvd., Suite 200, Arcadia, California 91007. Used by permission.

"Laura" for sharing her story as the case study of schizophrenia. Used with her permission.

Maxmen, Jerrold S. and Ward, Nicholas G., *Essential Psychopathology and Its Treatment, Second Edition Revised for DSM-IV*, for historical religious perspectives on mental retardation, pp 420-421, W.W. Norton & Company © 1995 Maxmen, Jerrold S. and Ward, Nicholas G. Used by permission.

NAMI. Family-to-Family materials for the Hearing Voices Skit, Stages of Reaction among Family Members, Life Burdens of Family Members, Coping Strategies, and Communication Guidelines. Used by permission.

Phillips, Kevin, *Case Study on Asperger's Disorder* by a 22-year-old man with Asperger's Disorder. On line at Kevin Phillips' website at: <http://www.angelfire.com/amiga/aut/index.html> and <http://www.angelfire.com/amiga/aut/belief.html>. Used by permission.

Robbins, Stephen James, *The Long Journey Home*, for a case study of post traumatic stress disorder. On line at: [grunt.space.swri.edu/srjourne.htm](http://grunt.space.swri.edu/srjourne.htm). Used by permission.

UUA, *The Welcoming Congregation Handbook – Resources for Affirming Bisexual, Gay, Lesbian and/or Transgender People*, for Participation Guidelines and Leadership Preparation, © 1990, 1999 UUA. Used by permission.

McMaster, Curtis P., *The Tragedy of Heroin Addiction*, for a case study of heroin dependence, in Helen Cothran, Ed., *Heroin*, Greenhaven Press, 2001, pp 29-30. © 2001 Curtis P. McMaster. Used by permission.

Park, Clara Claiborne, *The Siege: A Family's Journey into the World of an Autistic Child*, for a case study of a family with an autistic child, pp 3-5. Copyright © 1967, 1982 by Clara Claiborne Park. Copyright © renewed 1995 by Clara Claiborne Park. Used by Permission of Little, Brown and Co, Inc.

Rahman, Peggy, for the story *Dawn Gets Stuck*, the *UU Coffee Hour Skit*, and the song “*My Rainbow*”, © 2004 Peggy Rahman. Used by permission.

Wilson, Pamela, *Training Manual for Our Whole Lives Sexuality Education, Implementation Workshop*, developed for UUA, July 1999, for structure of program, leadership preparation. Used by permission

Young, Adena, *Battling Anorexia – The Story of Karen Carpenter*, for the study of Anorexia Nervosa. On line at <http://atdpweb.soe.berkeley.edu/quest/mind&Body/Carpenter.html>. Used by permission.

### **Front cover photo:**

Charming, determined and self-effacing, the Unitarian Dorothea Lynde Dix was the foremost crusader for people with mental illness in the United States in the mid-1800s. In an era when women didn't have the right to vote, she managed by sheer force of will, hard work, and astuteness to convince legislatures in many states to appropriate public funds to build over 30 hospitals for the care of the mentally ill. She was deeply religious, having been raised by her grandmother to be a Unitarian, later worshiping in the church of the Rev. William Ellery Channing beginning in 1823. The sense of religious purpose in her life is what drove her to her acts of public service. We follow in her footsteps.

Dix considered this daguerreotype “the only picture that seems to me a good likeness and to convey something of the *tone* and *type* of character.”<sup>1</sup> Many later portraits of Dix were made from this daguerreotype. The original is in the Houghton Library, Harvard University. Used by permission of the Houghton Library, Harvard University, call # bMS Am 1838 (994).

### **Back cover photo:**

Daguerreotype of Dorothea Lynde Dix at work taken by Marcus Aurelius Root c. 1848, Worcester Art Museum, Worcester, Massachusetts. Used by permission of Worcester Art Museum.

**Note:** Superscripts in this document refer to items in the End Notes.

# Table of Contents

<b>The Caring Congregation Program</b> .....	1
Program Description and Overview.....	1
Steps to becoming a Caring Congregation.....	3
<b>The Workshop Series</b> .....	4
Tailoring the Program to Your Congregation.....	4
Adding Artistic and Musical Dimensions to the Workshop.....	5
Participation Guidelines.....	6
<b>General Workshops for Adults and Youth</b> .....	7
<b>Workshop 1 - Mental Disorders and their Consequences</b> .....	8
People Bingo Card.....	12
UU Coffee Hour Skit.....	13
UU Coffee Hour Character Profiles.....	18
Mental Health and Mental Disorders.....	21
Categories of Mental Disorders.....	22
Myths and Stereotypes about those with Mental Disorders.....	24
Stigma of Mental Disorders – Consequences and Strategies.....	25
Executive Summary - A Report of the Surgeon General On Mental Health.....	26
<b>Workshop 2 - Specific Mental Disorders and how they are Diagnosed</b> .....	39
Hearing Voices Skit.....	45
Mood Disorders.....	50
Anxiety Disorders.....	52
Psychotic Disorders.....	57
Substance Related Disorders.....	59
Somatoform Disorders.....	62
Personality Disorders.....	64
Suicide.....	70
Unitarians, Universalists and Mental Health Care.....	72
<b>Workshop 3 - The History of Mental Disorders</b> .....	76
Time Periods in Mental Health History.....	79
Mental Health History Time Line.....	85
<b>Workshop 4 - Mental Disorders in Special Populations</b> .....	89
Terminology Match-up Cards.....	94
Disorders Usually First Diagnosed in Infancy, Childhood or Youth.....	97
Disorders of the Elderly.....	100
Words and Definitions.....	103
Risk Factors and Protective Factors for Racial and Ethnic Minorities.....	105
Executive Summary Mental Health: Culture, Race, and Ethnicity.....	106
<b>Workshop 5 - Mental Health Treatment</b> .....	116
The Recovery Model.....	123
Dimensions to Recovery.....	124

Therapies for Treating Mental Disorders.....	125
Common Psychiatric Medications – Generic and Brand Names .....	126
12-Step Programs .....	127
The Consumer Movement.....	128
A Combination of Treatment Strategies .....	129
WRAP: Wellness Recovery Action Plan™ .....	130
<b>Workshop 6 - Families and Friends of those with Mental Disorders.....</b>	<b>131</b>
Stages of Emotional Reactions among Family Members .....	136
Life Burdens in Caring for People with Mental Illness .....	137
Coping with a Loved One’s Mental Disorder .....	138
Special Coping Strategies .....	139
Coping Strategies for Mental Health Clients .....	140
Communication Guidelines.....	141
NAMI.....	142
Spirituality and Mental Disorders .....	144
Religion and Mental Health .....	147
<b>Workshop 7 - The Role of the Church .....</b>	<b>149</b>
<b>Pastoral Care Workshops.....</b>	<b>153</b>
<b>Workshop 1 - Mental Disorder and its Consequences and Treatment.....</b>	<b>154</b>
<b>Workshop 2 - Mental Disorders: Families, Religion and Pastoral Care .....</b>	<b>159</b>
Spirituality, Religion and Mental Health .....	162
Pastoral Care for People with Mental Disorders and their Families.....	164
<b>Workshops for Children.....</b>	<b>165</b>
Guidelines for Class .....	167
<b>Workshop 1 – Introducing Mental Disorders to Children.....</b>	<b>168</b>
<b>Workshop 2 – Recognizing Feelings.....</b>	<b>170</b>
Feelings Faces .....	173
Template for Feelings Art Project.....	174
<b>Workshop 3 – Being Compassionate to Someone with a Mental Disorder .....</b>	<b>175</b>
<b>Workshop 4 – Learning and Practicing Empathy and Communication Skills.....</b>	<b>178</b>
Story: Daun Gets Stuck.....	180
Feel and Speak Drama Game.....	184
<b>Other Program Ideas .....</b>	<b>187</b>
<b>Leaders Workshop: Training for Leaders for the Caring Congregation.....</b>	<b>192</b>
<b>Guidelines for Choosing Leaders.....</b>	<b>193</b>
<b>Suggested Weekend Training Agenda .....</b>	<b>195</b>
<b>Training Lessons .....</b>	<b>197</b>
Opening Rituals.....	198
Introduction to the Caring Congregation Curriculum.....	201
Introductions .....	202
Expectations of the Trainers and Attendees.....	203
Line Dance .....	204
Our Stories .....	206
Demonstration of an Example Workshop Session.....	207
Basic Facilitation Skills.....	208
Handling Hot Potatoes .....	210
Curriculum Treasure Hunt .....	212
Using the Caring Congregation Curriculum .....	215

Empathy .....	217
Stages of Emotional Reactions among Family Members .....	217
What would you do if ...?.....	218
Moving from Workshops to Congregational Action .....	219
Peer Teaching Assignments .....	221
Wrap Up and Closing Ritual .....	224
<b>Training Service and Forms</b> .....	225
Sample Worship Service on Mental Health .....	226
Leadership Training Evaluation before Teaching.....	229
Leadership Training Evaluation after Teaching.....	230
Caring Congregation Evaluation after Teaching.....	231
<b>Theological Basis for the Caring Congregation</b> .....	232
<b>Appendixes</b> .....	234
Planning: Possible items in a Caring Congregation Plan.....	235
A Power Study .....	237
<b>Glossary</b> .....	249
<b>Resources</b> .....	253
Books and Documents.....	253
Mental Health Organizations on the World Wide Web .....	259
<b>Index</b> .....	263
<b>End Notes</b> .....	268

## TABLES

<i>Table 1. Categories of Mental Disorders</i> .....	22
<i>Table 2. Myths and Stereotypes about those with Mental Disorders</i> .....	24
<i>Table 3. Time Periods in Mental Health History</i> .....	79
<i>Table 4. Mental Health History Timeline</i> .....	88
<i>Table 5. Summary of mental illness factors and ethnicity in Surgeon General's Report Mental Health: Culture, Race, and Ethnicity summarized and tabulated by Barbara F. Meyers</i> .....	105
<i>Table 6 Therapies for Treating Mental Disorders</i> .....	125
<i>Tables 7. Common Psychiatric Medications</i> .....	126
<i>Table 8. Examples of Ineffective and Effective Communication</i> .....	133
<i>Table 9. Categories of Mental Disorders</i> .....	158

# The Caring Congregation Program

*“You can judge a civilization by the way it treats its mentally ill.”* British Royal College of Psychiatrists

The Caring Congregation Program is a proposed congregational program focused on welcoming and supporting people with mental disorders and their families into our congregations. <sup>2</sup>

---

## ***Program Description and Overview***

This is a curriculum and resource manual for The Caring Congregation Program, a program that helps congregations become more intentionally inclusive and supportive towards people with mental disorders and their families. The goal of the workshops is to reduce prejudice by increasing understanding and acceptance among people who have mental disorders, giving ideas for specific supportive actions that can be undertaken. It intentionally honors the spiritual component in caring for mental disorders, thus building a community that will become a source of caring for those with mental disorders. As the workshop series explains, Unitarians and Universalists have been prominent in the history of treating mental disorders, so this work follows in a long-standing Unitarian and Universalist tradition.

---

## ***Training to Teach the Caring Congregation Curriculum is Required***

In order to teach the Caring Congregation curriculum, it is necessary that the teachers be adequately trained. Training lessons for this purpose are included in this document. Contact Rev. Barbara F. Meyers (com\_minister at mpuuc.org) about arranging for a training.

---

## ***Terminology: “Mental Disorders,” “Mental Health Clients,” “Religion / Spirituality”***

We have chosen to use the term “mental disorders” rather than “mental illness,” “madness,” “psychological problems” or some other term, in order to be consistent with the widely recognized and used definitions of the American Psychiatric Association in their Diagnostic and Statistical Manual.

The terms “mental health client” and “consumer” are often used interchangeably when referring to people who use mental health services. In this document, we have preferred to use the term “mental health client,” except when referring to the “consumer movement,” which is known nearly exclusively by that name. Also, “consumer” is used in several of the works that we quote from here. If people taking the class feel strongly about these terms, you might want to use the opportunity to find out why, and then use terminology that the class can be comfortable with.

The terms “religion” and “spirituality” both have many meanings, and there is sometimes a distinction made between them. For the purposes of this curriculum, we define “religion” as: *An ongoing process of restoring personal wholeness. In a more universal sense it is the process of restoring one's relationship with the world, with the universe, with Ultimate Reality, the Sacred, or God, however conceived*<sup>3</sup>. “Spirituality” we define as: *a form of religion, but a private and personal form of religion, that which a person feels internally that relates them to the sacred*. There is a distinction between spirituality and *organized* religion. Organized religion describes the social, the public, and the organized means by which people relate to the sacred and the divine, while spirituality describes such relations when they occur in private and personally. In this curriculum, we use *religion* in its broadest term, which refers to both personal and organized religion. We use the term *spirituality* to refer to the personal form of religion.

---

### ***Goals for Participants***

- To provide a safe place for people with mental disorders and their families to spiritually grow
  - To learn more about themselves and their attitudes regarding mental disorders
  - To learn more about their congregation in terms of inclusion and support
  - To actively make their congregation more welcoming and supportive to people with mental disorders and their families.
- 

***Age Range:*** Youth/Adult, with a special unit designed for children's Religious Education

***Size of Group:*** The program is intended to involve as many people in the congregation as possible, including those in leadership roles.

***Number of Sessions:*** Seven potential workshops, about 2 hours each for adults and youth; two streamlined workshops designed for pastoral care education; four lessons for educating children; flexible design

---

### ***Workshops:***

#### **FOR ADULTS and YOUTH**

- ***Mental Disorders and their Consequences:*** What is a mental disorder? Who are those with mental disorders? Stigma of having a mental disorder.
- ***Specific Mental Disorders and How they are Diagnosed:*** Mood Disorders, Anxiety Disorders, Psychotic Disorders, Personality Disorders, Substance Abuse and Mental Disorders
- ***History of Mental Disorders:*** The history of mental disorders and their treatment, including contributions by Unitarians and Universalists.
- ***Mental Disorders in Special Populations:*** Childhood, Youth, The Elderly, Race and ethnicity in mental health care
- ***Mental Health Treatment Options:*** Psychiatrists, Therapists, Support Programs, Alternative Care options, the Consumer Movement
- ***Families and Friends of those with Mental Disorders*** Helpful suggestions and resources for families and friends with a loved one who is living with a mental disorder.
- ***The Role of the Church:*** Religion / Spirituality and Mental Disorders. Finding gifts from the shadow. Prioritizing a congregational response. Celebration of completion of program. Advocacy materials.

The number of workshops and their content can be tailored to the situation at a particular congregation.

#### **FOR PASTORAL CARE**

A stream lined version of this training for those people doing pastoral care for people with mental disorders and their families

- ***Mental Disorders and their Consequences:*** What is a mental disorder? Who are those with mental disorders? How mental disorders are treated. Stigma of having a mental disorder
- ***Mental Disorders: Treatment, Families, Religion and Pastoral Care:*** The problems of families of those with mental disorders. Religion and spirituality and mental disorders. How to provide pastoral care for those with mental disorders and their families.

#### **FOR CHILDREN**

- ***Introducing Mental Disorders to Children:*** This lesson introduces mental disorders in a compassionate way. It shows that everyone has unique ideas, and aims to de-stigmatize mental illness to children
- ***Recognizing Feelings:*** Allows children to recognize and express their feelings.
- ***Being Compassionate to Someone with a Mental Disorder:*** Helps children understand what makes them feel cared for, and what they can do to care for others.
- ***Learning and Practicing Empathy and Communication Skills:*** Children will engage in role playing to practice telling their feelings and learning how to listen to be compassionate listeners to others.



## **FOR LEADERS of the WORKSHOPS for both ADULTS and CHILDREN**

- ***Learning how to Teach the Caring Congregation Program*** This workshop is intended for people who will be leaders of the workshops for adults and children. It gives basic information about the program and how it can be most effectively taught, including possible scenarios that might come up in teaching the program.
- 

### ***What does it mean to be a Caring Congregation?***

Congregations who publicly and successfully welcome people with mental disorders and their families into the congregation

- Include and address the needs of people with mental disorders to the best of their capability at every level of congregational life—in worship, in programs, in social occasions, for children, youth and adults—welcoming not only their presence, but the gifts of their lives as well.
- Assumes the presence of people with mental disorders, learns to support them, and, with their permission, includes their stories in worship, religious education and other programs.
- Encourages development of spiritual resources – exploration of a personal sense of truth and meaning in a place of safety and acceptance – to aid in caring for those with mental disorders and their families
- Provides pastoral care for people with mental disorders and their families, as is done for people with other kinds of situations of need
- Includes a nondiscrimination clause in by-laws and other official documents affecting congregational life.
- Engages in outreach to those with mental disorders in its advertising and by actively supporting groups that address mental health, both secular and sacred.
- Is aware of resources to address mental health issues in their community and provides referrals for people with mental disorders and their families
- Keeps track of legislative developments and works to promote justice, freedom, and equality in the larger society.
- Encourages and provides support groups for people with mental disorders and their families.
- Speaks out when the rights of people with mental disorders and their families are at stake.

### **Steps to becoming a Caring Congregation**

#### **Forming a committee**

Early in the process, it is important to form a Caring Congregation committee that will guide your congregation through the steps necessary to become a Caring Congregation. It should represent a diverse part of your congregation, containing people who have mental disorders, family members of people with mental disorders, and people without this experience. It is important to include people who are committed and energetic about this work.

#### **Choose and Train the leaders**

Identify leaders of this program and have them take the Leadership Training workshop to prepare for teaching the congregation.

#### **Deciding how to tailor the program for your congregation**

Each congregation will have members with their own unique experiences with mental disorders. The workshop program can be tailored to meet differing needs; guidelines for this are in the next section of this document.

#### **Offering the program, maintaining focus, and communicating with the congregation**

When you offer the program to the congregation, it is important that you monitor how it is doing so that your focus is clear and the objectives are being met. It is important to keep the congregation as a whole up to date on the progress that is being made by writing newsletter articles, appearing at Board meetings, presenting as a worship service topic, having guest speakers, or giving update presentations.

#### **Begin working on the plans developed during the workshops within and outside of your congregation**

# The Workshop Series

## Structure

The General Workshops are intended for adults and youth in the congregation.

<b>GENERAL WORKSHOPS</b>	
1	Mental Disorders and their Consequences
2	Specific Mental Disorders and how they are Diagnosed
3	History of Mental Disorders
4	Mental Disorders in Special Populations
5	Mental Health Treatment
6	Families and Friends of those with Mental Disorders
7	The Role of the Church

Pastoral Care workshops are a condensed version of the General Workshops. They do not require taking the General Workshops, but some people might find it helpful to get a broader education on mental health than is provided in the General Workshops.

<b>PASTORAL CARE WORKSHOPS</b>	
1	Mental Disorder and its Consequences and Treatment
2	Mental Disorders: Families, Religion, and Pastoral Care

These religious education lessons are designed especially for children of ages 7-12.

<b>WORKSHOPS FOR CHILDREN</b>	
1	Introducing Mental Disorders to Children
2	Recognizing and Expressing Feelings
3	Being Compassionate to Someone with a Mental Disorder
4	Learning and Practicing Empathy and Communication Skills

## Tailoring the Program to Your Congregation

### Shortening the General Workshop Program

The program is flexible, but the sequence of the workshops can be important. If you must do fewer workshops, the following priorities should guide your selections:

- Workshops 1, 6 and 7 provide basic information that cannot be sacrificed.
- Workshops 2, 4, and 5 give more detailed information about mental disorders and how they are treated. These could be tailored to specific needs in your congregation, if necessary, to have fewer than 3 workshops.
- Workshop 3 focuses on the history of mental disorders. An option for covering this information is to present it in a worship service or in an optional discussion program.

How ever you design it, schedule at least 2 hours for each workshop to allow for ample discussion time.

<b>Length of Program</b>	<b>Recommended Workshops</b>
2 Sessions	Tailor the 2 Pastoral Care Workshops for the congregation at large.
3 Sessions	1, 6, 7
4 Sessions	1, 2/4/5*, 6, 7 (* Combine materials from sessions 2, 4 and 5)
5 Sessions	1, 2/4*, 5, 6, 7 (* Combine materials from sessions 2 and 4)
6 Sessions	1, 2, 4, 5, 6, 7
7 Sessions	All
Variable	Have two general sessions (as suggested above) for the entire congregation. Then have sign-up sheets for special interest classes, for example: Children, Elderly, History, Specific Disorders, Medications, and Therapies. Then you could create a plan to offer the other lessons on a special interest basis to people specifically interested in that topic.

### **Augmenting or Enhancing the Program**

Leaders are encouraged to make the workshop series fit the needs of their congregation. Perhaps there is a situation of a person or family in the congregation who are faced with a mental disorder that is not discussed in this curriculum. Or maybe a congregation needs to cover a topic in more depth. If you wish to incorporate more information about the disorder in your teaching of the curriculum, you can do more research on the disorder using the DSM-IV manual and other books, and create optional lessons or handouts to present to the attendees. The best place to focus on new disorders would be in Workshops 2 or 4. A new lesson on family situations would fit best in Workshop 6.

Experience with this curriculum has shown that some of the most valuable information comes from the stories of real people. For each of the mental disorders described in the curriculum, there are selected case studies for your use in showing how the disorder shapes private lives. Even better is to invite guest or student speakers to talk about a particular situation that has touched them personally. If you want to do this, make sure you get the permission of the people involved before you ask them to speak. And, make it clear that they will not be asked to share their own experience with mental illness, or that of their family, unless they choose to do so. Allow them to back out without consequences, if they feel unable to share at the last minute.

### **Adding Artistic, Literary and Musical Dimensions to the Workshops**

Many outstanding composers, writers and artists have had mental disorders. One way to add other dimensions to your program is to have a composer, writer, and an artist of the day at each workshop. Display a poster of a piece of art, selected words by the writer, and play music of the composer as people are entering and leaving the workshop. Remind people of who these people are and what wonderful contributions these outstanding people have made to our world.

Here are some artists, writers, and composers to choose from:<sup>4</sup>

- **Poets:** William Blake, Robert Burns, Emily Dickinson, Gerard Manley Hopkins, Victor Hugo, Samuel Johnson, John Keats, Robert Lowell, Edna St. Vincent Millay, Boris Pasternak, Sylvia Plath, Edgar Allan Poe, Ezra Pound, Anne Sexton, Percy Bysshe Shelley, Sara Teasdale, Alfred, Lord Tennyson, Walt Whitman.
- **Writers:** Hans Christian Anderson, Honoré de Balzac, Samuel Clemens, Joseph Conrad, Charles Dickens, Isak Dinesen, Ralph Waldo Emerson, William Faulkner, F. Scott Fitzgerald, Graham Greene, Ernest Hemingway, William James, Charles Lamb, Herman Melville, Eugene O’Neill, Mary Shelley, Robert Louis Stevenson, Leo Tolstoy, Tennessee Williams, Virginia Woolf, Emile Zola.
- **Composers:** Robert Berlioz, Edward Elgar, George Frederic Handel, Otto Klemperer, Gustav Mahler, Sergey Rachmaninoff, Robert Schumann, Alexander Scriabin, Peter Tchaikovsky, Irving Berlin, Noel Coward, Stephen Foster, Cole Porter
- **Artists:** Paul Gauguin, Hugo van der Goes, Vincent van Gogh, Michelangelo, Edvard Munch, Georgia O’Keeffe, Jackson Pollock, Dante Gabriel Rossetti, Mark Rothko

## **Finding and Training for Leaders for the Caring Congregation**

Having the right leaders to teach this curriculum is critical to presenting it responsibly and successfully. This document contains a special workshop for training leaders: *Leaders Workshop: Training for Leaders for the Caring Congregation*. A section of this leadership workshop entitled *Guidelines for Choosing Leaders* discusses the topics of finding and training people for this task. Briefly, people are potential leaders when they have life experience and knowledge of mental illness through being providers, family members or clients of mental health services, and when they have a realistic, constructive attitude towards mental health and recovery, an ability to share one's emotions and facilitate such sharing in others, and comfort with emotional expression. The leaders are identified and then trained to become certified trainers of the curriculum. See the *Leadership Workshop* for more information about leadership training.

## **Participation Guidelines**

### **Respect anonymity**

Encourage participants to share activities, readings, and discussions with others outside the workshop, but stress the importance of keeping the content of personal sharing by participants anonymous. Any participant may request that a comment be kept confidential as well and is meant only for the other class members.

### **Set boundaries for personal sharing**

Each participant is responsible for setting his or her own boundaries for personal sharing. Invite participants to determine what and how much of their own identities, values, and history they choose to share; whatever boundaries each participant sets are to be respected by the group.

Make it clear that no one will be asked to share their own experience with mental illness, or that of their family, unless they choose to do so. Individuals need to control this decision. Be especially careful to respect people who choose to "come out" as mental patients or families of mental patients during the workshops. This might be the first time that they have chosen to talk of this openly, and the courage to do so must be deeply respected.

### **Speak from personal experience**

Participants should avoid using generalizations about people or speaking for others. Encourage "I think, feel, believe, experience ..." statements.

### **Respect differences**

Help participants to hear and understand different experiences and perspectives, rather than try to convince others that they are wrong.

### **Not a substitute for Professional help**

This curriculum is for educational purposes only, and is not to be used as a substitute for professional attention for a mental disorder. If a participant feels, as a result of what they are learning that they have an untreated mental disorder, they, and not the leader or the group, have the responsibility to seek professional help for themselves.

# General Workshops for Adults and Youth

The following chapters present the General Workshops which are intended for adults and youth in the congregation.

<b>GENERAL WORKSHOPS</b>	
1	Mental Disorders and their Consequences
2	Specific Mental Disorders and how they are Diagnosed
3	History of Mental Disorders
4	Mental Disorders in Special Populations
5	Mental Health Treatment
6	Families and Friends of those with Mental Disorders
7	The Role of the Church

# Workshop 1:

## Mental Disorders and their Consequences

“*My despair is transformed into hope and I begin anew the legacy of caring.*” Thandeka

**Purpose:** This session starts with an introduction to the Caring Congregation program. Then the participants will learn the definition of a mental disorder, the main categories of these disorders and their demographics. They will also learn about the stigma of mental illness and how it affects us all. The class will have a chance to share their own experiences and motivations to the extent that they wish to do so.

### Materials

- For presentation: newsprint and/or paper for handouts.
- *Creating Caring Congregations*, a video produced by Mental Health Ministries an organization of the Methodist California-Pacific Annual Conference. It can be ordered from [www.mentalhealthministries.net](http://www.mentalhealthministries.net).
- A VCR and TV screen is required for the Video.
- Equipment for playing music, (see “Adding Artistic and Musical Dimensions to the Workshops,”) if you will be using it.

### Preparation

- Prepare newsprint posters and/or handouts listing goals of the program, the workshop schedule, the definitions of *Mental Health and Mental Disorder*, and if desired, who has mental disorders.
- Copy the Participation Guidelines onto Newsprint to present to the class.
- Make copies for the participants of the *Handouts for Workshop 1* to use during class, and the *Mental Health: A Report of the Surgeon General—Executive Summary*. National Institute of Mental Health, 1999, as a reading assignment.
- Make a copy of the People Bingo cards for each member of the group
- For the skit, make copies of the *UU Coffee Hour Skit Illustrating Mental Health Stigma* for each person. And, make a copy of the *Character Profiles*, and cut out the description of each character to give it to the person who will be playing that character.
- Acquire the VCR and TV screen and make sure they are in working order and you know how to operate them.
- To prioritize the disorders that you will be presenting in detail in later workshops, you may want to plan to survey the class to see which disorders are most important to hear about. You can then plan to focus on those in the later workshops.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Explain to the class that at each class they will be seeing art and quotes and hearing music created by artists who have mental disorders. Tell them who the artist, writer and composer of the week are.
- Make copies of the *Glossary, References and End Notes* sections of this document for students.

### SESSION PLAN

#### Opening / Chalice Lighting

5 minutes

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading* by Susan Gregg-Schroeder (adapted) from Gregg-Schroeder, Susan. *In the Shadow of God’s Wings – Grace in the Midst of Depression*<sup>5</sup>

Come along with me  
as a sojourner in faith.  
Bring along

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

*Moment of meditation or prayer*

### **The Caring Congregation Program**

**10 minutes**

Present the goals of the workshop series using the newsprint or handouts you have prepared.

#### *The Caring Congregation Program*

A voluntary program that helps congregations to become more intentionally inclusive and supportive towards people with mental disorders and their families. The goal of the workshops is to reduce prejudice by increasing understanding and acceptance among people who have mental disorders, giving ideas for specific supportive actions that can be undertaken. It intentionally honors the spiritual component in caring for mental disorder, thus building a community that will become a source of caring for those with mental disorders. Share the Participation Guidelines for the workshops with the class. As we will learn in this program, Unitarians and Universalists have been prominent in the history of treating mental disorders, so this work follows in a long-standing Unitarian and Universalist tradition.

#### *Goals for Participants*

- To provide a safe place for people with mental disorders and their families to spiritually grow
- To learn more about themselves and their attitudes regarding mental disorders
- To learn more about their congregation in terms of inclusion and support
- To actively make their congregation more welcoming and supportive to people with mental disorders and their families.
- To learn about the symptoms of mental disorders to learn how to be helpful to others, not to categorize people or to become “amateur diagnosticians.” This point is very important. In fact, we recommend that you repeat it several times during the workshop to emphasize that people don’t earn the title of “Dr.” by having taken this class.

#### *Schedule for Workshop Series*

Present the list of workshops that will be part of this series as you have designed it, saying what will be discussed at each one.

### **People Bingo**

**10 minutes**

This introductory activity is designed for people to get to know a little more about one another and to start to find connections that they might have with other members of the group.

Hand out one copy of the People Bingo card to each member of the group. Make sure that everyone has something to write with. Tell the group that this is a timed assignment so it is important to work quickly. When you give the signal instruct the participants to go around and ask members of the group to sign their name under one of the squares that applies to them. Limit people to only sign off on either one or two of the squares on each person's People Bingo card. This encourages people to meet more people in the larger group. Participants should be encouraged to introduce themselves before they ask another participant to sign off on their sheets.

The game continues until the first three people in the group can call "Bingo." This means they have a vertical or horizontal row of squares that each contains a signature. Alternatively, you can let the game go until someone has a completely filled sheet.

Just like with traditional Bingo, have the winners read off their winning squares and who signed off on them. This is a good way to involve all the participants by asking them details on what they signed off on. This is also a chance to have the person who signed off see who else in the group might have the same interest or experience.

**What is Mental Health? Mental Disorder? How common is it? 25 minutes**

Present definitions of *Mental Health and Mental Disorder*, *Categories of Mental Disorders* and who has mental disorders using newsprint or handouts that you have prepared.

- *What is Mental Health, and what is Mental Disorder?*

Present the handout *Mental Health and Mental Disorder*. Go over each of the definitions carefully.

- *Brief introduction to the categories of mental disorders, and Causes of Mental Disorders.*

Distribute and present the charts *Categories of Mental Disorders*. Explain that we will be discussing the disorders in more detail later in the workshop series.

- *Who has Mental Disorders?*

According to the American Psychiatric Association, during any one-year period, up to 50 million Americans, more than 22 percent suffer from a clearly diagnosable mental disorder involving a degree of incapacity that interferes with employment, attendance at school or daily life.

- Near universality of mild emotional problems at some time in life
- Nearly every family has experienced clinically significant mental disorders in some member of their family at some point

**Video: Creating Caring Congregations 30 minutes**

This video, produced by Mental Health Ministries of the United Methodist Church and intended for use by congregations studying mental health issues, has four segments. Here is a description of the video from Mental Health Ministries:

Individuals share their personal experiences with various mental illnesses in the first three segments. Shawn's Story tells of an adolescent's experience with bi-polar depression, addiction and suicidal ideations. Carol's Story is about the most common illness of the brain, clinical depression, with accompanying anxiety issues. Jan's Story highlights how the normal life changes associated with the aging process can lead to depression in older adults. The final segment, How Congregations Can Respond, provides a five-step program of education, covenant, welcome, support and advocacy, to help churches begin to address mental health issues in the local church.

**Skit: Sunday Coffee Hour 20 minutes**

In every congregation there are those in need of a spiritual home because they have been touched by mental



illness. Unfortunately stigma, expressed through words and actions, acts as a barrier between those in need and the UU community that strives to be a caring and welcoming place for everyone.

This activity is a skit in which the class members will be acting out parts of people during a Sunday morning coffee hour after a church service at a congregation named “Caring Hearts UU.” The characters in the skit will be making statements that reflect some of the stereotypes about those with mental disorders. Please see the pages following this workshop for the characters, dialog of this skit, and follow these steps:

1. Decide what parts the class members will take. Hand out character profiles to each person and tell them to read them silently, but not to share them with the others until after the skit.
2. Hand out the pages to the script to all players.
3. Ask a participant or participants to read the letter that precedes the skit.
4. Ask the characters to perform the skit
5. When the skit is over, ask each character to read the character profile for the part that they read.
6. Enter into a discussion with the class after the skit about their experiences

*Suggested Questions for Discussion after the Skit:*

- In your character’s role, did anything that someone said, or didn’t say make you uncomfortable? Make you comfortable?
  - What do you think the effect of these stigmatizing statements have on people who have on people being treated for mental disorders and their families? The effect they have undiagnosed and untreated mental disorders? The effect they have on the Caring Hearts UU community?
  - Do you think Yumi and Bill will come back?
  - Is this a safe place for Jill and Mason to bring their daughter Andrea?
7. Discuss handouts “Myths and Stereotypes about those with Mental Disorders” and “Stigma of Mental Disorders – Consequences and Strategies” with the class

**Sharing of experiences and motivations**

**15 minutes**

Ask the participants to introduce themselves and say what motivates them to participate in the program. Leaders should go first to model self-disclosure. Acknowledge any difficulty that people may have in making these statements; for some it may be the first time that they will have ‘come out’ as having a mental disorder themselves or in their families. The importance and courage required for this moment should be deeply honored and respected. If there are many people in the group, you may want to have the people share in groups of 3 or 4 to allow each person enough time to talk. Note: We have placed this introduction at the end of the first session because we feel after people have heard about the myths of mental illness and why they are untrue; they may feel more comfortable in self-disclosure.

**Beginning Responses by a Faith Community**

**3 minutes**

Post a blank sheet of newsprint on the wall with the title: “*Responses of a Faith Community*”. Explain to the class that this paper will be used to keep track of ideas that people have during all of the workshops for how their faith community could respond to some of the situations that are brought up. Ask if anyone has any ideas to put on the list to start it out based on what was learned in this lesson. Post this list on the wall at each workshop, and keep track of answers to the question: “How might a faith community respond to this problem?” posed at various opportune times during the workshop.

**Closing**

**2 minutes**

*Reading*

*“You will know the truth, and the truth will set you free.” John 8:32*

**Assignment / Follow-up**

- Distribute hand out copies of the *Glossary*, *References* and *End Notes* sections for use in all workshops.
- Read *Mental Health: A Report of the Surgeon General—Executive Summary*, the report from the Surgeon General of the United States.
- Ask people to look and listen for any evidence of stigma of mental disorders that they may hear during the week ahead. They will be asked to share what they have learned next week.

## People Bingo Card

<b>B</b>	<b>I</b>	<b>N</b>	<b>G</b>	<b>O</b>
I am fluent in a language other than English _____	I like to sing. _____	Someone in my family has a serious mental disorder. _____	I have experience as a facilitator. _____	A friend lives with depression. _____
I have a garden. _____	I have a regular exercise routine. _____	I like to do craftwork. _____	No one in my family has gone to a therapist. _____	I have gone to a psychiatrist. _____
I practice meditation. _____	I like to read detective stories. _____	<b>FREE</b>  <b>SPACE</b>	I like to write. _____	I have gone to a therapist. _____
I have a pet. _____	I like to watch movies. _____	I like to go to plays. _____	I have hobbies that I enjoy. _____	I like to read non-fiction. _____
I know how to play a musical instrument. _____	I have a regular spiritual practice. _____	I like to volunteer. _____	My job is fulfilling. _____	I have a relative who has Alzheimer's. _____

## UU Coffee Hour Skit Illustrating Mental Health Stigma

Copyright © Peggy Rahman 2005

The letter from an UU family member should be read by volunteers. The leader may wish to have one person read the whole letter or have several people read one paragraph each.

### A LETTER TO THE CARING CONGREGATION FROM A UU FAMILY MEMBER

We often believe things to be true only to learn later, through advances in science, that we have been tragically mistaken. On issues regarding mental illness many of us have acted on mistaken beliefs, unknowingly causing harm to loved ones and members of our communities who suffer from mental illness. Part of the healing process for those of us with loved ones who have mental illness is to learn that we are not be responsible for what we did not know.

An example of harm done from mistaken belief can be given in the following example about sexual minorities. It used to be understood, as a medical truth, that homosexuality was a mental illness. It was also known as truth that being molested as a child was one cause of homosexuality. Consequently, many religious communities stigmatized homosexuals, discouraging or even forbidding members who are Gay, Lesbian, Bisexual or Transgender from teaching Sunday school to children. We did this with good intentions. We now know that what we, as UUs, understood as truth in the recent past about sexual minorities was harmful.

People who have been touched with mental illness are all too frequently hurt by statements made by good people who believe myths to be facts. Stigmatizing statements can be made by any one of us, including health care professionals and members of the faith community, even clergy.

As members of our UU community we strive to create a culture where everyone is cherished for who they are. Even the UU community has been a place where myths of the past have perpetuated stigma surrounding mental illness. Stigma, defined as a mark of shame and disgrace, does terrible harm. We must forgive ourselves and others for statements made that came from lack of knowledge, however noble the intentions. And yes, we too are not responsible for what we did not know.

The good news is that we are here, together, participating in this religious education about mental illness. We want to replace loss with the hope. We want to eradicate stigma. We are here because we are building a healthier community where we all can thrive, including those with mental illness and their families.

With this in mind the author of this skit has included stigmatizing statements that are truthful in that they have been heard by her and by other members of the UU community at UU functions and in other circumstances where educated and caring people were uneducated about mental illness. Many caused her to feel isolated from the UU community that she had grown to depend on before her daughter became ill.

The skit is an imaginary conversation that might take place after service while people are sharing refreshment. Some of the characters in the skit have mental illness. Others have family members who are. Many of them have not disclosed this information to the congregation.

The author tried her best to put humor into tragic circumstances. It's OK to laugh.

Class participants will be given the characters that they will read by the facilitator. Try and have family members sit together. Each actor will be given a personal note about their character that they will read when the skit is finished.

### **List of characters in the skit: (8)**

If there are more class participants than characters have one person read all words not in the dialogue such as "Yumi enters, they all greet," and give other class participants copies of the script with the profiles of cast members.

"**Caring Hearts UU**" is the name of the congregation where this skit takes place.

#### **The Jimanrea Family - Jill, Mason and Andrea**

Founding members of the congregation. Andrea is a phenomenal writer, outgoing and fun.

#### **The Jimyum Family - Yumi and Jim**

This is their first day Caring Heart UU. They are searching for spiritual home that is safe for them and their two young children.

#### **The Ternah Family - Peter and Hannah**

They have two children 14 and 12. They own an accounting and real estate business.

**Margaret** - The congregation's first paid music director.

## Coffee Hour at Caring Hearts UU: The Skit

(The skit begins with Jill, Mason, Yumi, Jim, Hannah and Peter)

- Jill:** (To Yumi and Jim). Hello, my name is Jill and this is my husband Mason. I am so pleased that you have come to join us today.
- Yumi:** (To Mason and Jill) My name is Yumi, and this is my husband Jim. We have been looking for a place to worship where our children can learn the values of my religion as well as my husband's. I think that we have found it! I am Buddhist and my husband is an atheist.
- Mason:** You have found the right place! Hanna and Peter, I want you to meet Yumi and Jim.
- Hannah:** How did you like the sermon on "Spiritual Awakening for Atheists"?
- Jim:** It was thought provoking. It was exciting hearing my spiritual atheist beliefs in a church of all places!
- Peter:** Well, our sermons aren't always so uncontroversial. Next week Mason will be giving a homily titled "Giving a Hand up in a Culture of Self Reliance"?
- Jim:** Yumi and I having been talking about that lately. We'll come.
- Peter:** I personally believe that government handouts can be degrading. There is always a way for people to get along without government assistance.
- Mason:** See, already it's controversial. So, Peter, you are certain to have an opinion on my homily last week about Social Security.
- Peter:** Yes, We spend too much on able bodied people who don't need Social Security. Putting those people to work could save the system for the elderly.
- Yumi:** But what if someone is disabled?
- Peter:** I can understand if you are paralyzed or something. But this mental illness disability stuff is a crock. People shouldn't be allowed to decide not to work just because they don't feel like it. I have a neighbor whom I am certain fakes his mental illness just so that he can stay on Social Security and Medicaid and not have to work.
- Jill:** Peter, I agree with you about giving so much government assistance to people for being crazy. Most of them don't even need medicine. I know, I have had depression for years and have never taken a pill. I have found that I can control depression with getting enough sleep, talking myself out of it, and staying active with my artwork.
- Peter:** If people took better care of themselves, there would be less cost to society.
- Hannah:** In fact, I know from experience that people can choose to be depressed and that they choose suicide as an act of hostility. That is why I believe that if you act too sympathetically towards them you are just giving attention for negative behavior.

**Jill:** As Mary Lou says, we certainly don't want to reward negative behavior of self-involved people.

**Hannah:** Yea, with Mary Lou's crazy parents, she is an authority.

(Margaret enters, greetings)

**Margaret:** I have been listening to you and want to say something about what Hannah said. It has been my personal observation that people who are mental look for the easy way out. Why, my brother, whom you all know is nuttier than a fruitcake, just puts himself into a state so that he can go to the hospital and get legal drugs to get high and stuff.

**Peter:** And our insurance premiums are going up to pay for that.

**Margaret:** I think that he was really spoiled by my parents. They weren't strict enough with him. They didn't know about tough love in those days.

**Jim:** Oh yes they did. (Yumi and Jim look at each other). I have been listening and have to say something. I don't believe that people choose to be mentally ill or anything. And I don't believe that people pretend to be mentally ill just to get onto Medicaid or suffer to go to the hospital just to get high. Why, there was an article in the paper yesterday about stress bringing on symptoms of mental illness.

**Mason:** What our country should do to prevent and even cure mental illness is rid ourselves of the stress of modern society.

**Peter:** Right on Tippy! I did some photo shoots in the 60's of families of the mentally ill. Their whole families were crazy, their houses were a mess. I would say to myself "Of course that poor soul has mental illness, just look at their family".

**Jill:** I am so glad that you have not come to photograph my house; you would think that I was ready for Napa. Did you ever think that the house is messy because people in the family are busy taking care of someone who is sick?

**Yumi:** That makes sense.

**Jill:** Margaret, I have been meaning to ask you. How is your brother now? I know he has had trouble with homelessness.

**Margaret:** Yes, and that is another issue. He has moved back in with my parents. He is never going to grow up until they kick him out. He is never going to do something useful with his life.

**Jill:** That's a shame.

**Margaret:** He's useless and I don't feel a bit sorry for him! People with mental illness are more likely to commit abusive acts to their families than anyone else.

**Peter:** Probably because their mothers are always nagging them to take their meds.

**Jill:** Hannah, on a totally different subject, we need to talk about next month's service on "Women's Spirituality Benefiting Mankind". I was thinking that Joan of Arc would be a great example of a person who uses her spiritual awakening to benefit

others. Andrea has some thoughts about that. (To Yumi and Jim). Andrea is my daughter.

(Andrea enters)

**Peter:** I don't think Joan of Arc is a good example. She wasn't a saint or a visionary. She was psycho. Speak of the angel. Hello Andrea. We hear that you have been studying Joan of Arc.

**Andrea:** That's true. Peter, she wasn't psycho, she was a very spiritual person.

**Peter:** Psycho AND spiritual? Now that's a schizophrenic idea if I ever I heard one.

**Hannah:** Andrea, it sounds like you have been listening to Catholic gobble-dee-gook.

**Andrea:** Actually, I got my information from my boyfriend Robert.

**Hannah:** The same Robert that goes to the school I am counselor at?

**Andrea:** Yes.

**Hannah:** I went to school with his father. Now that was a weird kid, always filthy. And he never looked at people in the eyes. Be careful Andrea, Robert's father is a very dangerous man. I know that for a fact because he has been in and out of looney bins for years. And, like father, like son. Robert could be dangerous too.

**Andrea:** I have met Robert's parents. They are very nice. And Robert is too. It is just that no one understands him.

**Hannah:** Be careful dear. When people are psychotic, they are dangerous.

**Andrea:** Mom and Dad, I don't feel well, can we go home now?

(Andrea, Mason leave, Jill stays behind for a while)

**Margaret:** Oh my, it's 12:00. Time for us to set up tables and chairs for our social action committee meeting. (to Yumi and Jim) We are doing outreach work for the homeless. You are welcome to stay.

**Yumi**

**And Jim:** No. Thank you.

**Peter:** See you next week.

## UU Coffee Hour Character Profiles

Character profiles are in italics - to be passed out along with the script to the corresponding character. The profiles will be shared after the script has been read, before the debriefing questions.

### **The Jimanrea Family - Jill, Mason and Andrea: Founding members of the congregation. Andrea is a phenomenal writer, outgoing and fun.**

Jill and Mason share profiles with one another but do not know about Andrea's secret, or share their concerns with Andrea.

*Jill and Mason have been members of the Caring Heart UU congregation since their daughter, Andrea, was in preschool. They joined Caring Heart UU because of the religious education program.*

*Andrea, 16, is a phenomenal writer, outgoing, and fun. Lately she has become withdrawn and surly. Jill and Mason are hoping that the Caring Heart UU community will help them and their daughter during what they see as a temporary rough patch.*

### **The Jimyum Family - Yumi and Jim: This is their first day Caring Heart UU. They are searching for spiritual home that is safe for them and their two young children.**

Yumi and Jim may share profiles with one another.

*Jim is a professional musician who also earns money as a landscape architect, when he can. His parents are members of the UU congregation in a neighboring city. Jim has schizo-effective disorder and has suffered from several breakdowns that have required hospitalization. Jim's family believed that his first breakdown was a result of illegal drug use with his musician friends. They kicked him out of their house under advice of a counselor who suggested that they practice "tough love". Jim moved in with an Aunt who is a teacher and has a mild case of bipolar disease. The reality is that Jim has never used illegal drugs and avoids alcohol.*

*Yumi is a mathematician who does research and teaches at the prestigious Great Brains University. She and Jim met in college when they were both seniors. Yumi's family is disappointed in her choice of mate, believing that his breakdowns are a result of character flaw and poor parenting.*

### **The Ternah Family: Peter and Hannah own an accounting and real estate business. They have two children 14 and 12.**

Peter's profile must not be shared with Hannah until the end of the skit.

*Peter: To Peter the family business is a way to pay the bills. He sculptures with cement in his spare time. He has always had trouble with moodiness. When he was in college he was given Ziterol for depression. Ziterol caused him to break out in terrible acne and to gain 75 pounds. He has kept his bout with medicine a secret from Hannah. Lately Peter has had thoughts that he knows are unreasonable but he can't stop them. The sound of the television hurts his ears. Mess gives him a headache. It seems that everything irritates him. He keeps his thoughts to himself because he doesn't want to worry Hannah.*

Hannah's profile must not be shared with Peter until the end of the skit.

*Hannah: Hannah's father abused her mother. Lately Peter has been getting angry for no apparent reason. Though Peter has never hit her or verbally abused her, Hannah has become*



*afraid of him. Hannah loves Peter very much attributing his moodiness to his artistic temperament and happily taking up the slack in the family business when Peter has been a little down. But his recent outbursts are too scary. She is thinking of getting a divorce.*

**Margaret - The congregation's first paid music director.**

*Margaret: Margaret's older brother has always been a sore point for her. When he was in high school he started taking illegal drugs. At one point he stole her new bicycle to sell for drug money. Her parents didn't attend her high school graduation where she was valedictorian because they were bailing her brother out of jail. She doesn't believe in psycho-babble.*

## **Handouts for**

### **Specific Mental Disorders and how they are Diagnosed**

*“My despair is transformed into hope and I begin anew the legacy of caring.”* Thandeka

- Mental Health and Mental Disorders
- Categories of Mental Disorders
- Causes of Mental Disorders
- Myths and Stereotypes about those with Mental Disorders
- Stigma of Mental Disorders – Consequences and Strategies
- *Mental Health: A Report of the Surgeon General—Executive Summary*

# Mental Health and Mental Disorders

## ***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.

A Mental Disorder is a psychological behavioral syndrome occurring in a person that results in clinically significant impairment or distress, not an expectable response to a particular event and not a manifestation of cultural norms

Every phrase of this definition is significant:

- ***psychological behavioral:*** A diagnosis of a mental disorder occurs where the psychological or behavioral symptoms are the most prominent symptoms
- ***syndrome:*** A pattern or cluster of symptoms that tend to occur together
- ***occurring in a person:*** An individual, not societal problem
- ***clinically significant impairment or distress:*** There is a difference between unconventional behavior and a mental disorder. People shouldn't be diagnosed with a mental disorder just because they're 'different'. It is acknowledged that in some cases there is a blurred line between normality and abnormality, and that diagnosis has a subjective component. Care should be taken not to over-pathologize behavior.
- ***not an expectable response to a particular event and not a manifestation of cultural norms***

## ***Mental Health and Mental Disorder are Points on a Continuum***

- Everyone experiences emotional distress during difficult times, whether or not they are diagnosed with a mental disorder.
- People will move back and forth along a continuum between mental health and mental disorder in living their lives.
- Understanding how to cope with mental disorders will help all people cope with the difficult times in their lives.

Sources:

- U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*
- American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*

## Categories of Mental Disorders

CATEGORY	CHARACTERISTICS	EXAMPLE DISORDERS
<b>Mood Disorders</b>	A disturbance of mood	Depression Bi-polar disorder
<b>Anxiety Disorders</b>	Characterized by apprehension usually accompanied by palpitations, and shortness of breath.	Obsessive compulsive disorder, Panic attack, Post traumatic stress disorder Agoraphobia.
<b>Psychotic Disorders</b>	Characterized by delusions, hallucinations, disorganized speech or behavior	Schizophrenia, Schizoaffective disorder, Delusional disorder
<b>Substance-Related Disorders</b>	These disorders result from taking a <i>substance</i> : i.e. a drug of abuse, the side effects of a medication, and toxin exposure.	Substance Dependence Substance Abuse
<b>Disorders usually first seen in infancy, childhood, or adolescence</b>	Some people with these disorders are not diagnosed until adulthood.	Retardation Autism Learning Attention deficit Disruptive behavior Feeding
<b>Cognitive Disorders</b>	Dysfunctions of the brain caused by neurological problem and/or drug abuse.	Delirium, Dementia, Memory disorders
<b>Eating Disorders</b>	Severe disturbances in eating behavior.	Anorexia Nervosa Bulimia Nervosa
<b>Somatoform Disorders</b>	Physical symptoms despite the absence of an underlying medical condition that can fully explain their presence.	Pain Disorder, Conversion Disorder, Hypochondria, Body Dysmorphic Disorder
<b>Personality Disorders</b>	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**

**Notes:**

- 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: Sleep, Sexual and Gender Identity, Impulse Control, Factitious (intentionally produced), and Dissociative (consciousness, identity, perception).

Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*

## Causes of Mental Disorders

The causes of most mental disorders are unknown, but the dimensions are becoming more understood.

### What we do know about causes:

- Several factors interact to produce a mental disorder:
  - Individual intrapsychic situation
  - family circumstances
  - social influences
  - biological and genetic factors
- Trauma and stress can be significant aggravating factors
- What *initiates* a disorder is usually different from what *perpetuates* it. What initiates and perpetuates a disorder may differ from what *exacerbates* it.
- A person may have a *predisposition*, or latent susceptibility, to a disorder which may be activated under certain conditions such as stress.

And, it is important to note:

- Not all aberrant behavior is a mental disorder. Interactions between various drugs that a person may be taking can cause problem behavior. These interactions can vary by age, sex, with various combinations of prescribed and over-the-counter medications. Additionally, aberrant behavior can be a result of other medical conditions such as diabetes, thyroid problems, or reaction to a toxin.

### Genetic factors in Mental Disorders

Based on studies of twins and adoptees

- Disorders with a significant genetic link: Schizophrenia, Bi-polar disorder, Depression
- Disorders with a weaker genetic link: Panic attack, Obsessive-compulsive disorder

Source: *Essential Psychopathology and Its Treatment, Second Edition* by Jerrold S. Maxmen and Nicholas G. Ward, pp 57-79.

## Myths and Stereotypes about those with Mental Disorders

Myth / Stereotype	The Facts
Violent	This common stereotype is vastly exaggerated by the media. In fact, although some mental disorders (anti-social personality disorder and the acute stage of some psychotic disorders) do have aggression and violence as possible symptoms, recent research has shown that using alcohol and drugs is a much more reliable predictor of violent behavior than is mental disorder. It is only when a mentally ill person abuses alcohol and illegal drugs that they are somewhat more likely than a non-mentally ill person to be violent. By any measure, however, the vast majority of violent acts are committed by people without mental disorder.
Comical	The media sometimes depict the experience of mental illness as being comical. This is disrespectful of the agony of those in these circumstances, and can be harmful to them.
Not curable, or poor outcome	As many as 80 percent of people suffering from mental illnesses can effectively return to normal, productive lives if they receive appropriate treatment. Many others can have their suffering significantly reduced.
Morally deficient; God’s judgment for sinful behavior	This was the prevailing thought before the 18 <sup>th</sup> century when the need for humane care became widely recognized. It has no place in today’s world.
Fear that it is ‘catching’	You do not develop a mental disorder by being around someone with one.
Mentally ill people are unreliable and unpredictable	For some disorders this may be true when a person is in a crisis, but is not generally true otherwise, and it is not true for all disorders.
Some people “don’t believe in” mental disorders or psychotherapy.	The facts that these disorders respond to clinical treatment and that they can be devastating to a person’s life belie the belief that they are feigned.
Spiritual experiences of mentally ill are not true religious experiences	Many people with and without mental disorders have mystical experiences. The true meaning of the experience depends on the meaning felt by the person having the experience.
You cannot communicate with people with mental disorders	Although symptoms of some mental disorders involve disturbances in communication, most people with mental disorders, even those in acute psychiatric stress, can communicate with others and tell at least some of what is happening with them.
Mental illness is evidence of character flaws, and you are weak if you need to seek help.	Tragically, this baseless stereotype keeps many people from getting the help they need, and that is readily available.
Mental illness is a result of poor parenting	Mental illness is caused by a variety of inherited and environmental factors. Abusive parenting can contribute to mental disorders. But, good parenting may not be able to shield a child from mental illness, since many causative factors are not in the power of a parent to affect.
People with mental disorders have nothing to contribute to society	This is patently untrue. Many of the most creative artists, poets and writers have lived with some sort of mental disorder. Since 20% of the population will develop a mental disorder every year, clearly there are millions of people with mental disorders who contribute to society. And, many gifted artists, musicians, poets and writers have had mental disorders.
People with mental disorders have bizarre, disruptive behavior	While it is true that some mental disorders involve disruptive behavior, most disorders do not. If guidelines on appropriate behavior are in place, disruption from any person with or without a mental disorder can be limited.

**Table 2. Myths and Stereotypes about those with Mental Disorders**

Perpetuating a stigma is counter to the first principle of the Unitarian Universalist faith: Respect for the inherent worth and dignity of every person.

## **Stigma of Mental Disorders – Consequences and Strategies**

### **Consequences of Stigma:**

The consequences of these stereotypes on people with mental disorders and their families include:

- Lack of respect and consideration
- De-humanization
- People kept from seeking help, thus suffering needlessly
- Misunderstanding
- Hostility, anger and frustration
- Hurt and wounded feelings
- Shunning and isolation
- Low self esteem
- Discouragement, disappointment and low expectations for life
- Suicide, and resulting trauma to the family left behind
- Discrimination in employment, housing, and other social activities
- Negative media images
- Insurance for physical, but not mental illness
- Cost to society at large. According to the American Psychiatric Association, the direct costs of support and medical treatment of mental disorders total \$55.4 billion a year. The indirect costs, such as lost employment, reduced productivity, criminal activity, vehicular accidents and social welfare programs increase the total cost of mental and substance abuse disorders to more than \$273 billion a year.
- Tragically, some of the worst consequences of stigma are when the person with the mental disorder believes it to be true of himself or herself, because it can rob the person of hope.

### **Strategies for addressing stigma:**

- Education. This program is an example.
- Respect, Listening, Understanding – Treat the person with the mental disorder as a respected person, listening to them without judgment and trying to understand their problems. This includes self-talk for those with mental disorders.
- Challenge Inaccuracies. When you hear them, when you see them in the media.
- Advocacy. Become proactive in advocating for those with mental disorders and their families.

If participants want to explore this topic further, two excellent books about research into the stigma associated with Mental Illness are:

- *Telling is Risky Business – Mental Health Consumers Confront Stigma*, by Otto F. Wahl, Rutgers University Press, 1999.
- *Don't Call Me Nuts! – Coping with the Stigma of Mental Illness*, by Patrick Corrigan and Robert Lundin, Chicago: Recovery Press, 2001.

## **Executive Summary <sup>6</sup>**

### **A Report of the Surgeon General On Mental Health**

**1999**

*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; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem.*

*Mental illness—the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.*

This is the first Surgeon General’s report ever issued on the topic of mental health and mental illness. The science-based report conveys several messages. One is that mental health is fundamental to health. The qualities of mental health are essential to leading a healthy life. Americans assign high priority to preventing disease and promoting personal well-being and public health; so too must we assign priority to the task of promoting mental health and preventing mental disorders. Nonetheless, mental disorders occur and, thus, treatment and mental health services are critical to the Nation’s health. These emphases, combined with research to increase the knowledge needed to treat and prevent mental and behavioral disorders, constitute a broad public health approach to an urgent health concern.

A second message of the report is that mental disorders are real health conditions that have an immense impact on individuals and families throughout this Nation and the world. Appreciation of the clinically and economically devastating nature of mental disorders is part of a quiet scientific revolution that not only has documented the extent of the problem, but in recent years has generated many real solutions. The decision to publish the report at this time was based, in part, on the tremendous growth of the science base that is enriching our understanding of the awe-inspiring complexity of the brain and behavior. This understanding increasingly supports mental health practices.

The body of this report is a summary of an extensive review of the scientific literature and of consultations with mental health care providers and consumers. Contributors guided by the Office of the Surgeon General examined more than 3,000 research articles and other materials, including first-person accounts from individuals who have experienced mental disorders. Today, a strong consensus among Americans in all walks of life holds that our society no longer can afford to view mental health as separate and unequal to general health. This consensus resonates with the Surgeon General’s conviction that mental health should be part of the mainstream of health.

The review of research supports two main findings:

- The efficacy of mental health treatments is well documented, and
- A range of treatments exists for most mental disorders.

On the strength of these findings, the single, explicit recommendation of the report is to *seek help if you have a mental health problem or think you have symptoms of a mental disorder.*

Once a person has made the decision to seek help for a mental health problem, he or she can choose from a broad variety of helping sources, treatment approaches, and service settings. There is no “one size fits all” treatment for mental disorders. Personal preference may influence, for example, the choice of psychotherapeutic, or “talk,” therapy over the use of medications; in another case, an individual may feel most comfortable raising questions about symptoms of mental distress with a family doctor, with a trusted member of the clergy, or, if a child’s health is the subject of concern, with a teacher or a school counselor. There are many individuals who are familiar with questions about mental health care and who, as a first point of contact, can provide invaluable assistance in obtaining appropriate and effective care.



Despite the efficacy of treatment options and the many possible ways of obtaining a treatment of choice, nearly half of all Americans who have a severe mental illness do not seek treatment. Most often, reluctance to seek care is an unfortunate outcome of very real barriers. Foremost among these is the stigma that many in our society attach to mental illness and to people who have a mental illness.

Stigma erodes confidence that mental disorders are valid, treatable health conditions. It leads people to avoid socializing, employing or working with, or renting to or living near persons who have a mental disorder, especially a severe disorder like schizophrenia. Stigma deters the public from wanting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social services. A consequent inability or failure to obtain treatment reinforces destructive patterns of low self-esteem, isolation, and hopelessness. Stigma tragically deprives people of their dignity and interferes with their full participation in society. It must be overcome.

Increasingly effective treatments for mental disorders promise to be the most effective antidote to stigma. Effective interventions help people to understand that mental disorders are not character flaws but are legitimate illnesses that respond to specific treatments, just as other health conditions respond to medical interventions. Fresh approaches to disseminating research information are needed urgently. While they are being developed, this report provides information that organizations, experts, and many other individuals can use to educate all Americans about mental health and mental illness.

#### Overarching Themes of the Surgeon General's Report

Key themes, summarized here, run throughout the report. The importance of information, policies, and actions that will reduce and eventually eliminate the cruel and unfair stigma attached to mental illness is one. The importance of a solid research base for every mental health and mental illness intervention is another. As our nation has seen in the past, establishing mental health policy on the basis of good intentions alone can make bad situations worse; evaluating the practicality and effectiveness of new approaches is efficient and, more critically, is accountable to those for whom an intervention is intended. Additional themes of the report include the following.

#### Public Health Perspective

In the United States, mental health programs, like general health programs, are rooted in a *population-based public health model*. Broader in focus than medical models that concentrate on diagnosis and treatment, public health attends, in addition, to the health of a population in its entirety. A public health approach encompasses a focus on epidemiologic surveillance, health promotion, disease prevention, and access to services. Although much more is known through research about mental illness than about mental health, the report attaches high importance to public health practices that seek to identify risk factors for mental health problems; to mount preventive interventions that may block the emergence of severe illnesses; and to actively promote good mental health.

#### Mental Disorders Are Disabling

The World Health Organization, in collaboration with the World Bank and Harvard University, mounted an ambitious research effort in the mid-1990s to determine the "burden of disability" associated with the whole range of diseases and health conditions suffered by peoples throughout the world. Possibly the most striking finding of the landmark Global Burden of Disease study is that the impact of mental illness on overall health and productivity in the United States and throughout the world is profoundly under-recognized. Today, in established market economies such as the United States, mental illness is the second leading cause of disability and premature mortality. Mental disorders collectively account for more than 15 percent of the overall burden of disease from *all* causes and slightly more than the burden associated with all forms of cancer (Table 1). These data underscore the importance and urgency of treating and preventing mental disorders and of promoting mental health in our society.

Table 1. Disease burden by selected illness categories in established market economies, 1990

	Percent of Total DALYs*
All cardiovascular conditions	18.6
All mental illness**	15.4

All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic disease	2.8
All drug use	1.5

\*Disability-adjusted life year (DALY) is a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration (Murray & Lopez, 1996).

\*\*Disease burden associated with “mental illness” includes suicide.

### **Mental Health and Mental Illness: Points on a Continuum**

As will be evident in the pages that follow, “mental health” and “mental illness” may be thought of as points on a continuum. *Mental health* refers to 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 health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. It is easy to overlook the value of mental health until problems surface. Yet from early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. These are the ingredients of each individual’s successful contribution to community and society. Americans are inundated with messages about *success*—in school, in a profession, in parenting, in relationships—without appreciating that successful performance rests on a foundation of mental health.

Many ingredients of mental health may be identifiable, but mental health is not easy to define. In the words of a distinguished leader in the field of mental health prevention, “. . . built into any definition of wellness . . . are overt and covert expressions of values. Because values differ across cultures as well as among subgroups (and indeed individuals) within a culture, the ideal of a uniformly acceptable definition of the construct is illusory. . .” (Cowan, 1994). In other words, what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures. The challenge of defining mental health has stalled the development of programs to foster mental health (Secker, 1998), although some strides have been made—for example, wellness programs for older people.

*Mental illness* refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer’s disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (over activity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior spawn a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (DSM-IV, 1994).

This report uses the term “mental health problems” for signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder. Almost everyone has experienced mental health problems in which the distress one feels matches some of the signs and symptoms of mental disorders. Mental health problems may warrant active efforts in health promotion, prevention, and treatment. Bereavement symptoms in older adults offer a case in point. Bereavement symptoms of less than 2 months’ duration do not qualify as a mental disorder, according to professional manuals for diagnosis (DSM-IV, 1994). Nevertheless, bereavement symptoms can be debilitating if they are left unattended. They place older people at risk for depression, which, in turn, is linked to death from suicide, heart attack, or other causes (Zisook & Shuchter, 1991, 1993; Frasure-Smith et al., 1993, 1995; Conwell, 1996). Much can be done—through formal treatment or through support group participation—to ameliorate the symptoms and to avert the consequences of bereavement. In this case, early intervention is needed to address a mental health problem before it becomes a disorder.

## **Mind and Body Are Inseparable**

As it examines mental health and illness in the United States, the report confronts a profound obstacle to public understanding, one that stems from an artificial, centuries-old separation of mind and body.

Even today, everyday language encourages a misperception that mental health or mental illness is unrelated to physical health or physical illness. In fact, the two are inseparable. In keeping with modern scientific thinking, this report uses mind to refer to all mental functions related to thinking, mood, and purposive behavior. The mind is generally seen as deriving from activities within the brain. Research reviewed for this report makes it clear that mental functions are carried out by a particular organ, the brain. Indeed, new and emerging technologies are making it increasingly possible for researchers to demonstrate the extent to which mental disorders and their treatment—both with medication and with psychotherapy—are reflected in physical changes in the brain.

## **Scope of the Report and General Conclusions**

### **Chapter 1: Introduction and Themes**

Chapter 1 of the report elaborates on the overarching themes highlighted above and describes the criteria applied to the scientific evidence that is cited through-out the report. The chapter also lists the key conclusions drawn from each succeeding chapter. These conclusions are provided, as well, in the following pages of this Executive Summary.

### **Chapter 2: The Fundamentals of Mental Health and Mental Illness**

The past 25 years have been marked by several discrete, defining trends in the mental health field. These have included:

- The extraordinary pace and productivity of scientific research on the brain and behavior;
- The introduction of a range of effective treatments for most mental disorders;
- A dramatic transformation of our society’s approaches to the organization and financing of mental health care; and
- The emergence of powerful consumer and family movements.

*Scientific Research.* The brain has emerged as the central focus for studies of mental health and mental illness. New scientific disciplines, technologies, and insights have begun to weave a seamless picture of the way in which the brain mediates the influence of biological, psychological, and social factors on human thought, behavior, and emotion in health and in illness. Molecular and cellular biology and molecular genetics, which are complemented by sophisticated cognitive and behavioral science, are preeminent research disciplines in the contemporary neuroscience of mental health. These disciplines are affording unprecedented opportunities for “bottom-up” studies of the brain. This term refers to research that is examining the workings of the brain at the most fundamental levels. Studies focus, for example, on the complex neurochemical activity that occurs within individual nerve cells, or neurons, to process information; on the properties and roles of proteins that are expressed, or produced, by a person’s genes; and on the interaction of genes with diverse environmental influences. All of these activities now are understood, with increasing clarity, to underlie learning, memory, the experience of emotion, and, when these processes go awry, the occurrence of mental illness or a mental health problem.

Equally important to the mental health field is “top-down” research; here, as the term suggests, the aim is to understand the broader behavioral context of the brain’s cellular and molecular activity and to learn how individual neurons work together in well-delineated neural circuits to perform mental functions.

*Effective Treatments.* As information accumulates about the basic workings of the brain, it is the task of translational research to transfer new knowledge into clinically relevant questions and targets of research opportunity—to discover, for example, what specific properties of a neural circuit might make it receptive to safer, more effective medications. To elaborate on this example, theories derived from knowledge about basic brain mechanisms are being wedded more closely to brain imaging tools such as functional Magnetic Resonance Imaging (MRI) that can observe actual brain activity. Such collaboration would permit investigators to monitor the specific protein molecules intended as the “targets” of a new medication to treat a mental illness or, indeed, to determine how to optimize the effect on the brain of the learning achieved through psychotherapy.

In its entirety, the new “integrative neuroscience” of mental health offers a way to circumvent the antiquated split between the mind and the body that historically has hampered mental health research. It also makes it possible to examine scientifically many of the important psychological and behavioral theories regarding normal development and mental illness that have been developed in years past. The unswerving goal of mental health research is to develop and refine clinical treatments as well as preventive interventions that are based on an understanding of specific mechanisms that can contribute to or lead to illness but also can protect and enhance mental health.

Mental health clinical research encompasses studies that involve human participants, conducted, for example, to test the efficacy of a new treatment. A noteworthy feature of contemporary clinical research is the new emphasis being placed on studying the effectiveness of interventions in actual practice settings. Information obtained from such studies increasingly provides the foundation for services research concerned with the cost, cost-effectiveness, and “deliverability” of interventions and the design—including economic considerations—of service delivery systems.

*Organization and Financing of Mental Health Care.* Another of the defining trends has been the transformation of the mental illness treatment and mental health services landscapes, including increased reliance on primary health care and other human service providers. Today, the U.S. mental health system is multifaceted and complex, comprising the public and private sectors, general health and specialty mental health providers, and social services, housing, criminal justice, and educational agencies. These agencies do not always function in a coordinated manner. The configuration of the system reflects necessary responses to a broad array of factors including reform movements, financial incentives based on who pays for what kind of services, and advances in care and treatment technology. Although the hybrid system that exists today serves diverse functions well for many people, individuals with the most complex needs and the fewest financial resources often find the system fragmented and difficult to use. A challenge for the Nation in the near-term future is to speed the transfer of new evidence-based treatments and prevention interventions into diverse service delivery settings and systems, while ensuring greater coordination among these settings and systems.

*Consumer and Family Movements.* The emergence of vital consumer and family movements promises to shape the direction and complexion of mental health programs for many years to come. Although divergent in their historical origins and philosophy, organizations representing consumers and family members have promoted important, often overlapping, goals and have invigorated the fields of research as well as treatment and service delivery design. Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability as well as with age or gender or by the racial and cultural identity of those who have mental illness.

Chapter 2 of the report was written to provide background information that would help persons from outside the mental health field better understand topics addressed in subsequent chapters of the report. Although the chapter is meant to serve as a mental health primer, its depth of discussion supports a range of conclusions:

- The multifaceted complexity of the brain is fully consistent with the fact that it supports all behavior and mental life. Proceeding from an acknowledgment that all psychological experiences are recorded ultimately in the brain and that all psychological phenomena reflect biological processes, the modern neuroscience of mental health offers an enriched understanding of the inseparability of human experience, brain, and mind.
- Mental functions, which are disturbed in mental disorders, are mediated by the brain. In the process of transforming human experience into physical events, the brain undergoes changes in its cellular structure and function.
- Few lesions or physiologic abnormalities define the mental disorders, and for the most part their causes remain unknown. Mental disorders, instead, are defined by signs, symptoms, and functional impairments.
- Diagnoses of mental disorders made using specific criteria are as reliable as those for general medical disorders.
- About one in five Americans experiences a mental disorder in the course of a year. Approximately 15 percent of all adults who have a mental disorder in one year also experience a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.
- A range of treatments of well-documented efficacy exists for most mental disorders. Two broad types of intervention include psychosocial treatments—for example, psychotherapy or counseling—and psychopharmacologic treatments; these often are most effective when combined.
- In the mental health field, progress in developing preventive interventions has been slow because, for most major mental disorders, there is insufficient understanding about etiology (or causes of illness) and/or there is

an inability to alter the *known* etiology of a particular disorder. Still, some successful strategies have emerged in the absence of a full understanding of etiology.

- About 10 percent of the U.S. adult population use mental health services in the health sector in any year, with another 5 percent seeking such services from social service agencies, schools, or religious or self-help groups. Yet critical gaps exist between those who need service and those who receive service.
- Gaps also exist between optimally effective treatment and what many individuals receive in actual practice settings.
- Mental illness and less severe mental health problems must be understood in a social and cultural context, and mental health services must be designed and delivered in a manner that is sensitive to the perspectives and needs of racial and ethnic minorities.
- The consumer movement has increased the involvement of individuals with mental disorders and their families in mutual support services, consumer-run services, and advocacy. They are powerful agents for changes in service programs and policy.
- The notion of recovery reflects renewed optimism about the outcomes of mental illness, including that achieved through an individual's own self-care efforts, and the opportunities open to persons with mental illness to participate to the full extent of their interests in the community of their choice.

### Mental Health and Mental Illness Across the Lifespan

The Surgeon General's report takes a lifespan approach to its consideration of mental health and mental illness. Three chapters that address, respectively, the periods of childhood and adolescence, adulthood, and later adult life beginning somewhere between ages 55 and 65, capture the contributions of research to the breadth, depth, and vibrancy that characterize all facets of the contemporary mental health field.

The disorders featured in depth in Chapters 3, 4, and 5 were selected on the basis of the frequency with which they occur in our society, and the clinical, societal, and economic burden associated with each. To the extent that data permit, the report takes note of how gender and culture, in addition to age, influence the diagnosis, course, and treatment of mental illness. The chapters also note the changing role of consumers and families, with attention to informal support services (i.e., unpaid services), with which many consumers are comfortable and upon which they depend for information. Persons with mental illness and, often, their families welcome a proliferating array of support services—such as self-help programs, family self-help, crisis services, and advocacy—that help them cope with the isolation, family disruption, and possible loss of employment and housing that may accompany mental disorders. Support services can help to dissipate stigma and to guide patients into formal care as well.

Mental health and mental illness are dynamic, ever-changing phenomena. At any given moment, a person's mental status reflects the sum total of that individual's genetic inheritance and life experiences. The brain interacts with and responds—both in its function and in its very structure—to multiple influences continuously, across every stage of life. At different stages, variability in expression of mental health and mental illness can be very subtle or very pronounced. As an example, the symptoms of separation anxiety are normal in early childhood but are signs of distress in later childhood and beyond. It is all too common for people to appreciate the impact of developmental processes in children, yet not to extend that conceptual understanding to older people. In fact, people continue to develop and change throughout life. Different stages of life are associated with vulnerability to distinct forms of mental and behavioral disorders but also with distinctive capacities for mental health.

Even more than is true for adults, children must be seen in the context of their social environments—that is, family and peer group, as well as that of their larger physical and cultural surroundings. Childhood mental health is expressed in this context, as children proceed along the arc of development. A great deal of contemporary research focuses on developmental processes, with the aim of understanding and predicting the forces that will keep children and adolescents mentally healthy and maintain them on course to become mentally healthy adults. Research also focuses on identifying what factors place some at risk for mental illness and, yet again, what protects some children but not others despite exposure to the *same* risk factors. In addition to studies of normal development and of risk factors, much research focuses on mental disorders in childhood and adolescence and what can be done to prevent or treat these conditions and on the design and operation of service settings best suited to the needs of children.

For about one in five Americans, adulthood—a time for achieving productive vocations and for sustaining close relationships at home and in the community—is interrupted by mental illness. Understanding why and how mental disorders occur in adulthood, often with no apparent portents of illness in earlier years, draws heavily on the full

panoply of research conducted under the aegis of the mental health field. In years past, the onset, or occurrence, of mental illness in the adult years was attributed principally to observable phenomena—for example, the burden of stresses associated with career or family, or the inheritance of a disease viewed to run in a particular family. Such explanations now may appear naive at best. Contemporary studies of the brain and behavior are racing to fill in the picture by elucidating specific neurobiological and genetic mechanisms that are the platform upon which a person's life experiences can either strengthen mental health or lead to mental illness. It now is recognized that factors that influence brain development prenatally may set the stage for a vulnerability to illness that may lie dormant throughout childhood and adolescence. Similarly, no single gene has been found to be responsible for any specific mental disorder; rather, variations in multiple genes contribute to a disruption in healthy brain function that, under certain environmental conditions, results in a mental illness. Moreover, it is now recognized that socioeconomic factors affect individuals' vulnerability to mental illness and mental health problems. Certain demographic and economic groups are more likely than others to experience mental health problems and some mental disorders. Vulnerability alone may not be sufficient to cause a mental disorder; rather, the causes of most mental disorders lie in some combination of genetic and environmental factors, which may be biological or psychosocial.

The fact that many, if not most, people have experienced mental health problems that mimic or even match some of the symptoms of a diagnosable mental disorder tends, ironically, to prompt many people to underestimate the painful, disabling nature of severe mental illness. In fact, schizophrenia, mood disorders such as major depression and bipolar illness, and anxiety often are devastating conditions. Yet relatively few mental illnesses have an unremitting course marked by the most acute manifestations of illness; rather, for reasons that are not yet understood, the symptoms associated with mental illness tend to wax and wane. These patterns pose special challenges to the implementation of treatment plans and the design of service systems that are optimally responsive to an individual's needs during every phase of illness. As this report concludes, enormous strides are being made in diagnosis, treatment, and service delivery, placing the productive and creative possibilities of adulthood within the reach of persons who are encumbered by mental disorders.

Late adulthood is when changes in health status may become more noticeable and the ability to compensate for decrements may become limited. As the brain ages, a person's capacity for certain mental tasks tends to diminish, even as changes in other mental activities prove to be positive and rewarding. Well into late life, the ability to solve novel problems can be enhanced through training in cognitive skills and problem-solving strategies.

The promise of research on mental health promotion notwithstanding, a substantial minority of older people are disabled, often severely, by mental disorders including Alzheimer's disease, major depression, substance abuse, anxiety, and other conditions. In the United States today, the highest rate of suicide—an all-too-common consequence of unrecognized or inappropriately treated depression—is found in older males. This fact underscores the urgency of ensuring that health care provider training properly emphasizes skills required to differentiate accurately the causes of cognitive, emotional, and behavioral symptoms that may, in some instances, rise to the level of mental disorders, and in other instances be expressions of unmet general medical needs.

As the life expectancy of Americans continues to extend, the sheer number—although not necessarily the proportion—of persons experiencing mental disorders of late life will expand, confronting our society with unprecedented challenges in organizing, financing, and delivering effective mental health services for this population. An essential part of the needed societal response will include recognizing and devising innovative ways of supporting the increasingly more prominent role that families are assuming in caring for older, mentally impaired and mentally ill family members.

### **Chapter 3: Children and Mental Health**

- Childhood is characterized by periods of transition and reorganization, making it critical to assess the mental health of children and adolescents in the context of familial, social, and cultural expectations about age-appropriate thoughts, emotions, and behavior.
- The range of what is considered “normal” is wide; still, children and adolescents can and do develop mental disorders that are more severe than the “ups and downs” in the usual course of development.
- Approximately one in five children and adolescents experiences the signs and symptoms of a DSM-IV disorder during the course of a year, but only about 5 percent of all children experience what professionals term “extreme functional impairment.”

- Mental disorders and mental health problems appear in families of all social classes and of all backgrounds. No one is immune. Yet there are children who are at greatest risk by virtue of a broad array of factors. These include physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect.
- Preventive interventions have been shown to be effective in reducing the impact of risk factors for mental disorders and improving social and emotional development by providing, for example, educational programs for young children, parent-education programs, and nurse home visits.
- A range of efficacious psychosocial and pharmacologic treatments exists for many mental disorders in children, including attention-deficit/hyperactivity disorder, depression, and the disruptive disorders.
- Research is under way to demonstrate the effectiveness of most treatments for children in actual practice settings (as opposed to evidence of “efficacy” in controlled research settings), and significant barriers exist to receipt of treatment.
- Primary care and the schools are major settings for the potential recognition of mental disorders in children and adolescents, yet trained staff is limited, as are options for referral to specialty care.
- The multiple problems associated with “serious emotional disturbance” in children and adolescents are best addressed with a “systems” approach in which multiple service sectors work in an organized, collaborative way. Research on the effectiveness of systems of care shows positive results for system outcomes and functional outcomes for children; however, the relationship between changes at the system level and clinical outcomes is still unclear.
- Families have become essential partners in the delivery of mental health services for children and adolescents.
- Cultural differences exacerbate the general problems of access to appropriate mental health services. Culturally appropriate services have been designed but are not widely available.

#### **Chapter 4: Adults and Mental Health**

As individuals move into adulthood, developmental goals focus on productivity and intimacy including pursuit of education, work, leisure, creativity, and personal relationships. Good mental health enables individuals to cope with adversity while pursuing these goals.

Untreated, mental disorders can lead to lost productivity, unsuccessful relationships, and significant distress and dysfunction. Mental illness in adults can have a significant and continuing effect on children in their care.

Stressful life events or the manifestation of mental illness can disrupt the balance adults seek in life and result in distress and dysfunction. Severe or life-threatening trauma experienced either in childhood or adulthood can further provoke emotional and behavioral reactions that jeopardize mental health.

Research has improved our understanding of mental disorders in the adult stage of the life cycle. Anxiety, depression, and schizophrenia, particularly, present special problems in this age group. Anxiety and depression contribute to the high rates of suicide in this population. Schizophrenia is the most persistently disabling condition, especially for young adults, in spite of recovery of function by some individuals in mid to late life.

Research has contributed to our ability to recognize, diagnose, and treat each of these conditions effectively in terms of symptom control and behavior management. Medication and other therapies can be independent, combined, or sequenced depending on the individual’s diagnosis and personal preference.

A new recovery perspective is supported by evidence on rehabilitation and treatment as well as by the personal experiences of consumers.

Certain common events of midlife (e.g., divorce or other stressful life events) create mental health problems (not necessarily disorders) that may be addressed through a range of interventions.

Care and treatment in the real world of practice do not conform to what research determines is best. For many reasons, at times care is inadequate, but there are models for improving treatment.

Substance abuse is a major co-occurring problem for adults with mental disorders. Evidence supports combined treatment, although there are substantial gaps between what research recommends and what typically is available in communities.

Sensitivity to culture, race, gender, disability, poverty, and the need for consumer involvement are important considerations for care and treatment.

Barriers of access exist in the organization and financing of services for adults. There are specific problems with Medicare, Medicaid, income supports, housing, and managed care.

## **Chapter 5: Older Adults and Mental Health**

- Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to the society, in spite of physiologic changes due to aging and increasing health problems.
- Continued intellectual, social, and physical activities throughout the life cycle are important for the maintenance of mental health in late life.
- Stressful life events, such as declining health and/ or the loss of mates, family members, or friends often increase with age. However, persistent bereavement or serious depression is not “normal” and should be treated.
- Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that present alone or co-occur should be recognized and treated as illnesses.
- Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular, dementia, depression, and schizophrenia, among other conditions, will all present special problems in this age group:
  - Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life;
  - Depression contributes to the high rates of suicide among males in this population; and
  - Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.
- There are effective interventions for most mental disorders experienced by older persons (for example, depression and anxiety), and many mental health problems, such as bereavement.
- Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults, when these interventions are modified for age and health status.
- Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider’s directions and advice, particularly about taking medications.
- Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical outcomes when mental illness is under-recognized and under-treated in primary care settings.
- Barriers to access exist in the organization and financing of services for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes, and managed care.

## **Chapter 6: Organization and Financing of Mental Health Services**

In the United States in the late 20th century, research-based capabilities to identify, treat, and, in some instances, prevent mental disorders are outpacing the capacities of the existing service system to deliver mental health care to all who would benefit from it. Approximately 10 percent of children and adults receive mental health services from mental health specialists or general medical providers in a given year. Approximately one in six adults, and one in five children, obtain mental health services either from health care providers, the clergy, social service agencies, or schools in a given year.

Chapter 6 discusses the organization and financing of mental health services. The chapter provides an overview of the current system of mental health services, describing where people get care and how they use services. The chapter then presents information on the costs of care and trends in spending. Only within recent decades, in the face of concerns about discriminatory policies in mental health financing, have the dynamics of insurance financing become a significant issue in the mental health field. In particular, policies that have emphasized cost containment have ushered



in managed care. Intensive research currently is addressing both positive and adverse effects of managed care on access and quality, generating information that will guard against untoward consequences of aggressive cost-containment policies. Inequities in insurance coverage for mental health and general medical care—the product of decades of stigma and discrimination—have prompted efforts to correct them through legislation designed to produce financing changes and create parity. Parity calls for equality between mental health and other health coverage.

- Epidemiologic surveys indicate that one in five Americans has a mental disorder in any one year.
- Fifteen percent of the adult population use some form of mental health service during the year. Eight percent have a mental disorder; 7 percent have a mental health problem.
- Twenty-one percent of children ages 9 to 17 receive mental health services in a year.
- The U.S. mental health service system is complex and connects many sectors (public–private, specialty–general health, health–social welfare, housing, criminal justice, and education). As a result, care may become organizationally fragmented, creating barriers to access. The system is also financed from many funding streams, adding to the complexity, given sometimes competing incentives between funding sources.
- In 1996, the direct treatment of mental disorders, substance abuse, and Alzheimer’s disease cost the Nation \$99 billion; direct costs for mental disorders alone totaled \$69 billion. In 1990, indirect costs for mental disorders alone totaled \$79 billion.
- Historically, financial barriers to mental health services have been attributable to a variety of economic forces and concerns (e.g., market failure, adverse selection, moral hazard, and public provision). This has accounted for differential resource allocation rules for financing mental health services.
  - “Parity” legislation has been a partial solution to this set of problems.
    - Implementing parity has resulted in negligible cost increases where the care has been managed.
- In recent years, managed care has begun to introduce dramatic changes into the organization and financing of health and mental health services.
- Trends indicate that in some segments of the private sector per capita mental health expenditures have declined much faster than they have for other conditions.
- There is little direct evidence of problems with quality in well-implemented managed care programs. The risk for more impaired populations and children remains a serious concern.
- An array of quality monitoring and quality improvement mechanisms has been developed, although incentives for their full implementation have yet to emerge. In addition, competition on the basis of quality is only beginning in the managed care industry.
- There is increasing concern about consumer satisfaction and consumers’ rights. A Consumers Bill of Rights has been developed and implemented in Federal Employee Health Benefit Plans, with broader legislation currently pending in the Congress.

## **Chapter 7: Confidentiality of Mental Health Information: Ethical, Legal, and Policy Issues**

In an era in which the confidentiality of all health care information, its accessibility, and its uses are of concern to all Americans, privacy issues are keenly felt in the mental health field. An assurance of confidentiality is understandably critical in individual decisions to seek mental health treatment. Although an extensive legal framework governs confidentiality of consumer-provider interactions, potential problems exist and loom ever larger.

- People’s willingness to seek help is contingent on their confidence that personal revelations of mental distress will not be disclosed without their consent.
- The U.S. Supreme Court recently has upheld the right to the privacy of these records and the therapist-client relationship.
- Although confidentiality issues are common to health care in general, there are special concerns for mental health care and mental health care records because of the extremely personal nature of the material shared in treatment.
- State and Federal laws protect the confidentiality of health care information but are often incomplete because of numerous exceptions which often vary from state to state. Several states have implemented or proposed models for protecting privacy that may serve as a guide to others.
- States, consumers, and family advocates take differing positions on disclosure of mental health information without consent to family caregivers. In states that allow such disclosure, information provided is usually limited to diagnosis, prognosis, and information regarding treatment, specifically medication.

- When conducting mental health research, it is in the interest of both the researcher and the individual participant to address informed consent and to obtain certificates of confidentiality before proceeding. Federal regulations require informed consent for research being conducted with Federal funds.
- New approaches to managing care and information technology threaten to further erode the confidentiality and trust deemed so essential between the direct provider of mental health services and the individual receiving those services. It is important to monitor advances so that confidentiality of records is enhanced, instead of impinged upon, by technology.
- Until the stigma associated with mental illnesses is addressed, confidentiality of mental health information will continue to be a critical point of concern for payers, providers, and consumers.

## Chapter 8: A Vision for the Future—Actions for Mental Health in the New Millennium

The extensive literature that the Surgeon General’s report reviews and summarizes leads to the conclusion that *a range of treatments of documented efficacy exists for most mental disorders*. Moreover, a person may choose a particular approach to suit his or her needs and preferences. Based on this finding, the report’s principal recommendation to the American people is to *seek help if you have a mental health problem or think you have symptoms of a mental disorder*. As noted earlier, stigma interferes with the willingness of many people—even those who have a serious mental illness—to seek help. And, as documented in this report, those who do seek help will all too frequently learn that there are substantial gaps in the availability of state-of-the-art mental health services and barriers to their accessibility. Accordingly, the final chapter of the report goes on to explore opportunities to overcome barriers to implementing the recommendation and to have seeking help lead to effective treatment.

The final chapter identifies the following courses of action.

- *Continue to Build the Science Base:* Today, integrative neuroscience and molecular genetics present some of the most exciting basic research opportunities in medical science. A plethora of new pharmacologic agents and psychotherapies for mental disorders afford new treatment opportunities but also challenge the scientific community to develop new approaches to clinical and health services interventions research. Because the vitality and feasibility of clinical research hinges on the willing participation of clinical research volunteers, it is important for society to ensure that concerns about protections for vulnerable research subjects are addressed. Responding to the calls of managed mental and behavioral health care systems for evidence-based interventions will have a much needed and discernible impact on practice. Special effort is required to address pronounced gaps in the mental health knowledge base. Key among these is the urgent need for evidence which supports strategies for mental health promotion and illness prevention. Additionally, research that explores approaches for reducing risk factors and strengthening protective factors for the prevention of mental illness should be encouraged. As noted throughout the report, high-quality research and the effective services it promotes are potent weapons against stigma.
- *Overcome Stigma:* Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others. For our Nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind, and behavior, stigma must no longer be tolerated. Research on brain and behavior that continues to generate ever more effective treatments for mental illnesses is a potent antidote to stigma. The issuance of this Surgeon General’s Report on Mental Health seeks to help reduce stigma by dispelling myths about mental illness, by providing accurate knowledge to ensure more informed consumers, and by encouraging help seeking by individuals experiencing mental health problems.
- *Improve Public Awareness of Effective Treatment:* Americans are often unaware of the choices they have for effective mental health treatments. In fact, there exists a constellation of several treatments of documented efficacy for most mental disorders. Treatments fall mainly under several broad categories—counseling, psychotherapy, medication therapy, rehabilitation—yet within each category are many more choices. All human services professionals, not just health professionals, have an obligation to be better informed about mental health treatment resources in their communities and should encourage individuals to seek help from any source in which they have confidence.
- *Ensure the Supply of Mental Health Services and Providers:* The fundamental components of effective service delivery, which include integrated community-based services, continuity of providers and treatments, family support services (including psycho-education), and culturally sensitive services, are broadly agreed upon, yet certain of these and other mental health services are in consistently short supply, both regionally and, in some instances, nationally. Because the service system as a whole, as opposed to treatment services considered in isolation, dictates the outcome of recovery-oriented mental health care, it is imperative to

expand the supply of effective, evidence-based services throughout the Nation. Key personnel shortages include mental health professionals serving children/adolescents and older people with serious mental disorders and specialists with expertise in cognitive-behavioral therapy and interpersonal therapy, two forms of psychotherapy that research has shown to be effective for several severe mental disorders. For adults and children with less severe conditions, primary health care, the schools, and other human services must be prepared to assess and, at times, to treat individuals who come seeking help.

- *Ensure Delivery of State-of-the-Art Treatments:* A wide variety of effective, community-based services, carefully refined through years of research, exist for even the most severe mental illnesses yet are not being translated into community settings. Numerous explanations for the gap between what is known from research and what is practiced beg for innovative strategies to bridge it.
- *Tailor Treatment to Age, Gender, Race, and Culture:* Mental illness, no less than mental health, is influenced by age, gender, race, and culture as well as additional facets of diversity that can be found within all of these population groups—for example, physical disability or a person’s sexual orientation. To be effective, the diagnosis and treatment of mental illness must be tailored to all characteristics that shape a person’s image and identity. The consequences of not understanding these influences can be profoundly deleterious. “Culturally competent” services incorporate understanding of racial and ethnic groups, their histories, traditions, beliefs, and value systems. With appropriate training and a fundamental respect for clients, any mental health professional can provide culturally competent services that reflect sensitivity to individual differences and, at the same time, assign validity to an individual’s group identity. Nonetheless, the preference of many members of ethnic and racial minority groups to be treated by mental health professionals of similar background underscores the need to redress the current insufficient supply of mental health professionals who are members of racial and ethnic minority groups.
- *Facilitate Entry Into Treatment:* Public and private agencies have an obligation to facilitate entry into mental health care and treatment through the multiple “portals of entry” that exist: primary health care, schools, and the child welfare system. To enhance adherence to treatment, agencies should offer services that are responsive to the needs and preferences of service users and their families. At the same time, some agencies receive inappropriate referrals. For example, an alarming number of children and adults with mental illness are in the criminal justice system inappropriately. Importantly, assuring the small number of individuals with severe mental disorders who pose a threat of danger to themselves or others ready access to adequate and appropriate services promises to reduce significantly the *need* for coercion in the form of involuntary commitment to a hospital and/or certain outpatient treatment requirements that have been legislated in most states and territories. Coercion should not be a substitute for effective care that is sought voluntarily; consensus on this point testifies to the need for research designed to enhance adherence to treatment.
- *Reduce Financial Barriers to Treatment:* Concerns about the cost of care—concerns made worse by the disparity in insurance coverage for mental disorders in contrast to other illnesses—are among the foremost reasons why people do not seek needed mental health care. While both access to and use of mental health services increase when benefits for those services are enhanced, preliminary data show that the effectiveness—and, thus, the value—of mental health care also has increased in recent years, while expenditures for services, under managed care, have fallen. Equality between mental health coverage and other health coverage—a concept known as parity—is an affordable and effective objective.

### **Scope of Coverage of the Report**

This report is comprehensive but not exhaustive in its coverage of mental health and mental illness. It considers mental health facets of some conditions which are not always associated with the mental disorders and does not consider all conditions which can be found in classifications of mental disorders such as DSM-IV. The report includes, for example, a discussion of autism in Chapter 3 and provides an extensive section on Alzheimer’s disease in Chapter 5. Although DSM-IV lists specific mental disorder criteria for both of these conditions, they often are viewed as being outside the scope of the mental health field. In both cases, mental health professionals are involved in the diagnosis and treatment of these conditions, often characterized by cognitive and behavioral impairments. Developmental disabilities and mental retardation are not discussed except in passing in this report. These conditions were considered to be beyond its scope with a care system all their own and very special needs. The same is generally true for the addictive disorders, such as alcohol and other drug use disorders. The latter, however, co-occur with such frequency with the other mental disorders, which are the focus of this report, that the co-occurrence is discussed throughout. The report addresses the epidemiology of addictive disorders and their co-occurrence with other mental disorders as well as the treatment of co-occurring conditions. Brief sections on substance abuse in adolescence and late life also are included in the report.

## Preparation of the Report

In September 1997, the Office of the Surgeon General, with the approval of the Secretary of the Department of Health and Human Services, authorized the Substance Abuse and Mental Health Services Administration (SAMHSA) to serve as lead operating division for preparing the Surgeon General's Report on Mental Health. SAMHSA's Center for Mental Health Services worked in partnership with the National Institute of Mental Health, National Institutes of Health, to develop this report under the guidance of Surgeon General David Satcher, M.D., Ph.D. The Federal partners established a Planning Board comprising individuals who represent a broad range of expertise in mental health: university-based researchers and educators, practicing mental health professionals, self-identified consumers of mental health services, and many knowledgeable advocates in diverse areas of the mental health field. Also included on the Planning Board were individuals representing Federal Operating Divisions, Offices, Centers, and Institutes and private nonprofit foundations with interests in the area of mental health.

### Editors

Howard H. Goldman, M.D., Ph.D., Senior Scientific Editor, Professor of Psychiatry, University of Maryland School of Medicine, Baltimore, Maryland.

CAPT Patricia Rye, J.D., M.S.W., Managing Editor, Office of the Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, Maryland.

Paul Sirovatka, M.S., Coordinating Editor, Science Writer, Office of Science Policy and Program Planning, National Institute of Mental Health, National Institutes of Health, Bethesda, Maryland.

### Senior Science Writer

Miriam Davis, Ph.D., Medical Writer and Consultant, Silver Spring, Maryland.

## References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Conwell, Y. (1996). *Diagnosis and treatment of depression in late life*. Washington, DC: American Psychiatric Press.
- Cowen, E. L. (1994). The enhancement of psychological wellness: Challenges and opportunities. *American Journal of Community Psychology*, 22(2), 149–179.
- DSM-IV. See American Psychiatric Association (1994).
- Frasure-Smith, N., Lesperance, F., & Talajic, M. (1993). Depression following myocardial infarction. Impact on 6-month survival. *Journal of the American Medical Association*, 270, 1819–1825.
- Frasure-Smith, N., Lesperance, F., & Talajic, M. (1995). Depression and 18-month prognosis after myocardial infarction. *Circulation*, 91, 999–1005.
- Murray, C.L., & Lopez, A.D. (Eds.). (1996). *The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge, MA: Harvard University.
- Secker, J. (1998). Current conceptualizations of mental health and mental health priorities. *Health Education Research*, 13(1), 57–66.
- Zisook, S., & Shuchter, S. R. (1991). Depression through the first year after the death of a spouse. *American Journal of Psychiatry*, 148, 1346–1352.
- Zisook, S., & Shuchter, S. R. (1993). Major depression associated with widowhood. *American Journal of Geriatric Psychiatry*, 1, 316–326.

# Workshop 2:

## Specific Mental Disorders and how they are Diagnosed

*“In the shadow of your wings I will take refuge, till the storms of destruction pass by.”* Psalm 57:1

### Purpose

Specific mental disorders from the DSM-IV in each category are presented. The categories of mental disorders are mood disorders, anxiety disorders, eating disorders, psychotic disorders, substance abuse, and personality disorders. There is also a discussion of suicide.

### Materials

- Newsprint and paper for handouts.
- The on-going list entitled **“Responses of a Faith Community”**
- If possible, have a copy of the DSM-IV-TR available for the meeting.
- Equipment for playing music, (see “Adding Artistic and Musical Dimensions to the Workshops,”) if you will be using it.

### Preparation

The most important planning to do for this workshop is to decide which of the mental disorders to discuss in class, and how to present them. There is more material here than can be presented if there is a lot of discussion in the class; along with a description of each of the mental disorders there is a case study and discussion questions. Criteria that you might use for deciding which disorders to focus on are: if members of the congregation or their families have a particular disorder, if the disorder is particularly prevalent in the community, or if you have a guest speaker who has experience with a disorder and can discuss it to the class. It is possible to discuss some disorders in depth, and hand out information about others. Of course, the workshop can be broken into two or three sessions if more detailed information about each disorder is desired. This is recommended if there is a lot of interest in the participants in the program.

In choosing how to discuss a disorder, consider the following:

- A very effective way of introducing and describing these disorders and what they imply for an individual or family is to have a guest or guests with one or more of the disorders either personally, or in their family.
- Another possible guest speaker might be a psychiatrist or other mental health professional who diagnoses these disorders as part of his or her practice.
- If you don't have access to a guest, ask the class if they have experience in this illness in themselves or in a friend.
- Finally, if no person can testify about a given disorder, you can read the case studies in this curriculum for that particular disorder.
- If is a good idea to spend at least 10-15 minutes on the subject of suicide, because it is so serious, and because it is a factor in many disorders.
- Give a brief overview of the disorders not presented using the handouts

As an example, the following is one possible lesson plan for this workshop:

WORKSHOP ELEMENT	MINUTES
Opening and check in	10
Diagnosis of mental disorders, handing out materials on disorders not to be discussed	5
<i>Substance Abuse</i> <u>Alcohol dependence</u> : Review the material on substance abuse disorders. Have a guest speaker from AA come and talk about Alcoholism.	20
<i>Mood Disorders</i> : <u>Depression</u> After an overview of depression, a class member talks about her experience with depression. Class discussion.	20
<i>Anxiety Disorders</i> <u>Panic attack</u> : Read the case study on Agoraphobia and have a class	20

discussion:	
Give an overview of <i>Psychotic Disorders</i> Perform <i>Hearing Voices Skit</i>	15
Give an overview of <i>Eating Disorders</i> and <i>Personality Disorders</i> based on the hand outs. Distribute copies of case studies for these disorders.	15
Suicide	10
Closing	5

General preparation for this workshop:

- Decide which disorders will be focused on, and which will not. Invite any potential guest speakers, or class members to speak. Decide which case studies will be read. Prepare a class lesson plan tailored for your use.
- Review the materials for the lessons, including the handouts.
- If you know that a specific mental disorder is of particular interest to the participants because of a personal or family situation, you can do extra reading in the DSM-IV about that disorder to be able to give detailed information. If the disorder of particular interest is not included in this curriculum, you can decide whether to research that disorder and present supplementary information on it during your workshop session.
- Prepare newsprint with the descriptions of Mood Disorders, Anxiety Disorders, Psychotic Disorders Substance Abuse Disorders, Personality Disorders, and Suicide from the materials provided for this session.
- Make copies of the *Handouts for Specific Mental Disorders and How They are Diagnosed* for students to use during class, and the *Reading Assignment for History of Mental Disorders* to be passed out as a reading assignment for next week.
- Prominently display the on-going list “**Responses of a Faith Community.**” Remember to ask “How could a faith community respond to this situation?” at appropriate times during the workshop.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Tell them who the artist, writer and composer of the week are.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings.

## SESSION PLAN

### Opening

**5 minutes**

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading* # 434 *May we be reminded here of our highest aspirations* Anonymous

*Moment of meditation or prayer*

### Workshop Components

#### Check in

**10 minutes**

Ask people checking in to give a sentence or two about how they are doing and share any observations of stigma of mental disorders during the week.

#### Diagnosis of Mental Disorders

**5 minutes**

To give an overview of the DSM diagnoses that we will be covering and what we will not be covering in this workshop and workshop 4, explain:

- We will be reviewing the major mental disorders as specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).
- The intent of the DSM is not to over-pathologize behavior; “*no diagnosis*” is the default diagnosis until shown not to be valid.
- Many diagnoses are ruled out if there is a substance related disorder or a general medical condition that can cause the symptoms
- Multiple diagnoses are possible unless explicitly ruled out.

- The DSM is over 900 pages long and identifies 265 mental disorders. We will of course not be describing every disorder, just the major categories and diagnoses. Among the categories of disorders we will *not* cover are:
  - Sleep Disorders
  - Sexual and Gender Identity Disorders
  - Impulse Control Disorders
  - Factitious Disorders (intentionally produced)
  - Dissociative Disorders (consciousness, identity, perception)
- The DSM includes other diagnostic categories that we will *not* be covering. They include:
  - the influence of one’s general medical condition. Some diseases which can involve the brain are characterized as “General Medical Conditions” and not “Mental Disorders.” This is because there is usually some recognized physical cause for the illness. These include epilepsy, Parkinson’s disease and other diseases causing involuntary movements.
  - psychosocial and environmental contributors to a disorder
- Although very widely used, the DSM has its detractors. For example:
  - Some<sup>7</sup> feel that diagnostic reliability and validity is not achieved with the DSM because its definition of mental disorder:
    - requires unexpectedness; what about rare conditions and reactions to extreme trauma?
    - is over inclusive in the impairment requirement.
    - requires that the disorder happens in an individual; what about symptoms that might be a reaction to a hostile environment?
  - Others<sup>8</sup> believe that mental illness itself is not a valid construct – it is a judgment that devalues some human behaviors.
- When studying mental disorders, it is common for people to recognize some of the symptoms in themselves. If this should happen, recognize that these are normal feelings and are nothing to be afraid of. You can always make an appointment with a mental health professional for a diagnosis if you think you may have a disorder.

### Discussion of mental disorders

**95 minutes**

Following the lesson plan you have created for this workshop, present the mental disorders to the class. The categories of mental disorders for which there are case studies in the following are:

- Mood disorders
- Anxiety disorders
- Eating disorders
- Psychotic disorders
- Substance abuse
- Personality disorders

There is also a general discussion on suicide.

Handouts for each category follow this workshop description.

### ***Presentation and Discussion of Mental Disorders:***

The following are general instructions for discussing each class of mental disorders along with some suggested discussion questions.

#### **Mood Disorders:**

Present the handout on *Mood Disorder*, going over the descriptions of Major Depressive Episode, Manic Episode, Depressive Disorder and Bipolar Disorder. Ask your guest speaker(s) or use the provided case study to explain the disorders.

---

#### Discussion Questions for Mood Disorders

Have you recognized manic or depressive behavior in yourself or others?

- Ask if anyone who has experienced these disorders would like to tell the class of their experience.

- Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community.*”
- 

### **Anxiety Disorders**

Present the handout on Anxiety Disorders, going over the descriptions of Panic Attack, Agoraphobia, Obsessive-Compulsive Disorder, and Post Traumatic Stress Disorder. Ask your guest speaker(s) or use the provided case study to explain the disorders.

---

#### Discussion Questions for Anxiety Disorders

- Have you ever experienced symptoms of a panic attack?
  - What would you do if you suspected a family member had developed agoraphobia?
  - Besides war, what other kinds of events do you think could trigger PTSD?
  - Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community.*”
- 

### **Eating Disorders**

Eating disorders are characterized by severe disturbances in eating behavior. There are two eating disorders: anorexia nervosa where a person refuses to maintain a normal body weight, and bulimia nervosa, which is characterized by binge eating followed by purging or other methods to avoid weight gain. These disorders can be very serious; the mortality for anorexia nervosa is over 10%.

---

#### Discussion Questions for Eating Disorders

- Have you ever experienced symptoms of an eating disorder or know someone who has?
  - Do you think the images in our media contribute to these disorders?
  - Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community.*”
- 

### **Psychotic Disorders**

Present the handout on Psychotic Disorders, going over the descriptions of Schizophrenia and Schizoaffective Disorder. Have the class engage in the “Hearing Voices” Skit. Ask your guest speaker(s) or use the provided case study to explain the disorders.

---

#### Discussion Questions for Psychotic Disorders:

- Can you imagine what it might be like to have a psychotic episode?
  - Can you identify with the fear and terror a psychotic person might experience?
  - Have you experienced being with someone who has a delusion? How did you react?
  - Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community.*”
- 

### **Hearing Voices Skit**

This skit simulates what it feels like for a psychotic person to hear voices. It should allow the class members to feel empathy toward people with these disorders. It is adapted from an exercise used by NAMI’s Family-to-Family program. The description of the exercise and materials for it are included after this workshop. After the skit completes, engage in a dialog with the class.

---

#### Discussion Questions after Hearing Voices Skit:

- What was it like to play the part of a “student” and hear voices?
  - What was it like to play the part of a “voice”?
  - Does this skit give you any understanding about the difficulties that a psychotic person may have in school, socially, or on a job?
  - Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community.*”
-



## Substance Related Disorders

Present the handout on Substance Related Disorders, going over the descriptions of Substance, the substance classes, Substance Dependence, and Substance Abuse. Ask your guest speaker(s) or use the provided case study to explain the disorders.

---

Discussion Questions for Substance Related Disorders:

- What is our responsibility as a society and as people of faith to help people with these problems, and work to lessen them? What actions can we take?
  - What would you do if you expected that you have a substance related disorder? If a member of your family had one?
  - Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community.*”
- 

## Personality Disorders

Present the handout on *Personality Disorders* going over the descriptions of Antisocial Personality Disorder, Borderline Personality Disorder, Antisocial Personality Disorder, Paranoid Personality Disorder, Narcissistic Personality Disorder, and Histrionic Personality Disorder. Ask your guest speaker(s) to tell their story or use the provided case studies to explain the disorders.

---

Discussion Questions for Personality Disorders

- If you in the future recognize one of these personality disorders in someone who you are interacting with, how will you react differently than you might have before?
  - If you recognize one of these personality disorders in yourself, what action will you take to verify it? Will you want to make changes?
  - Discuss the case study of Thomas Wolfe from the handout. Possible discussion questions:
    - Do you think Wolfe’s mental difficulties contributed to his artistic talent? If so, how?
    - Do you think Wolfe had to try to overcome his mental disorder to write successfully?
    - Do you think the wide-spread popularity of Wolfe’s autobiographical books means that readers recognize something of themselves in his mental anguish? If not, why?
    - What implications do the answers of these questions have to your self, your family, your community?
  - Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community.*”
- 

## Suicide

**10-15 minutes**

Present the chart labeled *Suicide* and read the following paragraph.

Being suicidal and committing suicide are not mental disorders themselves, rather a symptom of and a response to other disorders. Although people with all kinds of mental disorders can be suicidal, the most common occurrences are with depression, bipolar disorder and substance-related disorders. In the United States, among people aged 14-44, it is the second highest cause of death among women and the fourth highest cause of death among men. In *Night Falls Fast*, Dr. Kay Jamison describes the thinking of someone who is suicidal as follows:

“When people are suicidal, their thinking is paralyzed, their options appear sparse or nonexistent, their mood is despairing, and hopelessness permeates their entire mental domain. The future cannot be separated from the present and the present is painful beyond solace. ... This sense of unmanageable, of hopelessness, or invasive negativity about the future is, in fact, one of the most consistent warning signs of suicide.” pp 93-94.

Sometimes a person engages in self-injurious behavior, stopping short of suicide. One example of this is the strong urge some feel to cut themselves. Someone who has experienced it describes the urge to cut as follows:

*The Urge to Cut* by Karen Ilkka, private communication to Barbara Meyers

“Cutting oneself is a relief from the internal pain. It changes the focus from internal to external pain and distracts one. The visual wound is a representation of the terrible internal wound. It is self-punishment, self-hate, anger turned inward, and an expression of grief like cutting hair or tearing clothing. It is better than death, the alternative.”

---

Discussion about Suicide:

- Do you understand how someone can commit suicide when in a depressive episode?
- Ask if anyone has known someone who has attempted or succeeded in committing suicide, and would be willing to share the story with the class.
- Ask if anyone has felt suicidal themselves and would be willing to describe it to the class.
- Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community*.”

---

**Closing**

**5 minutes**

- *Reading:* from Thomas Wolfe<sup>9</sup>

*I think I shall always remember this black period with a kind of joy,  
with a pride and faith and deep affection  
that I could not at the time have believed possible,  
for it was during this time that I somehow survived defeat  
and lived my life through to a first completion,  
and through the struggle, suffering, and labor of my own life  
came to share those qualities in the lives of people all around me.*

**Assignments**

- Pass out copies of *Reading Assignment for History of Mental Disorders* to be discussed in the next workshop.

## Hearing Voices Skit

Before the exercise begins, tell the class that the skit will simulate the experience that a psychotic person might have hearing voices. Ask if any members of the class would like to be excused from the exercise, either because they have had heard voices themselves, or feel it would be too stressful for them.

Divide the class into three roles.

1. About 2/3 of the class should be “students.” Give each “student” a blank piece of paper, tell them to remain in their seats, and follow directions from the “teacher.”
2. About 1/3 of the class should be “voices.” The following pages of this exercise contain scripts for the “voices.” Reproduce these pages, cutting them at the dashed line, to create scripts for the “voices.” Give each “voice” a script, and tell them that they are to stand behind the “students” and repetitively say their script, over and over, trying to distract the “students”. Tell them it is OK to speak loudly, and even use profanity if they feel comfortable in adding it to their script.
3. One person, a class member or perhaps an instructor, should play the part of the “teacher.” The “teacher” sits in front of the “students” and gives them directions on what to draw on their papers. The instructions for the “teacher” are included in the following pages along with scripts for the “voices.” Hand the “teacher” his or her script.

When all people have been instructed about what to do in the exercise, ask the “teacher” to be seated in front of the “students,” starting to give his or her instructions. And, tell the “voices” to stand behind the “students” and begin repetitively speaking their scripts.

Let the exercise continue for a minute or two, and then ask everyone to stop.

Script for a “voice”

**Watch him (or her). She can't even follow simple directions. Let's take the dose up to the next level.**

REPEAT UNTIL THE EXERCISE STOPS

Script for a “voice”

**Her blood pressure dangerously is elevated; her heart rate is 120 beats / minute.**

REPEAT UNTIL THE EXERCISE STOPS

Script for a “voice”

**The leader of this stupid exercise is totally evil. George Bush sent him/her to trick you so that you will be sent to a mental hospital.**

REPEAT UNTIL THE EXERCISE STOPS

Script for a “voice”

**Hello this is Hitler. And, boy do I have a song for you. “Nobody likes me, everybody hates me. I think I’ll go eat worms: fat ones, skinny ones, slimy ones, silky ones. Watch how they do squirm.”**

REPEAT UNTIL THE EXERCISE STOPS

Script for a “voice”

**She thinks that she is such hot stuff, but her singing is totally off key.**

REPEAT UNTIL THE EXERCISE STOPS

Script for a “voice”

**Listen, you have got to get away from here. Those people behind you will hurt you when you are finished with your drawing. Go!**

REPEAT UNTIL THE EXERCISE STOPS

Script for a “voice”

**You’re boring. She is just being nice to you,  
pretending to like you.**

REPEAT UNTIL THE EXERCISE STOPS

Script for a “voice”

**This is the weather station. There is a 50%  
chance of showers and a 20% chance for a  
tsunami. Have a nice day.**

REPEAT UNTIL THE EXERCISE STOPS

Instructions for the “teacher”

Speaking slowly and softly, tell the “students” to follow your instructions carefully. Ask them to:

- Draw four squares across the top of the paper
- Draw four squares across the bottom of the paper
- Connect the squares at the top of the paper to those at the bottom
- Draw a circle around the outside of the paper

## Handouts for

### Specific Mental Disorders and how they are Diagnosed

*“In the shadow of your wings I will take refuge, till the storms of destruction pass by.”* Psalm 57:1

- Mood Disorders
  - Case studies of Depression and Bi-polar Disorder
- Anxiety Disorders
  - Case studies of Agoraphobia, Obsessive-Compulsive Disorder and Post Traumatic Stress Disorder
- Eating Disorders
  - Case study of Anorexia Nervosa
- Psychotic Disorders
  - Case study of Schizophrenia
- Substance Related Disorders
  - Case studies of Alcohol Dependence and Heroin Dependence
- Somatoform Disorders
  - Case study of Pain Disorder
- Personality Disorders
  - Case Studies of Borderline, Antisocial, Paranoid, Narcissistic, Histrionic, Schizotypal, and Dependent Personality Disorders, and a case of both Schizotypal and Borderline Personality Disorder Symptoms in one person.
- Suicide

## Mood Disorders

These disorders have a disturbance of mood as the predominant characteristic.

Lifetime prevalence: Major Depressive Disorder: 10-25% for women, 5-12% for men

Bipolar Disorder: 0.4 – 1.6%

### Mood Episodes:

**Major Depressive Episode:** 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

**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)

**Mood Disorders:** Diagnosed by the presence or absence of a mood episode.

**Major Depressive Disorder:** One or more Major Depressive Episodes

**Bipolar Disorder:** One or more Manic Episodes accompanied by Major Depressive Episodes

**Postpartum:** When a major depressive episode occurs within 4 weeks of giving birth, it is called Major Depressive Disorder with Postpartum Onset.

Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition* pages 345 – 428. See this reference for complete criteria.



## CASE STUDIES OF MOOD DISORDERS

---

**Case study: Major Depressive Disorder** from Gregg-Schroeder, Susan. *In the Shadow of God's Wings – Grace in the Midst of Depression* <sup>10</sup>

The symptoms were there, but I didn't recognize what was happening to me. Sadness and despair overwhelmed me. I felt disoriented and disconnected from my feelings and myself. I did not want to eat; I couldn't sleep. Nothing I did brought any pleasure; I was simply going through the motions. All I wanted to do was isolate myself from everyone. Any task I attempted took great effort. I felt utterly hopeless about the future. Soon I got to the point of believing that life was not worth living, and I developed an elaborate suicide plan. Yet, at the same time, I couldn't concentrate or think clearly. I felt as if I were falling into a bottomless black hole, and I saw no way out. I avoided the people who could help me most.

Fortunately, some people around me recognized the symptoms of severe clinical depression. I had several offers of help, but I felt such shame that I couldn't respond. After all, I was a professional, the one who was supposed to be helping others. I finally agreed to talk to a psychiatrist... It was one of the most humbling experiences of my life. I found myself weeping uncontrollably in [his] office. He suggested medication and recommended hospitalization. I reluctantly agreed to try medication but clearly stated my position, "I would rather be dead than have to go to the hospital."

The next week was a blur as I tried to keep up the pretense of working. I visited my regular doctor to get medication, and he immediately referred me to the psychosocial services offered by my health plan. Hospitalization was again recommended. My husband and I were so run down from trying to make it through each day that I reluctantly agreed.

---

**Case Study: Bipolar Disorder** from Jamison, Kay Redfield. *An Unquiet Mind – A Memoir of Moods and Madness* <sup>11</sup>

Dr. Kay Redfield Jamison, a professor of Psychiatry at Johns Hopkins University, is known for her co-authorship of the standard medical text for Bipolar Disorder. <sup>12</sup> She can speak authoritatively as a doctor but also because she herself is living with Bipolar Disorder.

In this account she describes how her first attack of this illness came during her senior year in high school. As with many people who experience their first episode of mania, everything seemed so effortless, and she didn't feel any warning signs that people with bipolar disorder later learn to sense; why should she? She felt wonderful; a myriad of plans for projects of all sorts came to her enthusiastic mind; she got little or no sleep; she read constantly; she wrote poetry and drama; she intuitively saw patterns in the workings of the universe; she made "expansive, completely unrealistic, plans" for her future which she saw as filled with promise; in short, she felt that she could do anything in the world. She talked constantly to her friends about what she was experiencing.

Her friends, she reports, "were less than transfixed by my insights into the webbing and beauties of the universe, although considerably impressed by how exhausting it was to be around my enthusiastic ramblings: You're taking too fast, Kay. Slow down, Kay. You're wearing me out, Kay. Slow down, Kay. And those times when they didn't actually come out and say it, I still could see it in their eyes: For God's sake, Kay, slow down."

Eventually, as in all cases of bipolar disorder, the depressive stage hit. Quickly and with mounting despair she started a downward slide, in which she couldn't seem to concentrate or remember anything she had read. Whereas before everything she read gave her marvelous insights, now nothing made sense. Assigned school work was impossible to follow. It was a frightening fall from her earlier euphoria.

She began to think of death, even suicide. She felt, "I was going to die, what difference did anything make? Life's run was only a short and meaningless one, why live?" Even getting out of bed was torturous. Whereas before she enthusiastically wanted and needed to share her ideas with friends, she now avoided them as much as possible. Before and after school, she tried to find a quiet corner in the school library where she could suffer in confused misery and despair by herself.

## Anxiety Disorders

These disorders are characterized by an unpleasant feeling of apprehension usually accompanied by physical discomfort, such as palpitations, shortness of breath and restlessness. People with these disorders usually seek help from a medical doctor for their physical symptoms. Estimated Lifetime prevalence: Panic attack: 1.2% in the general population, but up to 60% in cardiac clinics; Agoraphobia: 0.5 – 1%; OCD: 2.5%; PTSD: 8%.

### Panic Attack

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

### Agoraphobia

Anxiety about being in places or situations from which escape might be difficult, ex: being outside the home, or traveling in a plane. These situations are avoided, or endured with great distress, or with fear of having a panic attack.

### 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 they 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. The person attempts to suppress the thoughts

#### 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

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, dreams or feelings that the event is recurring.
- The person makes efforts to avoid all stimuli, thoughts, feelings or activities associated with the trauma.
- The person develops symptoms of increased arousal: ex. hyper-vigilance, angry outbursts, difficulty concentrating, startle response.

Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Ed.*, p 429- 484. See this reference for complete criteria.

## CASE STUDIES OF ANXIETY DISORDERS

---

**Case Study: Agoraphobia** from Handly, Robert, with Pauline Neff. *Anxiety and Panic Attacks – Their Cause and Cure: The Five-Point Life-Plus Program for Conquering Fear*<sup>13</sup>

It was the anniversary of a death in the family that first triggered a panic attack for Robert Handly, eventually leading to a devastating agoraphobia that severely constricted his life. He was 33 and established in his own successful executive search firm in the downtown business district. His father, who he had greatly admired and relied upon, had died almost exactly a year before during the Christmas season of a sudden heart attack. Since his father's death his mother had been inconsolable and sometimes suicidal. John felt the responsibility of looking after his mother's well-being in addition to his own young family. In the back of his mind he worried that the holidays would be hard on his mother because of what had happened the year before.

The day of his first panic attack began as usual, with no warning of what was about to happen. He ate breakfast, drove to work and started his habitual morning office routine. He relates, "And then it happened. With no warning, my heart began to pound. Perspiration broke out on my forehead. My stomach flopped over. I bolted upright while my mind raced out of control with fantasies of childhood's worst demon – ending with a vision of my father's pale face in his coffin. *What was happening to me?*"

He realized that the phone was ringing and when he answered, it was his mother. "I said, 'My God, Mother, something awful is happening to me. I feel as if I'm going to black out!' I gasped. 'I'm coming,' Mother screamed. The few minutes before she arrived seemed like hours. My heart was pounding out of my chest. Perspiration streamed down my face. I wanted to jump up and run out of the office, but at the same time I was afraid I would faint."

His mother took him to the doctor immediately, but by then he was feeling fine. None of the tests that were taken showed anything abnormal – certainly not a heart attack or imminent death which is what he and his mother had feared.

But when he later went back to the office, the symptoms started again. He was afraid the doctor had made a mistake and was sure that he would die right there. He managed to summon his wife who came and brought him home. Once home, he again felt very well. He and his wife "were both confused by what had happened."

---

**Case study: Obsessive-Compulsive Disorder** the character Melvin Udall played by Jack Nicholson in the movie *As Good As it Gets*

The movie *As Good As it Gets* contains a classic portrayal of obsessive-compulsive disorder for which Jack Nicholson received the Oscar for Best Actor in 1997. Jack plays Melvin Udall, a pulp-novelist with obsessive-compulsive disorder. As a result, he has many quirks in his daily behavior: he avoids cracks in the sidewalk, making his daily walks outside on busy sidewalks a perilous series of dodging and weaving around other people; he never washes with the same bar of soap twice; he has elaborate rituals involving locking and unlocking doors a set number of times before leaving his apartment; and, he has a strictly-followed routine of having breakfast at the same table in the same café always served by the same waitress, Carol, who is the only one who will tolerate his odd, eccentric, and often rude behavior. This includes his always using sterilized plastic utensils rather than restaurant silverware that might have germs on it. Any departure from this routine throws him into a foul-tempered panic, lashing out in rude diatribes to anyone near by.

As the movie progresses, a relationship between Melvin and Carol develops, and his always-concealed heart is touched in a way that it never has been before. As viewers, we begin to see how Melvin has been trapped by his disorder into a very constricted life where no one else has been let inside. His gruff, stand-offish manner has been a front constructed to let him find a small corner of the world to inhabit with the compulsions he feels driven to perform. No one can see his true, caring nature, not even himself.

This world comes apart when Carol must stay home to care for her son, and he can't have his breakfast served by her. Realizing that something is seriously wrong, he begins therapy and eventually is able to

develop a more genuine and human connection to Carol and then to others. His compulsions begin to disappear. It is a romantic, at once tragic and funny story, which leaves us with hope for the Melvins of the world.

---

***Case Study: Post Traumatic Stress Disorder*** from Stephen J. Robbins. *The Long Journey Home*<sup>14</sup>

It was June of 1969, and I was returning to the U.S. from my fourth and final tour of U.S. Navy flight duty in Vietnam. No longer would I have to drink myself to sleep each night, ever fearful of the rocket attacks that came more and more frequently. No longer would I have to see the sad faces of the long suffering Vietnamese children, their lives so torn by war. No longer would I have to hate myself because I was taking part in something that I believed in my heart to be very wrong. No longer would I have to pretend that I wasn't involved simply because I was a technician and not a warrior. No longer would I have to awake to the overpowering smell from the morgue just down the road or see the endless stacks of aluminum coffins, those high-tech final rewards. ...

The official end of the Vietnam War two years later seemed meaningless to me. I was either beyond caring or I somehow knew that my war was not at an end. ... Just like my latter days at DaNang Airbase, I was again visiting the bars every night. In 1985 the flashing blue lights of a police cruiser and a DUI arrest signaled the end of my drinking career. Giving up the one thing that had helped me kill the memories of Vietnam was not an easy thing to accomplish. But a year in an outpatient alcohol treatment program and many years in a twelve-step recovery program seemed to do the job. I felt like I was totally alone in the world, partially because I could not expose my family to the horrors of my mind. ...

By 1990 something was very wrong, and I knew it. The problems started with an inability to sleep at night. The next symptom that appeared was an inability to concentrate on anything in moments of minor stress. Neither of these things had ever happened to me before. Finally one night, when I had managed to fall asleep after being awake for about 48 hours, the war terror nightmares started. Usually I don't remember dreams, but I was then taking a psychology class in which we had a class assignment to remember dreams by writing them down the instant you awoke. This was an extremely rude awakening to say the least. After talking over what had happened with a friend the next day, I entered the PTSD treatment program at a local vets' outreach center.

Most experts say that PTSD frequently gets worse before it gets better. This was surely the case for me. The process of systematically uncovering and putting in proper perspective all the things that I had tried so hard to pretend didn't exist brought out tremendous amounts of anger and confusion in me. However, there were always my fellow vets and a few other friends to help me through the rough times. I remained in the treatment program for approximately one year and at the end of that year, was again ready to try and start a new life. ...

Not long after this I was talking to a lady who worked in the office where I was employed. She was married to a young man who was undergoing training as an Army nurse and who had been working long hours with military personnel wounded during the Gulf War. For some reason, I mentioned that I had been in a treatment program for Vietnam vets. She looked up, her eyes close to tears, and simply said, "Thank you for your service and welcome home."

I don't believe I was able to say anything at the moment. I rapidly returned to my office, closed the door, and cried my heart out. I have no idea of how long the tears continued; but when they were over, I knew beyond all doubt that something inside of me had changed. I was finally home, and my war was over. This young lady's simple words had triggered something wonderful in me, something I never again want to lose.

## Eating Disorders

Eating disorders are characterized by severe disturbances in eating behavior.

The estimated life-time prevalence for anorexia nervosa is about 0.5% in females, and for bulimia nervosa is 1%-3% in females. In males, the prevalence is about one-tenth of that in females.

### **Anorexia nervosa**

Characterized by:

- refusal to maintain a normal body weight (less than 85% of normal weight)
- intense fear of gaining weight
- an inaccurate perception of the shape or size of one's body
- in women, absence of at least three consecutive menstrual cycles

This disorder can be very serious; the mortality for anorexia nervosa is over 10%.

### **Bulimia nervosa,**

Characterized by:

- Recurrent episodes of binge eating with a sense of lack of control over binge eating
- Recurrent episodes of compensatory behavior to avoid gaining weight. Examples are: self-induced vomiting, laxatives, diuretics, fasting and excessive exercise.
- A self-evaluation that is unduly influenced by body shape and weight.

Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*, pages 583-595. See this reference for complete criteria.

## CASE STUDY OF EATING DISORDERS

---

*Case Study: Anorexia Nervosa* from *Battling Anorexia – The Story of Karen Carpenter* by Adena Young <sup>15</sup>

Karen Carpenter was well known in the 70s and 80s for her dazzling music. She was one half of the sibling music group, The Carpenters. Born in 1950, she grew up listening to the Beatles and performing with her older brother Richard, and in her lifetime captured 3 Grammy's, 8 Gold Albums, 10 Gold Singles, and 5 Platinum Albums. You could say that she lead her life in the spotlight. Young girls looked up to her. She was a role-model and a symbol of American culture. As it turns out, it was these social pressures that ultimately lead to her downfall.

Richard Carpenter recalls that Karen was "a chubby teenager." Genetically, she wasn't meant to be super thin. Unfortunately for this singer, the only body that she would stand to have was a thin one. The dieting began in 1967 when Karen's doctor put her on a water diet, bringing her weight down from 140 lbs to 120. When she had made it down to 115 lbs, people told her she looked good, but she could only reply that this was just the beginning of the weight loss, and that she wanted to lose still more. By the fall of 1975, Karen was down to 80 lbs. She was taking dozens of thyroid pills a day, and throwing up the little food that she ate. Karen's body was so weak that she was forced to lay down between shows, and the audience was gasping at her body as she walked on stage. It was this year in Las Vegas that Karen collapsed on stage while singing "Top of the World". It was a big scare to the audience and her family. After being rushed to the hospital, it was reported that Karen was 35 lbs underweight. It was this final collapse that made Karen Carpenter realize that she had a serious problem. She went to doctors and therapists, and eventually began to believe that she was well. However, in reality, her body was still suffering from the lack of food, the over dosages of laxatives, the lack of sleep, and the anxiety of being on the road. When she died in 1983, it was a shock to many people who believed that she had been cured.

---

# Psychotic Disorders

These disorders are characterized by the presence of psychotic symptoms as defined below.  
Lifetime prevalence: Schizophrenia: 0.5-1.5%; Schizoaffective Disorder: Unknown; Delusional Disorder: 0.05-0.1%

## Schizophrenia

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.

There is no mood disorder present in schizophrenia.

## 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.

## Delusional Disorder

This disorder is characterized by delusions involving situations that occur in real life. A type is specified.

<b>Situation</b>	<b>Type</b>
Being followed or poisoned	persecutory
Having inflated wealth	grandiose
Being loved at a distance	erotomantic
Being deceived by a sexual partner	jealous
Having a disease	somatic

Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*, pages 297- 343. See this reference for complete criteria.

## CASE STUDY OF PSYCHOTIC DISORDERS

---

### *Case Study: Schizophrenia* from an interview with “Laura”<sup>16</sup> written by Barbara Meyers

“Laura” grew up in a well-educated family of 2 girls and 2 boys. She believes that during childhood she was always depressed, although at the time she didn’t identify it as depression, thinking it was normal to feel that way. She didn’t know what happiness felt like. In school, she was the teacher’s pet and was teased, kicked or pinched by the other children as they passed her in class and on the playground. She remembers thinking “If people found out what I am really like inside, they would hate me.” As a result, she didn’t talk about her feelings to anyone. She wanted to stay at home because she was so unhappy at school, but her mother made her go to school. She didn’t tell her teacher or parents about what was happening to her either at school, or in her thoughts. Swallowing her anger, she believed it was all her fault.

In high school, Laura’s unhappiness was more obvious and her parents sent her to a counselor. The counselor told her that it was all her mother’s fault, which Laura didn’t believe because her mother was wonderful and quite supportive of her.

When it came time for college, Laura decided that she would go to a school in the mid-west and have a fresh start to try and remake herself into the sunny, outgoing person she believed she ought to be. She hid her real feelings and convinced her counselor that she was ready to make the move. At college, she pressured herself into being friendly and outgoing. She also confided in a roommate the treatment by other kids when she was a child. The roommate told her that she had a right to be angry.

She believes her schizophrenia began as feelings of anger started to come up. Her mental outlook suddenly changed from loving other people to being angry at and fearful of the world. Her anger was a rage and she couldn’t control her emotions. She began to hear voices after watching an intense, disturbing movie in a theater. She gave up trying to be friendly, and thought “Now everyone will see what a horrible person I am really like inside.”

Unlike many other schizophrenics who hear voices in their heads, for her the voices always sounded like they were coming from other people. It was impossible to tell when the voices were real and when they were hallucinations. Her psychosis had begun and soon she was hearing more and more voices. And paranoia began; she thought half of the people in the United States hated her and would like her dead. She saw counselors at college and later at home who tried talk-therapy and anti-depressants, neither of which helped.

Finally, 2 years after she had active psychotic symptoms, her parents took her to see a psychiatrist. Immediately the psychiatrist diagnosed schizophrenia and prescribed anti-psychotic medication. This was when she finally started getting some relief. Although she still heard voices, they did not hurt so terribly. Later, she went through a spontaneous spiritual healing which took away her anger.

Laura was able to complete college in her home town, eventually married and has a happy home life with her husband. Employment has not been possible; she has held over 30 jobs before she either resigned or was let go. She now is on psychiatric disability.

Laura’s life today has many positive aspects; she has a happy solid marriage, she audits classes at a local college, she sometimes tutors others, she engages in exercise, does housework, and does peer-counseling at a local mental health center. The voices still sometimes come, and she still sometimes feels that people dislike her. But these don’t interfere with her ability to be happy, or rob her of her peace of mind. She relies on taking anti-psychotic medication and feels that it has saved her life. She is happy.

---



## Substance Related Disorders

These disorders result from taking a **substance**: i.e. a drug of abuse (including alcohol), the side effects of a medication and 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 Dependence:

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. **Compulsive pattern of use**:
  - a. taking in larger amounts and over longer period than intended
  - b. time spent in activities necessary to obtain the substance
  - c. important activities given up
  - d. continued use despite persistent problems related to use

### Substance Abuse:

A maladaptive pattern of substance use that causes harmful consequences, but that doesn't meet the criteria for substance dependence; tolerance, withdrawal and compulsive use are not present

1. Recurrent substance use resulting in a failure to fulfill major role obligations
2. Recurrent substance use in situations in which it is physically hazardous
3. Recurrent substance-related legal problems
4. Continued substance use despite having persistent problems related to the substance

**Dual Diagnosis:** A diagnosis of a substance abuse disorder and another psychiatric disorder.

Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*, pages 191 – 295. See this reference for complete criteria.

## CASE STUDIES OF SUBSTANCE RELATED DISORDERS

**Case Study: Alcohol Dependence** The source work for this case study, about Bill Wilson, the co-founder of Alcoholics Anonymous is from Hartigan, Francis. *Bill W. – A Biography of Alcoholics Anonymous Co-founder Bill Wilson.*<sup>17</sup>

This biography of one of the founders of Alcoholics Anonymous chronicles the various stages in the slide of Bill Wilson into alcoholism from 1918 until 1934.

Stage	Secondary Effect	Description
1918 Drinking to calm his nerves.	Relaxation and fantasy	His drinking started during the First World War to steady himself during terrifying assaults. It also allowed him to fantasize about a wonderful family life he would have after the war and he would be able to begin what he envisioned as a distinguished career.
1919 Drinking to feel sorry for himself	Hung-over at work Blackouts begin Family concerned	Returning to New York after the war, he kept drinking to “nurse his resentment about the unfair treatment that he, a war veteran and a leader of men, was receiving.” He drank at bars until closing time and when at parties, and then he went to work the next day hung over. Sometimes, he experienced “blackouts, periods when he would later have no recall of what he had done or said.”
1921 Drinking as a bad habit	Drinking recognized as problem Family increasingly concerned Attempts to get away and sober up	Bill and his wife Lois were concerned that his drinking had turned into a bad habit. As an attempt to stop, Bill and Lois went to Vermont, where her family had a camp, and they spent much of the time walking in the natural setting surrounding the camp. This worked, temporarily because he was away from alcohol, but after he returned to New York, he again took up intense drinking. In following years, they would again return to Vermont as a way to try ad re-start a sober life.
1925 Drinking for no apparent reason	Spending all available money on alcohol Major impact on family	The Wilsons spent the year driving around the country on motorcycles. This was a tacit acknowledgement that he was drinking simply because he drank. “And when he drank, he got drunk. On one occasion, he even disappeared with all of his and Lois’s money. She found him in a bar, drunk and incoherent. He had spent every penny they had getting that way”.
1928 Drunk every day	Broke and in nasty temper Realizes he is in serious trouble, but can’t stop.	Bill drank from the start of the day and frequently went on spending sprees. Many of his outings left him broke and in a nasty temper, with no way to get home.
1934 Living to drink	Drinking sprees Serious health issues. Realizes that abstention is the only way out	Bill’s health was seriously impaired and he knew his very life was in danger. He realized that if he had even one drink, this would be the start of a continual drinking spree. The only way he and Lois discovered to avoid this pattern was to keep away from alcohol entirely. Eventually, this belief would make its way into the philosophy of AA.

Throughout his slide into alcoholism, Bill Wilson had disdain for those drunkards that dried out after “finding religion.” He realized that his drinking was uncontrollable and might land him either dead or institutionalized, but embracing religion to stop drinking “seemed to be trading one odious dependency for another. He could not see how he could give up his intellect to embrace the tenets of any faith and still call himself a man.” Of course, later he did just that, and his dramatic religious conversion in December of 1934 would give rise to the prominence of “a higher power” in the 12-steps of Alcoholics Anonymous.

---

**Case Study: Heroin Dependence** from McMaster, Curtis P. *The Tragedy of Heroin Addiction*, in Cothran, Helen, Editor, *Heroin* <sup>18</sup>

A glaring orange summer sun rises over the edge of I-95 as we flash past the acres of ochre squares that make up the Philadelphia panorama. The cityscape comes into our view, and the scene is transmuted by the sun's rays into a shimmering, surreal mural – a picture of eternal and flawless perfection.

But Duke and I can't appreciate the beauty. We are hurtling north-bound, into the ghetto known and "the badlands," against the onslaught of the withdrawal pains that will catch us if the day grows any longer. Duke is hunched over the wheel of our battered moving van, which doubles as a taxi for any heroin junkie who can put gas in the tank. I'm riding shotgun, mentally navigating the miles in an attempt to erase them.

Like countless other mornings, the trip feels more as if I'm running away than rushing to somewhere. It's impossible to remember how long I've been doing this; every day is exactly the same.

No words are spoken in the truck. We are too lost in misery to communicate and too intent on our mission to waste attention on anything else. The smell of our unwashed bodies mingles with the highway and industrial stench. Uncombed hair, dirty clothing and unshaven, sunken faces have become so standard we are long past embarrassment or concern.

I feel the searing pain of withdrawal knife through me. In mute agony I consider killing Duke and then myself – a desperation born of hatred and mercy. Our addiction to heroin has joined us to it and each other in a bond of utter hopelessness. Years of need and resentment lock us in the circling of gladiatorial slaves, where even the survivor loses.

It will be only minutes now. But fear turns these minutes into an eternity of expectation. We are parched travelers approaching an oasis that could be dry, but must not be.

It's business as usual. They see us coming.  
"How many?" they ask.  
"Four of poison," I respond.

In a smooth exchange, \$40 goes out the truck window and heroin comes in. Two blocks later we pull over and take water from a dripping hydrant. A moment later we are sitting cross-legged in the rear of the truck, performing the daily ritual: mix with water, heat for a moment, draw into syringe, tie off arm and search for the least-damaged vein; insert needle and pray for that rich red gush that signifies success. Finally we inject it slowly, and close our eyes to contain the warm glow that has become the only thing in life worth saving.

---

## Somatoform Disorders

### Somatization disorders

Psychological disorders in which a patient experiences physical symptoms despite the absence of an underlying medical condition that can fully explain their presence.

The essential feature of a somatization disorder is a pattern of many of physical complaints beginning in persons younger than 30 years of age that occur over several years and result in unnecessary medical treatment and/or cause significant impairment in functioning. The somatic symptoms are not intentionally produced or feigned and appear to be unconscious to the patient. All the following criteria are required for a diagnosis:

- Four different pain sites (e.g., head, abdomen, back, joints, extremities, chest, rectum) or functions (e.g., menstruation, sexual intercourse, urination)
- Two gastrointestinal symptoms other than pain (e.g., nausea, bloating, vomiting not caused by diarrhea, or intolerance of several different foods)
- One sexual or reproductive symptom other than pain
- One pseudo-neurological symptom (e.g., impaired balance, paralysis, aphonia, urinary retention)

### Somatoform Disorder Types

**Conversion Disorder** - a somatoform disorder that involves motor or sensory problems that would "suggest" a neurological condition. Psychological factors, however, can be shown to be associated with the onset or worsening of symptoms. The most commonly seen examples are the conversion paralysis or conversion blindness in which the patient resolves an underlying conflict ("primary gain") by the unconscious use of the symptom(s).

**Pain Disorder** - characterized by persistent and chronic pain at one or more sites in which psychological factors are thought to play a role.

**Hypochondria** - The hypochondriacal patient is preoccupied with the fear of having a serious disease. This preoccupation persists despite appropriate medical evaluation and reassurance.

**Body Dysmorphic Disorder** - characterized by an imagined defect in appearance or excessive concern or preoccupation with a slight physical defect.

Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*, pages 485-511. See this reference for complete criteria.

## CASE STUDY OF SOMATIFORM DISORDER

---

**Case Study: Pain Disorder** from Richard J. Schuster, MD, FACP, Somatization Disorders, Part XVII in *The Textbook of Primary and Acute Care Medicine*<sup>19</sup>

A 31-year-old man goes to see his doctor complaining of chest pain which he has had intermittently for four weeks. He has a medical history of experiencing pain at several body sites since the age of 18. The tests taken all show normal results, as have tests that he has had for prior pain conditions. He asks about having more tests and about referral to a specialist, and both requests are turned down by his physician.

A month later, he returns to the doctor complaining of intense abdominal pain for the past two weeks. Although the probability of significant coronary artery disease is low, an electrocardiogram and exercise tolerance test are ordered by the doctor, both of which show normal results.

The doctor can expect that this patient will be back again, whether his abdominal pain is a separate diagnosis or part of his somatization disorder. It is the recommended practice that the doctor set up a schedule of regular visits during which the patient's suffering is acknowledged, and new symptoms are responded to appropriately.

# Personality Disorders

## General criteria:

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

**Personality disorders:** with estimated prevalence in the general population

- **Borderline Personality Disorder:** a pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity. Prevalence: 2 %
  1. unbearable feeling of abandonment and frantic attempts to avoid it
  2. unstable interpersonal relationships, unstable self-image
  3. impulsivity in self-damaging ways (ex: substance abuse, recurrent suicidal behavior)
- **Antisocial Personality Disorder:** a pattern of disregard for, and violation of the rights of others. Prevalence: 3% of men and 1% of women
  1. repeated unlawful behavior
  2. deceitfulness, impulsivity, aggressiveness, irresponsibility, lack of remorse
- **Paranoid Personality Disorder:** a pattern of distrust and suspiciousness. Prevalence: 0.5-2.2%
  1. suspects unjustly that others are exploiting, harming or deceiving him or her, bears grudges
  2. preoccupied with unjustified doubts about the loyalty of friends or associates
- **Narcissistic Personality Disorder:** a pattern of grandiosity, need for admiration, and lack of empathy. Prevalence: less than 1%
  1. grandiose sense of self-importance, with fantasies of success, power, beauty, ideal love
  2. requires excessive admiration, is arrogant, interpersonally exploitive, lacks empathy
- **Histrionic Personality Disorder:** a pattern of excessive emotionality and attention seeking. Prevalence: 2-3%
  1. needs to be center of attention
  2. inappropriately sexually seductive, dramatic, theatrical and exaggerates emotion
- **Schizotypal Personality Disorder:** An acute discomfort with and reduced capacity for close relationships, with cognitive or perceptual distortions. Prevalence: 3%
  1. Displays superstitious, magical thinking, and inappropriate affect.
  2. Doesn't care to make friends.
- **Dependent Personality Disorder:** Overly dependent on others. Prevalence: 1-10%
  1. A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and inability to independently initiate activities
  2. Fear of separation

Sources:

- American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*, pages 685-729
- Bornstein, Robert F. *The Dependent Personality*, p 126

## CASE STUDIES OF PERSONALITY DISORDERS

---

### ***Case Study: Borderline Personality Disorder*** by T. L. Cole

I wasn't aware of having Borderline Personality Disorder until last year when I made some bad conclusions that resulted in the terrible loss of my two-year relationship with Carol, my therapist.

It all started the day I couldn't promise that I wouldn't hurt myself in a session with Carol. She had to do her job and called the police. I was very angry and scared because I had just been in the hospital two months before. I thought my husband would leave me, even though we had just celebrated our 26<sup>th</sup> year anniversary. Without thinking, I left her office, hoping she would come after me. But she didn't. I was crushed and then I got even angrier. When I went into the parking lot, there was a police officer standing there. I thought he was there to take me away but he only asked me a question that didn't pertain to me. My immediate thought and feeling was the Carol didn't care about me any more and called the police off. I felt that the only person I had totally trusted and "let-in" had abandoned me. Because of these feelings, I walked into the street half-hoping to be hit by a car, but that didn't happen.

Then, I went into the "I must cut on myself" mode. I walked to the store and bought razor blades and immediately sliced my hand in the parking lot. Oh my! Did that feel good! I proceeded to walk casually to a bus stop and continued to cut on the same spot while I watched my blood drip to the ground. I stayed there, in plain view, until somebody came to wait for the bus. I headed back in the direction of Carol's office, using the major streets, desperately hoping I was wrong about Carol and the police. My hopes were crushed again when a police car passed me – not even bothering to slow down or to look in my direction. I was in plain sight! I didn't understand and I was absolutely devastated. I don't know why, but I went back to Carol's office.

I was still bleeding as I entered the waiting room, but I hid my hand with my long-sleeved shirt. The receptionist told me that Carol was in session, so I sat on the stairs away from the other patients. While I waited, something snapped. I placed the razor blade on my hand, one more time, and sliced it. Suddenly, blood was spurting from the cut. I was relieved and just let it bleed onto the floor. Someone came up the stairs, saw the blood, and then all "hell" broke loose. Carol came out very angry. I was in shock and muttered to her, "I don't hate you." The police and paramedics came and I was transported to the hospital. Little did I know, it would be the next to last time I was to be in that office again.

After this incident, Carol decided to end our relationship. I begged and pleaded with her, but she stood firm stating that she felt she couldn't help me any more. My behavior, she said, was definitely understandable, but that I needed to know there were consequences for unacceptable behavior.

Even though my mind seems to understand her reasons, my heart has been broken. I cry almost every night before I go to sleep. This whole experience has been like having a member of my family dying.

---

### ***Case Study: Antisocial Personality Disorder*** from Black, Donald W., M.D., with C. Linton Larson. *Bad Boys, Bad Men – Confronting Antisocial Personality Disorder*<sup>20</sup>

Tom's temper was explosive and unpredictable, unusual in its intensity and hair-trigger nature. I know because I was the psychiatry resident assigned to care for him when he came to the hospital at his girlfriend's insistence. ... He was pleasant enough during our first meeting, cooperating as I performed the mental status examination, a routine then new to me. Tom moved effortlessly through the series of questions designed to assess memory and mental functions. He denied being depressed or anxious, or to using drugs, and smirked when I asked about voices, hallucinations, and paranoia. As my questions persisted he began to lose his patience, and I could hear the first rumblings of anger behind his answers. The test revealed no apparent signs of major psychiatric illness. ...

But Tom clearly was not normal. My interviews with him revealed a life of early abuse, violence, and crime. He learned to steal while young, snatching money from his mother's purse before moving on to neighbors' homes and nearby businesses. Adolescence brought experiments with drugs and sex, regular drinks with

older boys, and an unplanned pregnancy aborted by his teenage girlfriend. His dismal performance at school ended when he was expelled for setting fire to a rest room.

As Tom grew up, his exploits became more daring, violent, and difficult to ignore. Arrested frequently for breaking and entering, robbery, and fighting, Tom rambled through his teen years without any sense of direction. Girlfriends came and went, at first drawn to his sly good looks and tough physique, and then driven away by his unpredictable rage and jealousy, which sometimes erupted in sexual violence. Eventually his record caught up with him, and he was sent to prison on the armed robbery charge that preceded his hospitalization.

Four days after he entered the hospital, I was ready to let him go. The early charm he had shown dissolved into bickering, threats, and absurd demands. He argued constantly, hosted a parade of unkempt visitors and demanded special passes for his girlfriend. In fact, Tom snubbed every effort to treat him, showing no interest in the source of his anger or any means to control it. He greeted my every word with the same bored stare and dominated group therapy with rants about how others – his girlfriend, parents, neighbors, doctors, and just about everyone else – were responsible for all his problems. He argued that the hospital would do him no good, and after a while I found myself agreeing with him. ... I felt no satisfaction when Tom was finally discharged after repeatedly refusing counseling.

---

**Case Study: Paranoid Personality Disorder** from Kraepelin, Emil, *Manic-Depressive Insanity and Paranoia*<sup>21</sup>

The following letter was written by a German woman who was a paranoid patient who was convinced she had been cheated out of an inheritance that was rightfully hers, and that the conspirators perpetrating this deed were in league with the police.

During the fourteen years that I have lived here, I have led the life of a martyr which mocks at all comparison. It concerns the embezzlement of inherited money, and on account of this all imaginable evil and cunning was exercised, that I might be passed off as insane and so on, or that I should made so, and that the necessary means of living, credit, and honor should be taken from me. This inexcusable behavior by day and by night is carried on by the secret police and their aiders and abettors, female and male, young or old, poor or rich – all must assist; since it is for the police! The hounding was ordered in all houses and districts of the town and no regard was had for an old widow full of years. Since I came to Munich, all my letters have been kept back, opened, and delivered without a stamp. Letters about inheritance were sharply suppressed, so that I never could be present at the distribution like the other heirs. Every effort is made that I may not be seen and that I should not come into contact with anyone; indeed it is horrible and incredible that such abominable occurrences can happen, carried out by certain lawyers, who have embezzled my money; of course they have also a certain police jurisdiction at hand, which facilitates for them their infernal on-goings in order that it should not come to light; besides they are rich, with which one can close the mouth of many a crime... When I arrived in Munich I found my house in the greatest disorder, although, before I left home, I left everything punctiliously in order. The furniture was covered with a layer of dirt and dust, the bed-clothes were thrown about anyhow, every drawer and cupboard was opened, although I had carefully locked up everything, closed the box of keys and taken it with me; in the kitchen the pretty mirror was in fragments. It went so far that I was forced to hesitate about eating anything, for after these rascally tricks people are capable of anything, whatever can be conceived horrible and mean...

---

**Case Study: Narcissistic Personality Disorder:** two characters from *Anna Karenina* by Leo Tolstoy whose narcissism is discussed by Bayer, Linda, *Personality Disorders, The Encyclopedia of Psychological Disorders*.<sup>22</sup>

Many plays, novels and films contain portrayals of narcissistic people. An example is found in Leo Tolstoy's novel *Anna Karenina* where there are "two classic narcissists in Prince Stepan Arkadyevich Oblonsky, known as Stiva, and in his sister, the title character, Anna."

The narcissism of both Stiva and his sister Anna drive them to seek to be around people who will constantly admire them, shower attention and adore them. Anna "always wants to be the center of attention and has difficulty yielding that position to anyone else." Both Stiva and Anna marry and have families, but find that



these conventional relationships don't give them what they are compelled to seek from the world.

Consequently, both of them are unfaithful to their spouses, seeking in a succession of mistresses and lovers, perfect, unquestioning adoration which they believe is their due. Neither of them can feel any empathy towards their abandoned spouse, nor can they see that they have been in any way the cause of the damage to their marriage. Stiva even "feels sorry for himself" because his wife is angry with him.

Even after the damage to his family, Stiva feels compelled to keep up a charade of his importance, overspending on "elaborate, perfect dinners that are a reflection of his own sense of specialness."

Anna has been called "a stereotypical female narcissist." She is beautiful and is obsessed with admiring herself and having others admire her as well. When her husband ignores her, she finds this intolerable and becomes angry with him, retaliating by publicly mocking him.

In time, Anna walks out on her family, trying to prove to herself that she still has beauty, desirability and deserves public admiration. When "her lover tires of her and she suspects him of being unfaithful," Anna finds this intolerable and irreconcilable with what she sees as her place in the world, and she commits suicide.

---

***Case Study: Histrionic Personality Disorder*** from Hanson, Gary D. *Histrionic Personality Disorder (Formerly known as hysteria)*<sup>23</sup>

Twenty-seven-year-old Christy sought pastoral counseling at the request of her husband and because of disillusionment over her marriage, now in its fourth year. Her church counselor was already aware of Christy because the church's worship leader had threatened to resign several times over her emotional outbursts from being turned down for a lead in the latest dramatic presentation or a special music solo. Christy's husband, Tom, had expressed an urgent concern to their pastor after a recent event when Christy forgot their infant daughter and left her with a day care provider while Tom was out of town on a business trip. Christy had entered a modeling contest at a local mall, and as she basked in the attention of the local talk show cameras, the thought of her daughter, now in the care of a disgruntled day care employee, completely slipped her mind. This event—just one in a series of similar incidents—had triggered yet another bitter argument over Christy's lack of attention to her daughter and to Tom himself. Reluctantly, Christy agreed to discuss her issues with a pastoral counselor.

During the initial interview Christy was warm and charming. She maintained good eye contact and was dressed attractively and a bit provocatively. Struck by Christy's rapid changes in emotion, the counselor noticed that one minute she was smiling with elation, the next erupting into tearful sadness. The picture Christy painted of her life was one of extremes. She just didn't understand why her "fabulously handsome" husband could not understand her need for self-expression and her gift of adding life to any social setting. Christy "absolutely adored" her "precious" daughter who was an "angel" in her eyes, but who seemed to take after her father in being demanding of Christy's attention. As Christy moved from excited speech regarding her personal accomplishments to tears over her lack of understanding from her husband and daughter, she frequently used a compact mirror, stopping at one point to touch up her eye makeup before continuing the discussion.

From Christy's outward appearance, she could pass as a fashion model, actress, or TV talk show host. She is attractive, gregarious, energetic, and has a dramatic flair that often makes her the life of the party. She was acutely attuned to her surroundings, an astute judge of the likes and dislikes of others, and a ready resource for the latest fashion trends. But that is only one side of the story.

Sometimes Christy's style turns out to be more of a curse than a blessing. Although she impresses people positively upon a first meeting, she never develops any deep, committed relationships, and her shifting moods eventually start wearing on those around her. Her consuming need for approval and desperate striving to draw out affection are just too much. And no matter how much attention she receives it is never enough. Her thirst is unquenchable but her efforts persistent. And when she doesn't receive the attention she craves, she can quickly lose her charming style and become angry, pouty, rude, or condescending. These shifting moods leave her family, friends, and acquaintances hurt, bewildered, put off or mistrusting and cause them to keep their distance—the very thing Christy fears the most.

In addition to creating interpersonal problems, Christy's need to constantly evoke attention has another downside. She is constantly under pressure to perform and she is emotionally susceptible to the approval or disapproval of everyone she meets.

---

***Case Study: Schizotypal Personality Disorder*** based on a case study by David P. Bernstein, Ph.D., “Schizotypal Personality Disorder”<sup>24</sup>

“James” was brought to psychologist David Bernstein by his parents when he was in high school. They were concerned about various behaviors of his that had caused problems at school. These included outbursts of temper, lack of friends leaving him socially isolated, and “uneven academic performance.” They told Dr. Bernstein that James had always been a “peculiar and difficult child.” They believed that he was very bright, but had chosen to obsessively excel in learning about Native American culture, especially shamanism, to the exclusion of other interests. If allowed, he would embark on “rambling discourses” on this favorite subject.

James had no close friendships and was unmercifully teased by his peers to try to provoke him into an “infantile rage,” which left him embarrassed and humiliated. He had the outward mannerisms and dress of a much older man; he had the nervous habit of blowing his nose with a very large white cloth handkerchief, and he hid behind glasses with thick lenses. James told Dr. Bernstein that he felt awkward and uncomfortable in social situations. He was a very unhappy young man.

Based on his interviews, Bernstein believed that James met five of the criteria for Schizotypal Personality Disorder: odd beliefs, overly elaborate speech, peculiar appearance, no close friends, and excessive social anxiety. Even though James was an adolescent and personality disorders are enduring patterns of maladaptive behavior from adolescence to adulthood, Bernstein felt that this was an appropriate diagnosis because his symptoms were of “long-standing and predated his adolescence.”

With therapy, James made some positive improvements over the next several years; he made a few friends, he learned to control his temper, and he deliberately started wearing clothes similar to those his peers wore. These changes greatly effected James’ happiness. Even so, he remained a decidedly “odd and eccentric” individual.

---

***Case Study: Dependent Personality Disorder*** based on a study by Turkat, I.D., and Carlson, C.R. “Data-based vs. symptomatic formulation of treatment: The case of a dependent personality.”<sup>25</sup>

Carlson and Turkat relate the case of a 48-year-old married woman that had been referred to a therapist by her family physician. She told the therapist of a number of problems she was having: “difficulty sleeping ... anxiety in supermarkets ... avoidance of reading materials ... avoidance of social gatherings ... anxiety around her daughter ... and depressive feelings.” These problems had started 2 months following a diagnosis of diabetes in her 13-year-old daughter. Most of her symptoms related to situations in which some aspect of her daughter’s diabetes would be noticeable to her, for example when she was reading about diabetes.

Her therapist was at a loss to understand the reason for her symptoms, but agreed with her to begin a treatment consisting of teaching relaxation skills, anxiety management and attempting to better understand her problem. Within three months, she could better control her anxiety, especially when reading about diabetes, which had been the most problematic situation before. The therapist thought that they were making progress decided to taper off treatments, eventually gradually ending them all together. This strategy was carried out and she stopped seeing her therapist.

However, just two weeks after she completed treatment, all of her symptoms returned.

After the relapse, the therapist realized that he hadn’t accurately diagnosed the woman’s problem before. So he embarked with the woman in a concerted attempt to understand more about her life to get at the

basis of her problem. To do this, he engaged with her in a dialog about her past, how she had grown up, her family situation, and circumstances when she had previously had psychological problems. She reported that she had anxiety when in decision-making situations, which caused her to frantically attempt to seek reassurance. She was especially frantic when not able to get her husband's reassurance for any reason. When the therapist probed into the cause of her need for reassurance, they discovered that in her childhood she had never learned how to independently make decisions; her father "always told me what to do" and that "he did not permit me to be independent at all." Her parents "mapped out what I was to do and not to do" When she went to college, she studied nursing because "a lot of people my age went into nursing" Her first job as a nurse went smoothly because she had readily available supervisors, but in her second position, she did not have supportive supervisors and she didn't do well. "Her husband was her first and only lover," and she had been attracted to him because he was "very forceful" and an "independent decision-maker."

With this new understanding of her background and past behavior - her lack of self-direction, "excessive reliance on others, a lifelong pattern of associated distress and disrupted functioning," her therapist diagnosed her with dependent personality disorder.

---

***Case Study: Symptoms of both Schizotypal and Borderline Personality Disorders in one person***  
based on "Was Thomas Wolfe a Borderline?" by Dr. David Rosenthal <sup>26</sup>

In 1979, Dr. David Rosenthal of the National Institute of Mental Health undertook the task of trying to psychiatrically diagnose the famous American author Thomas Wolfe (1900 - 1938). Even though Wolfe had been dead for 40 years, Rosenthal was able to use Wolfe's extensive autobiographical writings, letters, and interviews with people who had known him. Many of these sources portrayed Wolfe as having stormy relationships first with his family and then others, ill at ease with strangers, suspicious, brooding, drinking to excess and prone to violent outbursts. One colleague related how Wolfe would enter the office "eyes flickering with spite, scorn, contempt, malice, anxiety, fear... here was an extraordinary child, lonely, lost, obsessed, embittered." When someone would get too close to him emotionally, he often ended the relationship by insulting them "with vindictive bitterness from deep inside him."

Rosenthal came to the conclusion that Wolfe exhibited the symptoms of both Schizotypal and Borderline personality disorders. Here are the symptoms that he identified:

Schizotypal characteristics exhibited by Thomas Wolfe:

- Over elaborate speech
- Suspiciousness or paranoid ideation
- Magical thinking / superstitions
- Inadequate rapport face-to-face: cold, histrionic demeanor
- Undue social anxiety and sensitivity to criticism, real or imagined
- Social isolation to some degree

Borderline characteristics exhibited by Thomas Wolfe:

- Inappropriate anger
- Unstable personal relationships
- Unstable moods
- Impulsive
- Paranoid ideation

Wolfe was an undeniable, internationally-recognized literary genius, whose largely autobiographical writings have had the enduring ability to portray the American and human experiences to millions of readers since they were written over 60 years ago. One wonders whether his experience with an unhealthy mental situation played a role in his ability to portray the angst of life, or whether he found a way to use his talent in spite of it. One also wonders whether his readers identify with some part of themselves that they see revealed in his troubled autobiographical character. Maybe the answer is some of all of these. Certainly the world was enriched with his presence, in all his woundedness, among us.

# Suicide

## Suicide Risk

(Number of times the expected rate in the population)

Previous Suicide Attempt	38
Mood Disorders	
Depression	20
Bi-polar Disorder	15
Substance Abuse	
Opiates	13
Alcohol	6
Schizophrenia	9
Personality Disorders	8
Anxiety Disorders	6

## Suicide Intent

Isolation – Is anyone nearby?

Timing – Is intervention possible?

Final Acts – Have they made plans, given away treasured possessions?

Preparation – Has extensive preparation been made?

Method – Is the method highly lethal?

## The QPR Model for helping someone who is suicidal

Q: Question a person about whether they are suicidal

P: Persuade the person to get help

R: Refer the person to the appropriate resource

Sources:

*Night Falls Fast – Understanding Suicide*, by Kay Redfield Jamison, pp 101, 41-42

*Question Persuade Refer – Ask a Question, Save a Life*, by Paul Quinnett.

**Reading Assignment for  
The History of Mental Disorders**

- Unitarians, Universalists and Mental Health Care

## Unitarians, Universalists and Mental Health Care<sup>27</sup>

Charming, determined and self-effacing, the Unitarian Dorothea Lynde Dix was the foremost crusader for mentally ill people in the United States in the mid-1800s. In an era when women didn't have the right to vote, she managed by sheer force of will, hard work, and astuteness to convince legislatures in many states to appropriate public funds to build over 30 hospitals for the care of the seriously mentally ill. She was deeply religious, having been raised by her grandmother to be a Unitarian, later worshiping in the church of the Rev. William Ellery Channing, the founder of American Unitarianism, beginning in 1823. The sense of religious purpose in her life is what drove her to her acts of public service.

When the early and mid-1800's saw the beginning of compassionate methods of caring for mentally ill people, Universalists and Unitarians from both the medical and social reform communities were prominent in developing and promoting them. A deeply felt religious sensibility, especially the belief in the inherent worth of each human soul, and the conviction that they had a responsibility to improve life in this world, is what motivated this work. These tenets have been and remain at the core of Universalist and Unitarian belief systems.

A film recently produced for an anti-stigma campaign by the Royal College of psychiatrists in Britain begins by stating, "You can judge a civilization by how it treats its mentally ill." It is instructive to keep these words in mind when listening to the history related here.

It is fair to say that mental disease has always existed among humankind. From the earliest of times, there have been associations, both heavenly and demonic, with mental illness. In colonial times the seriously mentally ill were cared for chiefly at home by their families. The insane who could not be cared for by their families were sent to local almshouses and jails, institutions that didn't have the facilities or ability to care for them. Often, they were kept in the most deplorable conditions, as Dorothea Dix discovered when she made surveys of the States. As Dix found, in many instances the mad were kept chained in an enclosed space, lying in their own filth, without adequate clothing, and abused physically and sexually. It was thought by many that the insane couldn't feel cold because their minds were deranged, and thus they were kept without heat, even in the winter.

The earliest hospitals serving the insane came in the larger cities of Philadelphia and Williamsburg. Asylums in North America were built starting in the early- to mid- 1800's following a model of care developed in Paris and York, England. The founders of these institutions proposed that mentally ill people be treated with kindness, removing the chains that restrained them. Their success with this "moral treatment" was encouraging and widely known.

After an initial building period, many of the asylums became under-funded and over-crowded, and the goals for humanitarian care were compromised. "Large numbers of chronic and aged patients led to a fundamental transformation in the character of mental hospitals. ... Slowly the positive images of hospitals that had prevailed in the mid-nineteenth century gave way to far more negative ones associated with hopelessness, abuse and untimely death. By World War II mental hospitals were identified as 'snake pits'..." In the mid-1900's the consensus was that mentally ill people could better be cared for in local communities, and a deinstitutionalization of these people began. However, support necessary for their care in the local communities was largely not forthcoming.

Many of these people ended up on the streets or in jails. It seems that in some ways, we have now some of the same conditions that Dorothea Dix found when she began her crusade. It is widely acknowledged, including by the Surgeon General of the United States in 1999, that there is currently a crisis in mental health care in the United States; for many, levels of care that they have come to need and depend on are no longer available, and the situation is not improving.

With this introduction, we will now introduce three of the most prominent figures in mental health care in the 1800's. They also happen to be Unitarians and Universalists.

**Dr. Benjamin Rush**, the first leader in the treatment of mental illness in the United States, was a prominent physician, a signer of the Declaration of Independence, and Member of the State convention that ratified the constitution in 1787. Rush was raised as a Presbyterian and attended a number of churches throughout his lifetime. Although never signing the membership book of a Universalist church, he clearly held Universalist beliefs, often attending a Universalist church in Philadelphia, and the Universalists claim him as one of their own.

When he began his career at Pennsylvania Hospital there were several locked cells for the insane, then often called "lunatics", "aliens", or "distracted persons", which greatly interested Rush. He soon became an advocate for humane treatment of these people, protesting the inhumane conditions in which they were being kept: "Putting mad people in cells is dishonorable to science and humanity of Philadelphia," he wrote. Since he was a distinguished physician, he was able to publish articles in the newspapers and with the Legislature, and people listened. His advocacy procured a state appropriation to open an insane ward at Pennsylvania Hospital which was completed in 1796. This was the first time that the insane had heat in the rooms that they occupied.

With the patients in this ward, he began to develop his innovative treatments for the insane. He became one of the first people to suggest that mental illness is subject to physical influences and may be cured with scientific treatment. A great number of the therapies he developed were far in advance of their time. These included diet, rest, exercise, occupational therapy, productive work, travel, diversion, music, and even a primitive version of "talk therapy". Above all, he advocated that the mad be treated with dignity, truthfulness, sincerity, respect and sympathy. He is now regarded as the "Father of American Psychiatry", and his portrait appears on the seal of the American Psychiatric Association.

Rush's religious views were deeply held and strongly influenced his actions throughout his life. He believed the mind was the receptacle of the presence of Deity in mankind, and that in the mind, human beings had a "sense of Deity", a religious sense. His compassionate work with the insane was a living out of his religious belief that in curing the mind, he was allowing a person to exercise this sense and thus access the presence of the Deity.

### **Dorothea Dix**

Dorothea Dix's career as a reformer began in 1841 when she was asked to take over a Sunday school class at the Middlesex County House of Correction in East Cambridge. After teaching her lesson to the women prisoners, she noticed that there were some insane prisoners who were being kept at the jail. Her instant compassion for these insane prisoners was the beginning of her life's calling. Soon thereafter, she was able to visit the Worcester State Lunatic Hospital, and saw the kind of humane care that was being given there. In 1843, she was appointed to make a survey of the almshouses and jails in Massachusetts to chronicle the conditions in which the insane were

being kept. Her report *Memorial: To the Legislature of Massachusetts* gave many shocking details of how the insane were being treated. Her observations were specific, shocking and overwhelming. Here are some examples: “*Medford*. One idiotic subject chained, and one in a close stall for 17 years” “*Granville*. One often closely confined; now losing the use of his limbs from want of exercise.” “*Shelburne*. I saw a human being, partially extended, cast upon his back amidst a mass of filth. The mistress says ‘He’s cleaned out now and then; but what’s the use for such a creature?’ ” “*Barnstable*: Four females in pens and stalls; two chained certain, I think all.” “*Bolton*: ... ‘Oh I want some clothes’, said the lunatic ‘I’m so cold.’ ... One is continually amazed at the tenacity of life in these persons. ... Picture their condition! Place yourselves in that dreary cage, remote from the inhabited dwelling, alone by day and by night, without fire, without clothes, without object or employment... No act or voice of kindness makes sunshine in the heart,” she wrote. Clearly, she had heart-felt compassion for the unfortunate insane people and was deeply shocked and angered at what she found.

Her *Memorial* documenting these conditions was presented to the Massachusetts State Legislature and was immediately reprinted in pamphlet form so it could be distributed to the public. It created a public uproar. Several communities denounced her report as not being accurate, and consisting of her fantasies. Other supporters rushed to her rescue with counter attacks. Interestingly, “her sterling character as a witness”, and her position as a woman and thus “ineligible for political advantage” worked in her favor. The Massachusetts Legislature reacted by passing an appropriation to increase the capacity of Worcester hospital by 150 beds. She would later point to this as her first achievement on behalf of the insane.

It can be said that in this first campaign, Dix learned the techniques that she would use successfully in many other situations. She would do detailed research and homework as to the conditions in a location. She would then present these findings to the appropriate legislative body, cultivating the sponsorship of influential people and sympathetic law makers, and she would publish the results of her work in *Memorials*. Among the *Memorials* she prepared were those to New York in 1844, New Jersey in 1845, Pennsylvania in 1845, Kentucky in 1846, Tennessee in 1847, North Carolina in 1848, Mississippi in 1850, and Maryland in 1852. During her career, she visited every state east of Colorado to persuade legislatures to take measures for the relief of the insane. In time, 30 hospitals were built directly attributable to her efforts as a reformer.

### **Dr. Joseph Workman**

Dr. Joseph Workman, known as the "Father of Canadian Psychiatry," was an immigrant to Canada from Ireland in 1829. He was one of the first doctors to be educated in Canada, graduating from the fledgling McGill University in 1835. He was a pioneering and public minded spirit, being on the ground floor of expanding a school system, building a Unitarian church, and creating an asylum in the new city of Toronto. Throughout his life, he had a fierce tenacity of purpose, a sense of justice and the ability to learn from his mistakes.

In 1853 he was appointed the interim Superintendent of the Provincial Lunatic Asylum in Toronto, becoming the permanent Superintendent a year later. It was a post he held until 1875. The asylum had been created in 1841 in an old jail described as “unfit for felons” [!] It was initially filled with seventeen patients who previously had been chained to the wall in the basement. In 1850 a new Asylum was built on 150 acres of land outside the center of the city.

Under Workman’s tenure, the Asylum became a modern institution and made him famous for his methods of dealing with the insane. His innovative treatment included allowing patients freedom,



promoted healthy living conditions for asylum inmates, and occupational therapy in the gardens, farm or with textiles.

Since the time of Rush, Dix and Workman there have been other Unitarians and Universalists who have worked on behalf of mentally ill people, although not as prominently as these three. A number of ministers and theologians have made this a central issue for their ministries and authored resolutions to be considered by the Unitarian Universalist General Assembly.

# Workshop 3:

## The History of Mental Disorders

*“Psychiatry was Religion before it was Psychiatry”*<sup>28</sup> Michael H. Stone, M.D.

**Purpose** This workshop reviews the history of mental disorders and their treatment, including contributions by Unitarians and Universalists. The goals are to learn how behaviors we now define as mental disorders have been treated throughout history in various cultures from Biblical to modern times. Allow us to gain a perspective on current mental health problems and challenges.

### Materials

- Newsprint and paper for the copies of the handouts
- The on-going list entitled **“Responses of a Faith Community”**
- Removable stick-on colored dots

### Preparation

- Review the quotes and the time line in this lesson.
- Copy the chart *Time Periods in Mental Health History* to a newsprint page.
- Make copies of the handouts: *Unitarians, Universalists and Mental Health Care*, and *Mental Health History Time Line*
- Make copies of historical quotes to hand out to class, cutting between them so that each quote is on a separate slip of paper
- Prominently display the on-going list **“Responses of a Faith Community”** and remember to ask the class “What should the response of a faith community be to this situation?” at appropriate times during the class.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Tell them who the artist, writer and composer of the week are.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings.

### SESSION PLAN

#### Opening

**5 minutes**

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading:* # 461 *Nothing worth doing is completed in our lifetime* by Reinhold Niebuhr

*Moment of meditation or prayer*

#### Time Periods of Mental Health History

**15 minutes**

Present the Time Periods of Mental Health History that you have copied onto newsprint.

Emphasize the beliefs about mental illness during each time period, and explain that we will next proceed to read a number of quotes about mental health from various time periods.

Remind the class to note that what is symptomatic of a mental illness differs in different parts of the world and at different times in history. The next class lesson will focus further how views and diagnoses of mental illnesses differ between cultures.

#### Identifying Mental Health Historical Quotes

**45 minutes**

This exercise can be made into a fun history lesson with the following game:

1. Randomly distribute the slips of paper with historical quotes to members of the class.
2. Pass out a set of colored stick-on dots for each person to use.

3. Tell the class that the quotes are to be read by the class members *at random*, without telling the source or year of the quote.
4. When a quote is read, ask all of the class members to see if they can guess the time period the quote was from, and indicate their guess by placing a colored dot on the Time Periods chart presented in the preceding discussion.
5. When all class members have “voted” with their dots, reveal the source and time period where the quote came from.
6. Then ask people to comment about how they feel about what is being stated in the quote. The following are some questions you might pose to the class.
  - Do you agree, disagree, or perhaps both disagree and agree?
  - Did it surprise you?
  - Did it make you uncomfortable?
  - Do you think much has changed between the time the quote was written and today?
  - Was this something new to you?
  - Did you find it interesting?
  - What emotions or feelings did it evoke in you? In response to what?
7. Remove the dots from the previous “votes.”
8. Repeat steps 4 - 7 until all quotes are read.

### **Shamanism – Another view of abnormal mental experience**

**20 minutes**

Tell the participants that they will now read aloud, about another view of abnormal mental experience – one that has existed since prehistoric times in indigenous cultures. Distribute the handout on shamanism. Use After the reading, they will discuss this kind of experience and try and reconcile its place within the history of mental illness that we have just discussed.

### **Unitarians, Universalists and Mental Health Care**

**10 minutes**

Copies of the handout “Unitarians, Universalists and Mental Health Care” were distributed last week to the attendants as reading assignments. Lead a discussion of the contributions of UUs to mental health issues. During the discussion, ask what they have learned that they didn’t know, and how they feel about it. Ask what barriers they see for Unitarians and Universalists in continuing their historic involvement in the area of mental health.

### **Current problems of mental health care in the United States**

**20 minutes**

Put up a blank piece of newsprint. Ask the participants to relate from their own experience what they think the current problems of mental health care in the United States and Canada are. Write each comment down. Ask for comments on each suggestion about whether they agree it is a problem and why. Ask people for personal stories to illustrate their points. Here is a list if they run out of ideas:

- Availability of mental health care
  - Housing and Homelessness
  - Criminalization of mentally ill people
  - Funding
  - Insurance
  - Legal issues, legislative action/inaction
- Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community*.”

### **Closing**

**5 minutes**

Reading # 463 *My heart is moved by all I cannot save* by Adrienne Rich

**Reading Assignment** Read *Mental Health Quotes* and *Mental Health History Timeline*

# **Handouts for**

## **Mental Health History**

*“Psychiatry was Religion before it was Psychiatry”* Michael H. Stone, M.D.

- Time Periods in Mental Health History
- Shamanism
- Historical Quotes about Mental Health
- Mental Health History Timeline

## Time Periods in Mental Health History

This table illustrates how the concepts of mental illness changed from primitive times up to the 20th Century

Time Period	Concepts of Mental Illness
Primitive times: Before 1000 B.C.E.	The causes of mental disorders were supernatural. Evil spirits can possess the body and must be exorcised.
Ancient civilization 1000 B.C.E. – 1000 C.E.	Concepts of mental illness in Greece and Rome: 1. Possession by evil spirits 2. A medical phenomenon. 3. Violation of moral principles and punishment by God. Humane treatment advocated by Romans, Greeks and Arabs.
Middle Ages 1000s – 1400s	In West, witchcraft or devil believed to cause mental illness Humane treatment ends: people locked up, placed on public exhibition, treated with cathartics, blood letting, and torture. More humane treatment prevailed in Moslem countries.
Renaissance 1500s – 1600s	Decline in the belief of possession by evil spirits. The brain is studied as modern medicine begins. Mentally ill people still kept in cellars, prisons and asylums.
1700s	Need for humane care recognized. Reform movement in France and England: chains removed.
1800s	Academic psychiatry begins. Legislation concerning mental health enacted. Hospitals built for long term care of mentally ill people.
1900s 1900 1930s 1940s – 1950s 1960s 1970s 1990s – 2000	New therapies: psychoanalysis and counseling insulin shock, lobotomy, and electro-convulsive therapy psychoactive drugs Deinstitutionalization Consumer movement and mental health advocates. Prevention, Short term care, Recovery

**Table 3. Time Periods in Mental Health History**

## Shamanism by Barbara F. Meyers

Shamanism is mankind's oldest religion and known way of healing. Nearly universally known, it originated in primitive times and has survived to today in many indigenous cultures including Siberian, Native American, Central and Southeast Asian, Korean, Celtic, and African. Typically, a person doesn't become a shaman simply by willing it, it is the supernatural spirits that choose him or her. The career of a shaman commonly begins with an involuntary visionary episode, called a 'shamanic illness' or 'shamanic crisis'. In *Spiritual Emergency* Stanslav and Christina Grof explain: "During this time, future shamans might lose contact with the environment and have powerful inner experiences that involve journeys into the underworld and attacks by demons who expose them to incredible tortures and ordeals. These often culminate in experiences of death and dismemberment followed by rebirth and ascent to celestial regions. Following such a crisis, one becomes a shaman and returns to the community as a fully functioning and honored member." Thereafter, the career of a shaman consists of blessing and healing others by means of rituals, chants and entering into non-ordinary states of consciousness to contact the spirit world on their client's behalf.

Some have suggested that the experience of 'shamanic crisis' is the result of loss of mental balance and the presence of mental disorders. Because the primary activity of the shaman is ecstasy at the wish of his clients, it has been inferred that the shaman is, by modern psychiatric definition, suffering from a psychotic mental disorder. The Grofs believe that there are "instances where modern Americans, Europeans, Australians, and Asians have experienced episodes that bear a close resemblance to shamanic crisis," in that they experience tortures, death and rebirth, and spontaneous creation of rituals similar to those practiced by shaman. When diagnosed by modern psychiatrists, these people may be labeled with some kind of psychotic diagnosis, perhaps schizophrenia or mood disorder with psychosis, and treated with psychotherapeutic drugs.

Some modern westerners, including some physicians and psychiatrists, believe that shamanism can have benefit in today's world. Consider the following article from the on-line journal *Psychminded.com* about a program at a Mexican psychiatric hospital to use shaman and folk healers:

"Mexican Indians suffering from mental illnesses can go to a Guadalajara hospital to be treated by shamans and traditional medicine men. The Hospital Civil Fray Antonio Alcalde in Guadalajara is the first institution in Mexico to use medicine men and shamans to treat mental illness among Indians, who account for more than 10 percent of the country's nearly 100 million inhabitants. ... After a long battle with medical doctors and authorities, the head of psychiatric services at the hospital, anthropologist Sergio Villaseñor, recently succeeded in launching a project called "Transcultural Psychiatry in Western Mexico," which combines modern and traditional medicine to cure mental illness. The attitudes of a typical Westerner and an Indian toward mental illness are very different, Villaseñor noted. "An Indian with schizophrenia thinks he has been bewitched and needs a cleansing. An Indian with depression thinks he has lost his soul and must call on the spirits to recover it," Villaseñor explained. The psychiatrist said it was a mistake to ignore the curative powers of shamans or traditional medicine men, many of whom base their treatments on the combination of a vast array of plants."

---

Discussion questions for Mental Health History:

- Do you believe that the 'shamanic crisis' is a mental disorder?
- Do you think symptoms of 'shamanic crises' should be treated with modern psychiatric techniques? In westerners? In indigenous people?
- What benefits do you see that shaman have had in their societies?
- What do you think about the concept of mental illness as possession by demons, especially in light of the view of shaman? Does this change your opinion about the beliefs of western society in the Middle Ages?
- Does Jesus fit the definition of a shaman?
- Do you think a shaman could be used to cure a westerner of a mental disorder? Would the culture of the 'patient' need to be that of the shaman in order for the cure to work?

## Historical Quotes about Mental Health

The following are the quotes are in historical order. If you find that you want to focus only on a few, the quotes with an asterisk (\*) are recommended as highest priority. Here are the quotes:

---

### Quotes (\*)

"Serious disabling diseases were thought by some cultures to be of supernatural origin – perhaps the result of a spell cast on a person, visitation by a demon, or the work of an offended god. The treatment was to extract the evil intruder and lure the healthy soul back."<sup>29</sup>

"Trepanation of the human skull is the removal of a piece of [skull] with out damage to the underlying blood-vessels, and brain. It is possibly one of the earliest forms of surgical intervention on the head of which we have any authentic record and its practice is widely spread in space and time. In some parts of the world it is still practiced in its early form by native medicine men.... Magical-therapeutic [indications for trepanation], where in a sense the cause was considered to be evil spirits which had to be let out and the effect could be "therapeutic" at times [included]: headaches, vertigo, neuralgia, coma, delirium, intracranial vascular catastrophes, meningitis, convulsions, epilepsy, intracranial tumors, mental diseases."<sup>30</sup>

**Sources:** Medical practices in Prehistoric times

---

### Quote (\*)

<sup>15</sup> But if you will not obey the voice of the LORD your God or be careful to do all his commandments and his statutes which I command you this day, then all these curses shall come upon you and overtake you.

<sup>28</sup> The LORD will smite you with madness and blindness and confusion of mind;

**Source:** Deuteronomy 28:15, 28 (RSV) circa 620 B.C.E.

---

### Quote

<sup>14</sup> Now the Spirit of the LORD departed from Saul, and an evil spirit from the LORD tormented him. <sup>15</sup> And Saul's servants said to him, "Behold now, an evil spirit from God is tormenting you. <sup>16</sup> Let our lord now command your servants, who are before you, to seek out a man who is skilful in playing the lyre; and when the evil spirit from God is upon you, he will play it, and you will be well." <sup>17</sup> So Saul said to his servants, "Provide for me a man who can play well, and bring him to me." <sup>18</sup> One of the young men answered, "Behold, I have seen a son of Jesse the Bethlehemite, who is skilful in playing, a man of valor, a man of war, prudent in speech, and a man of good presence; and the LORD is with him." <sup>19</sup> Therefore Saul sent messengers to Jesse, and said, "Send me David your son, who is with the sheep." <sup>20</sup> And Jesse took an ass laden with bread, and a skin of wine and a kid, and sent them by David his son to Saul. <sup>21</sup> And David came to Saul, and entered his service. And Saul loved him greatly, and he became his armor-bearer. <sup>22</sup> And Saul sent to Jesse, saying, "Let David remain in my service, for he has found favor in my sight." <sup>23</sup> And whenever the evil spirit from God was upon Saul, David took the lyre and played it with his hand; so Saul was refreshed, and was well, and the evil spirit departed from him.

**Source:** 1 Samuel 16:14 - 23 (RSV) circa 620 B.C.E.

---

### Quote (\*)

<sup>1</sup> They came to the other side of the sea, to the country of the Gerasenes. <sup>2</sup> And when he had come out of the boat, there met him out of the tombs a man with an unclean spirit, <sup>3</sup> who lived among the tombs; and no one could bind him any more, even with a chain; <sup>4</sup> for he had often been bound with fetters and chains, but the chains he wrenched apart, and the fetters he broke in pieces; and no one had the strength to subdue him. <sup>5</sup> Night and day among the tombs and on the mountains he was always crying out, and bruising himself with stones. <sup>6</sup> And when he saw Jesus from afar, he ran and worshiped him; <sup>7</sup> and crying out with a loud voice, he said, "What have you to do with me, Jesus, Son of the Most High God? I adjure you by God, do not torment me." <sup>8</sup> For he had said to him, "Come out of the man, you unclean spirit!" <sup>9</sup> And Jesus asked him, "What is your name?" He replied, "My name is Legion; for we are many." <sup>10</sup> And he begged him eagerly not to send them out of the country. <sup>11</sup> Now a great herd of swine was feeding there on the hillside; <sup>12</sup> and they begged him, "Send us to the swine, let us enter them." <sup>13</sup> So he gave them leave. And the unclean spirits came out, and entered the swine; and the herd, numbering about two thousand, rushed down the steep bank into the sea, and were drowned in the sea. <sup>14</sup> The herdsmen fled, and told it in the city and in the country. And people came to see what it was that had happened. <sup>15</sup> And they came to Jesus, and saw the demoniac sitting there, clothed and in his right mind, the man who had had the legion; and they were afraid. <sup>16</sup> And those who had seen it told what had happened to the demoniac and to the swine.

**Source:** Mark 5:1-16 (RSV) circa 60 C.E.

---

**Quote**

"We do not remember that our elders ever forbade the administration of the Holy Communion to those possessed by evil spirits; it should even be given to them every day if possible. For it must be believed that it is of great virtue in the purgation and protection of both soul and body; and that when a man receives it, the evil spirit which afflicts his members or lurks hidden in them is driven away as if it were burned with fire. And lately we saw the Abbot Andronicus healed in this way; and the devil will rage with mad fury when he feels himself shut out by the heavenly medicine, and he will try the harder and the oftener to inflict his tortures, as he feels himself driven farther off by this spiritual remedy."

**Source:** John Cassian in *Conferences of John Cassian*, circa 450 C.E.

---

**Quote (\*)**

"The devils can stir up and excite the inner perceptions and humors, so that ideas retained in the repositories of their minds are drawn out and made apparent to the faculties of fancy and imagination, so that such men imagine these things to be true. ... Now there are two ways in which devils can raise up this kind of images. Sometimes they work without enchaining the human reason, as has been said in the matter of temptation, and the example of voluntary imagination. But sometimes the use of reason is entirely chained up; and this may be exemplified by certain naturally defective persons, and by madmen and drunkards. Therefore it is no wonder that devils can, with God's permission, chain up the reason; and such men are called delirious, because their senses have been snatched away by the devil. And this they do in two ways, either with or without the help of witches."

**Source:** *The Malleus Maleficarum*, 1486<sup>31</sup>

---

**Quote**

My love is as a fever, longing still  
For that which longer nurseth the disease;  
Feeding on that which doth preserve the ill,  
The uncertain sickly appetite to please.  
My reason, the physician to my love,  
Angry that his prescriptions are not kept,  
Hath left me, and I desperate now approve  
Desire is death, which physic did except.  
Past cure I am, now Reason is past care,  
And frantic-mad with evermore unrest;  
My thoughts and my discourse as madmen's are,  
At random from the truth vainly express'd;  
For I have sworn thee fair, and thought thee bright,  
Who art as black as hell, as dark as night.

**Source:** William Shakespeare, Sonnet CXLVII, 1609.

---

**Quote**

"Children, Idiots, Distracted persons, and all that are strangers, or new comers to our plantation, shall have such allowances and dispensations in any Cause whether Criminall or other as religion and reason require."

**Source:** Massachusetts' first legal code, 1641<sup>32</sup>

---

**Quote**

"The numbers of people the number of lunaticks, or persons distempered in mind, and deprived of their rational faculties, hath greatly increased in this province, and some of them going at large, are a terror to their neighbours, who are daily apprehensive of the violences they may commit; and others are continually wasting their substance, to the great injury of themselves and families, ill disposed persons wickedly taking advantage of their unhappy condition, and drawing them into unreasonable bargains, &c."

**Source:** Benjamin Franklin, 1742 in requesting funds for treating mentally ill people at Pennsylvania Hospital<sup>33</sup>

---

**Quote**

"Putting mad people in cells is dishonorable to science and humanity of Philadelphia."

**Source:** Dr. Benjamin Rush, father of American psychiatry, circa 1783 in arguing to create a hospital ward for mental patients<sup>34</sup>

---



---

**Quote**

"Medford. One idiotic subject chained, and one in a close stall for 17 years" "Granville. One often closely confined; now losing the use of his limbs from want of exercise." "Shelburne: I saw a human being, partially extended, cast upon his back amidst a mass of filth. The mistress says 'He's cleaned out now and then; but what's the use for such a creature?' " "Barnstable: Four females in pens and stalls; two chained certain, I think all." "Bolton: ... 'Oh I want some clothes', said the lunatic 'I'm so cold.' ... One is continually amazed at the tenacity of life in these persons. ... Picture their condition! Place yourselves in that dreary cage, remote from the inhabited dwelling, alone by day and by night, without fire, without clothes, without object or employment... No act or voice of kindness makes sunshine in the heart. ... I have been asked if I have investigated the causes of insanity. I have not; but I have been told that this most calamitous overthrow of reason often is the result of a life of sin; it is sometimes, but rarely, added, they must take the consequences; they deserve no better care! Shall man be more unjust than God, who causes his sun and refreshing rains and life-giving influence to fall alike on the good and the evil? Is not the total wreck of reason, a state of distraction, and the loss of all that makes life cherished retribution, sufficiently heavy, without adding to consequences so appalling every indignity that can bring still lower the wretched sufferer?"

**Source:** Dorothea Dix, January, 1843 in chronicling the state of mentally ill people in Massachusetts<sup>35</sup>

---

**Quote**

"How instructive and humbling the thought that functional or structural changes in our organization, often so trivial as to be untraceable, may determine the entire difference between the philosopher and the madman, the chaste matron and the grossly obscene puerperal maniac."

**Source:** Dr. Joseph Workman, father of Canadian psychiatry, 1869<sup>36</sup>

---

**Quote**

"The two [attendants] who were first put in charge of me did not strike me with their fists or even threaten to do so; but their unconscious lack of consideration for my comfort and peace of mind was torture... Because I refused to obey a peremptory command, and this at a time when I habitually refused even on pain of imagined torture to obey or speak, [a] brute [attendant] not only cursed me with abandon, he deliberately spat on me. Vitriol could not have seared my flesh more deeply than the venom of this human viper stung my soul!"

**Source:** Clifford Beers, *A Mind that Found Itself*, 1905<sup>37</sup>

---

**Quote (\*)**

"There is no possible doubt that one of the most important sources of the sense of guilt which so often torments neurotic people is to be found in the Oedipus complex. More than this, perhaps the sense of guilt of mankind as a whole, which is the ultimate source of religion and morality, was acquired in the beginnings of history through the Oedipus complex."

**Source:** Dr. Sigmund Freud, *A General Introduction to Psychoanalysis*, 1916<sup>38</sup>

---

**Quote**

"Mental illness has outlived whatever usefulness it might have had and that it now functions merely as a convenient myth. As such, it is a true heir to religious myths in general, and to the belief in witchcraft in particular; the role of all these belief-systems was to act as *social tranquilizers*, thus encouraging the hope that mastery of certain specific problems may be achieved by means of substitutive (symbolic-magical) operations. The notion of mental illness thus serves mainly to obscure the everyday fact that life for most people is a continuous struggle, not for biological survival, but for a "place in the sun," "peace of mind," or some other human value. Sustained adherence to the myth of mental illness allows people to avoid facing this problem, believing that mental health, conceived as the absence of mental illness, automatically insures the making of right and safe choices in one's conduct of life. But the facts are all the other way. It is the making of good choices in life that others regard, retrospectively, as good mental health! ... My argument [is] that mental illness is a myth, whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations."

**Source:** Thomas Szasz, *The Myth of Mental Illness*, 1960<sup>39</sup>

---

**Quote (\*)**

WHEREAS, every second hospital bed in the United States is occupied by a mentally ill person with most public mental hospitals caring for 1,000 to 14,000 patients; and

WHEREAS, medical knowledge has developed to the degree that many of the mentally ill could, with proper individual care, be returned to live useful lives in society;

THEREFORE BE IT RESOLVED: That the churches and fellowships of the Unitarian Universalist Association study their own communities to determine whether facilities and budgets are adequate for the care of mental patients within their own communities, such facilities to include psychiatric units in general hospitals, "half-way houses" for discharged mental patients, vocational and counseling services, and special classes in the public school system for emotionally disturbed and mentally retarded children;

BE IT RESOLVED: That member churches and fellowships strive to inform themselves in this field in order to give compassionate understanding towards the mentally ill as family, friends, or employers and to assist through direct volunteer service in appropriate places; and

BE IT FURTHER RESOLVED: That Unitarians and Universalists accept positions of leadership in their communities where they can influence public opinion and government agencies so that the financial and medical needs of the mentally ill may be met.

**Source:** Unitarian Universalist Association General Resolution 1961: Mental Health <sup>40</sup>

---

**Quote (\*)**

"I don't share the psychiatric faith that the cure to mental illness is soon to be found. We believe that the kinds of behavior labeled mental illness have far more to do with the day-to-day conditions of people's lives than with disorders in their brain chemistry. We must work to change our own behavior when it distresses us, and work to help others who seek out help, but we must also work towards a future in which we are not systematically crippled by the imposition of beliefs in the inferiority of some people because of their color, their gender, or their expression of the pain we all sometimes feel. In short, we must work to eliminate the racism, sexism, and mentalism, which make lesser people of us all."

**Source:** Judi Chamberlin, *On Our Own – Patient-Controlled Alternatives to the Mental Health System*, 1977. <sup>41</sup>

---

**Quote**

"The American-based DSM is highly culture-bound... [In] China [and] Thailand ... 'magical thinking,' illusions and other cognitive peculiarities regarded as symptoms of schizotypal personality disorder in the West, may be rather normal expressions of thought in many people."

**Source:** Michael Stone, M.D. in *Healing the Mind – A History of Psychiatry from Antiquity to the Present*, 1997 <sup>42</sup>

---

**Quote**

"In Dallas, I founded and served as president of a non-profit called Group Homes, Inc., which established supportive living (and working) arrangements for people with long term mental illness being de-institutionalized. It became apparent that the Texas state Department of Mental Health was uncomfortable with volunteer citizens seeing their various sins of omission and commission. They reneged on commitments, drove Group Homes, Inc. out of business, and adopted a policy of state-run homes -- for a time."

**Source:** Rev. John Buehrens, 2002. <sup>43</sup>

## Mental Health History Time Line

DATE	EVENT
c. 10,000 B.C.E.	The earliest surgeries - boring holes in the skull - are performed in Europe, South America, and Africa. Investigators believe that these surgeries, called trepanations, were done to cure headaches, treat mental illnesses, and release evil spirits plaguing the mind.
c. 1000 B.C.E.	Israelite King Saul is visited by evil spirits numerous times. Eventually, he takes his own life.
400 B.C.E.	The Greek physician Hippocrates treats mental disorders as diseases to be understood in terms of disturbed physiology, rather than reflections of the displeasure of the gods or evidence of demonic possession.
0 - 200 C.E.	Romans Celsus, Aretaeus of Cappadocia and Soranus document mental diseases, their causes and recommended treatments for them.
918	First mental hospital established in Baghdad for the "afflicted of Allah."
c. 1050	Constantinus Africanus writes <i>De Melancholia</i> about the causes and treatments of mental illness, locating the site of illness in the brain.
12 <sup>th</sup> Cent.	Church built in Gheel, Belgium to honor St. Nymphna becomes a refuge for those inflicted with insanity. Gheel becomes a model for humane treatment, where mentally ill people live with families in the town, and are free to come and go as they please.
1377	Bethlehem Hospital, later called 'Bedlam', near London first used for mentally ill people.
1563	Johann Weyer writes <i>De Praestigiis Daemonum</i> , rejecting witchcraft as a cause of mental illness, and describing a wide range of diagnoses and therapies, including proposing a form of psychotherapy. Weyer becomes known as the 'first psychiatrist.'
1621	Paolo Zacchia writes <i>Questiones medio-legales</i> in which he discusses legal issues of mental illness, including a definition of legal insanity. Regarded as the father of legal medicine.
1670	Earliest records of private madhouses in England.
1756	Pennsylvania Hospital becomes the first hospital in the US to accept mentally ill patients.
1773	Public Hospital for Persons of Insane and Disordered Minds built in Williamsburg, Virginia, the first building in North America devoted solely to the treatment of mentally ill people.
1779	Franz Mesmer writes <i>Mémoire sur le Découverte de la Magnétisme Animal</i> [ <i>On the Discovery of Animal Magnetism</i> ] and gathers both a large group of followers and the outrage of the established medical community for his use of spiritualism, wands, and inducing 'hysterical crisis' in patients, sometimes with remarkable success.
1795	Dr. Philippe Pinel removes the chains from patients at the Salpêtrière asylum for insane women in Paris. He transforms the Salpêtrière and Bicêtre asylums into models of compassionate care for people with mental illnesses.
1796	William Tuke opens an institution called <i>The Retreat</i> at York, England which cares for people with mental illnesses with compassion and kindness.
1796	Christian Spiess publishes <i>Biographien der Wahnsinnigen</i> [ <i>Biographies of the Insane</i> ] among the first books to give a sympathetic view of individual mentally ill patients.
1796	Dr. Benjamin Rush opens ward for mental patients at Philadelphia Hospital advocating that mentally ill people be treated with dignity, truthfulness, sincerity, respect and sympathy.

1808	First use of the term 'psychiatry' meaning 'treatment of the mind' by Johann Reil.
1811	Johann Christian Heinroth becomes first person to occupy a university chair in 'Psychiatry' in Leipzig.
1812	Dr. Benjamin Rush publishes <i>Medical Inquiries and Observations upon the Diseases of the Mind</i> . This book was used as the definitive text on the subject in medical schools for the next 50 years.
1833	Worcester State Lunatic Hospital, the first public hospital in the United States for the treatment of mental illness opened in Worcester, Massachusetts largely due to the efforts of Horace Mann.
1843	Dorothea Dix publishes her <i>Memorial: To the Legislature of Massachusetts</i> , chronicling in detail the conditions under which mentally ill were being kept in prisons and almshouses. This document causes a public uproar and begins Dix's career as a mental health reformer. In 1848 the New Jersey State Lunatic Asylum, the first of the hospitals built as a result of Dix's efforts opens. By 1880, 32 mental hospitals and 15 training schools for patients would be built as a direct result of Dix's campaigning.
c. 1850	Otto Domrich becomes the first medical psychologist to write about "anxiety attacks."
1850	Mental Asylum built near Toronto, Canada, the first Canadian institution providing compassionate care for mentally ill patients.
1854	President Franklin Pierce vetoes bill for providing permanent funding for the care of people with mental illness in the United States using federal land grants.
1883	German psychiatrist Emil Kraepelin distinguishes mental disorders, systematically naming each disorder, in his textbook <i>Psychiatrie</i> , which goes through many editions.
Late 1800s	The expectation in the United States that hospitals for mentally ill people and humane treatment will cure nearly all of the sick does not prove true. State mental hospitals become over-crowded and custodial care supersedes humane treatment. <i>New York World</i> reporter Nellie Bly poses as a mentally ill person to become an inmate at an asylum. Her reports from inside result in more funding to improve conditions.
1895	Sigmund Freud and Joseph Breuer publish <i>Studien über Hysterie (Studies in Hysteria)</i> describing methods used in psychoanalytic theory. Freud came to the conclusion that unconscious thoughts cause problems in conscious life, and that the most important source of such unconscious thoughts was sexual in nature.
1901-1902	William James delivers a series of lectures entitled <i>The Varieties of Religious Experience – A Study in Human Nature</i> .
1905	Alfred Binet and T. Simon create the Binet-Simon test as a systematic measure of intelligence.
1905	Group therapy is introduced by Alfred Adler in his work with children in group settings. In 1907 Adler will publish <i>Organ Inferiority</i> , coining the term <i>inferiority complex</i> , positing that the quest for power is the most important motivating factor in human behavior.
1908	Clifford Beers publishes his autobiography, <i>A Mind That Found Itself</i> , detailing his degrading, dehumanizing experience in a Connecticut mental institution and calling for the reform of mental health care in America. Within a year, he and the psychiatrist Adolf Meyer will found the National Committee for Mental Hygiene, an education and advocacy group. This organization will evolve into the National Mental Health Association, the nation's largest umbrella organization for aspects of mental health and mental illness.

1911	Eugen Bleuler, a Swiss psychiatrist, coins the term <i>schizophrenia</i> in his book, <i>Dementia Praecox or the Group of Schizophrenias</i> . He also coins the words <i>autism</i> and <i>ambivalence</i> .
1913	Carl G. Jung breaks with Freud over Freud's insistence of the primacy of sexual interpretations of mental conditions. Jung goes on to found analytic psychology and to develop the concepts of the extroverted and introverted personality types, archetypes and the collective unconscious.
1917	Julius von Wagner-Jauregg uses malaria-induced fever to cause remission in patients with slight or incompetent paralysis, first used in 1917. Receives a Nobel prize for this work In 1927.
1921	Herman Rorschach publishes research on the Rorschach inkblot test that he had invented and that is still used today to reveal aspects of a patient's personality by reactions to ink blots.
1925	August Aichhorn publishes <i>Verwahrloste Jugend [Wayward Youth]</i> focusing on psychiatry of children.
1928	H. Luxenburger carries out the first study of twins regarding the inheritance of schizophrenia. Later he studies manic-depressives and epileptics using the same method.
1930s	<p>Prefrontal lobotomy introduced by Egas Moniz in 1936 for which he will receive a Nobel prize in 1949. Electro-shock therapy first used in 1938 by Ugo Cerletti</p> <p>Drugs, electro-shock and surgery are used to treat people with schizophrenia and others with persistent mental illnesses. Some are infected with malaria; others are treated with repeated insulin-induced comas. Others have parts of their brain removed surgically by lobotomy, which is performed widely over the next two decades to treat schizophrenia, intractable depression, severe anxiety, and obsessions.</p>
1935	Leo Kanner publishes <i>Child Psychiatry</i> , the first textbook in English on the subject. He views masturbation and homosexuality as abnormalities brought about by disruptive biological factors. He is also a pioneer in studying infantile autism.
1935	<i>Alcoholics Anonymous</i> is founded by "Bill" and becomes the exemplar of peer support groups. Its format and methods are copied by support groups for many other psychological conditions.
1938	B.F. Skinner publishes <i>The Behavior of Organisms</i> which states that neuroses are maladaptive behaviors learned from disadvantageous conditioned-response patterns.
1938	Franz Kallman, theorizing that heredity is a relevant factor in schizophrenia, establishes the first full-time genetics department in a psychiatric institution in the United States.
1939	World War II begins and Hitler decrees that patients with incurable medical illnesses be killed because they are "biologically unfit". Approximately 270,000 patients with mental illness are killed by physicians and medical personnel complying with the Nazi doctrine of racial purity. Many psychiatrists emigrate from Europe to the U.S. during the war.
1946	President Harry Truman signs the National Mental Health Act, calling for a National Institute of Mental Health to conduct research into mind, brain, and behavior and thereby reduce mental illness. As a result of this law, NIMH will be formally established on April 15, 1949.
1946	Lithium introduced as a treatment for psychosis. In 1949 J.F.J. Cade will publish results showing lithium helps mania. It will become the preferred treatment for bipolar disorder.
1948	Alfred Kinsey, W.B. Pomeroy and C.F. Martin publish <i>Sexual Behavior in the Human Male</i> , the results of a large-scale survey of sexual habits and practices of American males, which showed that homosexuality was more common than previously thought.
1952	<i>Diagnostic and Statistical Manual: Mental Disorders (DSM-I)</i> published giving descriptions and diagnostic categories of mental disorders. Since this time there have been three updates of this manual <i>DSM-II</i> in 1968, <i>DSM-III</i> in 1980, a revision <i>DSM-III-R</i> in 1987, <i>DSM-IV</i> in 1994.
1953	BF Skinner publishes <i>Science and Human Behavior</i> , describing his theory of operant conditioning, an important concept in the development of behavior therapy.

1954	Thorazine is released widely in the United States, beginning modern psychopharmacology. Psychiatric medications to follow were increasingly focused on specific disorders such as antidepressants, anti-anxiety drugs, anticycling agents and antipsychotics.
1958	Nathan Ackerman publishes <i>The Psychodynamics of Family Life</i> which focuses on the study and treatment of family groups.
1959	Eric Erikson publishes <i>Identity and the Life Cycle</i> which identifies 8 stages of human development from birth through the mature years.
1960s	Many seriously mentally ill people are removed from institutions. In the US they are directed toward local mental health homes and facilities. The number of institutionalized mentally ill people in the US will drop from a peak of 560,000 to just over 130,000 in 1980. Some of this deinstitutionalization is possible because of anti-psychotic drugs, which allow many psychotic patients to live more successfully and independently. However, many people suffering from mental illness become homeless because of inadequate housing and follow-up care. In 1961, the newly formed Unitarian Universalist Association passes General Resolution on Mental Health in response to the emptying of mental hospitals without adequate community funding.
1961	Psychiatrist Thomas Szasz's book, <i>The Myth of Mental Illness</i> , argues that there is no such disease as schizophrenia.
1973	Due to new clinical information and political pressure from the National Gay Task Force, the American Psychiatric Association changes the diagnosis of homosexuality from a disease to a condition that can be considered a disease only when subjectively disturbing to the individual.
1977	Judi Chamberlin, an ex-mental patient publishes <i>On Our Own – Patient-Controlled Alternatives to the Mental Health System</i> , articulating the case for the consumer movement.
1979	National Alliance for the Mentally Ill (NAMI) is founded in 1979 as an organization for schizophrenic patients and their families. NAMI has grown into the most effective group advocating for mentally ill people and their families with legislators and the public.
1980's - 1990's	Supportive therapy involving rehabilitation, social skills training, educating family members and alternative living arrangements becomes the treatment of choice for schizophrenic patients.
1992	A survey of American jails reports that 100,000 seriously mentally ill people are incarcerated. Over a quarter of them are held without charges, often awaiting a bed in a psychiatric hospital. Jails become among the largest institutions caring for mentally ill people
1999	For the first time, the Surgeon General of the US publishes a major study on mental health: <i>Mental Health: A Report of the Surgeon General</i> , which outlines a crisis in mental health care in the US. This is followed in 2001 by <i>Mental Health: Culture, Race, and Ethnicity</i> .
2002	President George W. Bush establishes the President's New Freedom Commission on Mental Health as part of his commitment to eliminate inequality for Americans with disabilities. Their report to the President is issued in April 2003 and embraces the Recovery model.

**Table 4. Mental Health History Timeline**

Sources include:

- *Healing the Mind* by Michael Stone,
- *History of Psychiatry* by George Mora, and
- Mental Health Timelines from:
  - PBS,
  - Aetna InteliHealth,
  - International Society for Suicide Prevention, and
  - Nursing and Midwifery History UK.

# Workshop 4:

## Mental Disorders in Special Populations

*“The mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender.”*

Dr. David Satcher, US Surgeon General

**Purpose** Introduce some of the unique characteristics of mental disorders and challenges in getting mental health care in children, youth, the elderly and racial minorities. Finally, we will discuss mental health care among the incarcerated.

### Materials

- Newsprint and paper for making copies.
- The on-going list entitled “*Responses of a Faith Community*”
- Equipment for playing music, (see “Adding Artistic and Musical Dimensions to the Workshops,”) if you will be using it.

### Preparation

As with workshop 2, the most important planning to do for this workshop is to decide which of the mental disorders to discuss in class, and how to present them. There is more material here than can be presented if there is a lot of discussion in the class; along with a description of each of the mental disorders there is a case study and discussion questions. Criteria that you might use for deciding which disorders to focus on are: if members of the congregation or their families have a particular disorder, if the disorder is particularly prevalent in the community, or if you have a guest speaker who has experience with a disorder and can discuss it to the class. It is possible to discuss some disorders in depth, and hand out information about others. As with workshop 2, the workshop can be broken into two or three sessions if more detailed information about each disorder is desired. This is recommended if there is a lot of interest in the participants in the program.

In choosing how to discuss a disorder, consider the following:

- A very effective way of introducing and describing these disorders and what they imply for an individual or family is to have a guest or guests with one or more of the disorders either personally, or in their family.
- Another possible guest speaker might be a psychiatrist or other mental health professional who diagnoses these disorders as part of his or her practice.
- If you don’t have access to a guest, ask the class if they have experience in this illness in themselves or in a friend.
- Finally, if no person can testify about a given disorder, you can read the case studies in this curriculum for that particular disorder.

As an example, the following is one possible lesson plan for this workshop:

WORKSHOP ELEMENT
Opening
<i>Childhood Disorders:</i> Review the chart “Disorders Usually First Diagnosed in Infancy, Childhood or Youth”, <i>Autism and Asperger’s Disorder:</i> Review the material about Autism and Asperger’s Disorder. Read the case studies and discuss. If there is time, read the case study on Attention Deficit Hyperactivity Disorder, and discuss with class.
<i>Disorders in the Elderly: Alzheimer’s:</i> Have a class member tell of a situation in their family where someone has Alzheimer’s. Go the Alzheimer’s Association website and find referral materials for class members.

*Racism in Mental Disorders*: Present the material in the sections: Words and Meanings, and Risk factors and Protective factors affecting mental disorders for racial and ethnic minorities. Then discuss the material in Strategies that improve mental health for racial and ethnic minorities.

Closing

- Review the materials for the lessons, including the handouts. For each of the major diagnostic areas, familiarize yourself with where in the DSM-IV manual you find the details, in case detailed questions are asked.
- Copy information from the handouts *Disorders usually first diagnosed in Infancy, Childhood and Youth, Disorders of the Elderly* onto newsprint ahead of the lesson to make it easier to present them.
- If desired, copy some of the definitions from *Words and Definitions* onto newsprint ahead of the lesson to make it easier to present them.
- Make copies of the *Handouts for Mental Disorders in Special Populations* for students to use during class, which includes the paper *Executive Summary – Mental Health: Culture* for a reading assignment.
- Prominently display the on-going list “**Responses of a Faith Community**” and remember to ask “What could the response of the faith community be?” and record the class’s answers.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Tell them who the artist, writer and composer of the week are.
- Copy the Terminology Match-up Cards sheets and cut them into cards for the class exercise.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings.

## SESSION PLAN

### Opening

5 minutes

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading #518* from the Ojibway Indians of North America

*Moment of meditation or prayer*

---

### **Disorders usually occurring first in Infancy, Childhood and Youth**

First present the handout on Disorders Occurring First in Infancy, Childhood and Youth.

If you have a guest or guests who have personal or family experience with one of the disorders, give a brief introduction to the disorder and then let the guest tell their own story about the disorder and how it affected them and their family. If you do not have a guest, you may read the case studies below.

---

Discussion Questions for Childhood Disorders:

- Some people debate whether there should be public funding of education for special education of children with these mental disorders, as the Americans with Disabilities Act requires. How do you feel about this?
  - Do you think children with these disorders should be ‘mainstreamed’ into the general population of school students?
  - What do you see as the pros and cons of using drug therapy for ADHD and other disruptive behavior disorders? Which side do you agree with? Would you be in favor of drug therapy if your child had one of these disorders?
  - Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “**Responses of a Faith Community.**”
-



## Disorders Usually Found in the Elderly

First present the handout on Disorders of the Elderly. If you have a guest or guests who have personal or family experience with one of the disorders, give a brief introduction to the disorder and then let the guest tell their own story about the disorder and how it affected them and their family. If you do not have a guest, you may read the case studies.

---

Discussion Questions for Dementia:

- Do you agree with the approach of playing along with delusions of an Alzheimer's patient, as in the case study?
- What do you think would be the deciding factors in your having a parent with Alzheimer's live at home with you versus in a residential care facility?
- How do you think you would feel if you noticed serious problems with memory? Who would you tell? What actions, if any would you take?
- Ask "How could a faith community respond to this situation?" Record the class's responses on the sheet "*Responses of a Faith Community.*"

---

## The Impact of Race and Ethnicity in Mental Disorders

### Terminology Match-up Cards

**10 minutes**

Tell the participants that we are going to learn some terms having to do with psychiatric diagnoses of people of minority race and ethnicity. Distribute the terminology match-up cards, one to each participant. Some cards will contain terms and some will contain definitions. When the cards have been handed out, ask participants to mill about and find their matches. When they are done, gather the group together and go over the definitions one at a time, using definitions in the handout *Words and Definitions*. Ask for comments and questions.

### Risk Factors and Protective Factors for Racial and Ethnic Minorities

**15 minutes**

Place a large piece of newsprint and tell the participants that we are now going to be looking at some of the differences in mental health and receiving mental health care among people of racial and ethnic minorities. Explain that we are first going to give our own opinions about why mental disorder and mental health care might differ with different racial and ethnic groups. After this, we will look at what the research has to say about this subject. Ask people what factors that they think might make mental health better or worse for people of racial and ethnic minorities. Emphasize that we want to look at *both* advantages and disadvantages. Write each suggestion down as it is given.

When people are finished making suggestions, distribute copies of the handout *Risk Factors and Protective Factors for Racial and Ethnic Minorities*. Explain that Risk Factors and Protective Factors are characteristics or conditions that, if present, increase or diminish, respectively, the likelihood that people will develop mental health problems or disorders. For each of the ethnic groups on the handout, review the risk factors, protective factors, mental illnesses that occur higher and lower for that group, and barriers to treatment by the mental health system.

*Discussion questions to pose for the group:*

- Do any of these findings differ significantly from what we noted as opinions earlier?
- Do any of these findings surprise you? Why?
- What do you think accounts for the differences seen in mental health care?
- What do you think accounts for the differences in protective factors?
- Do you think racism can cause mental disorders?
- Do you think it is significant that spirituality is a protective factor for some groups?

- Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community.*”

### **Strategies that improve mental health for racial/ethnic minorities**

**15 minutes**

Read the following paragraphs about strategies for improving mental health care for racial and ethnic minorities.

Some of the most important deterrents to mental illness are within the direct ability and interest of religious professionals and anti-racism workers. It is important that we work on these, building on them, as a way to improve mental health for ethnic and racial minorities

#### ***Spirituality***

In a recent book *Religion and Mental Health* edited by J.F. Schumaker, many different facets of religion and how it affects mental health are considered. In almost all the situations and cultures studied, it was found that spirituality was a significant protective factor for mental illness. It was found that a strong belief in a religious faith was correlated to fewer mental health problems, to more rapid recovery from mental illness, and to better support systems to keep a person well. Religious faith also helped family members and friends to be supportive of their loved one who has a mental disorder.

We as religious professionals and lay people need to be ready to participate, to network with others, and to use the information and materials that NAMI<sup>44</sup> and other groups produce for this purpose. We need to support those who are in need of mental health care, making sure they get the care they need, and helping their families and friends to also take supportive roles.

#### ***Positive ethnic and community identity***

When a person sees himself or herself, as an individual and as a member of a community, in a positive light, mental illness is less frequent and less severe. One of the saddest stories related in the Surgeon General’s Report was about how Native Americans were systematically denied of their culture – even to the extent of removing children from the homes of their parents. These people didn’t feel that they fit in anywhere and turned in large numbers to alcohol and substance abuse. The encouraging recent development for this culture is the return of tribal councils and local determination.

Similarly, the report relates another story of denial of culture – that of African Americans. Since the era of the civil rights movement, there has been an increase of racial pride and getting involved with one’s local community. The Report tells us that one of the protective factors for African Americans for mental illness is racial pride and community involvement. Mental health problems are increased when people don’t have anywhere they feel that they belong and can feel good about themselves.

It is important for us to recognize the importance of a positive ethnic identity, and support and participate in efforts to provide and regain this for people at risk of losing it, and people who don’t have it.

#### ***Local leadership and determination***

When people feel that they, or people who they see as working on their behalf, have the ability to control the circumstances of their own lives, the likelihood of mental illness is reduced. When we work with groups of people, it is important that we support efforts for self-determination for those people. This might include such things as:

- appointing mental health family members and clients to mental health boards
- support strong grievance procedures for people who think they have been mistreated by the mental health system
- peer support groups

#### ***Strong families***

Strong family households where the members care for each other are a primary protective factor against the development of mental illness. They also are of importance in limiting the adverse affects of mental illness after it has happened. As advocates for mentally ill people, it is important that we lead and support activities that will make their families strong. This will include the following:

- education,
- support groups,
- emergency assistance, and
- counseling for family members, especially when family discord has contributed to the mental illness

These activities need to be done in culturally and language specific ways so that they can be understood and used. Note that a strong family isn't restricted to traditional male-female parent + children. It is more inclusive, where families of choice, gay and lesbian parents, grandparents and other people live together for mutual support.

***Work on social problems such as racism, poverty, and violence***

Racism, poverty and violence are all strong risk factors for developing mental illness, and inhibitors for recovery from mental illness. They can, in fact, cause mental illness or aggravate it. It is incumbent upon us as community advocates to participate in social justice work aimed to eliminate these factors. This can take many different forms:

- Educate oneself on the causes, effects and remedies of racism, poverty, and violence by leading or taking workshops, lectures and other like activities
- Participate in social justice actions such as marches, letter-writing campaigns, and political advocacy.
- As one human being, strive to eliminate racist and violent attitudes and activities from one's life.
- Incorporate thoughts of a more just world in one's prayer and devotional life, seeking guidance on how to act.

*Discussion questions to pose to the group:*

- What can the majority culture learn from the minority cultures that will benefit the mental health of all people?
- Did this reading cause you to have any specific ideas about contributions that you personally, or your church could make to solve some of these problems? Record the class's responses on the sheet "***Responses of a Faith Community.***"

**Closing**

**5 minutes**

*Reading # 702 Where hate rules, let us bring love* Attributed to St. Francis of Assisi

**Assignment**

- Read the handout *Executive Summary – Mental Health: Culture* the report from the Surgeon General of the United States.

## Terminology Match-up Cards

<b>Race</b>	<b>Ethnicity</b>	<b>Culture</b>	<b>Idioms of distress</b>
<p>A social, not biological category. Especially potent when certain social groups are separated, treated as inferior or superior, and given differential access to power and other valued resources.</p>	<p>A common heritage shared by a particular group. It includes similar history, language, rituals, and preferences for music and foods.</p>	<p>A common heritage or set of beliefs, norms and values. It is dynamic, and continually changing over time.</p>	<p>Ways in which different cultures express, experience, and cope with feelings of distress.</p>

<b>Culture-bound syndrome</b>	<b>Amok</b>	<b>Ataque de nervios</b>	<b>Boufée delirante</b>
<p>Locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a DSM diagnostic category. These experiences are generally limited to specific societies or culture areas.</p>	<p>In Pacific Island &amp; Southeast Asian males. After a period of brooding, violent, aggressive, or homicidal behavior directed at people and objects.</p>	<p>In Latinos. Consists of uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression.</p>	<p>In West Africa and Haiti. Refers to a sudden outburst of agitated and aggressive behavior, confusion and psychomotor excitement that resembles a Brief Psychotic Disorder.</p>

<b>Dhat</b>	<b>Ghost sickness</b>	<b>Hwa-Byung</b>	<b>Mal de ojo (evil eye)</b>
<b>In India, refers to severe anxiety associated with the discharge of semen, Similar disorders occur in India, Sri Lanka and China.</b>	<b>In American Indians, a preoccupation with death and the deceased.</b>	<b>A Korean syndrome attributed to the suppression of anger.</b>	<b>In Mediterranean cultures there is a belief that some people, demons animals, or gods have the power to cause negative effects by just looking at someone.</b>

<b>Nervios</b>	<b>Neurasthenia</b>	<b>Susto</b>	<b>Wounded Spirit</b>
<b>Common among Latinos in the Americas, it refers to both to a general state of vulnerability to stressful life experiences and to a syndrome brought on by difficult life circumstances.</b>	<b>Recognized in China but the US. A condition characterized by fatigue, weakness, poor concentration, memory loss, irritability, aches and pains, and sleep problems.</b>	<b>A folk illness prevalent among Latinos in the Americas. It is attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness.</b>	<b>The name given to Post Traumatic Stress Disorder by some Native Americans.</b>

## Handouts for

### Mental Disorders in Special Populations

*“The mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender.”*

Dr. David Satcher, US Surgeon General

- Disorders Usually First Diagnosed in Infancy, Childhood or Youth
  - Case studies on Mental Retardation, Autism, Asperger’s Disorder, and Attention Deficit Hyperactivity Disorder
- Disorders Most Commonly Found in the Elderly
  - Case Studies of an Alzheimer’s patient and the Family of an Alzheimer’s patient
- Words and Definitions for Racial and Ethnic Mental Health
- Risk Factors and Protective Factors for Racial and Ethnic Minorities
- *Executive Summary – Mental Health: Culture - A Supplement to Mental Health: A Report of the Surgeon General*

## Disorders Usually First Diagnosed in Infancy, Childhood or Youth

Although most people with these disorders usually are diagnosed when they are infants, children or adolescents, this isn't a diagnosis requirement, and some are not diagnosed until adulthood.

### Mental Retardation

This disorder is characterized by an IQ of 70 or below, with onset before age 18 years and impairments in adaptive functioning. Prevalence: 1%

- This diagnosis is sub-divided into mild, moderate, severe, and profound retardation

### Learning Disorders

These disorders are characterized by academic functioning significantly below that expected for a person's age, intelligence, and education. Prevalence 2-10%. These include:

- *reading disorder*
- *mathematics disorder*
- *written expression disorder*

### Communication Disorders

These disorders are characterized by difficulties in speech or language. Prevalence: 10-15%. They include:

- *expressive language disorder*
- *mixed receptive-expressive language disorder*
- *phonological disorder* – difficulty in making sounds
- *stuttering*

### Autistic Disorder and other Pervasive Developmental Disorders

These disorders result from severe deficits and pervasive impairment in multiple areas of development, including reciprocal social interaction, communication and stereotyped behavior, interests and activities. Prevalence: 0.02 – 0.2%. They include:

- *Autistic disorder* is characterized by impairment in social interaction. There are also impairments in communication and in restricted repetitive and stereotyped patterns of behavior. These characteristics emerge from 6 to 30 months after birth.
- *Asperger's disorder* is a mild form of Autistic disorder in which the child is impaired in social interaction and has restricted behaviors, but does not have delays in cognitive development.

### Attention Deficit and Disruptive Behavior Disorders

- *Attention-Deficit / Hyperactivity Disorder (ADHD)* – a persistent pattern of inattention and/or hyperactivity-impulsivity. Prevalence: 3-7%
- *Conduct Disorder* – a repetitive and persistent pattern of behavior in which the rights of others or major societal rules are violated. Prevalence: 1-10%, higher in males.
- *Oppositional Defiant Disorder* – A pattern of negativistic, hostile and defiant behavior lasting at least 6 months. Prevalence: 2-16%.

Summarized from: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*, pages 39-134. See this reference for complete criteria.

---

**Case Study: Historical Religious perspectives on mental retardation** from Maxmen, Jerrold S. and Ward, Nicholas G. *Essential Psychopathology and Its Treatment, Second Edition Revised for DSM-IV*<sup>45</sup>

The history of mental retardation is a checkered one. In Europe during the 14<sup>th</sup> and 15<sup>th</sup> centuries, the mentally retarded were regarded superstitiously as blessed ‘infants of the good God.’ However, during the Enlightenment Martin Luther referred to the ‘feeble-minded’ as ‘Godless’ and thought society should rid itself of them. It was not until Binet developed psychometric tests so that schools could “track” school children into special programs that the range of human intellectual capacity became evident. In spite of noble intentions, these IQ tests were often used to exclude many children from school and to identify ‘imbeciles’ in need of sterilization so that mental retardation would not be propagated. Only with Folling’s discovery in 1934 of phenylketonuria, a treatable cause of mental retardation did the study of mental retardation become respectable.

---

**Case Study: Autism** from Park, Clara Claiborne. *The Siege – A Family’s Journey into the World of an Autistic Child*<sup>46</sup>

We start with an image – a tiny, golden child on hands and knees, circling round and round a spot on the floor in mysterious, self-absorbed delight. She does not look up, though she is smiling and laughing; she does not call our attention to the mysterious object of her pleasure. She does not see us at all. She and the spot are all there is, and though she is eighteen months old, an age for touching, tasting, pointing, pushing, exploring, she is doing none of these. She does not walk, or crawl up stairs, or pull herself to her feet to reach for objects. She doesn’t want any objects. Instead, she circles her spot. Or she sits, a long chain in her hand, snaking it up and down, up and down, watching it coil and uncoil, for twenty minutes, half an hour – until someone comes, moves her or feeds her or gives her another toy, or perhaps a book.

We are a bookish family. She too likes books. Rapidly, expertly, decisively, she flips the pages, one by one by one. Bright pictures or text are the same to her; one could not say she doesn’t see them, or that she does. Rapidly, with uninterrupted rhythm, the pages turn.

One speaks to her, loudly or softly. There is no response. She is deaf, perhaps. That would explain a lot of things – her total inattention to simple commands and requests, which we thought stubbornness; the fact that as month follows month she speaks no more than one word or two, and these only once or twice in a week; even, perhaps, her self-absorption. But we do not really think she is deaf. She turns, when you least expect it, at a sudden noise. The soft whirr as the water enters the washing machine makes her wheel round. And there are the words. If she were deaf there would be no words. But out of nowhere they appear. And into nowhere they disappear; each new word displaces its predecessor. At any given time she has a word, not a vocabulary.

Twenty-two months. Still not walking, talking, or responding to speech. The doctor is worried, and she is observed for three days in the hospital. There they find no evidence of phenylketonuria, or of any other physical deficiencies. The doctors watched her, remote and withdrawn in her hospital crib. They smiled at her; she looked through them. The doctors spoke; she heard nothing. They whistled; she turned round. They told us she was still within the curve of normal development, although at the very bottom; we should wait six months and then begin to worry.

**Note:** For those who wish to learn more of the story of Clara Claiborne Park’s autistic daughter as she grows into adulthood, Park has written a sequel: *Exiting Nirvana: A Daughter’s Life with Autism*, New York: Little Brown & Co, 2001.

---

**Case Study: Asperger’s Disorder** from the website of Kevin Phillips<sup>47</sup>

My name is Kevin Phillips. I was diagnosed with Asperger’s Syndrome on Wednesday 31st May 2000 by Professor Digby Tantam at the Northern General Hospital in Sheffield.



On Monday 3rd February 2003 I spoke in front of an audience for 45 minutes about my life with Asperger's Syndrome and what must be done in the future in several areas, including Education. There were 14 people with Asperger's and Autism in the Audience and twelve people who didn't have these conditions. It was done in Thorne, Doncaster, totally free of charge and my speech was videotaped. It was all part of a Portfolio project. It was a brilliant experience for me and hugely boosted my self-confidence. I had never done public speaking before this date.

It is inevitable that at times I wonder what my life would have been like if I didn't have Asperger's Syndrome. If ever asked if I would like to get rid of my Asperger's Syndrome, I say 'I would like it if I could get rid of 40% of it, and keep 60% of it. If I didn't have Asperger's Syndrome it is unlikely I would have struggled to hold employment posts down like I have done in the past. If I didn't have Asperger's Syndrome it is unlikely I would have had the concentration levels of a gnat. If I didn't have Asperger's Syndrome it is unlikely I would have been hypersensitive to certain noises. If I didn't have Asperger's Syndrome it is unlikely I would have found it difficult to be in the company of too many people. If I didn't have Asperger's Syndrome it is unlikely I would have had physical co-ordination problems. If I didn't have Asperger's Syndrome it is unlikely I would get in the bath at 9:30pm exactly on every Sunday night like I do. Not a minute more, not a minute less.

Alternatively, if I didn't have Asperger's Syndrome I may not have had an exceptional memory for dates and some things like I have, although my short-term memory is very poor. If I didn't have Asperger's Syndrome I may have been going round smashing phone boxes, nicking cars and beating old women up. If I didn't have Asperger's Syndrome it is unlikely that I would have had calendar calculating skills. If I didn't have Asperger's Syndrome it is unlikely I would have kept weather observations in my side garden. If I didn't have Asperger's Syndrome it is unlikely I would have been fanatical and obsessional in some of my interests like I am. And if I didn't have Asperger's Syndrome it is unlikely I would have wrote these words ... and it is unlikely you would have just read them.....

---

#### ***Case study: Attention Deficit Hyperactivity Disorder***

This case study is based on an account written by a man named Joseph Brooks.<sup>48</sup>

Joseph describes himself as being in constant trouble all through childhood – from kindergarten on up. The teachers realized that he was bright but didn't think he was trying. Because he was the class clown, quick with a smart-alecky retort, often got into fights, didn't do his homework, and he thought that teachers hated him.

When he got older, he began to do drugs something that allowed him to feel accepted by at least some others. He says, "Through out my teen years I sold, smoked and ate my way through most of your major street drugs. Lots of them. It's amazing I survived." Because of his drug use, he was often high at school and his classroom behavior and attendance got worse; he was expelled many times, had continual run-ins with the police, and his parents were at their wit's end.

He finally found a teacher who understood him when sent to probation school; she discovered he liked to read and let him read anything that interested him during class. With her help he was able to continue to learn mostly through reading and finally passed a GED test.

Meeting his wife was a turning point for Joseph. He says, "She helped me learn to stay out of harms way for the most part though she had to suffer through about 5 more years of my antics before I finally settled down. We were married at 18 and are still together today, nearly 19 years later."

At work, Joseph had difficulties getting along with his bosses, and jumped from one low-paying job to another. After age 30, things started to turn around for Joseph; he was able to find a job at a local college which was to prove a long-term position. He and his wife started a family and bought a house.

When his son started school, he says "I was horrified to see that he was nearly a carbon copy of myself." Fortunately, the schools of today are more knowledgeable about problem behaviors and his son's teacher suggested that he be screened for ADD, which he was diagnosed with. With his son's treatment and improvement, Joseph began to wonder whether he also had ADD. When he was tested, it was found that indeed he did have it, and began treatment for it. He says, "I don't notice any dramatic changes in myself but my wife says that she does. I do seem to be brooding a lot less and my work situation has improved."

---

## Disorders of the Elderly

These disorders do not occur only in the elderly, they can be caused by substance abuse, medication, head trauma, or another general medical condition. However, most dementia occurs in the elderly.

### Disorders of Cognition

Disorders of cognition reflect a recent onset of problems due to:

- memory impairment
- disorientation
- poor judgment
- confusion
- loss of intellectual function

### Dementia

Dementia is a disorder of cognition characterized by multiple cognitive deficits that include impairment of:

- memory
- judgment
- abstract thinking
- language skills

Subtypes of dementia include:

- Alzheimer's type (50%) is diagnosed by ruling out other causes of dementia. A common pattern for Alzheimer's is early deficits in memory followed by the development of language disturbance, impaired motor ability, and failure to recognize objects. Eventually patients become mute and bedridden. The average duration of the illness from onset of symptoms to death is 8-10 years.
- Dementia caused by a medical condition (20-30%)
- Vascular (9-15%)
- Substance-induced (7-9%).

Prevalence of dementia depends on age and gender:

Age	Women	Men
65	0.8%	0.6%
85	14%	11%
90	25%	21%
95	41%	36%

### Normal forgetfulness and Dementia

While it's normal to forget appointments, names or telephone numbers, those with dementia will forget such things more often and not remember them later.

Sources:

- American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*, pages 135-190.
- *Essential Psychopathology and Its Treatment, Second Edition* by Jerrold S. Maxmen and Nicholas G. Ward.

**Case Study: Alzheimer's patient** "{ TC "Disorders of the Elderly" } from DeBaggio, Thomas. *Losing My Mind – An Intimate Look at Life with Alzheimer's*<sup>49</sup>

There are no comprehensive accounts of Alzheimer's from the patient's point of view, because in the later stages of the illness mental function breaks down and communication is not possible. What we do have here is an account written by someone who first learns about his Alzheimer's diagnosis and then chronicles his thoughts during its early stages. In his book about the progress of his own case of Alzheimer's, Thomas DeBaggio relates the things that have gone through his mind. Here is a sampling of these thoughts:

- Upon first learning that he was diagnosed with Alzheimer's he viewed it as a "death sentence." He would cry and was continually depressed.
- He would lay in his bed searching for words that no longer came easily to him. He found that he was no longer able to explain to others why he was crying.
- He felt that Alzheimer's was evil; an evil that he knew would one day take him over completely, but that he was powerless to stop.
- His deteriorating memory sometimes allowed events of present and past times to merge, blurring the time and spatial differences. At times he realizes that this is happening. At other times he doesn't.
- He could start to think about something, but then his thoughts would wander and he would no longer remember what he was thinking about, or sometimes even who or where he was. He often felt disoriented.
- At one point he realized that although he knew the disease would kill him, he knew that before that happened, he wouldn't even be able to know what death was. Oddly enough, this thought comforted him.
- He realized that there will come a point in time when his loved ones would watch his condition deteriorate when he would no longer be able to understand what was happening to him. This thought pained him because he didn't want his family to go through this kind of pain because of him.
- He is tired of living with Alzheimer's and afraid of where the illness will take him, and frustrated with the long waiting game he seems to be engaged in with the illness.
- As he writes, he still has the hope to live, but knows that this won't always be the case.
- He poignantly asks his wife Joyce to hold him, "and then let me sleep. "

---

**Case Study: Family of Alzheimer's patient** from Miller, Sue. *The Story of My Father – A Memoir*<sup>50</sup>

From the time my father arrived back east permanently to live near me in [Sutton Hill] a continuing care retirement community in suburban Boston, he was hallucinatory. He was, then, really institutionalized, and it was damaging to him. The progression of his disease from this point on was more rapid than it had been before. He changed, and changed again. And in response, often lagging a step or two behind him, I changed also.

Most often, the hallucinations I had to accept as part of his reality were pleasant ones. He reported lively visits from friends. And gradually there came to be a focus to his dementia. The patterns and rhythms that had governed my scholarly father's life asserted themselves here too – from *within* this time – to shape his understanding of his new circumstances: Sutton Hill became some kind of university, a university in which my father's role was multifarious and changeable. Increasingly, when I'd ask him what he'd been doing, what was new, he'd answer that he'd been preparing a lecture.

He always had a lot of reading to do now to get ready for one thing or another – though in reality, of course, he couldn't read at all any longer – and when I visited he always reported how busy he'd been. Sometimes it seemed he was the professor; sometimes more a student, doing papers, going to class. He wondered, once, when he would get a new room assignment, and I thought he must see Sutton Hill as a college, or perhaps even a kind of prep school.

I welcomed the sense of usefulness and purpose his delusions gave him. I was glad when he reported he'd done things – familiar Dad-like things – that I knew he hadn't done. I lied. I went along with his mistakes. I still don't know if this was right or wrong, but I would do it again. I would choose to have my father feel happy and competent in some parallel universe. I was pleased for him that he'd come home to his own self-invented university.

One afternoon, toward the end of one of my visits, my father said, "You know, one thing I haven't figured out about this place."

"What's that?" I asked.

He looked puzzled. "Well, no one ever seems to *graduate* from here."

I burst into laughter, so he laughed too, purely at my amusement. He had a wonderful laugh. Not the sound of it so much but its innocence, the way it seemed almost to take him by surprise, nearly to embarrass him.

If Dad's delusional life had continued in this benign way, it would have been easy for me to continue to accede to it. But as the Alzheimer's disease was progressive, so was the nature of the delusions. Gradually there arose other, stickier dilemmas, ones I had no ready response to, instinctive or otherwise.

---

## Words and Definitions for Racial and Ethnic Mental Health

### Race

Race is not a biological category, but it does have meaning as a social category. Different cultures classify people into racial groups according to a set of characteristics that are *socially* significant. The concept of race is especially potent when certain social groups are separated, treated as inferior or superior, and given differential access to power and other valued resources. This is the definition adopted because of its significance in understanding the mental health of racial and ethnic minority groups in American society.

### Ethnicity

Ethnicity refers to a common heritage shared by a particular group. Heritage includes similar history, language, rituals, and preferences for music and foods. The term *race*, when defined as a social category may overlap with ethnicity, but each has a different social meaning.

### Culture

Culture is defined as a common heritage or set of beliefs, norms and values. *Cultural identity* refers to the culture with which someone identifies and to which they look for standards of behavior. Culture is dynamic, continually changing over time.

### Idiom of distress

A way in which different cultures express, experience, and cope with feelings of distress. One example is *somatization*, which involves symptoms suggesting a general medical condition but that are not fully explained by a general medical condition; in somatization there is an element of the expression of emotional distress through physical symptoms. Stomach disturbances, excessive gas, palpitations, and chest pain are common forms of somatization in Puerto Ricans, Mexican Americans, and whites. Some Asian groups express more cardiopulmonary and vestibular symptoms, such as dizziness, vertigo, and blurred vision. In Africa and South Asia, somatization sometimes takes the form of burning hands and feet, or the experience of worms in the head or ants crawling under the skin.

### Culture-bound syndrome

This term denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. These experiences are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for these experiences.

Examples of Culture-bound syndromes and idioms of distress:

- **Amok** – An episode, prevalent only among males, characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects. The original reports that used this term were from Malaysia. A similar pattern of symptoms is found in Laos, the Philippines, Polynesia, Papua New Guinea, and Puerto Rico and among the Navajo.
- **Ataque de nervios** – This is reported among Latinos and consists of uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression.

- **Boufée delirante** – A syndrome observed in West Africa and Haiti. It refers to a sudden outburst of agitated and aggressive behavior, confusion and psychomotor excitement. It resembles an episode of Brief Psychotic Disorder.
- **Dhat** – A folk diagnostic term used in India to refer to severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish discoloration of the urine and feelings of weakness and exhaustion. Similar disorders occur in India, Sri Lanka and China.
- **Ghost sickness** – A preoccupation with death and the deceased (sometimes associated with witchcraft) frequently observed among members of many American Indian tribes. Symptoms include bad dreams, weakness, loss of appetite, fainting, fear anxiety, confusion and a sense of suffocation.
- **Hwa-Byung** – A Korean folk syndrome attributed to the suppression of anger. It is characterized by sensations of constriction in the chest, palpitations, and sensations of heat, flushing, headache, anxiety, irritability, and problems with concentration.
- **Mal de ojo (evil eye)** – A concept found in Mediterranean cultures. Symptoms include fitful sleep, crying without apparent cause, diarrhea, vomiting, and fever. Children are especially at risk. Malina says: “It refers to the conviction that certain individuals, animals, demons, or gods have the power to cause some negative effect on any object, animate or inanimate, on which they may look.” Evil eye is mentioned in the Old and New Testaments and Apocryphal literature.<sup>51</sup>
- **Nervios** – A common idiom of distress among Latinos in the United States and Latin America. Refers to both to a general state of vulnerability to stressful life experiences and to a syndrome brought on by difficult life circumstances. It includes a wide range of symptoms of emotional distress.
- **Neurasthenia (shenjing shairuo)**– A condition often characterized by fatigue, weakness, poor concentration, memory loss, irritability, aches and pains, and sleep disturbances, neurasthenia is recognized in China, although it is not an official category in the DSM–IV.
- **Susto (Fright or Soul loss)** A folk illness prevalent among some Latinos in the United States and among people in Mexico, Central America and South America. It is attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Ritual healings are focused on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance.
- **Wounded spirit** – The name given to Post Traumatic Stress Disorder by some Native Americans.

Sources:

- DSM-IV-TR
- *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*
- Bruce Malina, *The New Testament World*, Westminster John Knox Press, 2001.

## Risk and Protective Factors affecting Mental Disorders for Racial and Ethnic Minorities

Culture, Race, Ethnicity				
	African-Americans	Native Americans and Alaskan Natives	Hispanic Americans: Mexicans, Puerto Ricans, Cubans Central Americans	Asian Americans, Pacific Islanders, Chinese, Koreans, Japanese, East Indians, Southeast Asians (Hmong, Laotians, Cambodians, Vietnamese)
<b>Risk Factors for Mental Illness</b>	Violence, Poverty, Homelessness, Inadequate Schools, Racism, Criminality, Paternal Criminality, One-parent families, In child welfare system, Poor physical health: diabetes, HIV, AIDS, heart disease, infant mortality	Poverty, Alcoholism, Homelessness, Removal from culture, "Boarding Schools" Foster care 25%-30% Poor physical health: Alcohol-related illness, Fetal alcohol syndrome, Infant mortality, SID	Mexican & Puerto Ricans: Less Education, Poverty, Unemployment War-related trauma for Central Americans Substance abuse by men, More incarceration, Poor physical health: Diabetes, Obesity, TB, High Blood Pressure	Low income for some: Southeast Asians, Pacific Islanders Exposure to war trauma: Southeast Asians Racism and Prejudice, Limited English proficiency for immigrants Culture conflicts for immigrants
<b>Protective Factors for Mental Illness</b>	Spirituality, Community support: "Collective efficacy" Confront problems openly	Indigenous spirituality Recent return to tribal courts and councils	"Family Households", Spirituality used to cope with mental illness, Less infant mortality, Less substance abuse by women, Aspiration to succeed, Resilience in immigrants	"Family Households", Educational attainment, Relative prosperity for some Asians, Low incarceration rate, Less substance abuse, Motivation to achieve
<b>Mental Illnesses higher than society at large</b>	PTSD, Schizophrenia, Somatization Physical symptoms of mental illness	Alcohol / Substance Abuse Suicide, PTSD, Anxiety Disorder, Mood Disorder, Depression	PTSD and Depression for immigrants and vets, Somatization, Worse among youth: Anxiety, depression, drug use and suicide Culture-bound syndromes: Fright, nerves, evil-eye Those born in US worse than those born abroad	Depression, Anxiety, PTSD among immigrants, Somatization, Suicide in older women, Culture-bound syndromes: Neurasthenia, Hwa-Byung (suppressed anger)
<b>Mental Illnesses lower than society at large</b>	Suicide, Depression, Bipolar disorder		Lower life-time disorders Less substance abuse in women, Suicide (except for youth), Those born abroad better than those born in US	Suicide
<b>Barriers to Treatment by Mental Health System</b>	Mistrust of mental health system, Racism / culture clash with clinicians, (2% A-A) Inadequate insurance, Stigma – reluctant to seek help, Use primary care Dr rather than mental health worker, Use unproven "alternative therapies"	Use unproven "alternative therapies" Culture clash with clinicians (1.5 / 100,000 N-A), Lack of health care Distrust of Government Dr. Little N-A MI Research, Cultural expression of distress: "Ghost sickness", "Wounded spirit"	Culture clash with clinicians (2.0/100,000 H-A), Fear of deportation, Language barriers with clinicians, Lack of health insurance	Very high stigma – mental illness reflects on family, Mind/Body image leads to Somatization, Little research on Asians All Asians: race = "other" Language problems Wait longer to seek help – thus sicker Use unproven "alternative therapies"

**Table 5. Summary of mental illness factors and ethnicity in Surgeon General's Report Mental Health: Culture, Race, and Ethnicity summarized and tabulated by Barbara F. Meyers.**

## Executive Summary<sup>52</sup>

### **Mental Health: Culture, Race, and Ethnicity**

A Supplement to  
**Mental Health: A Report of the Surgeon General**  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
U.S. Public Health Service

America is home to a boundless array of cultures, races, and ethnicities. With this diversity comes incalculable energy and optimism. Diversity has enriched our Nation by bringing global ideas, perspectives, and productive contributions to all areas of contemporary life. The enduring contributions of minorities, like those of all Americans, rest on a foundation of mental health.

Mental health is fundamental to overall health and productivity. It is the basis for successful contributions to family, community, and society. Throughout the life span, mental health is the wellspring of thinking and communication skills, learning, resilience, and self-esteem. It is all too easy to dismiss the value of mental health until problems appear. Mental health problems and illnesses are *real* and *disabling* conditions that are experienced by one in five Americans. Left untreated, mental illnesses can result in disability and despair for families, schools, communities, and the workplace. This toll is more than any society can afford.

This report is a Supplement to the first ever Surgeon General's Report on Mental Health, *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services [DHHS], 1999). That report provided extensive documentation of the scientific advances illuminating our understanding of mental illness and its treatment. It found a range of effective treatments for most mental disorders. The efficacy of mental health treatment is so well documented that the Surgeon General made this single, explicit recommendation for all people: *Seek help if you have a mental health problem or think you have symptoms of a mental disorder.*

The recommendation to seek help is particularly vital, considering *the majority of people with diagnosable disorders, regardless of race or ethnicity, do not receive treatment.* The stigma surrounding mental illness is a powerful barrier to reaching treatment. People with mental illness feel shame and fear of discrimination about a condition that is as real and disabling as any other serious health condition.

Overall, the earlier Surgeon General's report provided hope for people with mental disorders by laying out the evidence for what can be done to prevent and treat them. It strove to dispel the myths and stigma that surround mental illness. It underscored several overarching points about mental health and mental illness (see box). Above all, it furnished hope for recovery from mental illness.

But in the Preface to the earlier report, the Surgeon General pointed out that all Americans do not share equally in the hope for recovery from mental illness:

*Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender (DHHS, 1999, p.vi).*

#### **Mental Health: A Report of the Surgeon General** *Themes of the Report*

Mental health and mental illness require the broad focus of a public health approach. Mental disorders are disabling conditions. Mental health and mental illness are points on a continuum. Mind and body are inseparable. Stigma is a major obstacle preventing people from getting help.

#### **Messages from the Surgeon General**

Mental health is fundamental to health. Mental illnesses are real health conditions. The efficacy of mental health treatments is well documented. A range of treatments exists for most mental disorders.



This Supplement was undertaken to probe more deeply into mental health disparities affecting racial and ethnic minorities. Drawing on scientific evidence from a wide-ranging body of empirical research, this Supplement has three purposes:

To understand better the nature and extent of mental health disparities; To present the evidence on the need for mental health services and the provision of services to meet those needs; and To document promising directions toward the elimination of mental health disparities and the promotion of mental health.

This Supplement covers the four most recognized racial and ethnic minority groups in the United States. According to Federal classifications, African Americans (blacks), American Indians and Alaska Natives, Asian Americans and Pacific Islanders and white Americans (whites) are races. Hispanic American (Latino) is an ethnicity and may apply to a person of any race (U.S. Office of Management and Budget [OMB], 1978). For example, many people from the Dominican Republic identify their ethnicity as Hispanic or Latino and their race as black.

The Federal Government created these broad racial and ethnic categories in the 1970s for collecting census and other types of demographic information.<sup>1</sup> Within each of the broad categories, including white Americans, are many distinct ethnic subgroups. Asian Americans and Pacific Islanders, for example, include 43 ethnic groups speaking over 100 languages and dialects. For American Indians and Alaska Natives, the Bureau of Indian Affairs currently recognizes 561 tribes. African Americans are also becoming more diverse, especially with the influx of refugees and immigrants from many countries of Africa and the Caribbean. White Americans, too, are a profoundly diverse group, covering the span of immigration from the 1400's to the 21st century, and including innumerable cultural, ethnic, and social subgroups.

Each ethnic subgroup, by definition, has a common heritage, values, rituals, and traditions, but there is no such thing as a homogeneous racial or ethnic group (white or nonwhite). Though the data presented in this Supplement are often in the form of group averages, or sample means (standard scientific practice for illustrating group differences and health disparities), it should be well noted that each racial or ethnic group contains the full range of variation on almost every social, psychological, and biological dimension presented. One of the goals of the Surgeon General is that no one will come away from reading this Supplement without an appreciation for the intrinsic diversity within each of the recognized racial or ethnic groups and the implications of that diversity for mental health.

Clearly, the four racial and ethnic minority groups that are the focus of this supplement are by no means the only populations that encounter disparities in mental health services. However, assessing disparities for groups such as people who are gay, lesbian, bisexual, and transgender or people with co-occurring physical and mental illnesses is beyond the scope of this Supplement. Nevertheless, many of the conclusions of this Supplement could apply to these and other groups currently experiencing mental health disparities.

<sup>1</sup> The Office of Management and Budget has recently separated Asian Americans from Native Hawaiians and other Pacific Islanders (OMB, 2000).

---

## **Main Findings**

### **Mental Illnesses are Real, Disabling Conditions Affecting All Populations, Regardless of Race or Ethnicity**

Major mental disorders like schizophrenia, bipolar disorder, depression, and panic disorder are found worldwide, across all racial and ethnic groups. They have been found across the globe, wherever researchers have surveyed. In the United States, the overall annual prevalence of mental disorders is about 21 percent of adults and children (DHHS, 1999). This Supplement finds that, based on the available evidence, the prevalence of mental disorders for racial and ethnic minorities in the United States is similar to that for whites.

This general finding about similarities in overall prevalence applies to minorities living in the community.<sup>2</sup> It does not apply to those individuals in vulnerable, high-need subgroups such as persons who are homeless, incarcerated, or institutionalized. People in these groups have higher rates of mental disorders (Koegel et al., 1988; Vernez et al., 1988; Breakey et al., 1989; Teplin, 1990). Further, the rates of mental disorders are not sufficiently studied in many smaller racial and ethnic groups - most notably American Indians, Alaska Natives, Asian Americans, and Pacific Islander groups - to permit firm conclusions about overall prevalence within those populations.

This Supplement pays special attention to vulnerable, high-need populations in which minorities are over represented. Although individuals in these groups are known to have a high-need for mental health care, they often do not receive adequate services. This represents a critical public health concern, and this Supplement identifies as a course of action

the need for earlier identification and care for these individuals within a coordinated and comprehensive service delivery system.

<sup>2</sup> Most epidemiological studies using disorder-based definitions of mental illness are conducted in community household surveys. They fail to include non-household members, such as persons without homes or persons residing in institutions such as residential treatment centers, jails, shelters, and hospitals.

### **Striking Disparities in Mental Health Care Are Found for Racial and Ethnic Minorities**

This Supplement documents the existence of several disparities affecting mental health care of racial and ethnic minorities compared with whites:

Minorities have less access to, and availability of, mental health services. Minorities are less likely to receive needed mental health services. Minorities in treatment often receive a poorer quality of mental health care. Minorities are underrepresented in mental health research.

The recognition of these disparities brings hope that they can be seriously addressed and remedied. This Supplement offers guidance on future courses of action to eliminate these disparities and to ensure equality in access, utilization, and outcomes of mental health care.

More is known about the disparities than the reasons behind them. A constellation of barriers deters minorities from reaching treatment. Many of these barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness (DHHS, 1999). But additional barriers deter racial and ethnic minorities; mistrust and fear of treatment, racism and discrimination, and differences in language and communication. The ability for consumers<sup>3</sup> and providers to communicate with one another is essential for all aspects of health care, yet it carries special significance in the area of mental health because mental disorders affect thoughts, moods, and the highest integrative aspects of behavior. The diagnosis and treatment of mental disorders greatly depend on verbal communication and trust between patient and clinician. More broadly, mental health care disparities may also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status. The cumulative weight and interplay of all barriers to care, not any single one alone, is likely responsible for mental health disparities.

<sup>3</sup> Although a number of terms identify people who use or have used mental health services (e.g., mental health consumer, survivor, ex-patient, and client), the terms "consumer" and "patient" will be used interchangeably throughout this Supplement.

### **Disparities Impose a Greater Disability Burden on Minorities**

This Supplement finds that racial and ethnic minorities collectively experience a greater disability burden from mental illness than do whites. This higher level of burden stems from minorities receiving less care and poorer quality of care, rather than from their illnesses being inherently more severe or prevalent in the community.

This finding draws on several lines of evidence. First, mental disorders are highly disabling for all the world's populations (Murray & Lopez, 1996; Druss et. al., 2000). Second, minorities are less likely than whites to receive needed services and more likely to receive poor quality of care. By not receiving effective treatment, they have greater levels of disability in terms of lost workdays and limitations in daily activities. Further, minorities are over represented among the Nation's most vulnerable populations, which have higher rates of mental disorders and more barriers to care. Taken together, these disparate lines of evidence support the finding that minorities suffer a disproportionately high disability burden from unmet mental health needs.

The greater disability burden is of grave concern to public health, and it has very real consequences. Ethnic and racial minorities do not yet completely share in the hope afforded by remarkable scientific advances in understanding and treating mental disorders. Because of disparities in mental health services, a disproportionate number of minorities with mental illnesses do not fully benefit from, or contribute to, the opportunities and prosperity of our society. This preventable disability from mental illness exacts a high societal toll and affects all Americans. Most troubling of all, the burden for minorities is growing. They are becoming more populous, all the while experiencing continuing inequality of income and economic opportunity. Racial and ethnic minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health.

## **Main Message: Culture Counts**

Culture and society play pivotal roles in mental health, mental illness, and mental health services. Understanding the wide-ranging roles of culture and society enables the mental health field to design and deliver services that are more responsive to the needs of racial and ethnic minorities.

Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999). It refers to the shared attributes of one group. Anthropologists often describe culture as a system of shared meanings. The term "culture" is as applicable to whites as it is to racial and ethnic minorities. The dominant culture for much of United States history focused on the beliefs, norms, and values of European Americans. But today's America is unmistakably multicultural. And because there are a variety of ways to define a cultural group (e.g., by ethnicity, religion, geographic region, age group, sexual orientation, or profession), many people consider themselves as having multiple cultural identities.

With a seemingly endless range of cultural subgroups and individual variations, culture is important because it bears upon what *all* people bring to the clinical setting. It can account for variations in how consumers communicate their symptoms and which ones they report. Some aspects of culture may also underlie culture-bound syndromes - sets of symptoms much more common in some societies than in others. More often, culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness. All cultures also feature strengths, such as resilience and adaptive ways of coping, which may buffer some people from developing certain disorders. Consumers of mental health services naturally carry this cultural diversity directly into the treatment setting.

Culture is a concept not limited to patients. It also applies to the professionals who treat them. Every group of professionals embodies a "culture" in the sense that they too have a shared set of beliefs, norms, and values. This is as true for health professionals as it is for other professional groups such as engineers and teachers. Any professional group's culture can be gleaned from the jargon they use, the orientation and emphasis in their textbooks, and from their mindset or way of looking at the world.

Health professionals in the United States and the institutions in which they train and practice are rooted in Western medicine which emphasizes the primacy of the human body in disease and the acquisition of knowledge through scientific and empirical methods. Through objective methods, Western medicine strives to uncover universal truths about disease: its causation, diagnosis, and treatment. Its achievements have become the cornerstone of medicine worldwide.

To say that physicians or mental health professionals have their own culture does not detract from the universal truths discovered by their fields. Rather, it means that most clinicians share a worldview about the interrelationship between body, mind, and environment informed by knowledge acquired through the scientific method. It also means that clinicians view symptoms, diagnoses, and treatments in ways that sometimes diverge from their clients' views, especially when the cultural backgrounds of the consumer and provider are dissimilar. This divergence of viewpoints can create barriers to effective care.

The culture of the clinician and the larger health care system govern the societal response to a patient with mental illness. They influence many aspects of the delivery of care, including diagnosis, treatments, and the organization and reimbursement of services. Clinicians and service systems, naturally immersed in their own cultures, have been ill-equipped to meet the needs of patients from different backgrounds and, in some cases, have displayed bias in the delivery of care. The main message of this Supplement is that "culture counts." The cultures that patients come from shape their mental health and affect the types of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services. Cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated - *and they do count*. Cultural differences must be *accounted for* to ensure that minorities, like all Americans, receive mental health care tailored to their needs.

## **Personal Health Recommendation: Seek Help**

The efficacy of treatment is well documented, according to the main finding of *Mental Health: A Report of the Surgeon General*. There is evidence, described in this Supplement, that racial and ethnic minorities benefit from mental health treatment. And it is abundantly clear that good treatment is preferable to no treatment at all. Untreated mental disorders can have dire consequences - distress, disability, and, in some cases, suicide. Therefore, this Supplement underscores the personal health recommendation of the earlier report: *Every person, regardless of race or ethnicity, should seek help if they have a mental health problem or symptoms of a mental disorder.*

Individuals are encouraged to seek help from any source in which they have confidence. If they do not improve with the help received from the first source, they are encouraged to keep trying. At present, members of minority groups may experience limited availability of, and access to, culturally sensitive treatments. With time, access to these services should improve as a result of awareness of this problem and the courses of action identified in this Supplement. In the meantime, anyone who needs help must hear a simple, yet resounding, and message of hope: *Treatment works and recovery is possible.*

## **Organization of Supplement and Major Topics Covered**

The first chapter reviews the core messages of the original Surgeon General's Report on Mental Health. It also covers scope and terminology, the overall public health approach, and the science base for this Supplement. Chapter 2 lays the foundations for understanding the relationships among culture, society, mental health, mental illness, and mental health services. Chapters 3-6 provide information about each of the four major racial and ethnic minority groups, and Chapter 7 concludes with promising courses of action to reduce disparities and improve the mental health of racial and ethnic minorities.

Each chapter concerning a racial or ethnic minority group follows a common format. The chapter begins with the group's history in the United States, which is central to understanding contemporary ethnic identities, adaptive traditions, and health. Similarly, each chapter describes the group's demographic patterns, including their family structure, income and education, and health status. These patterns reflect the group's history, and they are relevant for understanding that group's needs for mental health services. The chapter then reviews the available scientific evidence regarding the need for mental health services (as measured by prevalence), the availability, accessibility, and utilization of services, and the appropriateness and outcomes of mental health services

## **Chapter Summaries & Conclusions**

### **Chapter 2: Culture Counts**

The cultures of racial and ethnic minorities influence many aspects of mental illness, including how patients from a given culture communicate and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery. Cultural and social influences are not the only determinants of mental illness and patterns of service use, but they do play important roles.

- Cultural and social factors contribute to the causation of mental illness, yet that contribution varies by disorder. Mental illness is considered the product of a complex interaction among biological, psychological, social, and cultural factors. The role of any of these major factors can be stronger or weaker depending on the specific disorder.
- Ethnic and racial minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism, discrimination, violence, and poverty. Living in poverty has the most measurable effect on the rates of mental illness. People in the lowest strata of income, education, and occupation (known as socioeconomic status) are about two to three times more likely than those in the highest strata to have a mental disorder.
- Racism and discrimination are stressful events that adversely affect health and mental health. They place minorities at risk for mental disorders such as depression and anxiety. Whether racism and discrimination can by themselves cause these disorders is less clear, yet deserves research attention.
- Mistrust of mental health services is an important reason deterring minorities from seeking treatment. Their concerns are reinforced by evidence, both direct and indirect, of clinician bias and stereotyping.
- The cultures of racial and ethnic minorities alter the types of mental health services they need. Clinical environments that do not respect, or are incompatible with, the cultures of the people they serve may deter minorities from using services and receiving appropriate care.

### **Chapter 3: African Americans**

The overwhelming majority of today's African American population traces its ancestry to the slave trade from Africa. The legacy of slavery, racism, and discrimination continues to influence the social and economic standing of this group. Almost one-quarter of African Americans are poor, and their per capita income is much lower than that of whites. They bear a disproportionate burden of health problems and higher mortality rates from disease. Nevertheless, African Americans are a diverse group, experiencing a range of challenges as well as successes in measures of education, income, and other indices of social well being. Their steady improvement in social standing is significant and serves as testimony to the resilience and adaptive traditions of the African American community.

- **Need for Services:** For African Americans who live in the community, rates of mental illness appear to be similar to those for whites. In one study, this similarity was found **before**, and in another study, **after** controlling for differences in income, education, and marital status. But African Americans are over represented in vulnerable, high-need populations because of homelessness, incarceration, and, for children, placement in foster care. The rates of mental illness in high need populations are much higher.
- **Availability of Services:** "Safety net" providers furnish a disproportionate share of mental health care to African Americans. The financial viability of such providers is threatened as a result of the national transformation in financing of health care over the past two decades. A jeopardized safety net reduces availability of care to African Americans. Further, there are very few African American mental health specialists for those who prefer specialists of their own race or ethnicity.
- **Access to Services:** African Americans have less access to mental health services than do whites. Less access results, in part, from lack of health insurance, especially for working poor who do not qualify for public coverage and who work in jobs that do not provide private health coverage. About 25 percent of African Americans are uninsured. Yet better insurance coverage by itself is not sufficient to eliminate disparities in access because many African Americans with adequate private coverage still are less inclined to use services.
- **Utilization of Services:** African Americans with mental health needs are less likely than whites to receive treatment. If treated, they are likely to have sought help in primary care, as opposed to mental health specialty care. They frequently receive mental health care in emergency rooms and in psychiatric hospitals. They are over represented in these settings partly because they delay seeking treatment until their symptoms are more severe.
- **Appropriateness and Outcomes of Services:** For certain disorders (e.g., schizophrenia and mood disorders), errors in diagnosis are made more often for African Americans than for whites. The limited body of research suggests that, when receiving care for appropriate diagnoses, African Americans respond as favorably as do whites. Increasing evidence suggests that, in clinical settings, African Americans are less likely than whites to receive evidence-based care in accordance with professional treatment guidelines.

#### Chapter 4: American Indians and Alaska Natives

American Indians and Alaska Natives (AI/ANs) flourished in North America for thousands of years before Europeans colonized the continent. As Europeans migrated westward through the 19th century, the conquest of Indian lands reduced the population to 5 percent of its original size. Movement to reservations and other Federal policies has had enduring social and economic effects, as AI/ANs are the most impoverished of today's minority groups. Over one quarter live in poverty, compared to 8 percent of whites. A heterogeneous grouping of more than 500 Federally recognized tribes, the AI/AN population experiences a range of health and mental health outcomes. While AI/ANs are, on average, five times more likely to die of alcohol-related causes than are whites, they are less likely to die from cancer and heart disease. The Indian Health Service, established in 1955, is the Federal agency with primary responsibility for delivering health and mental health care to AI/ANs. Traditional healing practices and spirituality figure prominently in the lives of AI/ANs - yet they complement, rather than compete with Western medicine.

- **Need for Services:** Research on AI/ANs is limited by the small size of this population and by its heterogeneity. Nevertheless, existing studies suggest that youth and adults suffer a disproportionate burden of mental health problems and disorders. As one indication of distress, the suicide rate is 50 percent higher than the national rate. The groups within the AI/AN population with the greatest need for services are people who are homeless, incarcerated, or victims of trauma.
- **Availability of Services:** The availability of mental health services is severely limited by the rural, isolated location of many AI/AN communities. Clinics and hospitals of the Indian Health Service are located on reservations, yet the majority of American Indians no longer live on them. Moreover, there are fewer mental health providers, especially child and adolescent specialists, in rural communities than elsewhere.
- **Access to Services:** About 20 percent of AI/ANs do not have health insurance, compared to 14 percent of whites.
- **Utilization of Services:** An understanding of the nature and the extent to which AI/ANs use mental health services is limited by the lack of research. Traditional healing is used by a majority of AI/ANs.
- **Appropriateness and Outcomes of Services:** The appropriateness and outcomes of mental health care for AI/ANs have yet to be examined, but are critical for planning treatment and prevention programs.

## Chapter 5: Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders (AA/Pis) are highly diverse, consisting of at least 43 separate ethnic groups. The AA/PI population in the United States is increasing rapidly; in 2001, about 60 percent were born overseas. Most Pacific Islanders are not immigrants; their ancestors were original inhabitants of land taken over by the United States a century ago. While the per capita income of AA/Pis is almost as high as that for whites, there is great variability both between and within subgroups. For example, there are many successful Southeast Asian and Pacific Islander Americans; however, overall poverty rates for these two groups are much higher than the national average. AA/Pis collectively exhibit a wide range of strengths - family cohesion, educational achievements, and motivation for upward mobility - and risk factors for mental illness such as pre-immigration trauma from harsh social conditions. Diversity within this population and other hurdles make research on AA/Pis difficult to carry out.

- **Need for Services:** Available research, while limited, suggests that the overall prevalence of mental health problems and disorders among AA/Pis does not significantly differ from prevalence rates for other Americans. Thus, contrary to popular stereotypes, AA/Pis are not, as a group, "mentally healthier" than other groups. Refugees from Southeast Asian countries are at risk for post-traumatic stress disorder as a result of the trauma and terror preceding their immigration.
- **Availability of Services:** Nearly half of AA/Pis have problems with availability of mental health services because of limited English proficiency and lack of providers who have appropriate language skills.
- **Access to Services:** About 21 percent of AA/Pis lack health insurance, but again there is much variability. The rate of public health insurance for AA/Pis with low income, who are likely to qualify for Medicaid, is well below that of whites from the same income bracket.
- **Utilization of Services:** AA/Pis have lower rates of utilization compared to whites. This under representation in care is characteristic of most AAPI groups, regardless of gender, age, and geographic location. Among those who use services, the severity of their condition is high, suggesting that they delay using services until problems become very serious. Stigma and shame are major deterrents to their utilization of services.
- **Appropriateness and Outcomes of Services:** There is very limited evidence regarding treatment outcomes for AA/Pis. Because of differences in their rates of drug metabolism, some AA/Pis may require lower doses of certain drugs than those prescribed for whites. Ethnic matching of therapists with AAPI clients, especially those who are less acculturated, has increased their use of mental health services.

## Chapter 6: Hispanic Americans

The Spanish language and culture forge common bonds for many Hispanic Americans, regardless of whether they trace their ancestry to Africa, Asia, Europe or the Americas. Hispanic Americans are now the largest and fastest growing minority group in the United States. Their per capita income is among the lowest of the minority groups covered by this Supplement. Yet there is great diversity among individuals and groups, depending on factors such as level of education, generation, and country of origin. For example, 27 percent of Mexican Americans live in poverty, compared to 14 percent of Cuban Americans. Despite their lower average economic and social standing, which place many at risk for mental health problems and illness, Hispanic Americans display resilience and coping styles that promote mental health.

- **Need for Services:** Hispanic Americans have overall rates of mental illness similar to those for whites, yet there is wide variation. Rates are lowest for Hispanic immigrants born in Mexico or living in Puerto Rico, compared to Hispanic Americans born in the United States. Hispanic American youth are at significantly higher risk for poor mental health than white youth are by virtue of higher rates of depressive and anxiety symptoms, as well as higher rates of suicidal ideation and suicide attempts.
- **Availability of Services:** About 40 percent of Hispanic Americans in the 1990 census reported that they did not speak English very well. Very few providers identify themselves as Hispanic or Spanish-speaking. The result is that most Hispanic Americans have limited access to ethnically or linguistically similar providers.
- **Access to Services:** Of all ethnic groups in the United States, Hispanic Americans are the least likely to have health insurance (public or private). Their rate of uninsurance, at 37 percent, is twice that for whites.
- **Utilization of Services:** Hispanic Americans, both adults and children, are less likely than whites to receive needed mental health care. Those who seek care are more likely to go to primary health providers than to mental health specialists.
- **Appropriateness and Outcomes of Services:** The degree to which Hispanic Americans receive appropriate diagnoses is not known because of limited research. Research on outcomes, while similarly sparse, indicates that Hispanic Americans can benefit from mental health treatment. Increasing evidence suggests that Hispanic Americans are less likely in clinical settings to receive evidence-based care in accordance with professional treatment guidelines.

## Chapter 7: A Vision for the Future

This Supplement has identified striking disparities in knowledge, access, utilization, and quality of mental health care for racial and ethnic minorities. Reducing or eliminating these disparities requires a steadfast commitment by all sectors of American society. Changing systems of mental health care must bring together the public and private sectors, health service providers, universities and researchers, foundations, mental health advocates, consumers, families, and communities. Overcoming mental health disparities and promoting mental health for all Americans underscores the Nation's commitment to public health and to equality. This chapter highlights promising courses of action for reducing barriers and promoting equal access to quality mental health services for all people who need them.

### 1. Continue to expand the science base.

Good science is an essential underpinning of the public health approach to mental health and mental illness. The science base regarding racial and ethnic minority mental health is limited but growing. Since 1994, the National Institutes of Health (NIH) has required inclusion of ethnic minorities in all NIH-funded research (NIH Guidelines, 1994, p. 14509). Several large epidemiological studies that include significant samples of racial and ethnic minorities have recently been initiated or completed. These surveys, when combined with smaller, ethnic-specific epidemiological surveys, may help resolve some of the uncertainties about the extent of mental illness among racial and ethnic groups.

These studies also will facilitate a better understanding of how factors such as acculturation, help-seeking behaviors, stigma, ethnic identity, racism, and spirituality provide protection from, or risk for, mental illness in racial and ethnic minority populations. The researchers have collaborated on a set of core questions that will enable them to compare how factors such as socioeconomic status, wealth, education, neighborhood context, social support, religiosity, and spirituality relate to mental illness. Similarly, it will be possible to assess how acculturation, ethnic identity, and perceived discrimination affect mental health outcomes for these groups. With these groundbreaking studies, the mental health field will gain crucial insight into how social and cultural factors operate across race and ethnicity to affect mental illness in diverse communities.

A major aspect of the vision for an adequate knowledge base includes research that confirms the efficacy of guideline- or other evidence-based treatments for racial and ethnic minorities. A special analysis performed for this Supplement reveals that the researchers who conducted the clinical trials used to generate treatment guidelines for several major mental disorders did not conduct specific analyses for any minority group. While the lack of ethnic-specific analyses does not mean that current treatment guidelines are ineffective for racial or ethnic minorities, it does highlight a gap in knowledge. Nevertheless, these guidelines, extrapolated from largely majority populations, are clearly the best available treatments for major mental disorders affecting all Americans. As a matter of public health prudence, existing treatment guidelines should continue to be used as research proceeds to identify ways in which service delivery systems can better serve the needs of racial and ethnic minorities.

The science base of the future will also determine the efficacy of ethnic- or culture-specific interventions for minority populations and their effectiveness in clinical practice settings. In the area of psychopharmacology, research is needed to determine the extent to which the variability in peoples' response to medications is accounted for by factors related to race, ethnicity, age, gender, family history, and/or lifestyle.

This Supplement documents the fact that minorities tend to receive less accurate diagnoses than whites. While further study is needed on how to address issues such as clinician bias and diagnostic accuracy, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, now under development, will extend and elaborate the "Glossary of Culture-Bound Syndromes," the "Outline for Cultural Formulation," and other concepts introduced in DSM-IV regarding the role and importance of culture and ethnicity in the diagnostic process.

In terms of the promotion of mental health and the prevention of mental and behavioral disorders, important opportunities exist for researchers to study cultural differences in stress, coping, and resilience as part of the complex of factors that influence mental health. Such work will lay the groundwork for developing new prevention and treatment strategies - building upon community strengths to foster mental health and ameliorate negative health outcomes.

### 2. Improve access to treatment.

Simply put, the Nation's health systems must work to bring mental health services to where the people are. Many racial and ethnic minorities live in areas where general health care and specialty mental health care are in short supply. One major course of action is to *improve geographic availability of mental health services*. Innovative strategies for

training providers, delivering services, creating incentives for providers to work in under-served areas, and strengthening the public health safety net promise to provide greater geographic access to mental health services for those in need.

Another step towards better access to care is to integrate mental health care and primary care. Primary care is where many minority individuals prefer to receive mental health care and where most people who need treatment are first recognized and diagnosed. A variety of research and demonstration programs have been or will be created to strengthen the capacity of these providers to meet the demand for mental health services and to encourage the delivery of integrated primary health and mental health services that match the needs of the diverse communities they serve.

Another major step in improving access to mental health services is to *improve language access*. Improving communication between clinicians and patients is essential to mental health care. Service providers receiving Federal financial assistance have an obligation under the 1964 Civil Rights Act to ensure that people with limited English proficiency have meaningful and equal access to services (DHHS, 2000).

Finally, a major way to improve access to mental health services is to *coordinate care to vulnerable, high-need groups*. People from all backgrounds may experience disparities in prevalence of illness, access to services, and quality of services if they are in under-served or vulnerable populations such as people who are incarcerated or homeless and children living in out of home placements. As noted earlier, racial and ethnic minorities are over-represented in these groups. To prevent individuals from entering these vulnerable groups, early intervention is an important component to systems of care, though research is needed to determine which interventions work best at prevention. For individuals already in under-served or high-need groups, mental health services, delivered in a comprehensive and coordinated manner, are essential. It is not enough to deliver effective mental health treatments: Mental health and substance abuse treatments must be incorporated into effective service delivery systems, which include supported housing, supported employment, and other social services (DHHS, 1999).

### **3. Reduce barriers to mental health care.**

The foremost barriers that deter racial and ethnic minorities from reaching treatment are the cost of services, the fragmented organization of these services, and societal stigma toward mental illness. These obstacles are intimidating for all Americans, yet they may be even more formidable for racial and ethnic minorities. The Nation must strive to dismantle these barriers to care.

*Mental Health: A Report of the Surgeon General* (DHHS, 1999) spotlighted the importance of overcoming stigma, facilitating entry into treatment, and reducing financial barriers to treatment (DHHS, 1999). This Supplement brings urgency to these goals. It aims to make services more accessible and appropriate to racial and ethnic minorities, it encourages mental health coverage for the millions of Americans who are uninsured, and it maintains that parity, or equivalence, between mental health coverage and other health coverage is an affordable and effective strategy for reducing racial and ethnic disparities.

### **4. Improve quality of mental health services.**

Above all, improving the quality of mental health care is a vital goal for the Nation. Persons with mental illness who receive quality care are more likely to stay in treatment and to have better outcomes. This result is critical, as many treatments require at least four to six weeks to show a clear benefit to the patient. Through relief of distress and disability, consumers can begin to recover from mental illness. They can become more productive and make more fulfilling contributions to family and community.

Quality care conforms to professional guidelines that carry the highest standards of scientific rigor. *To improve the quality of care for minorities, this Supplement encourages providers to deliver effective treatments based on evidence-based professional guidelines*. Treatments with the strongest evidence of efficacy have been incorporated into treatment guidelines issued by organizations of mental health professionals and by government agencies.

A major priority for the Nation is to transform mental health services by tailoring them to meet the needs of all Americans, including racial and ethnic minorities. To be most effective, *treatments always need to be individualized in the clinical setting according to each patient's age, gender, race, ethnicity, and culture* (DHHS, 1999). No simple blueprint exists for how to accomplish this transformation, but there are many promising courses of action for the Nation to pursue.

At the same time, research is needed on several fronts, such as how to adapt evidence-based treatments to maximize their appeal and effectiveness for racial and ethnic minorities. While "ethnic-specific" and "culturally competent" service models take into account the cultures of racial and ethnic groups, including their languages, histories, traditions, beliefs, and values, these approaches to service delivery have thus far been promoted on the basis of



humanistic values rather than rigorous empirical evidence. Further study may reveal how these models build an important, yet intangible, aspect of treatment: trust and rapport between patients and service providers.

### **5. Support capacity development.**

This Supplement encourages all mental health professionals to develop their skills in tailoring treatment to age, gender, race, ethnicity, and culture. In addition, because minorities are dramatically underrepresented among mental health providers, researchers, administrators, policy makers, and consumer and family organizations, racial and ethnic minorities are encouraged to enter the mental health field. Training programs and funding sources also need to work toward equitable racial and ethnic minority representation in all these groups.

Another way to support capacity development and maximize systems of care is to promote leadership from within the community in which a mental health system is located. Issues of race, culture, and ethnicity may be addressed while engaging consumers, families, and communities in the design, planning, and implementation of their own mental health service systems. To reduce disparities in knowledge, and the availability, utilization, and quality of mental health services for racial and ethnic minority consumers, mental health educational, research, and service programs must develop a climate that conveys an appreciation of diverse cultures and an understanding of the impact of these cultures on mental health and mental illness. Doing so will help systems better meet the needs of all consumers and families, including racial and ethnic minorities.

### **6. Promote mental health.**

Mental health promotion and mental illness prevention can improve the health of a community and the Nation. Because mental health is adversely affected by chronic social conditions such as poverty, community violence, racism, and discrimination, the reduction of these adverse conditions is quite likely to be vital to improving the mental health of racial and ethnic minorities. Efforts to prevent mental illness and promote mental health should build on intrinsic community strengths such as spirituality, positive ethnic identity, traditional values, educational attainment, and local leadership. Programs founded on individual, family, and community strengths have the potential to both ameliorate risk and foster resilience.

Families are the primary source of care and support for the majority of adults and children with mental problems or disorders. Efforts to promote mental health for racial and ethnic minorities must include strategies to strengthen families to function at their fullest potential and to mitigate the stressful effects of caring for a relative with a mental illness or a serious emotional disturbance.

### **References**

- Breakey, W. R., Fischer, P. J., Kramer, M., Nestadt, G., Romanoski, A. J., Ross, A., Royall, R. M., & Stine, O. (1989). Health and mental health problems of homeless men and women in Baltimore. *Journal of the American Medical Association*, 262, 1352-1357.
- Druss, B. G., Marcus, S. C., Rosenheck, R. A., Olfson, M., Tanielian, T., & Pincus, H. A. (2000). Understanding disability in mental and general medical conditions. *American Journal of Psychiatry*, 157, 1485-1491.
- Koegel, P. M., Burnam, A., & Farr, R. K. (1988). The prevalence of specific psychiatric disorders among homeless individuals in the inner city of Los Angeles. *Archives of General Psychiatry*, 45, 1085-1093.
- Murray, C. J. L., & Lopez, A. D. (Eds.). (1996). *The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Cambridge, MA: Harvard School of Public Health.
- Teplin, L. A. (1990). The prevalence of severe mental disorder among male urban jail detainees: Comparison with the Epidemiologic Catchment Area program. *American Journal of Public Health*, 80, 663-669.
- U.S. Department of Health and Human Services. (1999). *Mental Health: A report of the Surgeon General*. Rockville, MD: Author.
- U.S. Department of Health and Human Services. (2000). *Policy guidance on the Title VI prohibition against national origin discrimination as it affects persons with limited English proficiency*. Rockville, MD: Author.
- U.S. Office of Management and Budget. (1978). *Directive No. 15: Race and ethnic standards for Federal statistics and administrative reporting*. Washington, DC: Author.
- U.S. Office of Management and Budget. (2000). *Guidance on aggregation and allocation of data on race for use in civil rights monitoring and enforcement* (OMB Bulletin No. 00-02). Retrieved July 20, 2001, from <http://www.whitehouse.gov/omb/bulletin:b00-02.html>.
- Vernez, G. M., Burnam, M. A., McGlynn, E. A., Trude, S., & Mittman, B. (1988). *Review of California's program for the homeless mentally ill disabled* (Report No. R3631-CDMH). Santa Monica, CA: RAND.

# Workshop 5:

## Mental Health Treatment

“Comfort, comfort my people, says your God.” Isaiah 40:1

**Purpose** Introduce the major treatments used for mental disorders in North America, and their roles. Identify the facilities most widely used for psychiatric care. Discuss issues brought up by the consumer movement, a movement of mental health patients often critical of traditional means of treating mental disorders. It would be desirable for a psychiatrist or other mental health professional to attend this meeting and discuss some of the therapies that are used for mental disorders. It would also be desirable to have a mental health client advocate to talk about the consumer movement.

### Materials

- Newsprint and paper for making the handouts and charts
- The on-going list entitled “*Responses of a Faith Community*”
- Equipment for playing music, (see “Adding Artistic and Musical Dimensions to the Workshops,”) if you will be using it.

### Preparation

- If possible, invite a psychiatrist or therapist to present information on therapies for treating mental disorders. Also, if possible, invite a mental health client advocate to present information on the consumer movement.
- Copy the *Handouts for Mental Health Treatment* for each student to use during class.
- Optionally, copy *The Recovery Model, Dimensions to Recovery, Therapies for Treating Mental Disorders, 12-Step Programs, The Consumer Movement, A Combination of Treatment Strategies is Often Better than just One, and Example of a program to keep well: WRAP - Wellness Recovery Action Plan™* onto a newsprint chart for presentation.
- If you have a guest speaker, they may have other handouts that they want to distribute to the class. Try to get any such handouts ahead of time and make enough copies of these so that everyone will have one.
- Prominently display “*Responses of a Faith Community*” and remember to ask “What could the response of a faith community?” at appropriate times, recording the class’s answers.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Tell them who the artist, writer and composer of the week are.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings.

### SESSION PLAN

#### Opening

5 minutes

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading* Psalm 71:20-21 (RSV)

*Thou who hast made me see many sore troubles wilt revive me again;  
from the depths of the earth thou wilt bring me up again.  
Thou wilt increase my honor, and comfort me again.*

*Moment of meditation or prayer*

### Workshop Components

---

#### Reflection

5 minutes

Ask if anyone has any questions, comments or reflections on the last workshop or the readings done afterwards.

---

## The Recovery Model

20 minutes

Present the information on the handout *The Recovery Model*. Explain that this model, which originated in the consumer movement, has only recently been accepted by mental health clients, families and providers of mental health services. '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. It just means as much self-determination as possible.

Present the chart *Dimensions to Recovery*. Emphasize that there are many dimensions to recovery, only some of which are medical in nature. Discuss the four stages to Recovery. Can you see instances where this model might be helpful with a member of your congregation?

---

Discussion Questions about the Recovery Model

- What do you think about the definition of 'Recovery' in this model?
- What are the advantages and limitations of the Recovery Model in your opinion?
- What dimensions to recovery do you think are most often overlooked?
- Ask "How could a faith community respond to this situation?" Record the class's responses on the sheet "*Responses of a Faith Community*."

---

## Therapies for Treating Mental Disorders

35 minutes

Present the chart / handout *Therapies for Treating Mental Disorders*, and point out *Common Psychiatric Medications – Generic and Brand Names* as back up information.

Ask the class if any of them have direct experience with any of the therapies being presented and if they would be willing to share it with the class. Suggest that they might discuss such things as:

- How they were referred to the doctor, therapist, psychologist or group offering the treatment
- What the treatment involved: talking, taking medication, being given a treatment
- How long the therapy lasted
- Whether they found the treatment helpful or harmful in some way
- Ask "How could a faith community respond to this treatment situation?" Record the class's responses on the sheet "*Responses of a Faith Community*."

One possible way to introduce discussion of a psychosocial or behavioral therapy is to give a brief demonstration, either by acting it out with a visiting therapist or with a person playing the therapist role. Possibilities for this are the following:

- **Client-Centered Psychotherapy: Carl Rogers**

The principle behind the therapy of Carl Rogers, the great proponent of "client-centered psychotherapy," was the *Self-Actualizing Principle*. This is defined as the built-in motivation present in every life-form to develop its potentials to the fullest extent possible. Rogers believed that all creatures strive to make the very best of their existence and that if they are given an honest environment in which they are valued and authentically understood, they will succeed. This principle led to his famous requirements of the therapist. Rogers felt that a therapist, in order to be effective, must have three qualities:

1. **Congruence** -- genuineness, a true honesty with the client.
2. **Empathy** -- the ability to feel what the client feels.
3. **Respect** -- acceptance, unconditional positive regard towards the client.

He believed these qualities to be necessary and sufficient for a client to improve. That is, if a therapist shows these three qualities, the client will improve. But if the therapist does not show these three qualities, the client's improvement will be minimal, no matter how many other therapeutic techniques are used.

Dr. Rachel Naomi Remen, the director of the innovative Commonweal Cancer Help Program and a professor at The University of California San Francisco School of Medicine, relates an experience that she as a young, self-important, scientifically-trained physician had attended a seminar and witnessed a demonstration of Dr. Carl Rogers' approach. She had heard some of what Rogers did and admits to an initial prejudice against a technique which sounded to her like a "deplorable lowering of standards."<sup>53</sup> Yet she had also heard that Rogers had attained some remarkable results, so her curiosity led her to the seminar.

At first, Rogers' demeanor when explaining his approach did nothing to change her opinion. He was soft spoken and paused often for reflection to come up with the right words to explain his intuitive approach to therapy. Remen asked herself, "Could someone so seemingly hesitant have any expertise at all? I doubted it. ..." <sup>54</sup>

Finally, one of the other doctors attending the seminar volunteered to play the role of a client so that Rogers could demonstrate his approach to therapy. Rogers and the volunteer took chairs facing each other. Before he began, Rogers took a moment of silence to become centered, and then explained to the audience,

"Before every session I take a moment to remember my humanity," he said. "There is no experience that this man has that I cannot share with him, no fear that I cannot understand, no suffering that I cannot care about, because I too am human. No matter how deep his wound, he no longer needs to be alone with it. This is what will allow his healing to begin."<sup>55</sup>

The session that followed not only changed Remen's initial skepticism; it became one the experiences that led her to understand that there were ways to healing other than the medical approach of her training. She explains that Rogers conducted the session

"without saying a single word, conveying to his client simply by the quality of his attention a total acceptance of him exactly as he was. The doctor began to talk and the session rapidly became a great deal more than the demonstration of a technique. In the safe climate of Rogers's total acceptance, he began to shed his masks, hesitantly at first and then more and more easily. As each mask fell, Rogers welcomed the one behind it unconditionally, until finally we glimpsed the beauty of the doctor's naked face. I doubt that even he himself had ever seen it before. By that time many of our own faces were naked and some of us had tears in our eyes. I remember wishing that I had volunteered, envying this doctor the opportunity to be received by someone in such a total way."<sup>56</sup>

The only thing that came close to this in Remen's experience were a few precious moments that she had had with her beloved god-father. One can see that with the shedding of masks by the client doctor, Remen was also shedding masks of understanding of her professional role, and in the process learning about the importance of intuition in healing. It was one step in a process that eventually led her to change into a different kind of healer.

#### ▪ ***Group Therapy: AA-style 12-step meeting format***

- I. Welcome to the \_\_\_\_\_ meeting of Alcoholics Anonymous. My name is \_\_\_\_\_. I'll be your alcoholic leader for the evening.
- II. "For those who wish, could we have a moment of silence for those who still suffer, followed by the Serenity Prayer. ... God - Grant me the serenity to accept the things I can not change, the courage to change the things I can, and the wisdom to know the difference."
- III. "Alcoholics Anonymous is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism. The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions. A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety." (Reprinted with permission of the AA Grapevine)
- IV. "Tonight I have asked \_\_\_\_\_ to read a portion of Chapter Five - "How it Works."

- V. In May of 1935, Bill W., a New Yorker, away from home on a business trip to Akron, Ohio, sought out another alcoholic, Dr. Bob S., so that in sharing their experience, strength, and hope with each other he might remain sober if only for that day. It worked: He stayed sober and Bill W. and Dr. Bob became the first two members of what was to become Alcoholics Anonymous and sharing became the basis for A.A. meetings. Tonight we are gathered together to share our experience, strength, and hope with each other so that we might remain sober if only for today. The suggested format for sharing is to relate in a general way what it used to be like, what happened, and what it is like now.
- VI. "Not to embarrass you, but to get to know you better at the end of the meeting, if you have less than thirty days of sobriety, please introduce yourself by your first name.... Welcome!"
- VII. "At this time, we'll go around the circle and introduce ourselves.... My name is \_\_\_\_\_ and I am an alcoholic."
- VIII. "This is an open meeting of Alcoholic Anonymous. We are glad that you are all here - especially the newcomers. The meeting will last until the circle has shared. If you have to leave early, feel free to do so. Please limit your sharing to five minutes to allow the complete circle to share in a timely manner. Tonight I've chosen the topic \_\_\_\_\_."
- IX. I have asked \_\_\_\_\_ to read a portion of the "Big Book" entitled "The Promises".
- X. All stand in a circle holding hands. Choose someone to lead in the prayer of their choice. The leader for the evening meeting breaks the circle in a clockwise direction, greeting each one in turn with handshake or hug. Others, in like manner, follow.

- ***Behavioral Therapy: Progressive relaxation exercise***

Sit on a chair or on whatever you can sit upright with both feet flat on the ground. Read the following exercises to the class and have them follow them. Have them hold each position for 2-3 seconds before releasing.

1. Left foot: tighten the toes; hold; release
2. Right hand and forearm: make a fist; hold it; release
3. Right upper arm: bend the arm and "show off your muscles"; hold it; release
4. Left hand and forearm: make a fist; hold it; release
5. Left upper arm: bend the arm and tighten the muscles; hold it; release
6. Forehead: raise your eyebrows; hold it; relax your face
7. Eyes and cheeks: squeeze the eyes shut; hold it; relax
8. Mouth and jaw: clench your teeth and pull the corners of the mouth back; hold; relax
9. Shoulder and neck: pull up your shoulders and press your head back against their resistance; hold it; let your shoulders hang; relax
10. Chest and back: breathe in deeply and hold your breath pressing the shoulders together at the back at the same time; hold it; let your shoulders hang; relax
11. Belly: tighten the abdominal muscles (or draw in the belly); hold; release
12. Right thigh: shovel the right foot forward against resistance; hold; release
13. Right calf: lift up the right heel; hold; release
14. Right foot: tighten the toes; hold; release
15. Left thigh: move your left foot forward; hold; relax

### **The Consumer Movement**

**30 minutes**

If you have invited a representative from the consumer movement, they may have their own material that they want to present. If so, you can omit presenting the handouts. However, give copies of the handouts to the participants so they will have this information.

Explain that some people with mental disorders (called "mental health clients") do not agree that treatment as listed earlier in this workshop has been helpful to their wellbeing or recovery from their illness.

Ask if any of the participants have any experience with the consumer movement, or if they have had a negative experience with traditional mental health care. If so, they can give their own story as an example.

Present the information in the handout *The Consumer Movement*.

If no one can give a story about mistreatment in the mental health system, you can use the following from

Judi Chamberlin's book *On Our Own*, one of the first books to publish a case for the consumer movement. It is a very different view of the ideal mental health care system and may be controversial to some people, so you may want to be sensitive to this if you use this example:

- Mental health clients may have feelings ranging from anger to anxiety because it reminds them of some unfortunate experiences that they have had.
- Family members may have feelings of anger or anxiety because they disagree that this approach has validity for their family member, or because it gives them less control over their family member.

Excerpts from: Chamberlin, Judi. *On Our Own – Patient-Controlled Alternatives to the Mental Health System*<sup>57</sup>

Mental hospitals are similar to prisons, old-age homes, and state 'schools' – all exist to contain various kinds of unwanted people.

One of the main functions of the mental hospital, like other 'total institutions,' is control. The lives of patients are minutely supervised. As psychologist D.L. Rosenhan and his colleagues discovered when they faked the symptoms of mental illness and had themselves admitted to a number of mental hospitals:

Personal privacy is minimal. Patient quarters and possessions can be entered and examined by any staff member, for whatever reason. ... The pseudo patients had the sense that they were invisible, or at least unworthy of account.<sup>58</sup>

All the volunteers in the study experienced depersonalization, not because they were mentally ill but because 'patient contact is not a significant priority in the traditional psychiatric hospital'.<sup>59</sup>

What most psychiatrists call mental illness, Thomas Szasz has called 'problems in living'. ... When people do have problems in living, they can help one another. Psychiatrists have no monopoly on knowledge about loneliness, alienation, anger, or any other difficulties of living. ...

In the mental hospital, where understanding human contact is at a premium and where psychotherapy is almost unheard of, is hardly the place where people can learn useful new ways of dealing with life. Instead, knowing that there must be a better way, people have banded together to set up all kinds of alternative institutions. Many have folded, but others are still going and new ones are springing up all the time. ...

Patient-run and patient-controlled alternatives are quite different. Rather than a hierarchical structure in which some participants are clearly in charge of others, true alternatives feature a co-operative and democratic structure. ... They are places where no one, no matter how poorly functioning, is looked down on as hopeless or as less than human.

---

#### Discussion Questions about the Consumer Movement and the Recovery Model

- How does your experience compare to that expressed by mental health client advocates?
- Do you feel that mental health clients can make all decisions with regard to their care? What limits, if any do you see to this?
- What do you feel about forced treatment, including medication and ECT? What about legislation passed in many states to mandate forced medication in certain circumstances?
- Ask "How could a faith community respond to this situation?" Record the class's responses on the sheet "**Responses of a Faith Community.**"

#### Further Discussion Questions about Social / Political Implications of Mental Health Care

- Some have made the observation that our culture has the idea that we all have to be taking medication to be happy, and that this is being carried to an extreme. Do you agree? Why or why not?
  - Others have concluded that diagnosis of mental disorders has been and is used to control women. Examples cited have been diagnoses of hysteria in women in the 19<sup>th</sup> century, and eating disorders and depression in our times. Do you agree or disagree, and why?
-

## **Deciding Which Therapy to Use**

**20 minutes**

Present the chart *A Combination of Treatment Strategies Is Often Better than Just One*.

Ask the class if anyone would like to share their experience of treatment for a mental disorder either for themselves or for a member of their family. Ask them to discuss:

- which therapy or combination of therapies they used
- what their experience had been: what was good, what could have been better
- whether they thought any other of the other therapies discussed might have been helpful if used to augment their care

Give an example of a plan that has helped many people by present the information in: *WRAP - Wellness Recovery Action Plan™*. Ask class members what they think about the WRAP Plan, and whether they think it would work for people who they know.

## **Economic Considerations**

Engage the class in a discussion of the economics of choosing a therapy, using some of the following points, if necessary.

When it comes down to it, many times the kind of treatment that a person gets depends on what the person or their family is able to afford. The economic realities are:

- There are often limits on the number of visits to therapists that insurance companies will cover. Some therapists are even going out of business.
- The cost of some of the newer psychotropic medications is very high and can't be afforded except by people who are wealthy or have adequate insurance.
- Some people can't afford to be treated in the kind of facility and the kind of therapy that would be best for their situation.

Possible Discussion Questions:

- Has anyone in the class, or someone you know personally experienced being able to be treated adequately?
- What do you think society's responsibility is regarding getting adequate mental health treatment for all its citizens? What is a church's responsibility?

---

## **Closing**

**5 minutes**

*Reading: # 505 Let us be at peace with our bodies and our minds* by Thich Nhat Hahn

## **Handouts for Treatment of Mental Disorders**

*“Comfort, comfort my people, says your God.”* Isaiah 40:1

- The Recovery Model
- Dimensions to Recovery
- Therapies for Treating Mental Disorders
  - Common Psychiatric Medications – Generic and Brand Names
- 12-Step Programs
- The Consumer Movement
- A Combination of Treatment Strategies is Often Better than just One
- Example of a program to keep well: WRAP - Wellness Recovery Action Plan™



# The Recovery Model

- Recently embraced by mental health clients, families, providers, and the President's New Freedom Commission for Mental Health, 2003
- Recovery can be defined as:
  - Regaining meaningful social roles in society as one grows beyond the catastrophic effects of mental illness.
  - A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles.
  - Maintaining as much freedom, independence and autonomy as possible, making as many decisions as possible for oneself.
- Recovery does not necessarily mean:
  - The absence of symptoms
  - The absence of need for medication or other therapies
- Underlying assumptions of the Recovery Model:
  - Recovery from severe psychiatric disabilities is achievable
  - Recovery is not a function of one's theory about the causes of mental illness
  - Recovery requires a well-organized support system
  - A holistic view of mental illness that focuses on the person, not just the symptoms

## Stages of Recovery <sup>60</sup>

### **Prerequisites: ACCEPTANCE, NEEDS MET**

The person accepts that there is a problem with their mental health. And, the person's physical needs, including housing, care and medication are being met. Recognize that the model is not perfect and that there can be back-sliding.

### **The first stage: HOPE**

During times of despair, everyone needs a sense of hope, a sense that things can and will get better. It's not so much that people with mental illness will attain precisely the vision they create, but that they need to have a clear image of the possibilities before they can make difficult changes and take positive steps. They may need others to be hopeful for them, and work with them to acquire this sense of hope.

### **The second stage: EMPOWERMENT**

To move forward, people need to have a sense of their own capability and their own power. Their hope needs to be focused on things they can do for themselves rather than on new cures or fixes that someone else will discover or give them. Often people have to experience success before they believe they can be successful. Sometimes they need another person to believe in them before they're confident enough to believe in themselves.

### **The third stage: SELF-RESPONSIBILITY**

As people with mental illness move toward recovery, they realize they have to take responsibility for their own lives, and not have others do everything for them. This means they have to take risks, try new things and learn from their mistakes and failures. It also means they need to let go of the feelings of blame, anger and disappointment associated with their illness. Old patterns of dependency must be broken.

### **The fourth stage: A MEANINGFUL ROLE IN LIFE**

Ultimately, in order to recover, people with mental illness must achieve some meaningful role in their lives that is separate from their illness. Newly acquired traits like increased hopefulness, confidence and self-responsibility need to be applied to "normal" roles such as employee, son, mother and neighbor, apart from their mental illness. It is important for people to join the larger community and interact with people who are unrelated to their mental illness.

# DIMENSIONS TO RECOVERY

## **MIND**

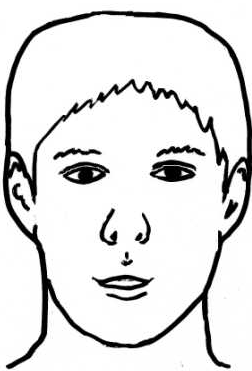
PSYCHOTHERAPY  
HOPE  
SELF ESTEEM  
EDUCATION

## **BODY**

NOURISHMENT  
MEDICATION  
REST  
EXERCISE  
SYMPTOM MANAGEMENT  
MEDICAL CARE

## **PLAY**

FUN  
HOBBIES  
ENTERTAINMENT  
LAUGHTER



## **RELATIONSHIPS**

FRIENDSHIPS  
FAMILY SUPPORT  
PEER SUPPORT  
ACCEPTANCE  
HELPING OTHERS

## **WORK**

MEANINGFUL OCCUPATION  
CREATIVE EXPRESSION

## **ENVIRONMENTAL**

HOUSING  
CONNECTING WITH NATURE  
ADEQUATE FINANCES

## **SPIRIT**

SPIRITUAL PRACTICE  
RELIGIOUS COMMUNITY  
FIND MEANING IN SUFFERING

Success involves as many of these dimensions as possible  
Each person's balance of these factors is unique.

This categorization uses 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.

## Therapies for Treating Mental Disorders

THERAPY	PURPOSE	EXAMPLES
Biological	Alleviate symptoms	Medications <ul style="list-style-type: none"> <li>• Antipsychotics for psychotic disorders</li> <li>• Antidepressants for depression</li> <li>• Anticycling agents for bipolar disorder</li> <li>• Hypnoanxiolytics for anxiety disorders</li> <li>• Stimulants</li> <li>• Electroconvulsive Therapy (ECT)               <ul style="list-style-type: none"> <li>○ Chiefly used when other therapies are not successful.</li> </ul> </li> </ul>
Psychosocial	Address underlying issues, which will lead to changes in behavior.	Individual Therapy <ul style="list-style-type: none"> <li>• Psychotherapy or counseling with a psychiatrist, psychologist or therapist</li> <li>• Pastoral counseling with a minister</li> </ul> Group Therapy <ul style="list-style-type: none"> <li>• Professionally run groups</li> <li>• Peer support groups ex: Alcoholics Anonymous</li> </ul> Couples and Family Therapy <ul style="list-style-type: none"> <li>• Marriage counseling</li> <li>• Family Therapy</li> </ul>
Behavioral	Address behavior, which will lead to change in feelings and attitudes	<ul style="list-style-type: none"> <li>• Biofeedback: Electronic instrument gives feedback to patient.</li> <li>• Relaxation Systematic relaxation of parts of the body</li> <li>• Operant Conditioning Reward and reinforce positive behaviors</li> </ul>

**Table 6. Therapies for Treating Mental Disorders**

Sources:

- *Essential Psychopathology and Its Treatment, Second Edition* by Jerrold S. Maxmen and Nicholas G Ward, pp 87-97.
- *The Soul in Distress* by Richard W. Roukema, M.D., pp 42-47, 59

## Common Psychiatric Medications – Generic and Brand Names

<b>ANTI PSYCHOTICS</b>	
<i>Brand Name</i>	<i>Generic Name</i>
Clozaril	clozapine
Haldol	haloperidol
Geodon	ziprasidone
Loxitane	loxapine
Mellaril	thioridazine
Moban	molindone
Navane	thiothixene
Orap	pimozide
Prolixin	fluphenazine
Risperdal	risperidone
Serentil	mesoridazine
Seroquel	quetiapine
Stelazine	trifluoperazine
Taractan	shlorprothixene
Thorazine	chlorpromazine
Trilafon	perphenazine
Zyprexa	olanzapine

<b>ANTI CYCLING AGENTS</b>	
<i>Brand Name</i>	<i>Generic Name</i>
Depakote	divalproex sodium
Eskalith-CR	lithium carbonate
Tegretol	carbamazepine

<b>HYPNOTICS</b>	
<i>Brand Name</i>	<i>Generic Name</i>
Ambien	zolpidem
Dalmane	flurazepam HCL
Halcion	triazolam
Restoril	temazepam
Sonata	zaleplon

<b>ANTI DEPRESSANTS</b>		
<i>Class</i>	<i>Brand Name</i>	<i>Generic Name</i>
TCA	Adapin, Sinequan	Doxepin
TCA	Anafranil	Clomipramine
TCA	Asendin	Amoxapine
TCA	Aventyl, Pamelor	Nortriptyline
TCA	Elavil	Amitriptyline
TCA	Ludiomil	Maprotiline
TCA	Norpramin	Desipramine
TCA	Surmontil	Trimipramine
TCA	Tofranil	Imipramine
TCA	Vivactil	Protriptylene
SSRI	Celexa	Citalopram
SSRI	Luvox	Fluvoxamine
SSRI	Paxil	Paroxetine
SSRI	Prozac	Fluoxetine
SSRI	Remeron	Mirtazapine
SSRI	Zoloft	Sertraline
MAOI	Marplan	Isocarboxizid
MAOI	Nardil	Phenelzine
MAOI	Parnate	Tranlycypromine
Atypical	Effexor	Venlafaxine
Atypical	Desyrel	Trazodone
Atypical	Wellbutrin	Bupropion

### **Abbreviations for Classes of Antidepressants**

TCA = Tricyclic Antidepressant

SSRI = Selective Serotonin Reuptake Inhibitor

MAOI = Monoamine Oxidase Inhibitor

<b>ANTI ANXIETY AGENTS</b>	
<i>Brand Name</i>	<i>Generic Name</i>
Ativan	lorazepam
BuSpar	bupirone
Librium	chlordiazepoxide
Serax	oxazepam
Valium	diazepam
Xanax	alprazolam
Zebeta	bisoprolol fumarate

<b>STIMULANTS</b>	
<i>Brand Name</i>	<i>Generic Name</i>
Ritalin	methylphenidate

**Tables 7. Common Psychiatric Medications**

## 12-STEP PROGRAMS

### The Basic Twelve Steps

1. We admitted we were powerless over \_\_\_“X”\_\_\_ - that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of our Higher Power.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to our Higher Power, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have our Higher Power remove all these defects of character.
7. Humbly asked our Higher Power to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly, admitted it.
11. Sought through prayer and meditation to improve our conscious contact with our Higher Power, praying only for knowledge of the will of our Higher Power for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to others with the same problem and to practice these principles in all our affairs.

#### Examples of “X”:

Alcohol	Marijuana	Consequences of Rape
Cocaine	Narcotics	Schizophrenia
Depression	Nicotine	Consequences of Incest
Emotions	Obsessive-Compulsive	Consequences of Trauma
Gambling	Overeaters	Incest Survivors
Manic Depression	Phobias	

#### 12-Steps and Psychiatric Medication

There is sometimes confusion and controversy in 12-step programs regarding the use of psychiatric medication, because of the belief that some of these medications are addictive and can be abused. The literature of Alcoholics Anonymous and other recovery programs state that it is not their official position to discourage taking professionally prescribed and monitored psychiatric medications.

## The Consumer Movement

*“Who then can so softly bind up the wound of another as he who has felt the same wound himself?”*

Thomas Jefferson

### Some mental health client views on limitations 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
- DSM diagnosis based on symptoms is supposed to be unique, but in practice, different diagnoses are often given for the same symptoms in the same person
- 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 client rights (see Personal Bill of Rights below)
- Self Determination and Self Advocacy
- Self Help and Peer Support, Peer-run Drop in Centers
- Networking with other mental health clients
- Lobbying and advocacy for rights of mental health clients
- Some mental health clients reject some or all medical intervention for mental disorders:
  - Psychiatric Medication
    - Against forced medication: Contentious issue between families and mental health clients
  - Psychiatric Hospitalization
  - Electroconvulsive Therapy (ECT)

### Personal Bill of Rights

#### I HAVE THE RIGHT TO ...

1. ASK FOR WHAT I WANT.
2. SAY NO TO REQUEST OR DEMANDS I CAN'T MEET.
3. CHANGE MY MIND.
4. MAKE MISTAKES AND NOT HAVE TO BE PERFECT.
5. FOLLOW MY OWN VALUES AND STANDARDS.
6. EXPRESS ALL MY FEELINGS, BOTH POSITIVE AND NEGATIVE.
7. SAY NO TO ANYTHING WHEN I AM NOT READY, IT IS UNSAFE, OR IT VIOLATES MY VALUES.
8. DETERMINE MY OWN PRIORITIES.
9. BE RESPONSIBLE FOR OTHERS' BEHAVIOR, ACTIONS, FEELINGS, OR PROBLEMS.
10. EXPECT HONESTY FROM OTHERS.
11. BE ANGRY AT SOMEONE I LOVE.
12. BE UNIQUELY MYSELF.
13. FEEL SCARED AND SAY, “I'M AFRAID.”
14. SAY, “I DON'T KNOW.”
15. TO NOT GIVE EXCUSES OR REASONS FOR MY BEHAVIOR.
16. MAKE DECISIONS BASED ON MY OWN FEELINGS.
17. MY OWN NEEDS FOR PERSONAL SPACE AND TIME.
18. BE PLAYFUL AND FRIVOLOUS.
19. BE HEALTHIER THAN THOSE AROUND ME.
20. BE IN A NON-ABUSIVE ENVIRONMENT.
21. MAKE FRIENDS AND BE COMFORTABLE AROUND PEOPLE.
22. CHANGE AND GROW.
23. HAVE MY NEEDS AND WANTS RESPECTED BY OTHERS.
24. BE TREATED WITH DIGNITY AND RESPECT.
25. BE HAPPY.

Sources: Katherine Hodges of Mad Lib & Chicagoland Alliance for Psychiatric Alternatives  
Mary Ellen Copeland in *Self-Advocacy*, National Mental Health Consumers' Self-Help Clearinghouse

## **A Combination of Treatment Strategies Is Often Better than Just One**

### **Therapies can complement and facilitate each other.**

- Medication can facilitate other therapies because it can give the ability to concentrate and cooperate in other activities
- Psychotherapy can accomplish what drugs cannot – It can allow a lasting change in fundamental underlying beliefs and feelings.
- Behavioral therapy can establish patterns of beneficial activity, reinforcing insights learned in psychotherapy.

### **Peer Support activities can complement traditional therapies**

- Receiving support from others who have had similar problems can be very helpful because they've been there. What worked for them may work for you.
- Giving support to others can enhance self-esteem
- Participation in networks and in advocacy on behalf of oneself or others is empowering
- Recent federally-sponsored research<sup>61</sup> shows that people who augment traditional medical therapies with peer support activities, such as drop-in centers, report significantly better well-being than those using only traditional medical therapies.
- ***Conflict with traditional therapy*** is usually over:
  - Forced treatment including forced hospitalization and forced medication
  - Disagreement by some with the medical model of mental health care treatment

### **Recovery Model activities give more control over life**

- Learning how to monitor one's triggers and early warning signs can make relapse less frequent.
- Deciding ahead of time what kind of treatment to have is empowering and enhances self-esteem
- Address as many dimensions of recovery as possible

### **Family Support is important**

- Recent research<sup>62</sup> has shown that Family Focused Therapy (FFT) in combination with medication is more effective treatment than medication alone.
  - FFT involves the family in helping with their loved one's illness through proactive therapy, education and communications skills building.
- For people without families, one may need to create one's own family support system to serve this role.
- We will talk more about families in Workshop 6.

# WRAP: Wellness Recovery Action Plan™ 63

by Mary Ellen Copeland, MA, MS

WRAP is a self-designed plan for staying well and for helping you to feel better when you are not feeling well to increase personal responsibility and improving your quality of life.

The first part of WRAP is developing a personal **Wellness Toolbox**. This is a list of resources you can use to develop your WRAP. It includes things like contacting friends and supporters, peer counseling, focusing exercises, relaxation and stress reduction exercises, journaling, creative, fun and affirming activity, exercise, diet, light, and getting a good night's sleep.

Next is creating a work book with the following six sections:

Section	Name	Contents
1	Daily Maintenance Plan	It includes three parts: 1.) a description of yourself when you are well, 2.) those Wellness Tools you know you must use every day to maintain your wellness, and 3.) a list of things you might need on any day.
2	Triggers	Identifying those events or that, if they happened, might make you feel worse--like an argument with a friend or getting a big bill. Then, using Wellness Tools, you develop an action plan you can use to get through this difficult time.
3	Early Warning Signs	Identifying, those subtle signs that let you know you are beginning to feel worse, like being unable to sleep or feelings of nervousness. Then, again, using your Wellness Toolbox, developing an action plan for responding to these signs you feel better quickly and prevent a possible difficult time.
4	When Things are Breaking Down	In this section, you list those signs that let you know you are feeling much worse, like you are feeling very sad all the time or are hearing voices. And again, using your Wellness Toolbox, develop a powerful action plan that you that will help you feel better as quickly as possible and prevent an even more difficult time
5	Crisis Plan or Advance Directive	In the crisis plan, you identify those signs that let others know they need to take over responsibility for your care and decision making, who you want to take over for you and support you through this time, health care information, a plan for staying at home through this time, things others can do that would help and things they might choose to do that would not be helpful. This kind of proactive advanced planning keeps you in control even when it seems like things are out of control.
6	Post Crisis Plan	You may want to think about this part of the plan in advance and even write some things to do in that time. However, you may want to write most of it as you are beginning to recover from the crisis—when you have a clearer picture of what you need to do for yourself to get well.

**Review your plans every day**, noting how you feel, and do what you need to do to help yourself get better or to keep yourself well. As you become familiar with your plan, you will find that the review process takes less time and that you will know how to respond without even referring to the book. People who are using these plans regularly and updating them as necessary are finding that they have fewer difficult times, and that when they do have a hard time it is not as bad as it used to be and it doesn't last as long.

**The WRAP approach empowers you to take control of your own health and wellness.** Since its development, it has been shared with thousands of people through the books *Wellness Recovery Action Plan™*, *Winning Against Relapse*, the *Winning Against Relapse Audio Tape*, the *Creating Wellness Video* series, numerous support groups, workshops and seminars, and on the web at [www.mentalhealthrecovery.com](http://www.mentalhealthrecovery.com).



# Workshop 6:

## Families and Friends of those with Mental Disorders

“And I applied my mind to know wisdom and to know madness.” Ecclesiastes 1:14

**Purpose** Introduce some of the challenges faced by the families and friends of those who have mental disorders. Look at the programs of organizations that support families in this position.

The most effective way for this session to be presented is through the experiences of one or more family members who have a loved one with a serious mental disorder. Ideally, they should be people who have learned to live with their loved one’s disorder in positive, active ways, and can thus be role models for other families who are struggling. If they have participated in the Family-to-family program from NAMI, they will be well-educated and will be able to help on the segment of the program that discusses the program. If you can’t find a speaker, you can read the case study of a family that is given here.

### Materials

- Paper and newsprint for copies and exercises.
- The on-going list entitled “**Responses of a Faith Community**”
- Equipment for playing music, (see “Adding Artistic and Musical Dimensions to the Workshops,”) if you will be using it.

### Preparation

- Summarize the charts for this session onto newsprint to display: *Communication Guidelines, Stages of Emotional Reactions among Family Members, Life Burdens in Caring for People with Mentally Illness, Coping with a Loved One’s Mental Disorder, Special Coping Strategies, Coping Strategies for Mental health clients* and NAMI.  
Prepare for the demonstration of “Communication with someone with a mental disorder” activity. See the description of that activity in the session plan below for details.
- Learn where the nearest local chapter of NAMI
- Make copies of *Reading Assignments for The Role of the Church* for next week’s lesson.
- Prominently display “**Responses of a Faith Community**” and remember to ask the class “What should the response of a faith community, recording the class’s answers.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Tell them who the artist, writer and composer of the week are.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings.

### SESSION PLAN

#### Opening

5 minutes

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading: #468 We need one another* by George E. O’Dell

*Moment of meditation or prayer*

#### Workshop Components

#### Stages of Emotional Reactions among Family Members

20 minutes

- Present the handout *Stages of Emotional Reactions among Family Members*.

Discussion questions:

- Do these stages “ring true” for you, or in situations you know of?

- Can you recognize which stage you or your family is in right now?
- Do you agree with the needs identified for each stage? Would you add any other needs?
- Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community*.”

### **Caring for people with Mental Disorders**

**20 minutes**

Present the handouts *Life Burdens in Caring for People with Mentally Illness*, *Coping with a Loved One’s Mental Disorder*, *Special Coping Strategies* and *Coping Strategies for Mental health clients*. Suggest to family members that they share the *Coping Strategies for Mental health clients* with their loved one.

Discussion Questions:

- If you have been in one of these situations, which of these suggestions have been helpful to you, which have been helpful to your loved one?
- Ask people to share any additional suggestions that they may have that have been helpful to them when living with their loved one’s mental disorder.
- Ask “How could a faith community respond to this situation?” Record the class’s responses on the sheet “*Responses of a Faith Community*.”

### **Stories of Family Members**

**30 minutes**

If you have invited any family members to your meeting, ask them to tell their stories. This might include:

- How the illness first manifested itself in their loved one
- What they tried to get help for their loved one
- What worked and what didn’t work
- Advice to give hope to the others in attendance who may have just started on this difficult journey

If you haven’t invited anyone to speak, you can use the following case study.

**Case Study: A Family’s Story** from Diane and Lisa Berger. *We Heard the Angels of Madness – A Family Guide to Coping with Manic Depression*<sup>64</sup>

In this book, Diane Berger tells of her first visit to a mental hospital to get help for her son Mark, who she suspected, because of his erratic behavior, had a drug problem. In addition to Mark, she was accompanied by her father. She realized that this was going to be a difficult time and in addition to her agony over her son’s condition, was concerned about how her father would handle it.

At the hospital Mark was interviewed by a drug counselor, and during the interview, Mark “burst out of the office and tore down the corridor to the elevators. He had no money or car, but he was angry and not acting rationally.” She, the counselor and her father went running after him.

Diane and the family had wanted Mark to be voluntarily admitted to the hospital, but this was something that he refused to do. He was convinced that lasers were being sent through his head causing his mind to race. She sat next to him and silently reached for his hand. She relates that “he angrily pulled it away and twisted around so I couldn’t see his face.” He said, “Don’t you see, bitch, this is my life, not yours. Go away.” This was language she had never heard from her son. This couldn’t be her son.

Eventually the police were called, Mark was subdued in handcuffs, strapped to a gurney, all of which Diane and her father witnessed, and Diane had to sign commitment papers for him, something she did in tears.

As she filled out the medical forms and questions about Mark, she was “aware that I was creating for Mark a record as a mental patient. ... Was I shutting out his future with this form? Labeling him for life? Would this follow him through schools and jobs? I couldn’t answer these questions, but I had to get him help now. ...”

The next day, Diane returned to the hospital to meet with Dr. Lee, the staff psychiatrist. He was brief and to the point. The drug screen had been negative. “Based on Mark’s behavior and the family history, he was probably manic-depressive, possibly schizophrenic. They couldn’t be positive so early, but manic-

depression was the tentative diagnosis. Manic depression, he continued, was a mood disorder, and Mark should immediately start on lithium.... Compared to this, a drug problem would be a blessing.”

### Communication with People with Mental Disorders

**30 minutes**

Communicating effectively with a person with a mental disorder is important for each party in a conversation. For a person with a mental disorder to know that someone understands them can reduce anxiety, help self-esteem and increase the likelihood of getting appropriate treatment. For the other person, they can learn that what they do can make a difference in the life of a person who is having serious problems, which makes it more likely that they will reach out effectively in future situations.

Present the handout *Communication Guidelines*

#### *Communication Demonstration*

This demonstration will show ineffective and effective ways to communicate with someone with a mental disorder. Before class, you will have prepared for this lesson by choosing a demonstration partner and deciding what roles and situation(s) to demonstrate. Your partner can be your co-facilitator or someone in the class. One person will play the part of a family member, and the other will play the part of the person with a mental disorder. Decide what situation(s) you will act out with that person and in general what you will say. Practice beforehand if this will make it more comfortable for you. Some possible scenarios are listed in the following chart. Of course you should improvise and ham it up to make it seem realistic. Use suggestions on the *Communications Guidelines* handout.

<b>Situation</b>	<b>Examples of Ineffective Communication</b>	<b>Examples of More Effective Communication</b>
A person has low motivation and can't seem to do anything.	“You’re lazy! Why don’t you get off your duff and make something of yourself.”	“I really like the way you helped me do the dishes.” “Remember the writing class you said you were interested in? What do you think about signing up for it?” “I want you to help me vacuum the house. That would be a great help to me.”
A person is fearful and full of anxiety.	“Oh my God! What a mess you are! You’re making me nervous. I can’t stand to be around you.”  “Why don’t you just buck up like the rest of us?”	“Other people have felt the way you do now and have gotten better. You will too.” “I would like you to come with me to the doctor to get help. That would help us both feel better.” “How horrible this must be for you.”
A person has poor judgment and has spent a lot of money on trivial items.	“You’re such an idiot! People like you can’t be trusted with money.”	“I am angry that you spent the money so unwisely. That hurts me because I know how hard it was to earn it. Next time, we will go on a shopping trip together.”
A person is angry and hostile and has shouted at a family member.	“Shut up! Don’t shout at me, you worthless bum.”	“I am angry that you shouted at me. I would like it better if you said things more quietly next time. I think that would be better for all of us.”

**Table 8. Examples of Ineffective and Effective Communication**

Explain to the class that you will be demonstrating ineffective communication and more effective communication. First, act out the situation using ineffective communication. Then repeat the situation using more effective communication. Ask the class to reflect on the exercise, what they learned, what was awkward, and what worked. If you have time, act out more than one situation. If you think it would work, you can ask the class to suggest situations of their own.

### **NAMI Support for Families**

**10 minutes**

Present the handout *NAMI* that describes the purpose and the Family-to-family program of NAMI. Ask if anyone has any experience with this organization and would like to share it with the class. Tell people how to take advantage of NAMI programs:

- A great deal of information is contained on the NAMI website at [www.nami.org](http://www.nami.org)
- You can sign up for direct email alerts by visiting: [www.nami.org/update/enewslist.htm](http://www.nami.org/update/enewslist.htm).
- Where to attend local NAMI meetings.

### **Closing**

**5 minutes**

*Reading # 706 May the light around us guide our footsteps* by Kathleen McTigue

### **Assignment**

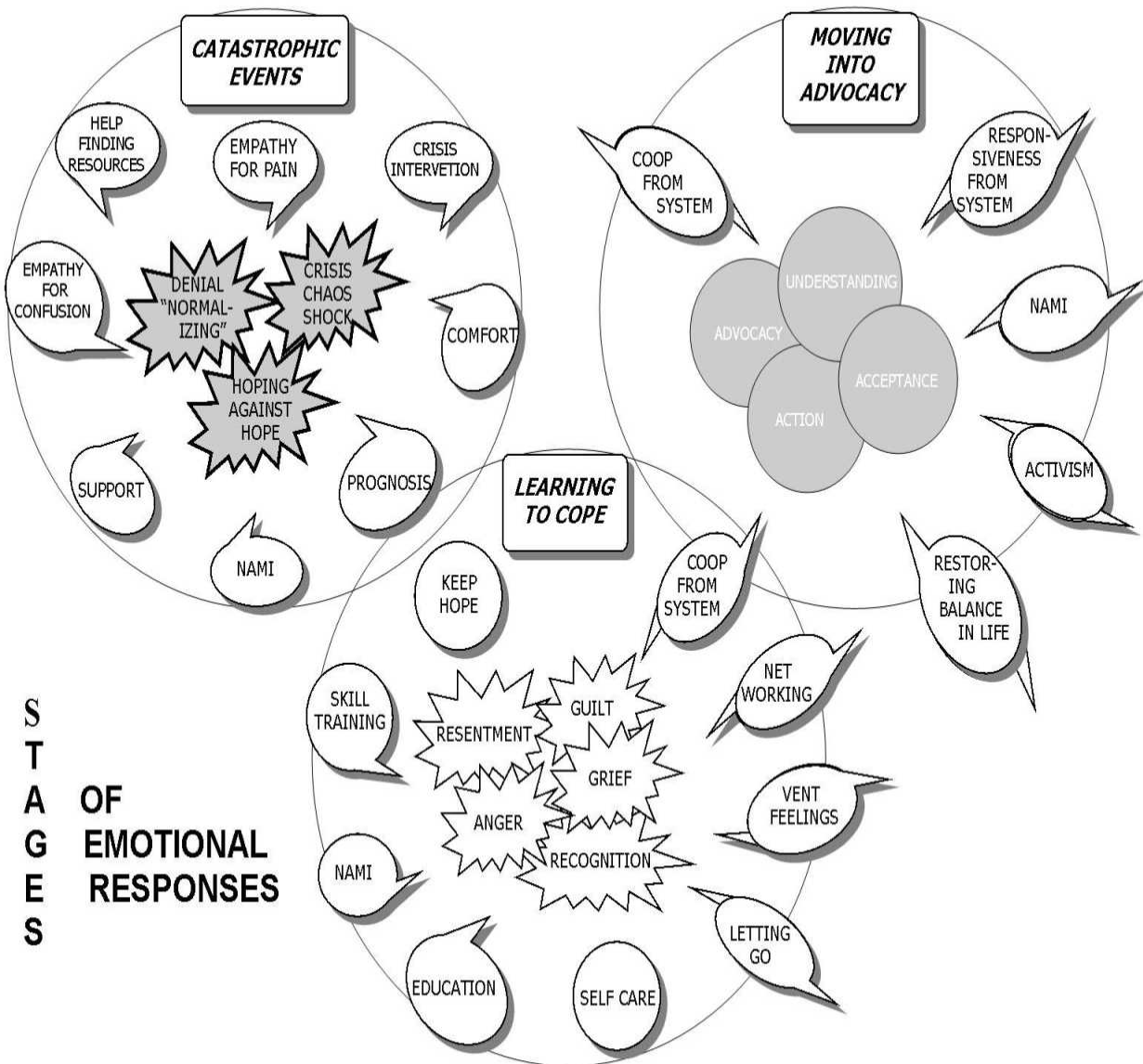
Distribute copies of the *Reading Assignments for The Role of the Church* to be discussed in workshop 7.

## **Handouts for Families and Friends of People with Mental Disorders**

*“And I applied my mind to know wisdom and to know madness.” Ecclesiastes 1:14*

- Stages of Emotional Reactions among Family Members
- Life Burdens in Caring for People with Mental Illness
- Coping with a Loved One’s Mental Disorder
- Special Coping Strategies
- Coping Strategies for Mental Health Clients
- Communication Guidelines
- NAMI

## Stages of Emotional Reactions among Family Members



### Characteristics and Needs for each Stage

**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

Source: NAMI Family-to-Family Education Course

## **Life Burdens in Caring for People with Mental Illness**

### **Burdens of the Primary Caretakers**

- Getting through the crisis and meeting needs of well family members
- Learning how to deal with residual symptoms
- Staying alert to signs of relapse
- Dealing with anxiety about relapse
- Dealing with impact on love relationship / marriage
- Dealing with financial worries and plans for future care

### **Burdens of Siblings and Adult Children**

- Coping with disproportionate attention being given to sibling or parent who is ill
- Experiencing sibling or parent as “bad” rather than “ill”
- Bearing the social stigma of having a “strange” family member
- Handling needs of care-taker or neglected well family members
- Having more chores and responsibilities
- Worry that you “caused” the illness, or that it is contagious
- Worry about how much you should do

### **Burdens of Spouses**

- Coping with the loss of an intimate confidant
- Dealing with “emotional silence” and sexual distance
- Dealing with ambivalent thoughts of divorce
- Taking on the dual role of single-parent and primary caretaker; worries about money
- Being the target of anger from your spouse and from your children
- Coping with stigma, social isolation, lack of peer group

Sources:

NAMI *Family-to-Family Education Course*

*The Caring Family: Living with Chronic Mental Illness* by Kayla Bernheim, Richard Lewine, and Caroline Beale.

## **Coping with a Loved One's Mental Disorder**

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

- Get professional help to learn what your own responsibilities and capabilities are.
- Be flexible and patient. Cures are rarely instantaneous.
- Learn to recognize the signs of the mental disorder.
- Tell them that you love and care about them.
- Make sure that they get the help that they need, for example, a therapist or a hospital stay. You may have to help make the appointment for them and go with them.
- If they are suicidal, get them immediate attention. Call 911 if there's an immediate danger.
- Visit them, especially if they're hospitalized. A smile, a flower, a picture or a short hug can make all the difference.
- Support continuing therapy.
- Support them in their efforts to find the medicines best for them.
- Monitor their medicine intake.
- Encourage physical exercise, good diet, plenty of sleep, creative activities, and sunlight.
- Learn to recognize the warning signs that a depressive episode is going to happen, and help to take action to head it off or minimize it.
- Avoid doing things that trigger their disorder, ex: if they become anxious or depressed when they are pressured to hurry, don't try and hurry them up.
- Keep days structured.
- Keep guns out of the house.
- Plan future activities for both of you to look forward to, and activities for yourself alone.
- Maintain some kind of social activity with your loved one, such as going to the movies.
- Join your own support group, formal or informal.
- Have a life of your own. If the depressed person needs monitoring or assistance, get help.
- Make the best of their good days. Drop the housework to enjoy time with your loved one.
- Read and learn all you can about the mental disorder that your loved one has.
- Live one day at a time.



## Special Coping Strategies

### For Children of People Who have a Mental Illness

- Tell the child what illness their parent has
- Give the child opportunities to discuss his or her questions and concerns
- When possible, let the child participate in decisions that affect the whole family
- Create opportunities for the family to be “normal.” Ex: going to church together, taking a vacation, going shopping
- Recognize the child’s accomplishments in school, sports, music.
- Make sure the child understands that they didn’t cause the illness to happen
- Give the child the option to visit the parent, if hospitalized
- Foster a sense of humor
- If they are overly disturbed about their parent’s illness, seek professional help

### For Siblings

- Listen to them, their fears and concerns
- Suggest they seek professional support if they have significant problems adjusting
- Siblings can have “survival guilt” about not being sick
- Encourage them to grieve for the loss of their “well” sibling
- Siblings can feel “invisible” to their family

### Adult Children

- They need to learn what illness their parent has
- They may fear that they will develop mental illness themselves
- No one comes through this experience unscathed: depression, anxiety, hopelessness, anger are all common reactions. Encourage professional help when necessary.
- A well parent or supportive sibling can be very helpful
- Encourage them to mourn for the loss of their childhood, a stable family structure, and their own potential

Sources:

Cathy Aines, former Executive Director, NAMI Vermont  
NAMI *Family-to-Family Education Course*

## Coping Strategies for Mental Health Clients

Here are some suggestions for coping with their mental illnesses from people who are living with mental disorders:

- 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. Other kinds of doctors may not know the latest in medications for mental disorders.
- Exercise. Elevate the heart rate for 15-30 minutes a day, with your doctor's permission. Examples: walking, jogging, aerobics, swimming ...
- Meditation. 15-60 minutes of quiet listening to your heartbeat and breathing.
- Eat a good solid balanced diet.
- No alcohol. Alcohol is a depressant and often interferes with anti-depressant medication.
- Little or no caffeine.
- Avoid getting over fatigued. Get plenty of rest. If you can't sleep, ask your doctor for something to help you sleep.
- Avoid getting over-committed in time to any activity or activities, so that you feel overwhelmed. Learn how to say "No" and not feel guilty. Learn how to "let it go" when things start to pile up and threaten to overwhelm you.
- 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 recognize onset of an episode and help you.
- Indulge in some creative activity. Ex: music, drawing, painting, crafts, creative writing, weaving ...
- Do something to make you laugh, cry, or get angry in a safe place. Example: watch a sad movie and cry.
- Join a peer support group.
- Take an adult school class: swimming, art, history ...
- Engage in volunteer work
- Help someone else, especially someone with problems similar to yours.
- Develop a sense of hope by working with a counselor to make pathways toward career goals
- Continue to be active with friends and make efforts to develop friendships
- Seek out helpful relatives
- Learn how to love yourself as an individual, spiritually and creatively. There is no one else on Earth quite like you.

## Communication Guidelines

### Expression of Empathy and Compassion

People with mental disorders can get discouraged with their illness and its stigma. It is important to have compassion for their experience. 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.”

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
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

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

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

Example: “I would like you to ...”

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

1. Look at the person. Speak firmly.
2. Say exactly what they did to upset you.
3. Tell them 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 them or their expressions of distress
Perpetuating stigma	Telling them to “buck up”
Character assassination	Setting too many demanding limits

Sources: Talks by Dr. Christopher Amenson to NAMI groups reported on line at:

[www.namidupage.org/support/crisis\\_tips.html](http://www.namidupage.org/support/crisis_tips.html) and [namiyolo.org/guidelinesforfamilies.html](http://namiyolo.org/guidelinesforfamilies.html)

# NAMI

## Description of NAMI

- Founded in 1979, a nonprofit, grassroots, self-help, support and advocacy organization of mental health clients, families, and friends of people with severe mental illnesses. Its full name used to be National Alliance for the Mentally Ill, but now, it is National Alliance on Mental Illness.
- Works to achieve equitable services and treatment for more than 15 million Americans living with severe mental illnesses and their families
  - Over 1000 local affiliates and 50 state organizations
  - Education and support on mental illness. Three major programs are profiled below
  - Combat stigma
  - Support increased funding for research
  - Advocate for adequate health insurance, housing, rehabilitation, and jobs for people with mental illnesses and their families.
  - Automated email alert when important issues need attention. You can sign up at: [www.nami.org/update/enevlist.htm](http://www.nami.org/update/enevlist.htm).

## 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 and their variations:
  - Schizophrenia
  - Bipolar disorder
  - Major depression
  - Panic Disorder
  - Obsessive Compulsive Disorder
- The causes of mental disorders
- Understanding psychiatric medications
- Empathy: Learn how it feels to be mentally ill
- How to develop effective communication skills
- Self care
- The Recovery model. Developing a plan with your loved one
- Dealing with mental health stigma

## NAMI's Peer-to-Peer Recovery Curriculum

This program, begun in 2001, is designed for mental health clients to learn to understand their illnesses and how to live with them, and plan for when they are in crisis. The following are examples of subjects addressed in the weekly classes:

- A relapse prevention plan and an advance directive are created by clients as the class progresses.
- Understanding mental health stigma and its consequences
- Information about major mental disorders and their symptoms
  - Schizophrenia
  - Bipolar disorder
  - Major depression
  - Panic Disorder
  - Obsessive Compulsive Disorder
- Dealing with: communication, sleep problems, feelings, decision making, addictions
- Coping strategies, spirituality
- Handling relationships
- Empowerment, advocacy

**NAMI's Provider Education Program** This new course helps providers of mental health services to learn what families and mental health clients must endure in living with their illnesses. A goal is to help providers appreciate the courage and persistence it takes for mental health clients and their families to find ways to recover from mental illness

Sources: [www.nami.org](http://www.nami.org); NAMI *Family-to-family Education Course*; NAMI *Peer-to-Peer Course*

## **Reading Assignments for The Role of the Church**

- Spirituality and Mental Disorders
- Religion and Mental Health

## Spirituality and Mental Disorders

The first source of the Unitarian Universalist Living Tradition is:

*“Direct experience of that transcending mystery and wonder, affirmed in all cultures, which moves us to a renewal of the spirit and an openness to the forces that create and uphold life”*

The importance of direct religious experience, or spirituality, to world religions and to the lives of individuals is unquestioned. But, when it occurs, when people see visions and hear voices, it can also fit the definition of psychosis. How do we determine the distinction between mystical experience and psychosis? Does it depend on the subjective attitude of the person experiencing it? Is there an interpretation of this experience that differs by culture? Are there different schools of thought among psychiatrists about mystical experience? To look at some of these questions, we'll look at some classic views and recent opinions on the subject of primary religious experience, and the interface between psychotherapy and religion.

### **William James**

William James's classic study of primary religious experience, *The Varieties of Religious Experience*, (1901-1902) identifies two kinds of direct personal religious experience, i.e. spirituality. He calls them the religion of health-mindedness and the religion of the sick soul. First he notes that human life's chief concern is happiness: "How to gain, how to keep, how to recover happiness, is in fact for most men [and women] at all times the secret motive of all they do, and of all they are willing to endure." Then, he explores the two kinds of religious experience:

1. *Religion of healthy-mindedness*: This occurs in "persons in whom happiness is congenital and irreclaimable. 'Cosmic emotion' inevitably takes in them the form of enthusiasm and freedom. When unhappiness is offered or proposed to them, they positively refuse to feel it." These people deliberately minimize evil. He gives Walt Whitman as an example of such a person.
2. *Religion of the sick soul*: This occurs in people whose view on life is "based on the persuasion that the evil aspects of our life are of its very essence, and that the world's meaning most comes home to us when we lay them most to heart." When this outlook results in passive joylessness, discouragement and dejection, it can lead to pathological depression. Leo Tolstoy is an example of a person with such an outlook.

James summarizes "the characteristics of the religious life" as follows:

1. That the visible world is part of a more spiritual universe from which it draws its chief significance;
2. That union or harmonious relation with that higher universe is our true end;
3. That prayer or inner communion, with the spirit thereof - be that spirit 'God' or 'law' - is a process wherein work is really done, and spiritual energy flows in and produces effects, psychological or material, within the phenomenal world.

Religion includes also the following psychological characteristics:

4. A new zest which adds itself like a gift to life, and takes the form either of lyrical enchantment or of appeal to earnestness and heroism.
5. An assurance of safety and a temper of peace, and, in relation to others, a preponderance of loving affections.

### **Carl G. Jung**

"Among all my patients in the second half of life – that is to say, over 35 – there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost what the living religions of every age have given to their followers, and none of them has really been healed who did not regain his religious outlook." Collected works of C.G. Jung, 1958

### ***Sigmund Freud***

Freud's views on religion are stated in his book *The Future of an Illusion*, (1955). As the psychologist Eric Fromm later described Freud's attitude toward religion: "He sees in the belief in God a fixation to the longing for an all-protecting father figure, an expression of a wish to be helped and saved, when in reality" people can save, or at least help themselves, "only by waking up from childish illusions and by using his own strength, his reason and skills."

### ***Paul Fleischman***

In *The Healing Spirit - Explorations in Religion and Psychotherapy* (1989), a recent but already classic text of psychiatry and religion, Paul Fleischman identifies ten elements of religious psychology. Each element is both psychological and religious. Each represents a need, problem or dilemma in human life. They are proposed as a common psychological base to all the varieties of religious experience.

#### The 10 Elements

1. *Witnessed Significance* - the need to be seen, known, responded to, confirmed, appreciated, recognized, identified, and cared for.
2. *Lawful Order* - the need for dependence upon someone or something, a need for limits or rules which can be known and counted upon.
3. *Affirming Acceptance* - the need to be accepted, integrated, whole, integral and unified: one will, one mind, one direction, one set of drives and impulses in one personality and one body.
4. *Calling* - the need to feel useful, used, relevant, connected to others. A drive to become who one was meant to become. Not just for priests, ministers, nuns, but for all people.
5. *Membership* - the need for a place inside of, and an orientation to history. Have a group, affiliation, community. Empathetic identification heals - the foundation of psychotherapy.
6. *Release* - the need to relax, lay down burdens, relinquish effort to control, relieved of guilt and anxiety, free of tension, and find inner peace. One of the most sought after treasures of spiritual and developmental practice.
7. *Worldview* - the need for a cosmos outside and around one, a cognitive-emotional sense of the world that is integrated, whole, meaningful, coherent, beautiful, sacred. Integrated into radiant beauty of the universe.
8. *Human Love* - every case of psychotherapy, to a greater or lesser extent, is a problem of the failure to love. Love is what binds a person to life, when life is otherwise unendurable.
9. *Sacrifice* - Suffering is inevitable, and sacrifice is how inevitable suffering can be made meaningful. Ex: vows of chastity in many organized religions, endurance of beatings, jail for a cause. A courageous, principled action.
10. *Meaningful Death* - the need to face one's own death confirmed, not shattered, with a sense of fulfillment, completion, continuity which enables one life to pass on courage, hope and vision in the act of expiration.

### ***Russell Shorto***

Russell Shorto in his recent book *Saints and Madmen* (1999) tries to identify a distinction between experiences that are mystic and those that are psychotic. He acknowledges that there is a blurred line between the two, and that many experiences that are identified in one culture as psychotic, in other cultures and times are considered to be religiously significant. "If you look at the great mystics, I can't think of one who did not show signs of what today would be considered severe psychosis or manic-depressive illness. We could say that the 'illness' of these mystics served as a spiritual death and rebirth experience, but that would be over-romanticizing because mystics get lost and confused, too." He points out that psychotic experience in mental illness can be

religiously meaningful to the person experiencing them. “You can look at it [your psychosis] as having to do with your relationship to a higher power. You were clearly in the grip of mental illness, but at least some of the experience was spiritually valuable. Your challenge now is to sort through it, to separate the wheat from the chaff, to isolate where you were onto something good and important, and then to figure out how to use those clues to reorient your life. The challenge is to find the deep meaning in your madness, to let that meaning flow through your whole life, to grow from your madness in ways that you couldn’t possibly have grown without it.” In the final analysis, Shorto concludes that the metaphor of play “might be a useful way to understand what separates the psychotic and the mystic, as well as what distinguishes the addict or the obsessive from the comparatively free striver. The one is dead certain, serious as a heart attack, hanging on for dear life. The other has learned how to play.”

### ***Spiritual Emergence***

A modern movement called *Spiritual Emergence* takes the controversial viewpoint that a radical revision of thinking about mysticism and psychosis is necessary. In this view, it is necessary to recognize ‘spiritual emergencies’, states of consciousness with a spiritual emphasis, and, as explained in the book *Spiritual Emergencies* (1989) by Stanislav and Christina Grof, “treat them appropriately because of their great positive potential for personal growth and healing, which would ordinarily be suppressed by an insensitive approach and indiscriminate routine medication.” Forms of spiritual emergency identified include:

- the shamanic crisis: the powerful inner experience at the beginning of a shaman’s career
- the awakening of Kundalini: the activation of previously dormant creative cosmic energy
- ‘peak’ experiences: the person feels a dissolution of personal boundaries and union with other people, nature or the universe
- the crisis of psychic opening: an overpowering occurrence of psychic or paranormal phenomena
- possession states: having the feeling that one’s body or psyche has been invaded and controlled by a hostile being

Even though they reject the medical treatment of these states, they firmly hold that it is important to have a guide who understands what is happening to help a person through the experience.

### **Gifts of the Shadow**

In her book *In the Shadow of God’s Wings*, Susan Gregg-Schroeder lists what she calls “Gifts of the Shadow” the gifts that depression gives us:

- The gift of Vulnerability – Come to terms with our suffering
- The gift of Discovering One’s Authentic Self – Reunite mind, body and spirit
- The gift of Patience within a Process – Learning to wait with patience
- The gift of Living with Paradox – Learn to live with the ambiguity of the world
- The gift of Creativity – Creativity can lead to transformation
- The gift of Hope – Abide in darkness and learn you aren’t alone

### ***Religious Ideation and Mental Disorders***

Religious ideation is very common among people with mental disorders. Perhaps this is so because in times of crisis people call upon the resources that have given them positive affirmation. It may be most helpful to understand the person’s experience of religion as being beneficial to the extent that it provides these positive life-affirming resources. To the extent that it is bringing a harmful message to the person, for example a suicidal message, our job should be to first make sure the person gets psychiatric help, and after he or she is stable help the person to build up the kind of positive relationship with religion that is found by so many people with and without mental disorders.



## Religion and Mental Health

The following are findings from *Religion and Mental Health*<sup>65</sup>, edited by John F. Schumaker, a book of articles reviewing recent research into the relationship between religiosity and mental health.

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

### **Results of Recent Studies of Religiosity and Mental Health**

Although studies aren't unanimous in their views, there is a wide consensus that religiosity is beneficial for a wide variety of mental disorders. These quotes are also from John F. Schumaker's aforementioned book, *Religion and Mental Health*.

**Psychopathology:** "One cannot give a general *a priori* formulation concerning the relationship between religion and psychopathology. One must always consider the individual person in describing the interface between religion and psychological symptoms." Jacob Belzen "The Psychopathology of Religion: European Historical Perspectives"

**Depression and suicide:** "Religion protects against suicide." Steven Stack "Religiosity, Depression, and Suicide" "Both depressive symptoms and major depressive disorder were significantly less common among religious copers [those who exhibit such behaviors as attending church, praying, reading religious literature and having attitudes of trust in God], who were also less likely to become depressed over time." Harold G. Koenig "Religion and Mental Health in Later Life"

**Neuroticism and psychoticism:** “There is no relationship between neuroticism and religiosity, but that a significant negative relationship exists between psychoticism and religiosity... There is no evidence to suggest that religious people experience lower levels of mental health, and some clear evidence to suggest that they enjoy higher levels of mental health.” Leslie Francis “Religion, Neuroticism, and Psychoticism”

**Primary religious experience and psychopathology:** “Highly similar mental and behavioral states may be designated psychiatric disorders in some cultural settings and religious experiences in others. Within cultures that invest these unusual states with meaning and provide the individual experiencing them with institutional support, at least a proportion of them may be contained and channeled into socially valuable roles.” Raymond H. Prince “Religious Experience and Psychopathology: Cross-Cultural Perspectives”

**Anxiety and fear of death:** “Much of the psychological research that we have found has documented the frequently beneficial role of religious commitment on clinical, psychiatric, and physical status... Can religion help to diminish or even prevent anxiety? The reply is an unqualified, ‘It depends...’ ” Peter Pressman, John Lyons, David B. Larson and John Gartner “Religion, Anxiety, and Fear of Death”

**Substance use:** “There is an impressive body of literature documenting the role of religion in preventing substance use.” Peter L. Benson “Religion and Substance Use”

**Meaning in life and psychological well-being:** “Most recent research and reviews of the evidence suggest that religiosity has a positive association with well-being and mental health.... Religion does appear to have an important role in the development of meaning systems. ” Kerry Chamberlain and Sheryl Zika “Religiosity, Meaning in Life, and Psychological Well-Being”

**Anti-Social behavior, delinquency:** “True, evidence is fairly strong that religiosity in our culture inhibits hedonism, including some acts that are contrary to law. But religious beliefs have the power to deter some very important delinquent and criminal acts only when supported by social bonds. And other severely harmful acts, such as murder, may not be controlled by religion at all.” William Sims Bainbridge “Crime, Delinquency, and Religion”

### **Other Observations on Religion and Mental Health**

**The role of religious ritual:** “Religious ceremonies play a significant role in reducing anxiety and isolation as emotions are acknowledged, expressed and resolved within a social milieu of attachment and connection to significant others.” Janet L. Jacobs “Religious Ritual and Mental Health”

**Religion, rationality and mental health:** “Existential beliefs are rarely amenable to reason and scientific inquiry, and yet many people yearn for answers to them. We must avoid dogmatic rejection of religious beliefs that offer meaning and hope to people, so long as they do not throw rationality into jeopardy. Fundamentalist dogmas, fanatical adherence to any system of belief, absolutist religiosity are the real enemies of reason.” James E. Alcock “Religion and Rationality”

**Consequences of Irreligion:** “Irreligion divests people of certain age-old pathways to psychological health.” Eric Fromm, *The Sane Society*, quoted in “Mental Health Consequences of Irreligion”

# Workshop 7:

## The Role of the Church

“At the root of the humanitarian attitude [towards insane people] was the Moslem belief, stated by the Prophet, that the insane person is loved by God and particularly chosen by Him to tell the truth.” George Mora

**Purpose** This session discusses religion and spirituality and mental disorders and the caring role that a congregation can play in helping people. It concludes in building a plan and covenant to become a Caring Congregation, and a celebration for completion of the program.

### Materials

- Paper and art supplies for creative exercise
- A roll of small stick-on color-coding label dots for the prioritizing exercise
- Goodies for the closing celebration (can be pot luck)
- Equipment for playing music, (see “Adding Artistic and Musical Dimensions to the Workshops,”) if you will be using it.

### Preparation

- Review anecdotes, notes, and social justice issues from handouts.
- Handouts *Religion and Mental Health on Spirituality and Mental Disorders* were distributed at the previous meeting. Prepare summaries of the ideas on these charts onto newsprint for presentation.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Tell them who the artist, writer and composer of the week are.
- Take list of “**Responses of a Faith Community**” and categorize it for the class, creating newsprint charts with these prioritized items to use in this lesson. Suggested categories, from Susan Gregg-Schroeder’s video *Creating Caring Congregations* (from the first workshop) are:
  - **Education:** programs, as follow-on to this curriculum, to understand mental illness
  - **Covenant:** formally commit the congregation to support a mental health ministry, and the activities that it will entail
  - **Welcome:** specific actions to help make the congregation a more openly welcoming place for people with mental disorders and their families.
  - **Support:** create specific support structures, such as support groups for mental health clients and for families, and offering pastoral support to those with mental disorders.
  - **Advocacy:** actions in the community and beyond to make the surrounding society a kinder place for people with mental disorders. Ex: lobbying, joining an advocacy group, becoming stigma busters.

### SESSION PLAN

#### Opening

5 minutes

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading* by Susan Gregg-Schroeder (adapted) from Gregg-Schroeder, Susan. *In the Shadow of God’s Wings – Grace in the Midst of Depression.*<sup>66</sup>

Come along with me  
as a sojourner in faith.  
Bring along  
a sense of expectancy  
a vision of high hopes

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

*Moment of meditation or prayer*

### **Religion / Spirituality and Mental Disorders**

**15 minutes**

[The handout *Spirituality and Mental Disorders* was given for homework at previous class]

Using your newsprint chart, review the material in this handout. Ask people to share any thoughts or experiences that the handout might have evoked. If you need to, use the following study questions:

- Do you agree more with the views of James, Jung or Freud?
- Do Fleischman's elements encompass your view of religion and mental health?
- What do you think of some of the modern thinking on finding meaning in mental illness?
- Which of the effects of religion on mental health are due to *organized* religion, which are due to spirituality, which are due to both?

### **Finding the Gift of Creativity in the Shadow**

**20 minutes**

This exercise is based on work of Rev. Susan Gregg-Schroeder in *In the Shadow of God's Wings*. The intended goal is for people to be able to see that good, creative things can come from a sad experience.

- Pass out blank sheets of paper, and have art supplies ready. Ask the class to think about a time when they were in particularly down, and then draw or write something that reflects their state of mind at that time. This could be a drawing, a poem, a short paragraph, a song, or some other creative response. This should take 5-10 minutes.
- Tell people to reflect how they overcame the situation and what they learned about themselves from this experience. Ask them to write a few words describing this.
- Ask people to share what they have done, first in small groups, and then, selectively with the class. Point out the creativity, tenacity, and courage demonstrated in the stories. These are what Gregg-Schroeder calls the gifts of the shadow.

### **Religion and Mental Health Care**

**15 minutes**

[The handout *Religion and Mental Health Care* was given for homework at previous class]

Using your newsprint chart, review the material in this handout. Engage the class in a discussion. The following are possible ways to discuss this:

- What do you think of the characteristics of religion which are helpful and harmful to mental health?
- How do you rate Unitarian Universalism and your congregation on these characteristics? This should engage the class members in a lively discussion about which ideas belong as part of Unitarian Universalism, and how they would rewrite the list for UUs. If they need some prompting, you can

propose that the following are characteristic of UUs, and start the debate.

- offers a sense of hope, meaning, and purpose, and thus emotional well-being
- affords solutions to many kinds of emotional and situational conflicts
- establishes moral guidelines to serve self and others
- promotes social cohesion
- offers a social identity and a place to belong

The following are not generally characteristic of UUs:

- provides reassuring fatalism enabling one to deal better with pain
- offers afterlife beliefs, helping one to deal with one's own mortality
- gives a sense of power through association with an omnipotent force
- generate unhealthy levels of guilt
- promote self-denigration and low self-esteem by devaluing human nature
- create anxiety and fear by beliefs in punishment in hell for 'evil' ways
- impede self-direction and a sense of internal control
- foster dependency and conformity with an over-reliance on external forces
- inhibit expression of sexual feelings
- interfere with rational and critical thought
- encourage black and white views of the world: all are 'saints' or 'sinners'
- instill ill-founded paranoia concerning evil forces threatening one's integrity

Some might think that one could debate whether the following would be characteristic of UUs:

- reduces existential anxiety by offering a structure in a chaotic world
- provides a foundation for cathartic collectively enacted ritual
- establish a foundation for unhealthy repression of anger

- Are there ones that your congregation can do better on?
- Take turns reading the anecdotes from Handout "Religion and Mental Health" and discuss. Which points of view do you agree with, disagree with?

### **Determining Congregational Priorities**

**20 minutes**

Display the categorized charts containing the items from "*Responses of a Faith Community*." Tell the class that we will be using these charts to prioritize what we will work on as a congregation. Ask if they have any more items to add to the chart before we begin prioritizing it. Add any items that they suggest.

Distribute the color coding label dots to the class by giving each person a number (for example 5) dots. Tell them that they will be asked to indicate which items on the plan that they see as highest priority by placing the dots next to the items. They can put more than one dot next to an item if they want to. Give them some time to register their preferences.

After the class is finished, summarize the findings for the class, and explain that they will be used to build a plan of how to proceed. Ask if anyone in the class feels strongly enough about a particular issue that they want to work on it with others. The responses to this should identify what is most important and who may be the potential leaders in the effort. See if you can agree on an overall approach for your congregation, and identify next step.

After the class is over, you can form a team of committed people, and form a plan to carry out the items that the congregation feels are most important. For this effort, you can use sample plan items in the Appendix: *Planning: Possible items in a Caring Congregation Plan*.

### **Closing Reflections**

**5 minutes**

Bring the group together in a circle and ask each person to give a short reflection of what they are feeling, what they learned as part of the curriculum, and what they plan to do with what they have learned.

**Closing and Celebration**

Closing words by Paul Fleischman

**10 minutes**From Fleischman, Paul R. *The Healing Spirit – Explorations in Religion and Psychotherapy*<sup>67</sup>*“At the conclusion of life, I would hope to say:**I was seen and known, heart and soul, and in the same way knew those who circled me;**I bowed to the one who opens in a dawn, and I lived in harmony with the order, the principles, and the laws of the day;**I knew myself, saw myself, and held in one embrace human faults, limits and successes;**I did my job, working in the common cause;**And I stirred up dust with my feet, tramping along in the undivided march of human history;**I laid down my burden and surrendered myself to the voice of the river, and I became a vessel, and out of me poured the fountain of life;**And when I looked up I saw one hand spinning the divine wheel of the world;**And I looked down, and knelt, lending my hand; and I continued on my way, shouldering my own pain as I followed the signs;**And now that I feel the chill of death upon me, I can sing of how I was sent forth, and who calls me home.”**May we hope for this vision for ourselves, our loved ones and others.**May our participation in this course help make it so.***Let's Celebrate!**

Let us eat and drink together, rejoicing in completing the curriculum and becoming a caring congregation.

# Pastoral Care Workshops

The following two workshops are designed specifically for training people to do pastoral care. They contain a stream lined version of this training for those people doing pastoral care for people with mental disorders and their families. They also contain some information unique to those who are doing pastoral care.

- ***Mental Disorders and their Consequences:*** What is a mental disorder? Who are those with mental disorders? How mental disorders are treated. Stigma of having a mental disorder
- ***Mental Disorders: Treatment, Families, Religion and Pastoral Care:*** The problems of families of those with mental disorders. Religion and spirituality and mental disorders. How to provide pastoral care for those with mental disorders and their families.

# Pastoral Care Workshop 1:

## Mental Disorder and its Consequences and Treatment

“My despair is transformed into hope and I begin anew the legacy of caring.” Thandeka

**Purpose:** This session starts with an introduction to the Caring Congregation program. Then the participants will learn the definition of a mental disorder, the main categories of these disorders and their demographics. They will also learn about the stigma of mental illness and how it affects us all. The class will have a chance to share their own experiences and motivations to the extent that they wish to do so.

### Materials

- For presentation: newsprint and/or paper for handouts.
- A VCR and TV screen is required for the Video.
- Equipment for playing music, (see “Adding Artistic and Musical Dimensions to the Workshops,”) if you will be using it.

### Preparation

- Prepare newsprint posters and/or handouts listing goals of the program, the workshop schedule, the definitions of Mental Health and Mental Disorder.
- Make copies for the participants of the handouts *Mental Health and Mental Disorder, Myths and Stereotypes about those with Mental Disorders*, and the *Mental Health: A Report of the Surgeon General—Executive Summary* National Institute of Mental Health, 1999, which follow the first general workshop in this curriculum.
- Make copies of *Therapies for Treating Mental Disorders* which follows general workshop 5 in this curriculum.
- Make copies of *Categories of Mental Disorders* which follows this workshop.
- Acquire the VCR and TV screen and make sure they are in working order and you know how to operate them.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Tell them who the artist, writer and composer of the week are. Explain that they will be seeing art, literature and music from artists who have mental disorders.
- Make copies of the *Glossary* and *References* sections of this document for students.

### SESSION PLAN

#### Opening / Chalice Lighting

5 minutes

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading* by Susan Gregg-Schroeder (adapted) from Gregg-Schroeder, Susan. *In the Shadow of God’s Wings – Grace in the Midst of Depression*<sup>68</sup>

Come along with me  
as a sojourner in faith.  
Bring along  
a sense of expectancy  
a vision of high hopes  
a glimpse of future possibility  
a vivid imagination  
For creation is not done.  
We are called to pioneer forth  
toward a future yet unnamed.  
As we venture forward,



we leave behind our desires for  
a no-risk life  
worldly accumulations  
certainty of answers.  
Let us travel light  
in the spirit of faith and expectation  
toward our hopes and dreams.  
Let us be a witness  
to the future breaking in.  
Come along with me  
as a sojourner in faith  
secure in the knowledge  
that we never travel alone.

*Moment of meditation or prayer*

**What is Mental Health? Mental Disorder? How common is it? 25 minutes**

Present definitions of *Mental Health and Mental Disorder*, *Categories of Mental Disorders* and who has mental disorders using newsprint or handouts that you have prepared.

- *What is Mental Health, and what is Mental Disorder?*

Present the handout *Mental Health and Mental Disorder*. Go over each of the definitions carefully.

- *Brief introduction to the categories of mental disorders.*

Present the chart *Categories of Mental Disorders*. As you discuss each category, ask if any of the participants have had experience with the disorder either personally or in a family member or friend, and would be willing to share it with the class. Acknowledge any difficulty that people may have in making these statements; for some it may be the first time that they will have ‘come out’ as having a mental disorder themselves or in their families. The importance and courage required for this moment should be deeply honored and respected.

- *Who has Mental Disorders?*

According to the American Psychiatric Association, during any one-year period, up to 50 million Americans, more than 22 percent, suffer from a clearly diagnosable mental disorder involving a degree of incapacity that interferes with employment, attendance at school or daily life.

- Near universality of mild emotional problems at some time in life
- Nearly every family has experienced clinically significant mental disorders in some member of their family at some point

**Video: Creating Caring Congregations 30 minutes**

This video, produced by Mental Health Ministries of the United Methodist Church and intended for use by congregations studying mental health issues, has four segments. Here is a description of the video from Mental Health Ministries:

Individuals share their personal experiences with various mental illnesses in the first three segments. Shawn’s Story tells of an adolescent’s experience with bi-polar depression, addiction and suicidal ideations. Carol’s Story is about the most common illness of the brain, clinical depression, with accompanying anxiety issues. Jan’s Story highlights how the normal life changes associated with the aging process can lead to depression in older adults. The final segment, How Congregations Can Respond, provides a five-step program of education, covenant, welcome, support and advocacy, to help churches begin to address mental health issues in the local church.

## Therapies for Treating Mental Disorders

30 minutes

Present the chart / handout *Therapies for Treating Mental Disorders*.

Ask the class if any of them have direct experience with any of the therapies being presented and if they would be willing to share it with the class. Suggest that they might discuss such things as:

- How they were referred to the doctor, therapist, psychologist or group offering the treatment
- What the treatment involved: talking, taking medication, being given a treatment
- How long the therapy lasted
- Whether they found the treatment helpful or harmful in some way

One possible way to introduce discussion of a psychosocial or behavioral therapy is to give a brief demonstration, either by acting it out with a visiting therapist or with a person playing the therapist role.

The following are possibilities for this exercise are given in General Workshop 5: Mental Health Treatment Options:

- *Client-Centered Psychotherapy: Carl Rogers*
- *Group Therapy: AA-style 12-step meeting format*
- *Behavioral Therapy: Progressive relaxation exercise*

## Stigma of having a Mental Illness

20 minutes

- Myths and Stereotypes about those with Mental Disorders

Put up a blank piece of newsprint and ask participants to engage in an exercise of relating common myths and stereotypes of mental disorder. One of the handouts is a table of myths and stereotypes of people who have mental disorders. When the group finishes their list, you may want to pass out a copy of this table and discuss the facts behind each stereotype.

- Consequences:

Next, put up another piece of newsprint and ask participants to state what they think the consequences of these stereotypes are on people with mental disorders and their families. Here is a list, if your group needs prompting.

- Lack of respect and consideration
- De-humanization
- People kept from seeking help, thus suffering needlessly
- Misunderstanding
- Hostility, anger and frustration
- Hurt and wounded feelings
- Shunning and Isolation
- Low Self Esteem
- Discouragement, disappointment and low expectations for life
- Suicide and resulting trauma to the family left behind
- Discrimination in employment, housing, and other social activities
- Negative media images
- Insurance for physical, but not mental illness
- The cost to society at large. According to the American Psychiatric Association, the direct costs of support and medical treatment of mental illnesses total \$55.4 billion a year. The indirect costs, such as lost employment, reduced productivity, criminal activity, vehicular accidents and social welfare programs increase the total cost of mental and substance abuse disorders to more than \$273 billion a year.

Next, discuss various strategies that are being used to address the stigma of mental disorders.

- Strategies for addressing stigma.
  - Education. This program is an example
  - Respect, Listening, Understanding – Treat the person with the mental disorder as a respected person, listening to them without judgment and trying to understand their problems.

- Challenge Inaccuracies. When you hear them, when you see them in the media.
- Advocacy. Become proactive in advocating for those with mental disorders and their families.

If participants want to explore this topic further, two excellent books about research into the stigma associated with Mental Illness are:

- *Telling is Risky Business – Mental Health Consumers Confront Stigma*, by Otto F. Wahl, Rutgers University Press, 1999.
- *Don't Call Me Nuts! – Coping with the Stigma of Mental Illness*, by Patrick Corrigan and Robert Lundin, Chicago: Recovery Press, 2001.

**Closing**  
*Reading*

**5 minutes**

“You will know the truth, and the truth will set you free.” John 8:32

**Assignment / Follow-up**

**5 minutes**

- Distribute copies of the *Mental Health: A Report of the Surgeon General—Executive Summary*, the report from the Surgeon General of the United States.
- Ask people to look and listen for any evidence of stigma of mental disorders that they may hear during the week ahead. They will be asked to share what they have learned next time.
- Distribute copies of the *Glossary* and *References* sections of this document to the students.

## Categories of Mental Disorders

Category	Characteristics	Example Disorders	Est. Lifetime Prevalence
<b>Mood Disorders</b>	A disturbance of mood as the predominant characteristic.	Depression Bi-polar disorder	10-25% Women 5-12% Men 0.4 - 1.6%
<b>Anxiety Disorders</b>	Characterized by an unpleasant feeling of apprehension usually accompanied by physical discomfort, such as palpitations, and shortness of breath.	Obsessive compulsive disorder Post traumatic stress disorder Agoraphobia Generalized anxiety disorder Panic attack	2.5% 8% 0.5 - 1% 3 - 5% 1-2%, up to 60% in cardiac clinics
<b>Psychotic Disorders</b>	Characterized by the presence delusions, hallucinations, disorganized speech or behavior	Schizophrenia, Schizoaffective disorder, Delusional disorder	0.5 - 1.5% Unknown 0.05 - 0.1 %
<b>Substance-Related Disorders</b>	These disorders result from taking a <i>substance</i> : i.e. a drug of abuse (including alcohol), the side effects of a medication and toxin exposure.	Substance Dependence Substance Abuse Example substances: Alcohol Amphetamine Opium Cocaine LSD PCP Inhalants Nicotine	15.0% 1.5% 0.7% 0.2% 0.6% Unknown Unknown 25.0%
<b>Disorders usually first seen in infancy, childhood, or adolescence</b>	Although most people with these disorders usually are diagnosed when they are infants, children or adolescents, this isn't a diagnosis requirement, and some are not diagnosed until adulthood.	Retardation Autism Learning disorders Attention deficit disorders Feeding disorders Disruptive behavior	1% 0.02 - 0.2% 2 - 10% 3 - 7% Unknown 1 - 16%, higher in males
<b>Cognitive Disorders</b>	Dysfunctions of the brain caused by neurological problem and/or drug abuse.	Delirium Dementia	0.4 - 1.1% Age Women Men 65 0.8% 0.6% 85 14% 11% 90 25% 21% 95 41% 36%
<b>Eating Disorders</b>	Severe disturbances in eating behavior.	Anorexia Nervosa Bulimia Nervosa	0.5% in females 1-3% in females
<b>Somatoform Disorders</b>	Physical symptoms, but absence of an underlying medical condition that can fully explain their presence	Pain Disorder, Conversion Disorder, Hypochondria, Body Dysmorphic Disorder	Pain 1- 10% Convers. 1-14% Hypochon. 1-5% Body Dys. 5-40%
<b>Personality Disorders</b>	An enduring pattern of inner experience and behavior that deviates markedly from cultural expectations, is pervasive since adolescence, is inflexible and leads to distress or impairment.	Paranoid Antisocial Borderline Histrionic Narcissistic Schizotypal Dependent	General In clinics .5-2.5% 10-30% 3% males 3-30% 2% 20% 2-3% 10-15% 1% 2-16% 3% Unknown 0-10% 4 -51%

**Table 9. Categories of Mental Disorders**

**Notes:**

- 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
- Estimated Lifetime Prevalence is the % of the general US population expected to have the disorder sometime in their life. Categories of DSM mental disorders **not** included in this chart: Sleep, Sexual and Gender Identity, Impulse Control, Factitious (intentionally produced), Dissociative (consciousness, identity, perception).

Sources: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition*; Bornstein, Robert F. *The Dependent Personality*, p. 126.

# Pastoral Care Workshop 2:

## Mental Disorders: Families, Religion and Pastoral Care

*“Comfort, comfort my people, says your God.”* Isaiah 40:1

**Purpose** Introduce the major treatments used for mental disorders in North America, and their roles. Identify the facilities most widely used for psychiatric care. It would be desirable for a psychiatrist or other mental health professional to attend this meeting and discuss some of the therapies that are used for mental disorders.

### Materials

- Newsprint and paper for making the handouts and charts
- Equipment for playing music, (see “Adding Artistic and Musical Dimensions to the Workshops,”) if you will be using it.

### Preparation

- If possible, invite a psychiatrist or therapist to present information on therapies for treating mental disorders.
- Copy the handout *The Recovery Model* after General Workshop 5: Mental Health Treatment Options.
- Copy the handouts *Communication Guidelines*, *Stages of Emotional Reactions among Family Members* and *Life Burdens in Caring for People with Mentally Illness* after General Workshop 6. Optionally, copy the charts onto a newsprint chart for presentation.
- Copy the handouts *Spirituality, Religion and Mental Health*, and *Pastoral Care for People with Mental Disorders and their Families* after this workshop.
- If you have a guest speaker, they may have other handouts that they want to distribute to the class. Try to get any such handouts ahead of time and make enough copies of these so that everyone will have one.
- If you will be displaying art, literature and playing music (see “Adding Artistic and Musical Dimensions to the Workshops,”) decide on the artists, obtain the posters, quotes and music. As the class is entering, have the music playing, and the art and quotes displayed. Tell them who the artist, writer and composer of the week are.

### SESSION PLAN

#### Opening

**5 minutes**

*Lighting a Chalice* using chalice-lighting words of the leader’s choice.

*Reading* Psalm 71:20-21 (RSV)

*Thou who hast made me see many sore troubles wilt revive me again;  
from the depths of the earth thou wilt bring me up again.  
Thou wilt increase my honor, and comfort me again.*

*Moment of meditation or prayer*

#### Workshop Components

#### Reflection

**5 minutes**

Ask if anyone has any questions, comments or reflections on the last workshop or the readings done afterwards.

#### The Recovery Model

**20 minutes**

Present the information on the handout *The Recovery Model*. Then lead a discussion about what has been

presented.

#### Discussion Questions about the Recovery Model

- Do you feel that mental health clients can make all decisions with regard to their care? What limits, if any do you see to this?
- What do you feel about forced treatment, including medication and ECT? What about legislation passed in many states to mandate forced medication in certain circumstances?
- What are the advantages and limitations of the Recovery Model in your opinion?

#### **Stages of Emotional Reactions among Family Members**

**20 minutes**

Present the handout *Stages of Emotional Reactions among Family Members and Life Burdens in Caring for People with Mentally Illness*.

Discussion questions:

- Do these stages “ring true” for you, or in situations you know of?
- Do you agree with the needs identified for each stage? Would you add any other needs?
- If you have been in one of these situations, which of these suggestions have been helpful to you?

#### **Communication with People with Mental Disorders**

**25 minutes**

Communicating effectively with a person with a mental disorder is important for each party in a conversation. For a person with a mental disorder to know that someone understands them can reduce anxiety, help self-esteem and increase the likelihood of getting appropriate treatment. For the other person, they can learn that what they do can make a difference in the life of a person who is having serious problems, which makes it more likely that they will reach out effectively in future situations.

Present the handout *Communication Guidelines*

*Role Playing Exercise:*

Divide the class into pairs. If possible, have one member of each pair be a person with an actual mental disorder, and the other a family member or friend. If you don't have this match, ask people to play these roles. *Caution:* If you are having someone without a mental disorder play the role of someone with a mental disorder, be cautious of problems of perpetuating stigma. If you aren't comfortable with these risks, limit it to controlled demonstrations with people who you know will have an honest and accurate portrayal.

Ask them to choose some actual or hypothetical situations and role play communicating using these communication guidelines. You may want to demonstrate how to role-play such a situation with one of the students before the class begins.

Allow about 10 minutes for the role playing exercise. After it is over, bring the class back together and ask the students to reflect on the exercise, what they learned, what was awkward, what worked.

---

#### **Spirituality, Religion and Mental Health**

**20 minutes**

Present the handout *Spirituality, Religion and Mental Health*.

Discussion Questions:

- Have you ever had an experience that you would consider a *primary religious experience*? If so, would you be willing to share it with the class, including telling how it has made a difference in your life?
  - Do you feel that delusions and psychoses experienced in mental disorders can be spiritually significant to the mentally ill person?
  - How do you feel about the relationship of organized religion to mental health? Do you agree with either of the points of view expressed in the handout – that it is harmful, or that it is beneficial? Why?
-

## **Pastoral Care for those Mental Disorders and their Families**

**20 minutes**

Present the handout *Pastoral Care for People with Mental Disorders and their Families*.

Pastoral Care Discussion questions:

- What problems do you see in following these recommendations? Are there things you are comfortable doing and other things you wouldn't be comfortable doing?
- Are there members of your pastoral team who would like to specialize in any problems of this sort, or will the entire team take them all on?
- Do you know of individuals or families in your congregation who could benefit from pastoral care as suggested in this handout? If so, how might you approach them?

---

## **Closing**

**5 minutes**

Reading by Paul Fleischman

*“At the conclusion of life, I would hope to say:*

*I was seen and known, heart and soul, and in the same way knew those who circled me;*

*I bowed to the one who opens in a dawn, and I lived in harmony with the order, the principles, and the laws of the day;*

*I knew myself, saw myself, and held in one embrace human faults, limits and successes;*

*I did my job, working in the common cause;*

*And I stirred up dust with my feet, tramping along in the undivided march of human history;*

*I laid down my burden and surrendered myself to the voice of the river, and I became a vessel, and out of me poured the fountain of life;*

*And when I looked up I saw one hand spinning the divine wheel of the world;*

*And I looked down, and knelt, lending my hand; and I continued on my way, shouldering my own pain as I followed the signs;*

*And now that I feel the chill of death upon me, I can sing of how I was sent forth, and who calls me home.”*

*May we hope for this vision for ourselves, our loved ones and others.*

*May our participation in this course help make it so.*

## Spirituality, Religion and Mental Health

*“Direct experience of that transcending mystery and wonder, affirmed in all cultures, which moves us to a renewal of the spirit and an openness to the forces that create and uphold life” 1<sup>st</sup> UU Source*

### **Russell Shorto**

Russell Shorto in his recent book *Saints and Madmen* acknowledges that there is a blurred line between experiences that are psychotic and those that are religiously important. “If you look at the great mystics, I can’t think of one who did not show signs of what today would be considered severe psychosis or manic-depressive illness. We could say that the ‘illness’ of these mystics served as a spiritual death and rebirth experience, but that would be over-romanticizing because mystics get lost and confused, too.” He points out that psychotic experience in mental illness can be religiously meaningful to the person experiencing them. Shorto concludes that the metaphor of play “might be a useful way to understand what separates the psychotic and the mystic, as well as what distinguishes the addict or the obsessive from the comparatively free striver. The one is dead certain, serious as a heart attack, hanging on for dear life. The other has learned how to play.”

### **Paul Fleischman**

In *The Healing Spirit - Explorations in Religion and Psychotherapy*, Paul Fleischman identifies ten elements of religious psychology. Each element is both psychological and religious and each represents a need, problem or dilemma in human life. They are:

1. **Witnessed Significance** - the need to be seen, known, responded to, confirmed, appreciated, recognized, identified, and cared for.
2. **Lawful Order** - the need for dependence upon someone or something, a need for limits or rules which can be known and counted upon.
3. **Affirming Acceptance** - the need to be accepted, integrated, whole, integral and unified: one will, one mind, one direction, one set of drives and impulses in one personality and one body.
4. **Calling** - the need to feel useful, used, relevant, connected to others. A drive to become who one was meant to become. Not just for priests, ministers, nuns, but for all people.
5. **Membership** - the need for a place inside of, and on orientation to history. Have a group, affiliation, community. Empathetic identification heals - the foundation of psychotherapy.
6. **Release** - the need to relax, lay down burdens, relinquish effort to control, relieved of guilt and anxiety, free of tension, and find inner peace. One of the most sought after treasures of spiritual and developmental practice.
7. **Worldview** - the need for a cosmos outside and around one, a cognitive-emotional sense of the world that is integrated, whole, meaningful, coherent, beautiful, sacred. Integrated into radiant beauty of the universe.
8. **Human Love** - every case of psychotherapy, to a greater or lesser extent, is a problem of the failure to love. Love is what binds a person to life, when life is otherwise unendurable.
9. **Sacrifice** - Suffering is inevitable, and sacrifice is how inevitable suffering can be made meaningful. Ex: vows of chastity in many religions, endurance of beatings, jail for a cause. A courageous, principled action.
10. **Meaningful Death** - the need to face one's own death confirmed, not shattered, with a sense of fulfillment, completion, continuity which enables one life to pass on courage, hope and vision in the act of expiration.

### **Carl G. Jung**

“Among all my patients in the second half of life – that is to say, over 35 – there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost what the living religions of every age have given to their followers, and none of them has really been healed who did not regain his religious outlook.”



### **Relationship of Religion and Mental Health – Two Sets of Views**

There have been different views of the way that religion and mental health are thought to relate to one another. The following are from a recent book *Religion and Mental Health* edited by J.F. Schumaker which contains studies on the relation of religion to mental health. 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'
9. instill ill-founded paranoia concerning evil forces threatening one's integrity
10. interfere with rational and critical thought

---

Religious ideation is very common among people with mental disorders. It may be most helpful to understand the person's experience of religion as being beneficial to the extent that it provides positive life-affirming resources. To the extent that it is bringing a harmful message to the person, for example a suicidal message, our responsibility should be to first make sure the person gets appropriate help, and after he or she is stable help the person to build up the kind of positive relationship with religion that is found by so many people with and without mental disorders.

# Pastoral Care for People with Mental Disorders and their Families

## General

- **Part of a team:** Your care augments that of mental health care specialists.
- **Education:** Learn about mental illnesses and how to recognize them. As much as possible, keep up to date with the latest findings in mental health. Encourage education of all parties.
- **Presence:** Be emotionally present, listen and recognize their unique gifts. Visit them if hospitalized.
- **Encouragement:** Encourage them to stick to the treatment plan prescribed by the mental health professional they are seeing, including taking prescribed medications.
- **Prayer:** Pray with and for the mentally ill person and their family, when you think it will be helpful.
- **Referrals:** Develop a referral list of therapists, psychiatrists and clinics and hospitals taking patients with mental disorders. Learn the low-cost alternatives in your community. Locate support groups in your community which specialize in a particular disorder and encourage client / family participation.
- **When to refer to a psychiatrist** Make a psychiatric referral when a person has a mood disorder, psychotic disorder, is suicidal, is abusing drugs, or is severely anxious.

## Depression

- The depressed person needs to be reassured that help is possible.
- The family needs help in recognizing the illness and dealing with the afflicted person

## Schizophrenia and Psychotic Disorders

- When talking to a person in acute crisis, simplify your communication style and write down suggestions so they can be referred to in your absence.
- Call the schizophrenic person periodically, because they may be isolated and lonely.
- When emotions in a family are dramatic and highly expressed, the schizophrenic person does poorly, so encourage the family to keep the emotional level subdued;

## Suicidal People

- A mental health professional should be consulted immediately. If you think the situation is grave enough, you can take them to the hospital yourself

## Anxiety Disorders

- A person may ask nothing more than your listening to them with understanding
- Give them encouragement to face their fears
- Make a proper referral to a therapist if you feel there is a mental disorder.

## Personality Disorders

- You can't deal with every person the same way; learn how to tailor your style slightly to account for a particular personality type. For example: an obsessive-compulsive person works best with details; a histrionic person enjoys being in a crowd and performing

## Dementia

- See if your congregation can offer respite to the caregivers on a dependable basis.
- Encourage caregivers to go to support groups and find adult day-care centers.

## Emotionally Disturbed Children

- Be a good listener to children who seem disturbed and to their parents. If you suspect sexual or physical abuse, find shelter for them.
- Give respite care to family caregivers of severely affected children.

Primary Source: *The Soul in Distress – What Every Pastoral Counselor should know about Emotional and Mental Illness*, by Richard W. Roukema, M.D, The Haworth Pastoral Press, 1997.

# Lessons for Children Ages 7-12

## Religious Education about Mental Disorders for Children

**Age Level:** These lessons are designed for children ages 7-12, or grades 2-5. This is a wide age range. Children in grades 4 and 5 will be capable of more introspection and insight than younger children. Therefore, one must tailor the lesson to the appropriate age range for your class. To help tailor the lessons, the discussion questions in each lesson are divided into 2 age ranges: questions for all children, and questions for older children. Other than this difference in discussion questions, the basic lessons for all ages are the same.

### Motivation and Purpose

- Motivation:
  - Children with family members who have mental illness are at greater risk of depression, they live with fear, apprehension and feelings of guilt, and they are likely to act out cruelly towards those with mental illness.
  - Ill treatment of children with mental illness is a cause of treatment avoidance later in life, increases the rate of post traumatic stress disorder and of suicide, and impacts the long-term outcome of success.
  - The care of children when there has been a mental health crisis in the congregation needs to be focused on so as to let them get beyond the situation in a healthy way.
- Purpose / Goals: To make children aware of mental disorders and how the actions that they can take towards those with mental disorders can be helpful or hurtful. Teach them about feelings. Give them communication strategies that will strengthen their abilities to interact compassionately with their peers and with adults. Presence during the class of a respected adult or child who is living with a mental disorder is highly desirable.
- The lessons need to be flexible enough to be tailored for any situation that may have occurred in a congregation, such as:
  - A parent or a sibling with a mental disorder
  - A classmate with a mental disorder
  - A teacher or other congregation member who has committed suicide
  - A situation where people's rights have been denied due to a mental disorder
  - A child in the class has a mental disorder

### Guidelines for the children's classes

The following are guidelines that the children should use for this class. They will be explained to the children at the first session and repeated at the beginning of each lesson. You may want to make a chart, like the one following this introduction, and post it prominently in the classroom for everyone to see.

When teaching younger children, you can simplify these rules, and just show them the first one: Respect what other people share.

#### **Respect what other people share**

Everyone is to be treated with respect, have a chance to share, to be heard, and to be included. We pay attention to those around us, welcome new comers, help those who are lonely, hurting or struggling. We listen and we don't interrupt, or talk when someone else is talking. We will not say hurtful things; instead we say kind things and honestly say how we feel. We will work to understand that others have different experiences.

#### **Personal sharing**

People are asked to share their own experience with mental illness, or that of their family, if they choose to

do so. Each of us decides if we want to share; whatever we decide is OK.

### **Speak for yourself**

We can only speak for ourselves, not others. We will start sentences with “I think ...”, “I feel ...”, or “I believe ...”.

### **When talking about feelings**

When we talk about our feelings, we use language that owns our own feelings and shows empathy for the feelings of others. For example, to tell others how they have affected our feelings, we say “When you do \_\_\_ it makes me feel \_\_\_\_\_. And, when trying to understand the feelings of others, we say “It must feel \_\_\_\_\_ when you \_\_\_\_\_.”

### **Confidentiality**

We can choose to share activities, readings, and discussions with their families and others, as long as we don't name names. We don't talk about people behind their backs or exclude them from our activities.

### **Teasing, isolation, and bullying will not be tolerated**

Everyone is encouraged to share his or her own thoughts and feelings without fear of being laughed at or criticized. Teasing, ignoring or bullying a child because of a disclosure of mental disorder will not be tolerated.

Be especially careful to respect children who choose to “come out” as mental patients or families of mental patients during the workshops. This might be the first time that they have chosen to talk of this openly, and the courage to do so must be deeply respected.

## **THE CHILDREN'S WORKSHOPS**

These lessons are designed to educate children about mental illness, teach them about their and others' feelings, and how to accept and communicate with others when issues relating mental disorders are present.

1. Introducing mental disorders to children
2. Recognizing feelings
3. Being compassionate to someone with a mental disorder
4. Learning and practicing communication skills

## **Guidelines for Class**

### **Respect what Other People Share**

**Everyone is included**

**Listen and pay attention to others; No interrupting**

**Help others who are lonely, hurting or struggling**

**Say kind things**

### **Personal Sharing**

**Each person decides for themselves what to share**

### **You don't know what others are thinking**

**Don't say things like: "Everybody knows that \_\_\_\_\_"**

**Do say things like: "What I think is \_\_\_\_\_"**

### **When Talking about Feelings**

**To tell others how they have affected your feelings, say:**

**"When you do \_\_\_\_\_, I feel \_\_\_\_\_."**

**To express understanding towards others, say:**

**"If this happened to me, I would feel \_\_\_\_\_."**

### **Confidentiality**

**We can share what we learn here with others who aren't here, but we don't name names**

**We don't say things like: "Johnny said he is always depressed."**

**We do say things like: "We learned about feelings, and we all talked about our own feelings."**

### **No Teasing, Isolation or Bullying**

# Children's Workshop 1:

## Introducing Mental Disorders to Children

*"Melvin has his ideas – that's all."* Daniel Pinkwater

**Purpose:** This lesson introduces mental disorders in a compassionate way. It shows that everyone has unique ideas, and aims to de-stigmatize mental illness to children.

### Materials

- The book *Uncle Melvin* by Daniel Pinkwater, MacMillan Publishing Company, 1989.
- Art supplies – paper, crayons, colored pencils
- (Optional) A green hat to wear when reading the story

### Preparation

- Read over the lesson and decide how you are going to present it to the class.
- Make a large chart with Guidelines for the Class on it
- Make sure that all children will be able to see the pictures in the book. If necessary enlarge the pictures using a computer, or making flip charts.
- This book liberates the words "crazy" and "looney bin" from their usual negative meanings. If the children ask about them, explain that "crazy" is another way of saying "mental disorder" and that a "looney bin" is a "place where people with mental disorders live." You can explain that words like "crazy" and "looney bin" can also be harmful if used to demean people.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the song.

### SESSION PLAN

#### Opening / Chalice Lighting

5 minutes

#### *Lighting a Chalice*

Come into the circle of love and justice.  
Come into the community of caring, loving, and strength.  
Come and you shall know peace and joy.

*Song: From You I Receive # 402 in the Singing the Living Tradition hymnal*

**Note:** A good way to teach children a song is to have them read the words first aloud. Then you sing a verse of the song to have them learn the tune. Then ask them to sing again with you.

Explain the **Guidelines for the Class** (listed before the workshops).

#### Story: *Uncle Melvin* by Daniel Pinkwater

15 minutes

Read the story *Uncle Melvin* by Daniel Pinkwater to the class. Act out the parts dramatically, wearing a green hat, if you have brought one. Make sure all children can see the pictures. If children interrupt by asking questions, decide if they can be answered quickly or if you want to hold them for the discussion time below. The following are possible brief questions with suggested answers:

- How can Uncle Melvin do all these things if he is crazy? [*People with mental disorders can do lots of things, as the story shows.*]
- Can't people explain to Uncle Melvin that what he believes isn't real? [*They're not real to other people, but they're real to Uncle Melvin.*]
- Why can't Charles have a regular baby sitter rather than Uncle Melvin? [*Charles and his parents trust Uncle Melvin because they know he loves Charles and is very reliable.*]
- What is a Looney Bin? [*A place where people with mental disorders live. Some are in mental hospitals, and some are in homes with other people with mental disorders.*]
- Why does Uncle Melvin live in a Looney Bin? [*It is a safe place for him to be and his needs are*

*cared for there.]*

### Discussion

**10 minutes**

Enter into discussion with the class around ideas from the book. Here are some suggested discussion questions. You can add other questions as well.

#### Questions for All Children:

- Why do you think that Charles liked having his Uncle Melvin around?
- Have you ever believed something that other people didn't believe?
- Have you ever known anyone who reminds you of Uncle Melvin?

#### Questions for Older Children:

- When Charles asks if Melvin is crazy, his father says that "Melvin has his ideas – that's all." What do think of this suggestion?
- Charles' father says he knows that Charles won't make fun of Uncle Melvin. Have you ever heard someone make fun of crazy people? What do you think about it?

### Song

**3 minutes**

Introduce and teach the song: *My Rainbow* to the class. Sing it through a couple of times with the class.

## My Rainbow

Peggy Rahman

Peggy Rahman

Treble  
My rain-bow's strength is in my song, With light as clear as days are

4  
Tr.  
long. With love that's big - ger than the

6  
Tr.  
sky. We'll walk to - ge - ther by and by.

Copyright © June 2004

### Activity: Drawing something you imagine

**15 minutes**

Pass out the art supplies and ask each child to draw something from their own imagination that they think other people might not know about.

### Sharing Drawings

**10 minutes**

Ask each child to share their pictures with the class, explaining what the picture is and what it means to them.

### Closing

**5 minutes**

There are all sorts of people in this world.  
We learn to know them and respect them,  
As the special people that they are,  
No matter how crazy we think they are, or they think we are.  
We are all living in this world together  
And together we are making it a special place for every one.  
Go in peace.

# Children's Workshop 2:

## Recognizing Feelings

*"Feelings are important."*

**Purpose:** This lesson allows children to recognize their feelings. Its goal is to foster creation of a safe, caring community of peers.

### Materials

- A copy of the book *Today I Feel Silly & Other Moods that Make My Day* by Jamie Lee Curtis, Joanna Cotler Books, 1998. ISBN 0-06-024560-3
- Colored pencils or crayons for children to draw with
- Poster board for feelings puzzle
- Several glue sticks to make feelings puzzle
- Several pairs of child-safe scissors

### Preparation

- Make a copy of the Feeling Faces chart for each child to refer to in the Feelings Activity
- Make a copy of the Template for Feelings Art Project for each child
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings and songs.

In this lesson, we will be talking about feelings with the children. It does open up the possibility that children will talk about intimate family matters in a way that may create difficulties. If you think this might be a problem with the children in your class, it would be good to think about this possibility and how you plan to handle it. For example, you might suggest that a child see you or the minister after class to talk more privately about the situation. You can also remind the children about the confidentiality rule.

### SESSION PLAN

#### Opening / Chalice Lighting

**5 minutes**

*Lighting a Chalice* adapted from # 439 in *Singing the Living Tradition* by Sophia Lyon Fahs

We gather in wonder just thinking about how precious our lives are –

The wonder of this moment,

The wonder of being together, people near to each other –

Yet each with our own thoughts.

Each listening, each trying to speak –

Yet knowing we can't understand each other completely.

We gather in wonder before all things we cannot see or hear or touch.

*Song: Morning Has Come # 397 in the Singing the Living Tradition hymnal*

Review the **Guidelines for the Class** (listed before the workshops).

#### Story: *Today I Feel Silly & Other Moods that Make My Day* by Jamie Lee Curtis **10 minutes**

Read the story to the class. Each page shows a girl in a different mood. It ends by saying "Whatever I'm feeling inside is okay!" This is a perfect lead-in to the next activity.

#### Activity: Recognizing and Expressing Feelings

**10 minutes**

Pass out copies of the Feelings Faces chart to each child, and explain that we are going to be talking about feelings, and the Feelings Faces chart like the story we just read is to give examples of kinds of feelings a person might have. If they have feelings that are not on the chart, that is OK. The chart is just to give examples. Explain that lots of times feelings just happen without our trying to make them happen. We don't



need to feel ashamed of any feeling that just pops into our minds. There are times when we can't help feeling whatever we're feeling. We have a lot less control over our feelings than we have over our actions. There is no reason to feel ashamed at suddenly feeling angry at somebody. Sometimes we can't help that. But we can keep ourselves from acting in an angry way. For example, we can stop ourselves from punching somebody. Ask the children if there are any words on the chart that they don't understand. If so, ask if another child can give an explanation.

Write the sentence on the black board: "I felt \_\_\_\_\_ when \_\_\_\_\_." This will be a template for the children to use. Tell the children they will be explaining how they felt this week by filling in the blanks in the sentence. Give them some examples like:

"I felt happy when my mother took me to the ball game."

"I felt shy when I was in a room filled with strange people."

Start by giving your own feelings this week, and then ask the children to raise their hand when they have something to share. Sharing more than one feeling is fine. Don't pressure children who aren't comfortable in sharing, but make sure that everyone has at least one chance to share if they want to. If some children look confused, ask the children if anyone didn't understand. If so, ask if another child can give an explanation.

When everyone has shared, thank the children for being so honest with each other about their feelings. Explain that after the song, we will be drawing our feelings and making a puzzle.

**Song** Verse 1 of "Love Will Guide Us" #131 in *Singing the Living Tradition*.

**3 minutes**

**Activity: Drawing Feelings Art Project**

**15 minutes**

Have the children sit at a table with crayons and colored pencils available to them.

Pass out a copy of the Template for Feelings Art Project to each child. Tell them that they are going to work together to make a collage about feelings; that each drawing that they make will be one piece of a puzzle the class will make together.

Point out that the Template has a curved line down the center, making two pieces of a puzzle that we will be creating when they are finished. They will be drawing something that reminds them of a feeling on one side of the curved line. If they have time, they can draw on the other half with a different feeling. Examples of kinds of things they might draw are: a particular color or shape that they associate with a feeling, like "drawing bubbles for the happy feeling," or "coloring it all blue for a sad feeling." They could also draw figures or squiggles, or anything that they associate with a particular feeling. They could even write some words.

Make it clear that they have 20 minutes to finish and that when they are finished they will cut their paper on the curved line and glue their pieces on the big feeling puzzle. Ask them to decide which feeling they want express in their piece.

**Activity: Making a Feelings Puzzle**

**5 minutes**

As the children finish their drawings, ask if someone wants to help cut the pictures apart. Cut around the square of the picture, and then down each curved line.

Assemble the pieces of the feelings puzzle, the glue and the poster board. Ask for children to volunteer to create the puzzle. Everyone should get a chance to help, if at all possible

To make the puzzle, fit the pieces together in a collage, fitting pieces of each child's drawing with that of another child, and then paste it onto the poster board. You should end up with a beautiful patchwork of multicolored squares.

**Discussion: Reflections on the Feelings Puzzle****10 minutes**

Comment on how beautiful the puzzle looks. Engage the children in a discussion around the puzzle. The following are suggested questions:

**Question for All Children:**

How do you feel about seeing the whole puzzle together? *[If no one points it out, make the point that the puzzle shows us how our feelings are connected to the feelings of others, and that there are people with all kinds of feelings in this world. This is one thing that makes the world such a wonderful place.]*

What feeling did you draw, and why did you pick a particular color or design?

**Question for Older Children:**

Are some feelings harder to draw than others? If so, why do you think so?

To get at the difficulty question: Choose several feelings from the Feelings Faces chart, and ask the children to raise their hands if they think it is hard to express. Ask why it is difficult, if some people think it is. Ask them to raise their hands if they think it is easy to express, and ask why they think it is easy, if they raise their hands.

Point out how some feelings are different from others, and some people have a different way of feeling the same feeling. Reiterate that each child has a right to feel their feelings exactly the way he or she feels them.

**Closing**

Adapted from # 657 in *Singing the Living Tradition* by Sophia Lyon Fahs

**2 minutes**

Some feelings are like shadows, clouding our days with fears of unknown problems.

*Other feelings are like sunshine, blessing us with the warmth of happiness.*

Some feelings weaken how one feels about oneself. They block our growth or our creativity.

*Other feelings nurture self-confidence and enrich our feeling of personal worth.*

Some feelings can lead people to do hurt other's feelings

*Other feelings help us to understand feelings and how to care for others*

Fears of bad things happening can weaken a person's self-confidence, what we feel is important and what other people feel is important.

Go in peace.

# Feelings Faces



Happy



Calm



Angry



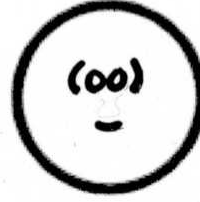
Excited



Surprised



Hurt



Bashful



Lonely



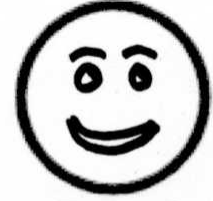
Confused



Nervous



Sad



Proud



Scared



Frustrated

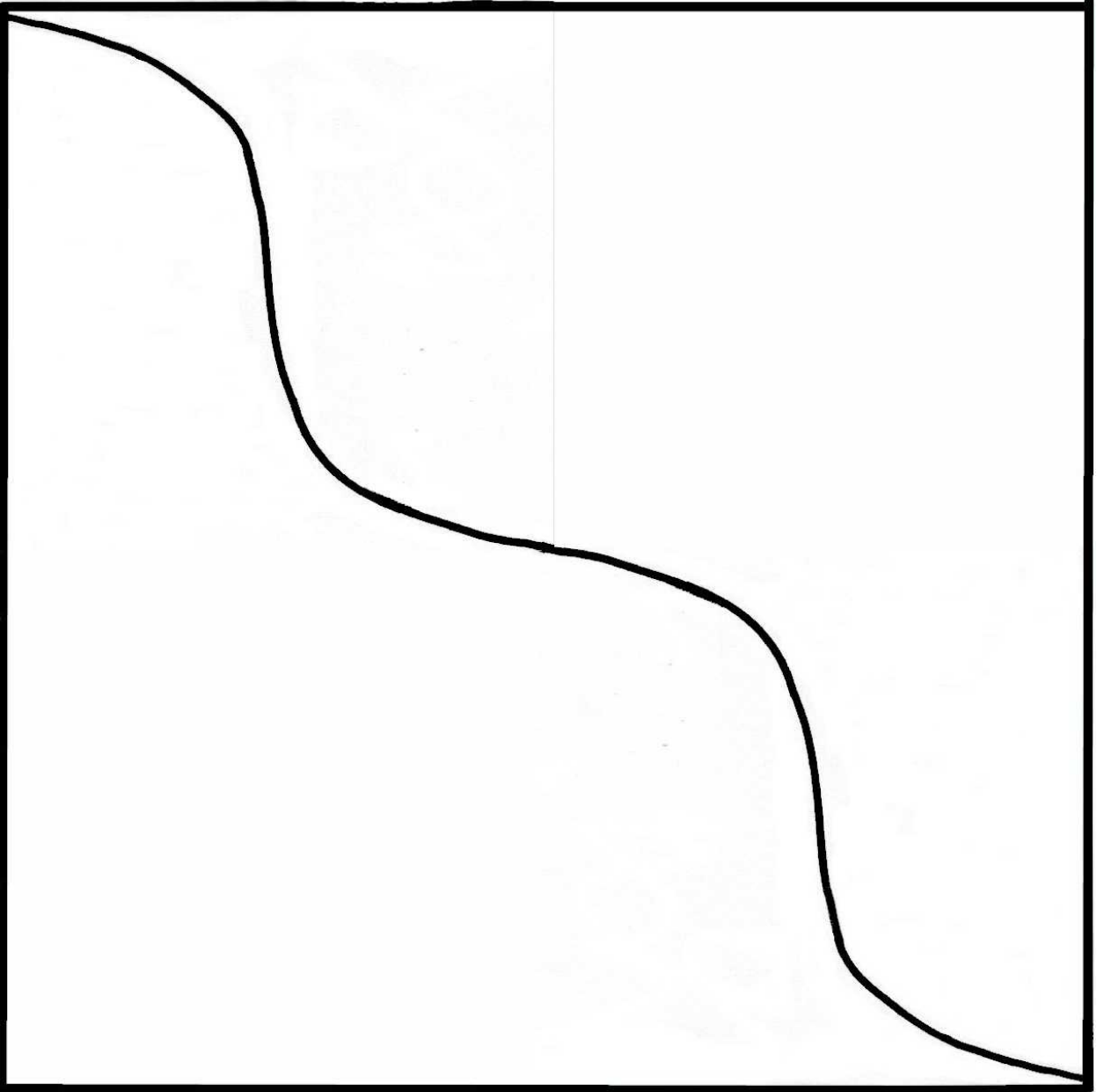


Embarrassed



Great

## Template for Feelings Art Project



# Children's Workshop 3:

## Being Compassionate to Someone with a Mental Disorder

*"You safe, Miss Nella. Safe."* Regina Hanson

**Purpose:** This lesson allows children to understand what makes them feel cared for, and what they can do to care for others. Its goal is to foster creation of a safe, caring community of peers.

### Materials

- The book *The Face at the Window* by Regina Hanson, Clarion Books, 1997.
- A ball of yarn

### Preparation

- Read over the lesson and decide how you are going to present it to the class.
- Make sure that all children will be able to see the pictures in the book. If necessary enlarge the pictures using a computer, or making flip charts.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings and songs.

### SESSION PLAN

#### Opening / Chalice Lighting

**5 minutes**

*Lighting a Chalice* adapted from #453 in *Singing the Living Tradition*

May the chalice that we now light  
Inspire us to use our lives  
To help and not to harm  
To be kind and not to be mean  
And to serve each other  
So that all may live as they wish to live.

*Song: Morning Has Come* #397 in the *Singing the Living Tradition* hymnal

Review the **Guidelines for the Class** (listed before the workshops).

#### Story: *The Face at the Window* by Regina Hanson

**20 minutes**

Tell the class that we will now hear a long story about a girl named Dora who learned how to be kind to someone who has mental health problems. Remind them it will be a long story. Read the story to the class, acting it out as dramatically as you can. Make sure all children can see the pictures. If children interrupt by asking questions, decide if they can be answered quickly or if you want to hold them for the discussion time below.

#### Discussion

**15 minutes**

Enter into discussion with the class around ideas from the book. Here are some suggested discussion questions with possible answers in brackets. You can add other questions as well.

In the story, Lureen and Trevor tease Dora, making fun of her fear of Miss Nella.

#### Questions for All Children:

- How did this teasing make Dora feel? [*This teasing makes Dora even more frightened.*]
- What things did Dora start to believe after this experience? [*Miss Nella makes the bad storm. That she could hear a 3-legged horse when the rain fell.*]
- Who helped Dora handle her fear, and what did she do? [*Her parents helped her handle her fear and they went to visit Miss Nella with her parents to say that she was sorry.*]
- What could Miss Nella see and hear that no one else could? [*She could hear a 3-legged horse. She could hear thousands of crabs who were talking.*]
- How did Dora and her parents help Miss Nella? [*They told her she was safe.*]

- How did Dora feel about Miss Nella at the end of the story? [*She thought that she was a friend.*]

**Questions for Older Children:**

- Have you ever seen or heard things that weren't there? Do you know anyone who has?
- Have you ever been teased because of a fear that you had? How did it make you feel?
- What are some of the things that you or your friends do so when they are afraid or very sad?
- What are some helpful ways to handle someone who is afraid or very sad? [*You can tell them they are safe, or help them to become safe, by getting an adult to help. You can not tease them, and stop others from teasing them.*]

**Song** *Voice Still and Small* #391 in *Singing the Living Tradition*  
using these words adapted for this lesson by Peggy Rahman.

**3 minutes**

Love will guide us  
Peace has tried us.  
Hope inside of us  
Will lead the way  
On the road from  
Greed to giving  
Love will guide us night and day

Love will hold us  
When we are frightened  
Care will shine a  
Light in our hearts  
We travel together  
And learn from each other  
Always connected  
Never apart

**Activity:** **How We Are Cared For**

**10 minutes**

- Ask the children to sit in a circle.
- Pick up the ball of yarn and explain to the children that we are going to play a game about telling how they can feel cared for. As the teacher, start the game, by holding the ball of yarn and saying: "I feel cared for when . . .", filling in the rest of the sentence.
- Then, holding onto the end of the yarn, throw the ball to a child in the circle. There will now be a yarn connection between you and the child.
- Then, and ask the child to say: "I feel cared for when . . .", completing the sentence based on their own experience.
- Tell the child to hold onto the yarn and throw the ball to someone who hasn't spoken yet.
- Repeat this exercise until everyone in the circle has shared. Tell the children that they can say something that someone else has said, if they want to.

At the end of the activity, there should now be a web of yarn within the circle joining all the people together.

**Discussion**

**3 minutes**

Enter into discussion about the exercise and the web of yarn. Here are some suggested discussion questions with possible answers in brackets. You can add other questions as well.

- Ask if there were any similar caring activities that different children mentioned.
- Jiggle your end of the yarn and ask "What happens when one person jiggles their yarn?" [*Everyone else in the class can feel the movement.*]
- What does this suggest to you about what it means to care for others, especially caring for others with mental disorders? [*Everyone's hurt and everyone's happiness affects us all. So, when we*

*care for someone, we are helping to caring for everyone ]*

- Thank the class for their sharing because they have taught the other class members how to care for each other.

**Closing**    Adapted from Reading # 692 in *Singing the Living Tradition* by Lauralyn Bellamy    **2 minutes**

If you have found comfort,  
Go and share it with others

If you have found someone to understand you  
Try and understand someone else

If you have found peace  
Try and help someone who is afraid

If you have dreamed dreams,  
Help one another, that they may come true!

If you have known love,  
Give some back to a bruised and hurting world.

Go in peace.

# Children's Workshop 4:

## Learning and practicing empathy and communication skills

*"May we speak right from our hearts."*

**Purpose:** This lesson allows children to practice their communication skills. In particular, they will engage in role playing to practice telling their feelings and being good, compassionate listeners to others through the use of "I" speaking and reflective listening.

### Materials

- Big paper, chalk board, or white board to write on.
- Display the "Feelings" collage from a previous lesson.

### Preparation

- Read over the story and the dramatic exercise, especially the teacher directed discussion questions.
- Prepare the cards for the dramatic exercise by using the cards at the end of the story.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings and songs.

### SESSION PLAN

#### Opening / Chalice Lighting

**5 minutes**

*Lighting a Chalice* Mission Peak Unitarian Universalist Congregation, Original source unknown.

We light this chalice to remind ourselves  
To treat all people kindly  
Because they are our brothers and sisters  
To take good care of the Earth, because it is our home  
To live lives full of goodness and love  
Because that is how we will become  
The best people we can be.

*Song: Touch the Earth, Reach the Sky #301 in the Singing the Living Tradition hymnal*

Review the **Guidelines for the Class** (listed before the workshops).

#### Activity: Story: Daun Gets Stuck

**15 minutes**

This story will be interactive. Make sure that each child gets an opportunity to participate. The story is *Daun Gets Stuck* by Peggy Rahman, which follows this lesson, and which is about some children reacting to another child's fearfulness. It is shaped by words that children suggest at the beginning of the story, which are then used when telling the story. See the pages following this lesson for directions for telling the story with the children's words substituted.

#### Discussion about the story:

**7 minutes**

After telling the story, engage in discussion with the class about the story.

#### Questions for All Children:

- How do you think Daun felt when stopping play with the others, and freezing when jumping? [*alienated, scared, lonely, angry*]
- Why did the other children like to have Daun play with them at the beginning? [*Daun was very creative and made up the best games*] Why didn't they want Daun to join them later? [*Daun slowed them down. Daun was acting "weird," and they didn't understand why*]
- Do you think it was right for the other children to call Daun bad names? What other things could they have done or said instead? [*Asked why Daun was scared. Told Daun it was OK to watch*]



*playing sometimes. Told their parents. Told the teacher.]*

**Questions for Older Children:**

- What are some reasons for Daun feeling scared? *[was very frightened of stepping on cracks, didn't think anyone understood, just wanted to be alone]*
- How do you think Eirun felt when Eirun's best friend Daun starting behaving strangely? *[Eirun didn't understand. Maybe Eirun had done something wrong to scare Daun.]*

**Activity: Feel and Speak Drama Game**

**20 minutes**

In this activity, the class members will take act out various situations where different kinds of feelings are felt and expressed. In each situation, they will try and react to each other and act out their assigned feelings. The goal is to play roles so as to gain empathy to the inward feelings of others. This should be a fun, but poignant activity.

The directions and materials for this game are in the pages following this lesson.

**Discussion: Challenging Inappropriate Behavior**

**8 minutes**

Enter into a conversation with the class about what they have just done in the two exercises. The goal is to leave them with helpful communications skills with regard to mental illness. Some suggested questions and answers are given below. Try to get them to use reflexive listening and "I: speaking as in the behavior guidelines for the class.

**Questions for All Children:**

- In the story, remember that Daun sat in the playground at the end. What do you think should happen at the next Sunday School class? *[The children say that they understand why Daun was scared, and try to encourage Daun to overcome the fear. The children talked to the Sunday School teacher, and the teacher found a way to help Daun to stop being frightened. The children found another game to play that wouldn't frighten Daun.]*
- What would you say if someone teases you when you are afraid? *["I" speaking: "When you said \_\_\_\_, I felt \_\_\_\_\_. Try to ignore them. Remind them that they are sometimes afraid, too. Tell a teacher or parent. ]*

**Questions for Older Children:**

- What would you do if you had a friend who was very scared or very sad all the time? *[Use Reflexive listening: It must feel \_\_\_\_ when you \_\_\_\_\_. Tell a trusted adult: parent, teacher, doctor, minister.]*
- If you heard someone making fun of someone with a mental disorder, what could you do? *[Tell them to stop. Tell a trusted adult: parent, teacher, doctor, minister]*
- If you felt very sad or very scared for a long time, what could you do? *[Tell a trusted adult: parent, teacher, doctor, minister.]*

**Song** *Come, Sing a Song with Me # 346 in the Singing the Living Tradition hymnal*

**3 minutes**

**Closing** *Adapted from #414 in the Singing the Living Tradition by Vincent Silliman*

**2 minutes**

As we leave this friendly place,  
Love gives light to every face;  
May we listen to others' parts  
May we speak right from our hearts  
May the kindness which we learn  
Light our hearts 'til we return.

Go in peace.

## Daun Gets Stuck

Copyright © by Peggy Rahman 2004

The class will help to tell the story by supplying some of the words which will be used. The following is a list of words for the class to choose before the story is told. They will be substituted when reading the story. Write these words on the large paper or black board where everyone can see them. Then ask for the class to suggest words for each blank, and write down the suggested words so they can see them.

1. \_\_\_\_\_ A favorite breakfast
2. \_\_\_\_\_ Another favorite breakfast
3. Unkind slurs you have heard people call others who are “different.” (*If necessary, the teacher can suggest possible examples: stupid, mental ...*)
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
  - c. \_\_\_\_\_
  - d. \_\_\_\_\_
4. \_\_\_\_\_ A reason you would want to play on a playground with lots of cracks in the asphalt
5. \_\_\_\_\_ A reason you would want to play jump rope on smooth asphalt

When reading the story, substitute the word the children suggested in the appropriate blank.

### The Story

“Daun, you take being organized to the ridiculous extreme,” complained Anna Mann, Daun’s mother on the morning that there weren’t any matching clean socks in the house. “Can’t you be a little messy, just this once?”

“No, I can’t be messy,” insisted Daun. “You don’t understand, I just can’t.”

“We’ll be late for the new Harry Potter movie,” said Anna.

“That’s OK. I’ll stay home and do the laundry,” said Daun.

“You’re kidding,” said his Dad, Albert.

“That’s OK. Go ahead without me. I can manage,” Daun persisted.

Every day Daun would get dressed in exactly the same way. Socks first, then underpants, then shirt, then pants, then shoes. Every morning Daun had   1   for breakfast. Sundays were different because on Saturday night, Daun and Eirun, who was Daun’s best friend, would spend the night together. It was different when Eirun was with Daun. Daun’s father would wake up early and make them chocolate pancakes and   2   for breakfast. Everything was different with Eirun there. One Sunday, Daun wore Eirun’s socks with holes. “I love Sunday’s,” said Daun to Eirun, “because you are the best.”

When Eirun stayed at Daun’s house, Daun’s family would walk with Daun and Eirun to Sunrise

Unitarian Universalist Church. On the way there, Eirun would play the game “Step on the crack and you break your father’s back. Bet you can’t get all the way to school without stepping on a crack.”

“I don’t want to play that game any more,” answered Daun. “I don’t want to break my father’s back.”

“Don’t be \_\_\_\_3a\_\_\_\_,” quipped Eirun. “It’s just a game.”

“I know,” answered Daun. “I’m not stupid.”

Daun was very careful not to step on the cracks all the rest of the way.

“You’re such a slowpoke,” hurried Eirun.

Daun and Eirun liked to jump rope on the church’s playground while Daun’s family was setting up for the service. A big oak tree divided the playground into two parts. The asphalt part was full of cracks. Some were gigantic; looking like a big earthquake had ripped the playground to pieces. Others were tiny making the asphalt look like old elephant skin.

At Sunrise UU there were codes of conduct that the children made up. One of the codes was that everyone who wanted to play in a game could. Mr. Pritha, the Religious Education director, was very careful that everyone lived up to the codes of conduct.

On most Sundays, Robin, Chris and Quan would join Daun and Eirun. They all played jump rope. Daun loved to make up new games, especially the really hard ones that required turning while jumping, jumping between two ropes, touching the ground after each jump, and even running into the ropes backwards before starting to jump.

“We are the jump rope champions of the whole world!” said Robin, proudly.

The next time that Daun and Eirun went to Sunday school, Daun stopped after each step and looked. As they walked further on, Daun began to step backwards one time for each step forward. Daun’s father said, “Hurry up kids, we can’t be late because we are on the setup committee.”

“Go ahead. We know the way,” answered Daun.

“You’re going to make us late,” said Eirun.

“You go ahead,” said Daun.

“No. I’ll wait,” answered Eirun.

They barely made it on time for Sunday school with only five minutes left to play jump rope with their friends.

“What’s wrong with you today?” asked Eirun.

“I don’t know,” said Daun. “I’m getting a scary feeling, and I don’t know why.”

“That’s \_\_\_3b\_\_\_ said Eirun. “There’s nothing to be scared of.”

Daun stood quietly at the edge of the asphalt, under the tree. Daun couldn’t move. “You go ahead,” said Daun. “I will join you in a while.”

Daun sat down under the tree, head on knees.

After Sunday school started, Eirun came back out to find out what was happening with Daun. “Are you still scared?” asked Eirun.

Daun looked down and didn’t answer.

“Do you want me to go get your Dad?”

“No,” said Daun.

“What’s wrong with Daun?” asked Robin.

“Let’s go play,” said Quan. “Daun will join us when ready.”

On the way home, Eirun said, “We missed you. You make up the best games.”

The next Sunday, Daun stayed at Eirun’s house. Eirun’s family drove to church. When they got there, Daun proclaimed. “I have a new game that is really hard. But we can only play on smooth asphalt.”

“OK. I have a new game that is really hard,” proclaimed Daun. “We can only play on the smooth asphalt.”

Chris said that he wanted to play where there were lots of cracks because \_\_\_4\_\_\_.

“And besides that, there is only a teeny tiny area with smooth asphalt,” Quan pointed out.

“I don’t care,” said Daun. “I will only play on the smooth asphalt because \_\_\_5\_\_\_.”

Now, that’s really \_\_\_3c\_\_\_,” said Robin impatiently.

“Let’s give Daun’s new game a chance,” said Eirun. “Anyone who wants to play the smooth asphalt game, play with us.”

They all played Daun’s game until it was time for Sunday school. “This is no fun. I’m not playing that \_\_\_3d\_\_\_ game any more. After Sunday School, Let’s all play the *normal* way,” said Robin, staring at Daun.

“Our friends don’t like your new game rule,” said Eirun. “I don’t want to play it any more.”

“I don’t care,” said Daun.

“Why not?” asked Eirun.

“Because, like I told you, when I am out there, I get a scary feeling,” said Daun.

“You really are a \_\_\_3d\_\_\_,” said Eirun. “I don’t want to play with you until you quit being so weird.”

After Sunday school, Quan, Robin, and Chris started to play jump rope in the middle of the asphalt.

“I’m sorry Daun,” said Eirun. “I wasn’t being a very good friend when I called you \_\_\_3d\_\_\_.”  
“Really, there is nothing to be scared of. Come on. We miss you and the cool games you make up. That is, most of the cool games you make up.”

Daun took a deep breath and walked very slowly to the middle of the playground where there were lots of cracks.

“Oh no, here comes Eirun with that \_\_\_3b (as an adverb)\_\_\_ Daun,” Robin whispered to Quan.

But, when Daun and Eirun came closer, Robin said “Oh Daun, we are *so* glad that you have come over to play with us.”

“So, you finally decided not to be such a \_\_\_3b\_\_\_!” teased Quan.

When it was Daun’s turn to jump rope, Daun froze and started to cry.

“Lost your turn,” said Chris. “Go to the end of the line. That’s the rule.”

“I don’t want to play with Daun any more,” complained Robin to Chris. “Daun is getting too mental and not much fun

“Play time is over,” said Daun’s father. “Clean up your ropes so we can go home.”

But Daun didn’t move. Daun stayed in the middle of the asphalt playground full of cracks and sat down.

## Feel and Speak Drama Game

Tell the class that they are going to play a game where they get to act out the part of another child. The rules of the game are as follows:

- **Teachers Role Play:** The teachers pick out two cards and role play one of the situations to show the children how the game works.
- **Pass out the cards:** Each child will get a card that tells what kind of child they are going to pretend that they are. Tell the children that this will be a guessing game; it might be helpful for the teacher to act out some role, for example a hyperactive child, and ask the children to guess what kind of behavior is being displayed, so as to get them into the groove. Pass out the cards to the children in the classroom, and tell them not to show the cards to the other children. Ask if they have any questions about the part that they are going to play, and if so, privately help them to get some ideas about how to play the part.
- **Situations to be acted out:** Three children at a time will be given a situation to act out, playing the part of the child on their card. Encourage them to really get into the role pretending that they are the child on their card, acting differently than they might act themselves. Tell them that it is OK to act mean in this pretend situation if they think the type of child on their card would act that way. But, when we give permission to children to act mean in this pretend situation, it would be good to also add a statement that when someone is acting that way we should remember that they're acting that way because the rules of the game say that they HAVE to. In addition, the teacher might be encouraged to watch out for the possibility that someone is using this game as an opportunity to say things in a way that really does hurt people, or that someone has inappropriately taken the "pretend" meanness personally. Tell the children for each situation to take a few moments to think about how they are going to act out the situation pretending they are the kind of child on their card. Give each group about 5 minutes to act out their situation.

Some suggested situations that will be acted out are listed below. You can change these situations or add more situations if you feel it would work with your class. For example, you might make it like a game of charades, with one child acting out a part and the others guessing what is being acted out. Or, even better, let the children come up with their own situations and act them out.

1. **Vacation Time:** “Hyperactive Child,” “Child who Stutters” and “Happy Child” will act together. Each child in this situation will be trying to tell the others about somewhere fun they went on their vacation.
  2. **School Project:** “Easily Hurt Child,” “Very Smart Child” and “Critical Child” will act together. These children will talk about what kind of school science project they will do together for their science class.
  3. **Party:** “Very Sad Child,” “Friendly Child” and “Frightened Child” will be going to a party together. They will talk about what they want to do at the party, who will be there, and how they’re looking forward to it.
- **Discussion after acting out each situation:** After each group of children has had 5 minutes or so to act out a situation, the teacher will ask them to stop, and ask the rest of the class the following:
    - Can you guess what kind of child was being acted out for each person? If the others can’t guess, tell the child to read the card that they have.
    - Can you tell what kind of feelings each kind of child had during the scene? *[Refer to particular things that were said that elicited “different” behavior from each child.]*

- Do you think that any child's behavior was difficult for the others to understand? Knowing what kind of child was being acted out, do you now understand better why they acted that way? Why, or why not?
- Can you guess how the "different" child would like to have been treated?

## Feel and Speak Drama Cards

Copy this page and cut out these cards. One card is to be given to each child for the Feel and Speak Drama Game.

<p><b><u>Hyperactive Child</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• can't keep his or her mind on anything for more than a couple of minutes</li><li>• is very active, running around</li><li>• interrupts people</li><li>• likes to play soccer</li></ul>	<p><b><u>Child who Stutters</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• stutters over words in nearly every sentence</li><li>• is very excited about a trip the family took to Disneyland</li></ul>	<p><b><u>Happy Child</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• is cheerful</li><li>• always sees the bright side of things</li><li>• loves parties with ice cream and cake</li></ul>
<p><b><u>Easily Hurt Child</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• is quiet</li><li>• gets his or her feelings hurt easily</li><li>• is very kind to others and especially likes science class</li></ul>	<p><b><u>Very Smart Child</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• knows a lot &amp; learns faster than anyone</li><li>• math and science are favorite subjects</li><li>• is impatient with slower learners</li></ul>	<p><b><u>Critical Child</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• criticizes and picks on other children</li><li>• doesn't like science</li><li>• likes art projects</li></ul>
<p><b><u>Very Sad Child</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• is always sad</li><li>• can't be happy</li><li>• always sees the bad side of things</li><li>• doesn't feel like doing anything</li></ul>	<p><b><u>Friendly Child</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• likes to be friends with everyone</li><li>• wants everyone to be happy</li><li>• likes to play party games</li></ul>	<p><b><u>Frightened Child</u></b></p> <p><b>This child:</b></p> <ul style="list-style-type: none"><li>• is afraid of new situations that he or she doesn't know about</li><li>• likes doing puzzles with the family</li></ul>



# Other Program Ideas

## **A Film Night or Film Series**

Your congregation might want to sponsor a film night or film series featuring movies which portray mental illness with refreshments and discussion after the viewing. Very few movies avoid the stereotypes of mental illness as violent, comical or hopeless. The following are movies that attempt to be accurate in their portrayal of mental illness, and give a measure of hope and thus would be good choices for such a film program.

### ***Mood Disorders***

#### ***Mr. Jones* (Bipolar Disorder)**

Mr. Jones suffers from bipolar disorder. When he is manic, he does risky things, like trying to fly off a high building. After such episodes, he is brought to a psychiatric ward. 114 minutes.

#### ***My Sister's Keeper* (Bipolar Disorder)**

Kathy Bates plays a woman coping with a severe form of bipolar disorder. We see the person, not the disorder, and her interactions with her family are realistically portrayed. 90 minutes

#### ***Pumpkin Eater* (Depression)**

Jo, the mother of 8 small children leaves her husband to marry a screenwriter named Jake. As Jo's happiness changes to despair when Jake is unfaithful, she realizes that only psychiatric help can help her. 110 minutes

#### ***Sophie's Choice* (Depression, Bipolar Disorder, Suicide)**

Nathan is a chemist and his girlfriend Sophie is a Polish refugee. Nathan and Sophie's relationship is menaced by Nathan's violent behavior, and Sophie's disturbing memories of her war experience. The film culminates in a flashback revealing the cause of Sophie's unbearable pain. 150 minutes

### ***Anxiety Disorders***

#### ***As Good As It Gets* (Obsessive-Compulsive Disorder)**

Melvin is a novelist with an obsessive-compulsive disorder. Carol is a waitress at the local diner where Melvin eats breakfast every morning. Carol isn't distressed by Melvin's eccentricities, and begins to bring out his deeply concealed heart. 138 minutes

#### ***Coming Home* (Post Traumatic Stress Disorder)**

Sally volunteers at a Veteran's hospital after her husband Bob is sent to Vietnam, and meets men struggling to recover, physically and psychologically. Luke, a paraplegic, is bitter and full of rage. Gradually, he recovers emotionally and he and Sally become lovers. Then Sally's husband returns from Vietnam. 131 minutes

#### ***David and Lisa* (Anxiety and Compulsive Disorders)**

David is trapped by his anxieties, and Lisa is a fragile compulsive. They meet in a mental institution and fall in love. 94 minutes

#### ***The Fear Inside* (Agoraphobia)**

Meredith suffers from agoraphobia and is terrified to go outside. She takes in a female boarder for company, but discovers her boarder and a friend are wanted for robbery and murder. To escape, she must go outside. 100 minutes.

#### ***Ordinary People* (Post Traumatic Stress Disorder, Suicide)**

A family has suffered the tragic loss of their eldest son in a boating accident. The younger son, Conrad who had been on the boating outing with his brother, later attempts suicide. Conrad begins therapy sessions which help him find some relief from the feelings of grief and guilt. 124 minutes

#### ***The Horse Whisperer* (Post Traumatic Stress Disorder)**

During a tragic horse ride, young Grace loses a leg and her horse Pilgrim becomes wild and unridable. Booker, a man who tames horses, is asked by Grace's mother to try and rehabilitate the horse. Booker is successful and, Grace

challenges her fear of riding and begins recovering emotionally. 170 minutes

### ***Psychotic Disorders***

#### **A Beautiful Mind** (Schizophrenia)

This is a movie based on the life of mathematician John Forbes Nash Jr. who overcame years of suffering with schizophrenia to win the Nobel Prize. 136 minutes

#### **Benny and Joon** (Schizophrenia and personality disorder)

Benny needs someone to look after his mentally ill sister Joon. Sam is looking for a place to stay, and ends up moving in with Benny and Joon, becoming Joon's caretaker. Joon and Sam fall for each other and Benny has a hard time dealing with this situation. 99 minutes

#### **The Fisher King** (Schizophrenia, Post Traumatic Stress Disorder, Depression)

Jack, a disk jockey spends his time on the radio insulting his listeners, but when one caller takes Jack's advice literally and shoots up a New York City restaurant, Jack becomes suicidally depressed. He is rescued by Perry, a homeless psychotic man, who believes he's on a quest for the Holy Grail. 137 minutes

#### **Hope on the Streets** (Schizophrenia, bipolar disorder, substance abuse)

This film presents five stories of real homeless people and their families. The people have various diagnoses – paranoid schizophrenia, bipolar disorder and substance abuse. They show the devastation that mental illness and homelessness can bring to the affected person and their family. 58 minutes

#### **I Never Promised You a Rose Garden** (Schizophrenia)

This film tells about the struggle of Deborah, a schizophrenic teenager, to cope with her mental illness that causes her to have visual hallucinations. She attempts suicide to escape. After a stay in a mental hospital, and with the help of a caring psychiatrist, Deborah is eventually able to control her condition. 96 minutes

#### **Out of the Shadow** (Schizophrenia)

A woman's struggle with paranoid schizophrenia is documented over a five-year period by her documentary-making daughter. In flashbacks, the film discusses the story of the family's ordeal over several decades. (60 minutes)

#### **Shine** (Schizophrenia or Schizoaffective Disorder)

This is the true story of David Helfgott, a child piano prodigy who had a nervous breakdown and a number of hospitalizations in mental institutions. His story documents the struggle to heal following a painful failure, and the smothering love and overzealous plans of a misguided parent. 105 minutes

### ***Eating Disorders***

#### **The Best Little Girl in the World** (Anorexia Nervosa)

This is a television movie about a teenage girl from a solid middle class background who slowly starves herself to death. 96 minutes

#### **Kate's Secret** (Bulimia Nervosa)

This television movie tells the story of Kate, a housewife and mother who is secretly bulimic. Once discovered and confronted by her doctor, she has many battles trying to overcome her problem in a clinic for anorexia and bulimic women, but finally gets on the road to recovery. 100 minutes

#### **The Famine Within** (Eating Disorders)

This is a documentary by Katherine Gilday that documents the contemporary obsession with an unrealistic body size and shape among North American women and the eating disorders it engenders. 90 minutes

### ***Substance Related Disorders***

#### **Days of Wine and Roses** (Alcoholism)

Clay, a public relations man who likes to drink, marries Kirsten who doesn't drink, and after a few months, Kirsten is able to put away as much liquor as her husband. As the years pass, Joe loses one job after another and his wife neglects their child until he begins to realize that both of them are alcoholics. A former alcoholic persuades Joe to get help for his problem. 138 minutes

#### **Lady Sings the Blues** (Drug Addiction)

This film captures the essence of Billie Holliday in this semi-biographical sketch of the tragic life of the famous blues

singer and drug addict. 144 minutes

### Leaving Las Vegas (Alcoholism)

Ben is a Hollywood screenwriter who has been fired for alcoholism. He takes his severance pay to Las Vegas, intending to drink himself to death. There he meets Sera, a prostitute, and a symbiotic relationship between them develops. 115 minutes

### Pollock (Alcoholism)

This is the true story of the last 15 years of the life of Jackson Pollock, who was a leader of abstract expressionist painting whose work had major influence on the modern art movement, and who was an alcoholic. 122 minutes

### Traffic (Drug Addiction)

This film tells three intersecting stories, illustrating the complexities of the drug problem. First, a Mexican police officer, Javier learns that his superior officer is corrupt. Second, a conservative judge takes a position as the new US drug czar, not realizing that his teenage daughter is becoming a drug addict. Third, federal agents are guarding a drug smuggler who is about to testify against a wealthy drug lord. 147 minutes

## ***Disorders first Diagnosed in Infancy, Childhood or Adolescence***

### Forrest Gump (Mental Retardation)

This film shows scenes of American social history from the early 1960s through 2000. Vietnam, desegregation, Watergate and more are presented from the perspective of lovably slow-witted Forrest Gump as he finds himself entangled in situations he can't understand. 157 minutes

### Rainman (Autism)

Charlie receives word that his father has died and he finds that the three-million-dollar estate has been left to the caretakers of his autistic older brother, Raymond, who he didn't previously know of. Charlie learns how to deal with Raymond's many idiosyncrasies, but he also actually begins to care about his brother. 138 minutes

### What's Eating Gilbert Grape (Mental Retardation, Suicide)

Gilbert is the eldest brother in a large family, whose morbidly obese mother who hasn't left the house since her husband committed suicide years before. Arnie is Gilbert's retarded teenage brother who needs constant supervision. Gilbert feels like he is living a stressful, dead-end life, stocking shelves at a grocery store. Gilbert's future seems grim until Becky and her grandmother arrive in town. 118 minutes

### The Quiet Room (Selective Mutism)

A seven-year-old girl becomes mute in protest as her parents become more and more hostile to each other. 98 minutes

## ***Dementia***

### Iris (Alzheimer's dementia)

This movie tells the true tale of the onset and progression of Alzheimer's dementia in author Dame Iris Murdoch, and how her devoted husband struggles to take care of her until he is forced to take her to a nursing facility. 90 minutes

### The Madness of King George (Dementia caused by the blood disorder porphyria)

*The Madness of King George* tells the true story of the mental illness of King George III of England. 110 minutes

## ***Personality Disorders***

### American Gigolo (Narcissistic Personality Disorder)

Julian, a slick L.A. hustler, services an upscale clientele in the Hollywood area. He becomes involved with a senator's wife and their relationship extends beyond Julian's normal encounters. This is a look at moral decay and redemption. 117 minutes

### Girl, Interrupted (Borderline Personality Disorder)

This movie tells the story of Susanna, who is diagnosed as having borderline personality disorder. She occasionally hallucinates, and, after attempting suicide, she checks into Claymoore, a suburban Boston mental hospital for a stay that turns out to be nearly two years. At first, she is angry and antisocial. Eventually, she begins writing and tries to become well enough to leave. 127 minutes

### Silence of the Lambs (Anti-Social Personality Disorder)

FBI trainee Clarice is sent to interview serial killer Hannibal Lecter at his cell in a mental hospital. Intrigued by

Clarice, Lechter demands information about her personal life, and the two form a strange connection. 120 minutes

*Streetcar Named Desire* (Histrionic Personality Disorder)

This is the story of a fragile overly-dramatic former prostitute who visits her sister only to be taunted mercilessly by her brother-in-law. 131 minutes

*Toto the Hero* (Paranoid Personality Disorder)

Thomas is certain he lost a childhood to a wealthy neighborhood playmate Alfred, because he believes their infant name tags were switched in the hospital. As an old man, he has nothing but a lifetime of bitter memories until a chance happening. 94 minutes

***Dissociative Disorders***

*Sybil* (Dissociative Identity Disorder)

Based on a true story, Dr. Cornelia Wilbur, a psychiatrist, helps Sybil, a woman with Dissociative Identity Disorder (formerly called Multiple Personality Disorder), heal her incredible interior wounds. Sybil is slowly able to heal her inner self with the support, guidance, and love of Dr. Wilbur. 122 minutes

***Mental Disorders in the Criminal Justice System***

*Brother's Keeper* (Mental Retardation)

This 1992 documentary chronicles the story of a retarded man from Munnsville, New York, Delbert Ward, who confessed to killing his brother, but then retracted his confession and maintained his innocence. The people of his community rallied behind him. 105 minutes

*The Execution of Wanda Jean* (Mental Retardation)

A documentary filmed in 2002 depicts the story of Wanda Jean Allen, an African-American lesbian whose low IQ indicated borderline retardation. By the age of 29, Wanda Jean had killed twice - and would become one of the most controversial death-row inmates in recent history. 87 minutes

*Titicut Follies* (Many judged to be criminally insane)

This classic 1967 documentary gives a bleak, graphic portrayal of the conditions at the State Prison for the Criminally Insane at Bridgewater, Mass., showing treatment of the inmates by the guards, social workers and psychiatrists. After its release, attempts to suppress the film resulted in a very limited audience. 84 minutes.

*The Young Poisoner's Handbook* (Conduct Disorder)

This is the true story of poisoner Graham Young, whose fascination with toxic substances led him to do experiments in which he poisoned his stepmother, sister and others. After Graham was arrested for his deeds, a doctor attempted to rehabilitate the young man so he could once again enter society. 93 minutes

Here are some general questions which might be used to stimulate discussion on any of these movies:

- In what ways did the portrayal of the characters in the film seem representative or unrepresentative of the experience of people with mental disorders or their families as you understand them? Were any stereotypes enforced or debunked?
- Did you gain any insights from this film that will help you understand people with mental disorders and their families? What was helpful? Unhelpful?
- Was anything in this film disturbing to you?
- Does this film help the cause of better understanding of mental health issues? If so, why? If not, why not?

**An Outside Speaker or Panel**

Contact a local psychiatrist or therapist organization, a local chapter of NAMI, members of the local mental health board, and/or mental health client advocates and ask them to speak at a forum, service, or other program sponsored by your congregation. They can address a variety of themes such as: mental health care needs in your community, mental health client resources, the latest medications, or programs for family members.

## **A Worship Service or series of Worship Services**

Work with your minister and lay worship team to plan a worship service centered on the experience of mental illness, either as family members or as mental health clients or both. People could share what they have learned in the Caring Congregation Program, as well as their own personal experiences with mental health issues. It is important to include ways in which the congregation can support mental health issues. Some of the information in the workshops might become part of a sermon or homily to be presented. See the suggested order of service in the training materials for a sample worship service on mental health.

# Leader's Workshop: Training for the Caring Congregation Curriculum

*"You, then, that teach others, will you not teach yourself?"* Romans 2:21 NRSV

Planning for teaching the curriculum can contribute greatly to making the program a success at a congregation. The following steps are recommended when planning to teach the curriculum.

## **1. Identify congregations to be trained**

- Congregations that are interested in participating in the program
- Between 4 and 10 congregations should be included in one training to ensure a critical mass for group discussion and adequate time and attention to each congregation

## **2. Have each congregation identify two or three potential leaders**

Because discussion of mental disorders is complex and often an emotionally-charged subject, it is very important that the people who will be leaders in teaching the curriculum have some background and/or training so as to make them effective and responsible in their leadership and maximize the positive benefits of the program.

- Leaders should have life experience in one or more mental health backgrounds:
  - mental health professional
  - family member of someone with mental health issues
  - mental health client (person with a mental disorder)

If possible, the two identified leaders should come from different categories, ex: a professional and a mental health client, rather than two professionals. This gives leaders the advantage of providing different lenses on the issue when teaching the class.

- Leaders should have
  - A realistic, constructive attitude towards mental health and recovery
  - The ability to share one's emotions and facilitate such sharing in others
  - Comfort with emotional expression
  - Ability to give constructive feedback on the program and their training to lead it

See the *Guidelines for Choosing Leaders* on the next page for more details.

## **3. Leaders trained at a weekend training**

Lead by leader trainers

## **4. [Optional but Highly Recommended] Have a worship service on Mental Health.**

Announce at the service that the upcoming Caring Congregation curriculum. This is one way that the congregation can get involved quickly.

## **5. Leaders teach the program in their home congregations**

## **6. Start a Mental Health Task Force in the congregation**

This task force will carry out activities planned in the curriculum

## **Guidelines for Choosing Leaders** <sup>69</sup>

Choosing effective leadership is critical to the success of the program. At least two co-leaders should be chosen for teaching the curriculum at each congregation. The following are some of the questions that congregations can use when deciding who to use as leaders. It is highly recommended that the minister help select leaders keeping the following guidelines in mind.

### **Leaders should have life experience in one or more mental health backgrounds**

It is important that the leaders have appropriate background to responsibly teach the workshops. They should come from at least two of the following categories so that they can draw on their own direct experience of dealing with a mental disorder:

- mental health professional
- family member of someone with mental health issues
- mental health client (person with a mental disorder)

It is critical that the co-leaders should come from different perspectives. That is, at least one leader must be a mental health client or family member. For example, a mental health professional and a mental health client would make a good teaching team

### **Respected within the congregation**

Some of the ideas presented in the curriculum challenge people's currently held beliefs about mental illness. So, it is important that the congregation receive them from someone who they trust and can believe. Therefore, leaders should be people who are generally respected by the congregation.

### **Attitudes toward mental illness, families and mental health clients**

Leaders should try and be honest with themselves and acknowledge any internalized feelings of societal stigma toward mental illness, or discomfort that they have discussing this topic. If they feel that they have a negative attitude toward people or families affected by mental disorders, they are probably not good leaders for the class.

If a leader feels that a participant needs professional help for a mental disorder, they should be willing and able to make such a recommendation to the attendee. If the leader feels a participant is dangerously suicidal, they should be ready and willing to get immediate help for the person, such as calling emergency services or accompanying the person to the hospital.

### **Motivation to become a leader**

Try and be clear about why someone wants to become a leader of this workshop series. If they are someone who is angry at people who are not mentally ill, and want to use the workshop series as a way to vent that anger, they are not ready for this role. If they feel sorry for people or families who have mentally disorders and want to show their pity, they are not ready. However, if they have a sincere interest in doing some work to increase their own awareness and knowledge of mental disorders, and if they have a sincere interest in helping others do the same, proceed with enthusiasm.

### **Ability to share**

A leader needs to be comfortable sharing their own thoughts, feelings, and experiences of mental disorders. He or she needs to create an authentic and open environment in which participants can learn and be comfortable in sharing themselves. Leaders should model sharing behavior.

**Leadership style**

The leader's role is that of a facilitator who creates an environment in which participants can explore their own attitudes and learn new information. The workshops are designed for an open discussion format among participants, not as primarily a lecture format. A leader needs to adjust his or her style to accommodate such a format.

**Comfort with emotional expression**

When speaking about their experience with mental disorders, it may happen that strong emotional expressions will occur. The leader needs to be able to be comfortable and compassionate in such circumstances.



# Suggested Weekend Training Agenda

## Friday Evening

- 5:00 DINNER
- 6:00 Opening Ritual
- 6:20 Welcome and Background of Caring Congregation
- 7:00 Introductions
- 7:15 Expectations of the Trainers and Attendees
- 7:45 Line Dance
- 8:00 BREAK
- 8:15 Our Stories
- 8:45 Reflections
- 9:00 ADJOURN

## Saturday

- 8:00 BREAKFAST
- 8:20 Opening Ritual
- 8:30 Demonstration of an Example Workshop Session Workshop 1: Mental Disorders and their Consequences. Includes UU Coffee Hour Skit
- 10:30 BREAK
- 10:45 Basic Facilitation Skills
- 11:45 Handling Hot Potatoes
- 12:30 Lunch
- 1:30 Curriculum Treasure Hunt
- 2:00 Using the Caring Congregation Curriculum
- 2:45 BREAK
- 3:00 Empathy:
  - Understanding people with mental disorders
  - Understanding family members
- 4:00 Case Studies: What would you if ...?
- 5:00 DINNER
- 6:00 Moving from Workshops to Congregational Action
- 7:00 Peer Teaching Assignments. Break participants into four groups. Choose which workshops to be used in peer teaching exercises tomorrow. Groups plan teaching of their workshop. No formal closing of the day.
- 9:00 ADJOURN

## **Sunday**

- 9:00 BREAKFAST
- 9:20 Opening Worship
- 9:50 Pass out evaluation forms  
Set up for teaching the lessons.  
As each group presents, the other people act as the class.  
After each lesson, there will be a 15-minute feedback and a break.
- 10:00 Peer Teaching Session I
- 10:30 Feedback on Peer Teaching Session I
- 10:45 BREAK
- 11:00 Peer Teaching Session II
- 11:30 Feedback on Peer Teaching Session II
- 11:45 LUNCH
- 12:45 Peer Teaching Session III
- 1:15 Feedback on Peer Teaching Session III
- 1:30 BREAK
- 1:45 Peer Teaching Session IV
- 2:15 Feedback on Peer Teaching Session IV
- 2:30 BREAK
- 2:45 Evaluation of Training (Whole group together again)
- 3:00 Wrap-up and Closing Ritual
- 3:30 ADJOURN

# Training Lessons

Opening Rituals  
Introduction to the Caring Congregation  
Introductions  
Expectations of the Trainers and the Attendees  
Line Dance  
Our Stories  
Demonstration of an Example Workshop Session  
Basic Facilitation Skills  
Handling Hot Potatoes  
Curriculum Treasure Hunt  
Using the Caring Congregation Curriculum  
Empathy  
What would you do if ...?  
Moving from Workshops to Congregational Action  
Peer Teaching Assignments  
Wrap up and Closing Ritual

## Opening Rituals

**Purpose:** Begin each session with a religious ritual signifying the holy work that will be done both here, and when we teach the workshops to our congregation.

### Materials:

A vessel to be used as a *chalice*, candle and matches

A poster of art of the chosen artist (see below)

A CD or DVD with the chosen music and a CD player to play it for the class

### Adding Artistic, Literary and Musical Dimensions to the Workshops

Many outstanding composers, writers and artists have had mental disorders. One way to add other dimensions to your program is to have a composer, writer, and an artist of the day at each workshop. Display a poster of a piece of art, selected words by the writer, and play music of the composer as people are entering and leaving the workshop each day. Remind people of who these people are and what wonderful contributions these outstanding people have made to our world.

Here are some artists, writers, and composers to choose from:<sup>70</sup>

- **Poets:** William Blake, Robert Burns, Emily Dickinson, Gerard Manley Hopkins, Victor Hugo, Samuel Johnson, John Keats, Robert Lowell, Edna St. Vincent Millay, Boris Pasternak, Sylvia Plath, Edgar Allan Poe, Ezra Pound, Anne Sexton, Percy Bysshe Shelley, Sara Teasdale, Alfred, Lord Tennyson, Walt Whitman.
- **Writers:** Hans Christian Anderson, Honoré de Balzac, Samuel Clemens, Joseph Conrad, Charles Dickens, Isak Dinesen, Ralph Waldo Emerson, William Faulkner, F. Scott Fitzgerald, Graham Greene, Ernest Hemingway, William James, Charles Lamb, Herman Melville, Eugene O'Neill, Mary Shelley, Robert Louis Stevenson, Leo Tolstoy, Tennessee Williams, Virginia Woolf, Emile Zola.
- **Composers:** Robert Berlioz, Edward Elgar, George Frederic Handel, Otto Klemperer, Gustav Mahler, Sergey Rachmaninoff, Robert Schumann, Alexander Scriabin, Peter Tchaikovsky, Irving Berlin, Noel Coward, Stephen Foster, Cole Porter
- **Artists:** Paul Gauguin, Hugo van der Goes, Vincent van Gogh, Michelangelo, Edvard Munch, Georgia O'Keeffe, Jackson Pollock, Dante Gabriel Rossetti, Mark Rothko

### Preparation:

- Decide on which poet, writer, composer and artist you are going to feature. Obtain the poster, music, and literary passage so that they can be used in the class. Display the poster, the selected words by the writer, and play music of the composer as people are entering. For each day of the training, choose a composer, writer and artist to feature.
- Obtain the *chalice*, candle and matches.
- Obtain a copy of *Singing the Living Tradition*, Beacon Press, 1993 for the readings.

### Opening Ritual for the First Day

**Time: 20 minutes**

#### Session Plan:

**Entering** Play music of the chosen composer as people are entering.

**Lighting a Chalice** using chalice-lighting words of the leader's choice.

**Reading** by Susan Gregg-Schroeder (adapted) from Gregg-Schroeder, Susan. *In the Shadow of God's Wings – Grace in the Midst of Depression*<sup>71</sup>

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

### ***Moment of meditation or prayer***

#### ***Lesson***

Welcome the class and introduce your co-facilitator.

Speak briefly about what we are to do together in this training, making the following points:

- We are here to do holy work:
  - the holy work of recognizing the inherent worth and dignity of all people;
  - the holy work of bearing witness to the oppression of being mentally ill in our society;
  - the holy work of learning how to advocate for people who cannot advocate for themselves;
  - the holy work of allowing ourselves to learn from those who are suffering;
  - to embrace this work as part of a congregation's living out its values in the world.
- We acknowledge and celebrate the commitment that the participants have to doing this work, and the commitment that their congregations have to learn from us.
- Explain that many outstanding composers, writers and artists have had mental disorders. One way that we as leaders can add a dimension to our program is to have a composer, writer, and an artist of the day at each workshop. And, display a poster of a piece of art, selected words by the writer, and play music of the composer as people are entering and leaving the workshop each day. Each day, remind people of who these people are and what wonderful contributions these outstanding people have made to our world. Tell them who the composer, artist and writer of the day are.

**Reflection**

Ask the class members to speak *briefly* as they are moved about why they are participating in this holy work. Not everyone has to speak.

**Benediction**

*Take Courage Friends* by Rev. Wayne Arnason, #698 from our hymnal

**Opening Ritual for the second Day**

For the *Opening Ritual* for the second and following days of the teacher training workshop, use a briefer (10 minute maximum) variation of this ritual:

**Entering** Play music of the chosen composer as people are entering. When all have arrived, announce who the composer, artist and write of the day are.

**Lighting a Chalice** using chalice-lighting words of the leader's choice.

***A moment of meditation or prayer*****Opening Ritual for the Final Day**

If you hold the final day of training on a Sunday, you have the following are options for the opening:

You may want to have a brief Opening Worship service with a homily on the subject of mental health. The Appendix contains a sample order of service, opening, closing, readings, hymns and homily to use for such a service. (30 minutes)

– Or –

You can use the same form of opening as for the second day. (10 minutes)

## Introduction to the Caring Congregation Curriculum

**Purpose:** Give an introduction to the curriculum and how the training class will proceed.

**Materials:** Sheets of newsprint

### Preparation:

- Prepare a handout or newsprint that contains the agenda for the training.
- Prepare two sheets of newsprint and post them up on the wall. On one sheet write the title “Parking Lot,” and on the other write the title “Possible Responses by a Faith Community.”
- Make copies for the class members of the curriculum section “The Caring Congregation Program” which is on pages 1-3 of the curriculum
- If class members don’t yet have a copy of the Caring Congregation Curriculum, make sure that each student will have a copy to work with.

**Time: 40 minutes**

### Session Plan:

Go over the agenda for the training, explaining what will be done each day. Ask if there are any items not on the agenda that the class would like to discuss. Record these on the “Parking Lot,” explaining that the sheet labeled “Parking Lot” will be used during the training to capture any questions or issues that come up during the training that have to wait until later to be addressed. Say that we will do our best to address issues, or to point to places where the answers can be found.

Explain that the sheet labeled “Possible Responses by a Faith Community” will be used to capture ideas that come up of how a faith community can address the problems identified in the workshop. This will model how such a sheet will be used during their own upcoming teaching of the curriculum to capture ideas that the congregation wants to work on.

Go over the handout “The Caring Congregation Program,” in particular the goals of the program and the characteristics of a caring congregation. Briefly explaining what the lessons of the curriculum are and what issues they address. Explain that we will not be doing training on the Pastoral Care and Children’s workshops:

The Pastoral Care workshops are essentially a condensed form of the 7 workshop classes with some specific information for people doing pastoral care.

The children’s classes all consist of a story and an activity of some sort. They build upon each other with different concepts being added at each lesson.

Explain that we would like feedback at the end of the training about whether there should be specific training for these two other sets of workshops.

Note: This lesson closely follows a lesson in the *Training Manual for Our Whole Lives Sexuality Education*.

## Introductions

**Purpose:** To enable participants to get to know each other and build group rapport.

**Materials:** Newsprint chart “Please Tell Us”

**Preparation:** Make a newsprint chart with the following on it:

**PLEASE TELL US:**

Your name

Your congregation

Whether you are:

1. a mental health professional,
2. a family member
3. a mental health client,
4. or some combination of these

Something about you that we would never guess

**Time: 15 minutes**

**Session Plan:**

Explain that it is now time for participants to introduce each other briefly giving the information on the “Please Tell Us” chart. Explain that this should take no more than 1 minute per person. And, they will get chances to tell their stories in more depth later in the training.

Model the process by introducing yourself first. Then, have your co-facilitator introduce him/her self.

Have the class begin introducing themselves.

When the class has completed, make appropriate remarks about the range and depth of experience represented here.

Move to the next activity: Expectations of the Trainers

Note: This lesson closely follows a lesson in the *Training Manual for Our Whole Lives Sexuality Education*.



## Expectations of the Trainers and Attendees

**Purpose:** Let the class know what they are expected to do as trainers of the Caring Congregation. Let them know the guidelines for participation of all attendees

**Materials:** Each student will have a copy of the curriculum

**Preparation:** Go over the items in the Session Plan.

**Time: 30 minutes**

### Session Plan:

1. Explain that as trainers, they are expected to:
  - Co-lead the workshops at their congregation. The co-leaders can divide up the work in any way that they think is useful. For example, one person can lead and another can support. They might alternate who leads and supports. The person doing the support role might be available if there is a problematic situation that comes up.
  - Help shape the program for their congregation. This would involve choosing workshop structure and any additional elements that they may want to have.
  - Help evaluate the training program - There are evaluations of this training both before and after you lead the workshops. This is especially important for this field test
  - Help evaluate the Caring Congregation program after they teach it.

Remind the students of the class that everyone makes mistakes from time to time, and to be patient with themselves as they learn new ways of teaching and facilitating.

2. Ask the class if anyone has any questions or concerns about these expectations. If concerns are brought up, ask the class to help brainstorm solutions.
3. There are guidelines for the participants in Caring Congregation workshops that need to be explained to the attendees. These are found on page 6 in the front matter at the beginning of this program. Go over these items, having class members read the text after each one. Ask the class for comments:
  - Respect anonymity
  - Set boundaries for personal sharing
  - Speak from personal experience
  - Respect differences
  - Not a substitute for Professional help

## Line Dance

**Purpose:** An ice-breaking exercise to get people to know each other in a controlled listening and speaking format.

**Preparation:** Go over the directions for exercise in the session plan.

**Time:** 15 minutes

### Session Plan:

Explain that they will now be doing a mixer to enable them to get to know each other a little bit better and to start make connections with each other in a structured listening and speaking format.

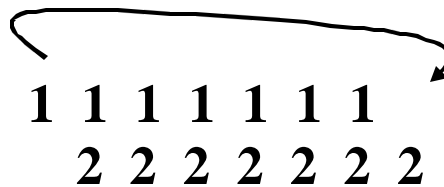
Ask the participants to number off by 2's. i.e. 1, 2, 1, 2, 1, 2 ... Ask all the 1s to line up in one line and the 2s to line up in another parallel line with each 2 facing a corresponding 1, with about an arm's length between them, as shown below. If there is not an even number of students, have a co-facilitator take part in the exercise.

**1 1 1 1 1 1 1**  
**2 2 2 2 2 2 2**

### Two lines facing each other

Tell the students that we will be posing a question and that they are to take turns answering by talking to the person they are facing. Allow 1-2 minutes for each participant to respond before going on to the next question. Ask them to just listen and not engage in conversation at this point. There should be a pause between switching roles from listener to speaker to allow for reflection on what has been said and heard. If you want, you can use a gong to indicate it is time to pause and take turns.

After each question, there is a "line dance" in which line "1" moves one person to the left to face a new partner. The left-most "1" then moves behind the line to become the right-most "1", as shown in the diagram below. The idea is to give each person a chance to listen and speak in a meaningful way to a number of others in the class.



### Line Dance

Here are some example questions to ask: You can tailor the questions to the class. Give them a longer time to answer the questions that require more thought.

- Think back to your childhood. What were some of the first things you learned about mental illness?
- How did you learn these first things about mental illness?
- How did you internalize those beliefs?

- What if anything happened to change your understanding of mental illness?
- Why do you want to teach this curriculum?
- Do you have any fears about teaching this curriculum?
- What are your hopes about teaching this curriculum?

After you have completed the questions, gather the group together and ask if they want to share any particularly meaningful exchanges.

## Our Stories

**Purpose:** Explore and analyze one's experience around issues of mental health.

**Materials:** None

**Preparation:** Decide if you will model sharing of stories by sharing your own. Decide if you will use a time-keeper for this exercise to make sure all have adequate time to share.

**Time:** 30 minutes for sharing followed by 15 minutes of reflections

### Session Plan:

1. Begin with the following points:  
Since you have all been chosen as trainers for this curriculum, you all have had experience with mental health issues, either as a provider, a family member or a mental health client.  
To teach the curriculum, it is important that you explore your own experience and feelings about issues of mental health.  
We will break up into small groups and share each other's stories. Following this, we will get back together to share our reflections on this experience.
2. If you wish, you can model this sharing of stories by first sharing your own story before the groups begin.
3. Break up the class into groups of no more than 3 people each. Try to have a mix of experiences (provider, family member, or mental health client) in each group. Give them directions:
  - They have 30 minutes to share the stories.
  - In order to make sure everyone has enough time to tell their stories, explain that someone in each group needs to act as a time-keeper. This duty can be shared so that someone else keeps track of the time-keeper's time.
  - You are in control of how much you want to share with others.
  - Try and share your feelings about mental health issues and how they developed during your story
4. After the 30 minutes have elapsed, bring the whole class back together, and engage the class for reflective questions:  
What was this experience like for you?  
What feelings about mental health issues came up during the stories?  
How much in common did you have with the other members of the group?  
Did you notice differences in experience, feelings, or perspective between providers, family members, and mental health clients?

If it doesn't come out of the discussion, make the point that negative experiences and feelings about mental health make it difficult for people to overcome these issues and move on in their lives. The goal of these workshops is to overcome some of the negative societal stigma that revolves around this issue.

## Demonstration of an Example Workshop Session

**Purpose:** Teaching this workshop has several purposes:

Have the class experience how it feels to be a participant in a workshop session.

Demonstrate how a workshop is taught.

Introduce mental health from the perspective of a religious congregation.

**Materials:** Materials required for the teaching of Workshop 1: Mental Disorders and their Consequences. In particular:

- *Creating Caring Congregations*, a video produced by Mental Health Ministries an organization of the Methodist California-Pacific Annual Conference. It can be ordered from [www.mentalhealthministries.net](http://www.mentalhealthministries.net).
- A VCR and TV screen for showing the video

**Preparation:**

Prepare as specified in the directions for Workshop 1: Mental Disorders and their Consequences.

**Time: 2 hours**

**Session Plan:**

Teach Workshop 1 as specified in the Caring Congregation Curriculum. Remember that you are modeling how this teaching should be done, so try and be good role models!

Engage the class in reflection about this workshop demonstration.

What was it like to be a participant in this workshop?

Can you articulate the unique role that a worship community can play in recovery from mental illness?

Reflect on being a teacher of this workshop:

What would you do the same, do differently than the leaders?

Did anything look like it might be particularly difficult to teach?

Are there things that you would want to add to teaching this material?

## Basic Facilitation Skills

**Purpose:** To learn effective group facilitation skills.

**Materials:** The handout “Effective Group Facilitation Techniques” on page 209.  
Newsprint

**Preparation:** Choose which role playing exercises to use and decide how you will conduct them with the class.

**Time: 1 hour**

### Session Plan:

1. Engage the class in a discussion about *Teaching* versus *Facilitation*

Explain that in the Caring Congregation workshops, a mixture of teaching and facilitation will be used. This lesson is to learn effective group facilitation skills for those parts of the curriculum that will require facilitation, and for handling general classroom dynamics.

Ask the class what comes to mind when they think about the difference between teaching and facilitating a class. Record their answers on newsprint.

If they haven't suggested the following points, add them yourself.

- Teaching is imparting a body of knowledge to students. This is most appropriate when the teacher has this knowledge and the students do not.

With facilitation:

- The focus is more on two-way communication, with all people included.
  - There is less focus on right or wrong answers
  - It is more participant-directed and the facilitator is less of an expert who has all the right answers, rather someone who focuses and guides the dialog.
2. Bring the class' attention to the handout “Effective Group Facilitation Techniques” on page 209. Go over the points in the handout, asking the class for comments or questions.
3. Engage the class in a role-playing exercise to demonstrate the techniques. Choose two or three situations and have selected members of the class act them out briefly. Then have the group comment on what was done right or wrong. Possible situations:
- One group member looks very bored and isn't paying attention  
[Example answers: Ask yourself, and maybe the class, why they are getting bored; Give examples and tell stories rather than lecturing; Stop talking and ask the class for feedback; Take a break if needed.]
  - The facilitator does most of the talking  
[Example answers: Co-facilitator privately point this out to facilitator. “Let's hear what Mary has to say.”]
  - Group members give advice  
[Example answers: Remind people that we are here to be supportive, but not to give advice.]
  - Group members disagree with each other  
[Example answers: Point out the obvious: We have a disagreement. Let's listen to each point of view.]
  - Someone in the group starts to cry  
[Example answers: Hand them a tissue. Remark that you can see they feel deeply about this.]

Note: This lesson closely follows a lesson in the *Training Manual for Our Whole Lives Sexuality Education*.

## Handout: Effective Group Facilitation Techniques

- Responsibilities of a facilitator
  - Foster personal responsibility
  - Encourage appropriate participation.
  - Provide focus
  - Handling problems that may come up
- Fostering group participation
  - One person speaks at a time.
  - Make sure that everyone is included and invited to speak if necessary.
  - Maintain eye contact with the whole group. Pick up on group members' non-verbal communication – signs of boredom, confusion, etc.
  - Call participants by name and make references to their earlier comments.
  - Ask open-ended questions (rather than yes/no questions)
  - Ask others how they have handled similar situations
- Keeping the group on task without controlling it.
  - Avoid the urge to maintain control of everything that happens.
  - Let the other group members do most of the talking.
  - Differences of opinion are OK. Exploring disagreements can be fruitful.
  - Don't let people give advice to others; have them say what has worked for them.
  - Expressions of distress are OK. Recognize them and don't pretend they will go away.
- Be an “active listener”
  - Restate; Question; Summarize; Reflect underlying feelings; Validate feelings; Share
- Personal demeanor
  - Share appropriate personal stories and anecdotes to demonstrate a point.
  - Be yourself, aware of your capabilities and limitations. Let your personality emerge.
  - Be patient, kind and empathetic.
  - Use “I” language and encourage others to do the same
  - Be a role model (attitudes, knowledge and skills) Model the use inclusive language for all cultural, linguistic, social and racial groups
  - Keep a lively pace. Use humor when appropriate.
  - Be nonjudgmental and unshockable
- Suggestions for problematic situations
  - Monopolizer: “It is clear you have a lot of issues. Let's give others a time to share.”
  - Group Conflict: Consider taking a “time out.” Reflect on why conflict happened.
  - Emergencies: Establish an emergency resource to call on if necessary. Take the person aside privately. It may involve calling the family, a doctor or hospital.
  - Talk of suicide: Use your emergency resources. Give out suicide hotline numbers

### Sources:

Pamela Wilson, Sexuality Trainer, Metropolitan Washington, DC, 1996, in OWL Training materials  
Depression and Bipolar Support Alliance support group materials  
“Tips for the Facilitator Leading Discussions” from South Bronx People for Change, July 1984

## Handling Hot Potatoes

**Purpose:** Address how to handle problematic situations which may come up during teaching of the curriculum.

**Materials:**

Newsprint

Handouts about what to do with suicide statements, and the other psychiatric problems

**Preparation:** Prepare a sheet of newsprint with the situations that will be discussed in the class. On the sheet, write:

- Suicidal Statements
- Disruptive Behavior
- Crisis Intervention
- Hostility between attendees
- People who monopolize the discussion
- Disclosure of personal problem

**Time: 45 minutes**

**Session Plan:**

Explain that we will be discussing how to handle problematic situations which may come up during teaching of the curriculum. And, that the situations we will discuss are listed on the newsprint sheet. Ask if anyone in the class wants to add any other situation to the list.

Decide how you are going to address each of the issues. You may decide to:

Use brainstorming among the class members

Create a role-playing situation and act out a situation, followed by discussion about the issue and how it was handled.

Give some suggested techniques for handling the situation. See the list below.

Here is a list of suggested techniques for handling problematic situations

- **Suicidal Statements**

Suicidal statements must be taken seriously. Have the co-facilitator work with the person separately to determine the seriousness of the statement and take appropriate action. If the situation is serious, you may have to accompany them to the nearest hospital emergency room.

*The QPR Model for helping someone who is suicidal*

Q: Question a person about whether they are suicidal

P: Persuade the person to get help

R: Refer the person to the appropriate resource

- **Disruptive Behavior:** interrupting, speaking when others are speaking, distracters  
Calmly remind the class that one person speaks at a time and others are to listen. People can be disruptive when they think they aren't being listened to. The facilitator needs to take the opportunity to do active listening to the "disruptor." One option is to have a co-facilitator take the person outside the group and talk to them. If there is a continually repeating offender after being listened to, tell them you will have to ask them to leave the



class if they don't stop their disruptive behavior. And then do that if need be.

- **Crisis Intervention:**

If someone is having a psychiatric crisis, have the co-facilitator work with the person to determine the nature of the situation. If it is such that they can't continue with the class, locate a family member or friend that can help that person to get the professional attention they need.

- **Hostility between attendees**

While expressing differences of opinion is encouraged, open hostility doesn't help. Ask each party to take a turn telling their side of the dispute while the other listens. Ask the opposing party to summarize the other's point of view. If they are so hostile that the class is disrupted, handle as for Disruptive Behavior, above.

- **People who monopolize the discussion or know "all the answers"**

Remind people that no one has "all the answers" to mental health questions, and that each of us has something to share from our own perspective. Then ask that those who have shared a lot be quiet for a time to let the others have a turn.

- **Disclosure of personal problem**

Suggest they talk to minister or a therapist. Remind the class of the confidential nature of the statements and that they should not be disclosed to others.

- **A know-it-all or someone who speaks "psychobabble"**

Remind people that we are all learning from each other in the class, that no one has all the answers, and that we can best learn when people use ordinary language when talking to each other.

- **Someone who believes that any difficult person has a mental illness**

Remind people that being cruel, difficult, mean, or just eccentric aren't enough to have a diagnosis of a mental disorder. There are a specific set of symptoms that need to be met.

## Curriculum Treasure Hunt

**Purpose:** Build familiarity with the curriculum

**Materials:**

Copies of the curriculum for each participant

**Preparation:**

- Make a copy of the handout “Curriculum Treasure Hunt Tasks” for each person.
- Make newsprint with an outline of the organization of each workshop

**Time: 30 minutes**

**Session Plan:**

Explain that rather than just walk participants through the curriculum in a tedious way, you’re going to take them on a curriculum treasure hunt so they can “discover” what it consists of. The object of this activity is for them to get to know the curriculum – its overall content, structure and format.

Divide the group into teams of 2-3 people. This might be a good way for people who will be co-trainers to start learning together as part of a team. Distribute the handout “Curriculum Treasure Hunt Tasks” and give the following instructions

- You need to fill in each of the blanks on your Treasure Hunt handout. Be sure to note the Workshop number and page number in the curriculum where you find the answer.
- Tell them to try not to look at the quiz answers in the Training material on page 214, even though this will be hard.
- Take a few minutes to decide how you will work as a team on this project. The goal is to get to know the curriculum and to fill in all the blanks on your handout.
- Notice if there is something you really want to teach.
- Let me know when you are finished.

Have the teams begin. When they finish (about 15-20 minutes), congratulate them all on real-time learning.

Review the answers to the Treasure Hunt using the “Curriculum Treasure Hunt Task Answers” sheet.

Review the organization of the curriculum workshops with the class. Explain each of the following as the group follows on (on newsprint).

Each workshop has the following parts: Purpose, Materials, Preparation, and Session Plan with time limits for each major task in the Session Plan.

Handouts are given with the workshop where they are to be used

Some of the workshops have homework assignments. Reading assignments are given with the workshop prior to that where they will be used.

Each Session Plan has a beginning reading with a moment of meditation, and a closing reading to emphasize that the curriculum activities are held in a religious space.

For each of the mental disorders covered in the curriculum, there is a case study

Note: This lesson closely follows a lesson in the *Training Manual for Our Whole Lives Sexuality Education*.

## Handout: Curriculum Treasure Hunt Tasks

*Directions:* Fill in the blanks of each of the following statements. As you're finding the requested information, keep reading if something interests you. The goal is to have you get to know the layout of the curriculum and get an overview of the content.

The curriculum contains \_\_\_\_\_ workshops for adults and youth, \_\_\_\_\_ workshops for pastoral care, and \_\_\_\_\_ lessons for children.

To tailor the program to fit my congregation's needs, see \_\_\_\_\_

A sample homily for teaching about Unitarian Universalists and their involvement in mental health issues is found: \_\_\_\_\_

To find out about the role of shamans and mental illness, see \_\_\_\_\_

To learn about mental retardation, see \_\_\_\_\_

To learn about Alzheimer's disease, see \_\_\_\_\_

To find a case study on Schizophrenia, see \_\_\_\_\_

To learn about the experience of families, see \_\_\_\_\_

To learn what the Surgeon General of the United States has said about mental health, I can see \_\_\_\_\_ and \_\_\_\_\_

To learn about mental disorders in minority communities, see \_\_\_\_\_

To learn about stereotypes and facts about mental illness, see \_\_\_\_\_

To find an exercise about empathy for people with mental disorders, see \_\_\_\_\_

To get an overview of all the elements needed in recovery from mental illness, see \_\_\_\_\_

To find out how to plan for ongoing actions for my congregation see \_\_\_\_\_

To learn how mental illnesses are treated, see \_\_\_\_\_

## Curriculum Treasure Hunt Tasks Answers

*Directions:* Fill in the blanks of each of the following statements. As you're finding the requested information, keep reading if something interests you. The goal is to have you get to know the layout of the curriculum and get an overview of the content.

The curriculum contains 7 workshops for adults and youth, 2 workshops for pastoral care, and 4 lessons for children.

To tailor the program to fit my congregation's needs, see Tailoring the Program to Your Congregation, page 4

A sample homily for teaching about Unitarian Universalists and their involvement in mental health issues is found: Reading Assignment before History of Mental Disorders Workshop 3, page 72

To find out about the role of shamans and mental illness, see Handout for Mental Health History Workshop 3, page 80

To learn about mental retardation, see Disorders usually occurring first in Infancy, Childhood and Youth in Workshop 4, page 97

To learn about Alzheimer's disease, see Disorders found in the Elderly in Workshop 4 on page 100

To find a case study on Schizophrenia, see Psychotic Disorders, Workshop 2, page 58

To learn about the experience of families, see Workshop 6, page 131

To learn what the Surgeon General of the United States has said about mental health, I can see Workshop 1, page 8 or page 26 and Workshop 4, page 89 or page 106

To learn about mental disorders in minority communities, see Workshop 4, page 89

To learn about stereotypes and facts about mental illness, see Workshop 1, page 8 or page 24

To find an exercise about empathy for people with mental disorders, see Hearing Voices Skit in Workshop 2, page 45

To get an overview of all the elements needed in recovery from mental illness, see Dimensions to Recovery in Workshop 5, page 124

To find out how to plan for ongoing actions for my congregation see Determining Congregational Priorities in Workshop 7, page 151 or Building a Caring Congregation Plan, page 235

To learn how mental illnesses are treated, see Therapies for Treating Mental Disorders in Workshop 5, page 116

## Using the Caring Congregation Curriculum

**Purpose:** Explain how the curriculum can be tailored for a particular congregation. Talk about any barriers that may exist for getting it started effectively.

**Materials:** Copies of the curriculum for each member

**Preparation:** Review the steps in the session plan

**Time: 45 minutes**

**Session Plan:**

Explain that the curriculum can be tailored for each congregation. Ask the class to turn to the introductory material in the front of the curriculum where they will find information about tailoring the program.

Go over suggestions for shortening the program. Explain that the program is flexible, but the sequence of the workshops can be important. If you must do fewer workshops, the following priorities should guide your selections:

- Workshops 1, 6 and 7 provide basic information that cannot be sacrificed.
- Workshops 2, 4, and 5 give more detailed information about mental disorders and how they are treated. These could be tailored to specific needs in your congregation, if necessary, to have fewer than 3 workshops.
- Workshop 3 focuses on the history of mental disorders. An option for covering this information is to present it in a worship service or in an optional discussion program.
- However you design it, schedule at least 2 hours for each workshop to allow for ample discussion time.

### Recommendations

Length of Program	Recommended Workshops
2 Sessions	Tailor the 2 Pastoral Care Workshops for the congregation at large.
3 Sessions	1, 6, 7
4 Sessions	1, 2/4/5*, 6, 7 (* Combine materials from sessions 2, 4 and 5)
5 Sessions	1, 2/4*, 5, 6, 7 (* Combine materials from sessions 2 and 4)
6 Sessions	1, 2, 4, 5, 6, 7
7 Sessions	All
Variable	Have two general sessions (as suggested above) for the entire congregation. Then have sign-up sheets for special interest classes, for example: Children, Elderly, History, Specific Disorders, Medications, and Therapies. Then you could create a plan to offer the other lessons on a special interest basis to people specifically interested in that topic.

Go over suggestions for augmenting or enhancing the program making the following points:

- There may be a situation of a person or family in the congregation who are faced with a mental disorder that is not discussed in this curriculum.
- Maybe a congregation needs to cover a topic in more depth because of a situation that has happened there.

If you wish to incorporate more information about the disorder in your teaching of the curriculum, you can do more research on the disorder using the DSM-IV manual and other books, and create optional lessons or handouts to present to the attendees. The best place to focus on new disorders would be in Workshops 2 or 4. A new lesson on family situations would fit best in Workshop 6.

Experience with this curriculum has shown that some of the most valuable information comes from the stories of real people.

- For each of the mental disorders described in the curriculum, there are selected case studies for your use in showing how the disorder shapes private lives.
- Even better is to invite guest or student speakers to talk about a particular situation that has touched them personally. If you want to do this, make sure you get the permission of the people involved before you ask them to speak. And, make it clear that they will not be asked to share their own experience with mental illness, or that of their family, unless they choose to do so. Allow them to back out without consequences, if they feel unable to share at the last minute.

Point out the material in the curriculum under the heading “Other Program Ideas.” This discusses how the program can be augmented by a film night or film series, outside speakers, or worship services.

Point out the Theological Basis for the Caring Congregation Curriculum. This might be used as a resource for a worship series, or a small group ministry discussion.

Point out the sample order of service for a church service on Mental Health. This is an excellent way to kick off the program at your congregation.

Point out the Glossary.

Point out the Resources section that lists a wide variety of resources on mental disorders, personal stories, the history of mental disorders, resources for mental health clients and families, religion and mental illness, curricula, UU publications and world-wide websites.

Ask the class members if they have particular situations in their congregations that they believe require tailoring. If they do, ask them to describe the situation and have the class brainstorm how they might alter the curriculum for their congregation.

Encourage the facilitators to develop a referral list for hospitals, suicide hot lines, and mental health programs in the community so they can refer someone, or ask the minister to refer someone to these programs.

Break into groups representing teachers from each congregation. Ask them to talk together having a preliminary discussion about:

- how you might tailor the curriculum for your congregation
- any barriers that they see to making the program a success in their community

Give them 10 minutes for this. Of course they will come back to this later. This is just to let any important problems surface now.

Bring the class back together and engage in a discussion about what they found when they were discussing tailoring the program.

# Empathy

**Purpose:** To feel empathy with mental health clients and family members

**Materials:** “Hearing Voices Skit” from Curriculum

**Preparation:** Prepare for leading the “Hearing Voices Skit” from Workshop 2 of the Caring Congregation Curriculum

**Time: 1 hour**

**Session Plan:**

Discuss the importance of having empathy with mental health clients and family members. This can help us to understand why mental disorders are so difficult to deal with. Empathy can help us comprehend such things as:

- why people don't take their prescribed medications
- what the families are going through
- what it feels like to have active psychiatric symptoms
- what it feels like to try and help someone who doesn't want help

Explain that we will start this empathy discussion by using a skit based on an exercise from the NAMI Family-to-Family class.

Lead the class in enacting the “Hearing Voices Skit” from Caring Congregation Curriculum Workshop 2, and the following class discussion as specified in that workshop.

Explain that there is a wealth of understanding in the room because each of us has some significant experience with mental illness. So, we will try and learn from each other here about the experience of mental disorder from our own perspective, to build empathy. Remind them they can ask that any story be kept in confidence. Show the Emotional Reactions chart from Workshop 6 if you think this would be helpful.

Ask mental health clients in the class to share ways in which they feel that they are and are not understood by others, in church, in their everyday lives, in their families, by their therapists. Encourage them to tell stories of when they felt understood, and when they didn't feel understood.

Ask family members to share ways in which they feel that they are and are not understood by others in church, in their everyday lives, in their families, by their loved one. Encourage their stories. You may want to show the *Stages of Emotional Reactions among Family Members* chart from page 136 to allow them to put this in perspective.

Ask the provider members to share ways that they are either encouraged or they are frustrated and misunderstood by those they are trying to help. Encourage stories that they may want to share, while acknowledging that they can't violate confidentiality of their role as a provider.

Ask the class what this exercise was like for them. Do they feel any increased empathy towards the experiences of others? Are there some issues they still need to work on?

## What would you do if...?

**Purpose:** To identify challenging situations that might occur and possible strategies for managing them. To address any burning questions or parking lot questions that haven't been covered yet.

**Materials:** Newsprint

**Preparation:** Create a starting point list of situations to be covered in this lesson on newsprint.

- What if you have a lesson that seems to be falling flat?

[Possible answer: Open it up to the group to come up with ideas of how to connect to the subject.]

- Typically 2-3 people dominate the discussion. They usually have good points.

[Possible answer: Have co-facilitator enforce time limits]

- There are 2-3 people who never speak

[Possible answer: Ask these people to share their thoughts.]

- There are some people in the congregation who object to having sermons, children's lessons, and religious education about mental illness

[Possible answer: Talk to them and listen; they may be in denial. Proceed; you can't please everyone.]

- There is someone who is very hostile towards some kinds of treatments ex: acupuncture

[Possible answer: Listen and reflect without hostility. Validate / respect their beliefs.]

- There is someone who is very hostile towards medical treatment

[Possible answer: Listen and reflect without hostility. Validate / respect their beliefs.]

- There is someone who is very hostile towards people who don't take their medication

[Possible answer: Listen. Find someone to talk about undesirable side-effects of medication; Act out.]

- A person is picking on a child with mental illness

[Possible answer: Get the minister involved. This should not be allowed to continue.]

- A pillar of the church making derogative statements about people with mental disorders

[Possible answer: Say to them, "You are a person of integrity and I am troubled by what you said.]

- People who can't make the bridge from "we-they" into "us." (Internalized stigma.)

[Possible answer: Try role-playing.]

- Anything from the Parking Lot? Hot Potatoes? Family Problems?

**Time: 1 hour**

### Session Plan:

Tell the participants that in leading the workshops challenging situations may come up. In addition, they may have some burning questions about leading the curricula, or parking lot questions that haven't been addressed so far.

Create a list of these questions, by asking the class to add to the list of situations with any burning questions that they may have.

Emphasize that we will be addressing how to handle these situations using the class Guidelines.

Decide how to proceed. Possible options:

- Choose one or two situations and have volunteers act them out in front of the class.
- Break the class into groups and give each group one or two questions to brainstorm possible strategies for responding them. Let the groups work for 20 minutes, then bring the group back together and have each group present the situation and their solutions.
- Have the class discuss these responses.

Note: This lesson closely follows a lesson in the *Training Manual for Our Whole Lives Sexuality Education*.



## Moving from Workshops to Congregational Action

**Purpose:** Show how a congregation can take what they have learned in the Caring Congregation Curriculum and begin to take congregational action.

**Materials:**

Copies of the curriculum for each person.

Sticky dots to use for prioritizing congregational actions.

**Preparation:**

- Review the items on the “Possible Responses by a Faith Community” chart. If you don’t think there are enough items to make a meaningful exercise, add more items to the list yourself using items listed in the Appendix Planning: Building a Caring Congregation.
- Prepare newsprint sheets with the headings: Education, Covenant, Welcome, Support, and Advocacy, to be used in the categorizing exercise.

**Time: 1 hour**

**Session Plan:**

1. Refer to the sheet “Possible Responses by a Faith Community.” This should have a number of possible congregational actions listed on it. Ask the class members if they want to add anything else to this list.
2. Tell the class that they can use this sheet to help understand and prioritize the work that they already are doing or will do.

Ask class members to help with categorization using categories suggested by Susan Gregg-Schroeder. Have a volunteer come up and lead this exercise, calling on class members for input. It is OK for people to add new items to the list, if they think of something else that isn’t listed.

- Education – activities that educate a congregation about mental disorders. This program is one example.
  - Covenant – an agreement with the congregation that it wants to become known as a Caring Community for those with mental disorders
  - Welcome – ways to reach out to the outer community, and to welcome those who come to our doors with mental health issues.
  - Support – activities that provide direct support to those with mental disorders and their families.
  - Advocacy – engage in activities that advocate for the interests of those with mental disorders
- Give each person 5 sticky dots and ask them to place the dots next to the items that they prioritize the highest. They can put more than one dot on an item.
  - Give them a few minutes to vote, and then review that they have chosen. Ask the class what they think of the priorities that have emerged.
3. Point out the Appendix Planning: Building a Caring Congregation Plan and go over the points made on these pages, particularly Gunnar Christiansen’s Steps to a Mental Health Ministry.
  4. Point out the Appendix: A Power Study and explain that this gives an example of an analysis of who has the power to make decisions that affect mentally ill people. This is one possible activity that a congregation can undertake to understand the situation in their community.
  5. Encourage the class to help identify someone in their congregation to spear-head the

implementation of the work items developed by the classes they teach.

6. Ask the class if there are particular situations that they think would affect such mental health planning activity in their congregations. If there are problems identified, have the group brainstorm their possible solution.

## Peer Teaching Assignments

**Purpose:** To enable participants to practice conducting the actual curriculum activities.

**Materials:**

- Trainer resource “Leading the Peer Teaching Assignments”
- Handout “Peer Teaching Assignment Sheet”

**Preparation:**

- In advance, pre-select team members for each of the peer teaching sessions. Co-teachers from a congregation should work together. If there are more than four teams, decide who should work together.
- Select the activities that you will use for the assignments for each group.
- Have materials available for the lessons that will be taught.

**Time: 15 minutes to start groups**

**Session Plan:**

Tell the group that we will now start getting the experience of teaching an actual lesson. Explain that you have divided them into groups for this activity. Each group will get a chance to teach a 30-minute workshop lesson, which will be followed by a 15-minute peer evaluation from the people being taught.

They can decide on one of two possible methods for conducting the workshop:

The team plans the activity, prepares materials and one or two co-facilitators make the presentation.

The team plans the activity, and all members of the team participate in the presentation.

Read the names of the people in the different groups. Ask them to sit together and give each group their assignment sheets.

As groups begin, move from group to group making sure they have the supplies they need for their presentation, and responding to their questions.

## Handout: Peer Teaching Assignment Sheet

As part of the training experience, we are asking you to work with several other colleagues to conduct a portion of one of the workshops from the Caring Congregation Curriculum. The members of your team are:

---

---

---

Your peer teaching assignment is Workshop \_\_\_\_\_:

---

- Plan the activity with all the others in your group and decide who will be making the presentation to your peer group.
- Conduct the workshop lesson just as you would be expecting to conduct it during an actual class. Plan to take half an hour for the presentation.
- Once you have completed the teaching assignment, we'll take 15 minutes to discuss how things went. First the members of your team will give feedback; the members of the large group will offer constructive feedback.
- You will conduct this workshop at \_\_\_\_\_ on \_\_\_\_\_.

Relax, work and have fun!

Note: This lesson closely follows a lesson in the *Training Manual for Our Whole Lives Sexuality Education*.

## Leading the Peer Teaching Assignments

The goal of peer teaching is to give participants actual experience using the curriculum and to increase their confidence and skills when conducting workshops on their own. You want them to have a successful experience. Spend time with each group making sure that they have a full understanding of the activity and that they are not planning anything that will derail the activity. Give them some time to digest the activity and begin their planning before sitting down with them. Also, avoid taking over their planning. Walk a fine line.

You must bring all the materials needed for the activity. So make your choices prior to the training and make sure that you have a thorough understanding of each of the activities you've chosen. If for some reason you haven't conducted these workshops yourself, try to get some experience with them prior to the workshop.

### **Possible Peer Teaching Assignments:**

Workshop 2 – Specific Mental Disorders and how they are diagnosed

- Substance Abuse
- Mood Disorders
- Anxiety Disorders

Workshop 3 – History of Mental Disorders

- Time periods in mental health history and Identifying Mental History Quotes (abbreviated version of quotes)

Workshop 4 – Mental Disorders in Special Populations

- Childhood Disorders
- Disorders of the Elderly

Workshop 5 – Mental Health Treatment

- Therapies for Treating Mental health disorders
- The Consumer Movement

Workshop 6 – Families and Friends of those with Mental Disorders

- Communication with people with mental disorders

Workshop 7 – The Role of the Church

- Religion / Spirituality and Mental Disorders

Note: This lesson closely follows a lesson in the *Training Manual for Our Whole Lives Sexuality Education*.

## Wrap Up and Closing Ritual

**Purpose:** End the workshop with a religious ritual signifying the holy work that was done here, and that will be done when we teach the workshops to our congregation

**Materials:**

A chalice, candle and matches

**Preparation:**

Choose chalice lighting words

**Time: 30 minutes**

**Session Plan:**

1. Ask the class if there is anything that we haven't covered that we need to cover. Use anything that may still be in the Parking Lot.
2. Engage in a closing ritual

*Opening*

Light a chalice using chalice lighting words of the leader's choice.

Reading

*Every human being  
Has a great, yet unknown gift:*

*To care,  
To be compassionate,  
To become present to the other,  
To listen,  
To hear,  
And to receive.*

*If that gift would be set free and made available,  
Miracles could take place.*

-- Henri J.M. Nouwen (1932-1996)  
Dutch priest and author

*Reflection*

Ask the class members to speak as they are moved about how they feel about participating in this curriculum. Try and get everyone to speak.

*Benediction*

*Never doubt that a small group  
Of thoughtful, committed citizens  
Can change the world.  
Indeed, it's the only thing that ever has.*

-- Margaret Mead (1901-1978)  
US Anthropologist, Author

# **Training Service and Forms**

Sample Worship Service on Mental Health  
Leadership Training Evaluation Before Teaching  
Leadership Training Evaluation After Teaching  
Caring Congregation Evaluation After Teaching

## Sample Worship Service on Mental Health

**Note:** This service is designed as a kick-off to offering the Caring Congregation Curriculum

*"I have myself an inner weight of woe that God himself can scarcely bear."*  
from "Elegy" by Theodore Roethke

**Call to Worship** # 429 *Come into this place of peace* by William F. Schulz

**Chalice Lighting**

**Opening Hymn** #18 *What Wondrous Love*

**A Time for Children of all Ages:** *Alexander and the Terrible, Horrible, No Good, Very Bad Day*  
by Judith Viorst

**The Children depart**

**Readings:**

I Samuel 16, verses 14 to 23

"The Journey" by Mary Oliver

#666 "The Legacy of Caring" by Thandeka, read responsively

**Prayer and silence** Prayer by Paul Fleischman

**Joys and Concerns**

**Hymn** #127 *Can I See Another's Woe?*

**Sermon** *Living with Mental Illness*

**Witness** Stand as you are comfortable if you or someone you love is living with mental illness.

**Offertory**

**The Caring Congregation at our Church**

**Closing Hymn** #151 *I Wish I knew how it would Feel to be Free*

**Benediction** #698 *Take Courage Friends* by Wayne Arnason



## A Time for Children of all Ages:

*Alexander and the Terrible, Horrible, No Good, Very Bad Day* by Judith Viorst

After you read the story, you can engage the children in a dialog on how to be with people who are having very bad days, or what they can do if they are having a very bad day.

### Readings

#### 1 Samuel 16:14-23

This reading shows an occurrence of mental torment in Saul, the first Israelite king, to illustrate that mental illness has been around for all of recorded civilization.

<sup>14</sup> Now the spirit of the LORD departed from Saul, and an evil spirit from the LORD tormented him. <sup>15</sup> And Saul's servants said to him, "See now, an evil spirit from God is tormenting you. <sup>16</sup> Let our lord now command the servants who attend you to look for someone who is skillful in playing the lyre; and when the evil spirit from God is upon you, he will play it, and you will feel better." <sup>17</sup> So Saul said to his servants, "Provide for me someone who can play well, and bring him to me." <sup>18</sup> One of the young men answered, "I have seen a son of Jesse the Bethlehemite who is skillful in playing, a man of valor, a warrior, prudent in speech, and a man of good presence; and the LORD is with him." <sup>19</sup> So Saul sent messengers to Jesse, and said, "Send me your son David who is with the sheep." <sup>20</sup> Jesse took a donkey loaded with bread, a skin of wine, and a kid, and sent them by his son David to Saul. <sup>21</sup> And David came to Saul, and entered his service. Saul loved him greatly, and he became his armor-bearer. <sup>22</sup> Saul sent to Jesse, saying, "Let David remain in my service, for he has found favor in my sight." <sup>23</sup> And whenever the evil spirit from God came upon Saul, David took the lyre and played it with his hand, and Saul would be relieved and feel better, and the evil spirit would depart from him.

#### The Journey by Mary Oliver

One day you finally knew what you had to do, and began,  
Though the voices around you kept shouting their bad advice —  
Though the whole house began to tremble  
And you felt the old tug at your ankles.  
“Mend my life!” each voice cried.

But you didn't stop.  
You knew what you had to do,  
Though the wind pried with its stiff fingers at the very foundations —  
Though their melancholy was terrible.

It was already late enough, and a wild night,  
And the road full of fallen branches and stones.  
But little by little, as you left their voices behind,  
The stars began to burn through the sheets of clouds,  
And there was a new voice, which you slowly recognized as your own,  
That kept you company as you strode deeper and deeper into the world,  
Determined to do the only thing you could do —  
Determined to save the only life you could save.

## Prayer

“At the conclusion of life, I would hope to say:  
I was seen and known, heart and soul, and in the same way knew those who circled me;  
I bowed to the one who opens in a dawn, and I lived in harmony with the order, the principles, and the laws of the day;  
I knew myself, saw myself, and held in one embrace human faults, limits and successes;  
I did my job, working in the common cause;  
And I stirred up dust with my feet, tramping along in the undivided march of human history;  
I laid down my burden and surrendered myself to the voice of the river, and I became a vessel, and out of me poured the fountain of life;  
And when I looked up I saw one hand spinning the divine wheel of the world;  
And I looked down, and knelt, lending my hand; and I continued on my way, shouldering my own pain as I followed the signs;  
And now that I feel the chill of death upon me, I can sing of how I was sent forth, and who calls me home.”

May we hope for this vision for ourselves, our loved ones and fellow travelers on this Earth.  
Amen.

by Paul Fleischman in *The Healing Spirit – Explorations in Religion and Psychotherapy*, Cleveland: Bonne Chance Press, 1994.<sup>72</sup>

## Outline of a Sermon on Living with Mental Illness

1. Introduction
  - Why talk about mental health in church?
    - Because mental illness robs you of your spirit and a religious community can help you reconnect.
    - Recent research shows a positive correlation between religiosity and good mental health.
  - If this is a kick-off to the Caring Congregation workshops, explain this.
2. Dorothea Dix’s story (from Workshop 3)
3. Sharing a personal story of mental illness
  - This is very important and powerful because it connects people emotionally to you and your goals. A guest from NAMI or elsewhere can be invited if necessary.
4. The Caring Congregation
  - Explain what the Caring Congregation Curriculum is. Later you will talk about how it will be implemented in your church

## The Caring Congregation at our Church

Describe how the curriculum will be implemented in your congregation, with details about what days and times, how people can sign up, and where they can get more information. If this service is not to be the kick-off of the curriculum, omit this part of the service.

## Witness

This is a *very* important element of the service, one where the people connect openly with the problem of mental health and how it has impacted the lives of so many people.

- Ask people to stand if they or a loved one is living with mental illness. Typically, 75%-100% of the congregation will stand. Most of them will be surprised that so many stood up.
- After they stand, acknowledge their courage with this verse from John 8:32: “You will know the truth, and the truth will make you free.”

## Leadership Training Evaluation before Teaching

1. Please give us feedback on the Training for the Caring Congregation Curriculum.  
What is your overall evaluation of this training experience?

\_\_\_\_\_ Excellent  
\_\_\_\_\_ Good  
\_\_\_\_\_ Average  
\_\_\_\_\_ Poor  
\_\_\_\_\_ Very Poor

2. What parts of this training experience did you find most helpful?

3. What parts of this training experience did you find least helpful?

4. How can we make this training better? (Give as many ideas as you have.)

5. How ready do you feel to conduct the Caring Congregation Curriculum workshops?

1                      2                      3                      4                      5  
\_\_\_\_\_

Not at all ready                      ←————→                      Completely ready

Note: This evaluation closely follows a lesson in the *Training Manual for Our Whole Lives Sexuality Education*.

## Leadership Training Evaluation after Teaching

Please give us feedback on the training for teaching the Caring Congregation Curriculum, attaching other sheets if necessary to fully answer the questions.

1. Now that you have taught the Caring Congregation, what is your overall evaluation of the training workshops?

\_\_\_\_\_ Excellent  
\_\_\_\_\_ Good  
\_\_\_\_\_ Average  
\_\_\_\_\_ Poor  
\_\_\_\_\_ Very Poor

2. What parts of the training experience did you find most helpful?

3. What parts of the training experience did you find least helpful?

4. What did you wish you had learned in the training that you didn't learn? How can we make this training better?

5. Did you have any particular successes or failures during your teaching experience that might call for changes in the selection of trainers, the training or the curriculum?

## Caring Congregation Evaluation after Teaching

Please give us feedback on the Caring Congregation Curriculum, attaching other sheets if necessary to fully answer the questions.

1. Now that you have taught the Caring Congregation, what is your overall evaluation of the Curriculum Workshops?

Excellent  
 Good  
 Average  
 Poor  
 Very Poor

2. How did you adapt the curriculum to fit the needs of your congregation? How easy was this to do?

3. What plans for follow-on activities did your congregation make? Who has the responsibility to carry them out?

4. What parts of the workshops were the easiest to teach?

5. What parts of the curriculum did you find most difficult to teach? Why?

6. How can we improve the curriculum for the teacher?

7. How can we make this curriculum more helpful to the attendees?

# Theological Basis for The Caring Congregation

The theological underpinnings of the Caring Congregation are important. They help us to articulate why we are engaged in this enterprise as religious people. And it helps us understand what this engagement implies across a broad range of actions that we might choose to undertake. This summary talks about the Unitarian Universalist Principles that relate to the Caring Congregation, and proceeds to discuss this program using the terminology of Systematic Theology.

## Unitarian Universalist Values

Deepens understanding of and commitment to UU Principles, in particular:

- The inherent worth and dignity of every person;
- Justice, equity, and compassion in human relations;
- Acceptance of one another and encouragement to spiritual growth in our congregations; and
- A free and responsible search for truth and meaning.

## Systematic Theology

This theological categorization is based on an introduction to systematic theology given by Rebecca Parker in a series of lectures on a *Theology of Religious Education*.

**Theology** – What is the relationship between human and the ultimate?

- William Ellery Channing's *Faculties of the Soul*: each human soul has the capacity of reason, emotion, imagination, the ability to create, senses, the ability to respond to beauty, the ability to feel the presence of the holy. This is true for people with mental disorders, even though some of these faculties can be clouded by the disorder. This does not make them less of a human soul.
- Each human being is valuable in his or her own right, just by being human.
- Using this curriculum helps us to call forth these faculties through educating people with mental disorders and their families about their condition and how to live with it. And by educating congregations to recognize and give support in this process. This is a sacred task.

**Soteriology** – What do we need to be sheltered against, and how are we sheltered?

- Oppression of people with mental disorders is wide-spread in our society. It is present in collective social and health-care systems, in individuals who make up the general public, in families of those with mental disorders, and, perhaps most perniciously, internalized by those with mental disorders themselves. This pervasive stigma with regard to mental illness keeps people from seeking help and from accepting themselves as precious human beings.
- Reject the idea of inherent good or evil persons. Each person is capable of both good and evil, and need to have systems created to encourage and enable them to choose life-affirming, rather than oppressive actions.
- This program helps to counter this oppression with education and a message of inclusiveness and hope.

**Pneumatology** – What is the spirit that animates all things and connects us together?

- The spirit is within each of us, within us collectively, and is continually present. Do not accept the idea of predestination, spirit as wholly other, or spirit as all-powerful.
- Mental disorders don't come as a predestined curse that must be suffered, rather there are actions that humans can do to help themselves and support others to limit the effects of these disorders. It is possible to build communities that help in dealing with the disorder.
- Some people come to find a mental disorder as a gift of grace that can, in time, strengthen, purify and

make their lives more holy.

***Eschatology*** – Where is human-kind heading?

- We are moving forward towards the possibility of the kingdom of God on Earth – a “beloved community” that accepts all people as having the ability and right to dignity and self-determination.
- This curriculum helps to create a corner of that kingdom that has been widely neglected. Parts of the beloved community are available to us now and the program helps us to make this happen.

***Ecclesiology*** – What holds us together as a church community?

- The members of a church freely decide to join and participate in the programs of the church. They covenant to support and uphold the members in good times and in times of trouble.
- This program extends the support of that covenant to those with mental disorders.

***Missiology*** – What is our relationship to other churches?

- Since UUs make up only a small percentage of the populace, in order to have a real and significant difference in society, it is hoped that this program can be shared not only with other UU churches, but with churches of other denominations, so that it can be tailored for their values and used to counter oppression of those with mental disorders.

# Appendixes

- Planning: Building a Caring Congregation Plan
- A Power Study: Who has the Power to Make Decisions that Affect Mentally Ill People in Alameda County, California?



# Planning: Building a Caring Congregation Plan

## I. Gunnar Christiansen's Steps to a Mental Health Ministry

Dr. Gunnar Christiansen identifies the following steps (to be followed in order) in building a ministry that serves those with mental illness. You may want to consider these and adapt it for your congregation.

1. Gain approval from the senior clergy person and lay leadership
2. Establish a task force at your congregation
3. Education. Learn how you can respond to the need effectively. Get your pastoral care team involved. Taking this class counts as education.
4. Provide a support group for family members and a group for mental health clients.
5. Provide the full range ministry to those who have a mental disorder as you do to others, including pastoral care
6. Establish guidelines for appropriate behavior in church. Examples of such guidelines for adults can be found at: [www.uua.org/interconnections/leadership/vol1-2-leadership.html](http://www.uua.org/interconnections/leadership/vol1-2-leadership.html)
  - Guidelines for all adults (not just those with mental disorders)
  - Guidelines for children, for example, how to handle hyperactive children
7. Outreach to those with mental disorders in the community surrounding a congregation. Examples are providing low-cost housing and/or a drop-in center.
8. Provide a model as an employer by offering jobs to those with mental disorders
9. Advocacy on behalf of those with mental disorders to local, state and national government. See the topic below for some specific suggestions for doing this.

## II. Get connected with mental health organizations. Consider joining and working with:

- NAMI national and local chapters: [www.nami.org](http://www.nami.org)
- Faith Net ([www.faithnetnami.org](http://www.faithnetnami.org)): A group of NAMI members supports the development within the Faith Community of a non-threatening, supportive environment for those with serious mental illness and their families.
- Pathways to Promise ([www.pathways2promise.org](http://www.pathways2promise.org)) is an 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.
- Mental health client groups: [www.mentalhealthconsumer.net/index-links.html](http://www.mentalhealthconsumer.net/index-links.html) , [www.mhselfhelp.org](http://www.mhselfhelp.org)
- Identify any locally based groups and consider affiliating

## III. Offer church services on mental health topics

## IV. Work with pastoral care team to provide care to mentally ill people and their families

- Provide training for pastoral care team on mental health issues using the two pastoral care workshops in this curriculum.

## V. Advocacy

Advocacy for those with Mental Disorders involves research into your community situation and identifying the issues where you can make the most impact. The following are some suggested activities and possible forms that advocacy might take.

- Do a mental health power study for your local community

A *power study* is a study of one's local community that determines who has the power to make decisions affecting the mental health of the residents of that community. An example of such a power study is *Mental Health Power Study: Who has the Power to make Decisions that affect*

*Mentally Ill People in Alameda County, California*, which is given after this workshop.

- From the information collected in doing the power study, identify those issues that you feel are most critical to affect those in your community, and form a plan to tackle them.
- Advocacy work might involve a wide-ranging set of activities, including:
  - Get involved politically in state and local issues affecting those with mental disorders, particularly where your representatives are not serving justice. Keep track of important legislation and make your voice heard when necessary. Use the NAMI legislative network to get action alerts, and alert your congregation to take action when necessary.
  - Sponsor educational events to provide information about mental illness. Provide opportunities for people to speak openly about their mental illness.
  - Volunteer in a mental health related agency or group
  - Sponsor a group home for those with mental disorders.
  - Sponsor a support group for those with mental disorders.
  - Sponsor a drop-in center for those with mental disorders.
  - Form an anti-stigma team. Write letters to the editor, write letters to politicians, alert NAMI
  - Offer employment opportunities for those with mental disorders
  - Work on some of the underlying problems causing racial and ethnic mental disorders
    - Promote positive ethnic and community identity
    - Promote local leadership and determinations
    - Promote strong families
    - Work on social problems such as racism, poverty and violence

# **A Power Study: Who has the Power to Make Decisions that Affect Mentally Ill People in Alameda County, California? <sup>a</sup>**

by Barbara F. Meyers

December 11, 2000

## **Who are the People with Mental Illness in Alameda County?**

A publication, *Mental Illness Is Everybody's Business*, by NAMI gives a brief description of mental illness, its causes and treatment: "Mental illness is a term used for a group of disorders causing severe disturbances in thinking, feeling, and relating. They result in substantially diminished capacity for coping with the ordinary demands of life. Mental illnesses can affect persons of any age – children, adolescents, adults, and the elderly – and they can occur in any family. Several million people in this country suffer from a serious, long-term mental illness. The cost to society is high due to lost productivity and treatment expense. Patients with mental illness occupy more hospital beds than do persons with any other illness.

The most serious and disabling mental illness is schizophrenia. It affects about one person in a hundred. Common symptoms of schizophrenia are disconnected and confusing reasoning and judgment, hallucinations and delusions. Depressive illnesses are the most common psychiatric disorders, affecting about 6 percent of the population. It is a major cause of suicide. Other disabling mental illnesses include severe anxiety and panic disorders, personality disorders and obsessive compulsive disorder.

The causes of biologically based brain diseases are not well understood, although it is believed that the functioning of the brain's neurotransmitters is involved. Many factors may contribute to this disturbed functioning. Heredity can be a factor. Stress may contribute to the onset of mental illness in a vulnerable person.

Medications, which are expanding in number and effectiveness, can markedly reduce symptoms for many people. Supportive counseling, self-help support groups and community rehabilitation programs promote recovery and build self-confidence. Housing and employment services enable some people to develop independent living skills, hold a job, and achieve a fulfilling life."

For the purposes of determining who will serve those with mental illness, Alameda County Behavioral Health Services defines the following categories, based on ability to pay for treatment.

- The rich: people who can pay for their own treatment by themselves or with insurance. These people typically are not served by the public mental health system unless they call a public access line for advice.
- The poor: people who can't afford to either pay by themselves, or to pay for insurance. These people will be charged for public mental health clinic services on a sliding fee scale.
- The very poor: qualify for Medi-Cal, State of California medical insurance
- The indigent: refugees, illegal aliens, don't qualify for Medi-Cal

### *Numbers of mentally ill people served by County:*

- Tens of thousands of mentally ill people are served by Alameda County services each year.
- About 250-300 people a month are involuntarily committed to mental hospitals in Alameda County.
- A study done by I.D.E.A. Consulting for Alameda County of mental health patients served by Medi-Cal system tells us some statistics about these patients:
  - In FY 1997-98 there were 10,778 clients (mental health patients) served by Medi-Cal in Alameda County. Of these, 71% were adults, 26% were youth (under 18 years of age), and 3% were over 65 years of age.
  - Of these clients, 7% required crisis intervention services 18% of the clients required inpatient services, 19% required day treatment, and 90% required outpatient services.
  - Over the past 5 years, the length of stay in a mental hospital has dropped: in FY 1993/94, 71% of clients had inpatient stays of 17 days or less, while in FY 1997/98, 89% of clients had stays of 17 days or less.
  - Also, over the last 5 years, the rate of return to inpatient services after 6 months rose from 33% to 52%. One might speculate that these two statistics are related.
  - In terms of ethnicity, African Americans and Caucasians represent by far the highest numbers of clients, with Hispanic and Asians relatively infrequent.

## **Those Having Power to Make Decisions affecting those with Mental Illness**

### ***Alameda County Officials and Staff***

In California, the counties are the governmental entity that ultimately receives the lion's share of the public money intended to address mental health problems; the federal government provides funding to the states, and the state of California provides the bulk

---

<sup>a</sup> It is acknowledged that this power study is dated. It is given here as an example of what one might want to include in a power study for their own community.

of that funding to the counties. Behavioral Health Care Services (BHCS), online at [www.co.alameda.ca.us/health/behavior](http://www.co.alameda.ca.us/health/behavior), a division of the Alameda County Health Care Services Agency, manages Alameda County's mental health care system. An organization chart for BHCS is given on the next page. The key administrators with decision-making authority are Marye L. Thomas MD, Director of BHCS and Barbara Majak RN, MPH, Deputy Director, and Stan Taubman, DSW, Director of Office of Management Services. The organizational chart for this agency is on the next page.

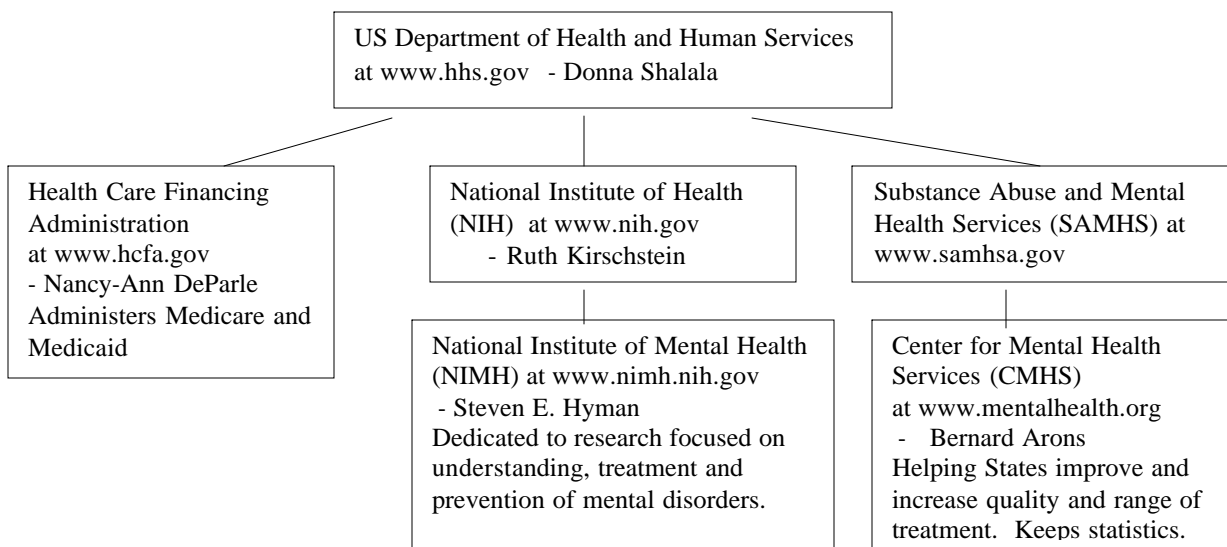
The stated mission of BHCS for mental health services is: "To provide a comprehensive network of integrated programs and services for all people with serious psychiatric disabilities, regardless of age, ethnicity, language or geographic location, in order to minimize hospitalization, stabilize and manage psychiatric symptoms, and help them achieve the highest possible level of successful functioning in their community of choice; and to provide mental health crisis and recovery services for the general population following major disasters." The legally mandated services that BHCS must provide: psychiatric crisis or emergency care, inpatient care, outpatient/day care, case management, conservatorship, administration and evaluation. It does by funding psychiatric hospitals, support centers, a phone referral access line in seven languages, and by contracting with many social service providers throughout the county. The network of services it offers currently consists of over 400 individual practitioners, more than 90 community-based agencies, 20 hospitals and other institutions. The budget of BHCS was \$322,540,000 in 1998-99.

BHCS has a sophisticated system of care that utilizes data and information for managing client needs, quality of care and costs. A major factor in Alameda County's ability to effectively implement changes is in the stability of their management team; the administrative team has the same individuals working together successfully for over thirteen years. The county's relationship with providers is strong. The agency's stated value is to maintain clients whenever possible in the community and to work as partners in treatment and planning involving the client network to coordinate care for clients. For the seriously mentally ill, the agency's emphasis is on early intervention and prevention.

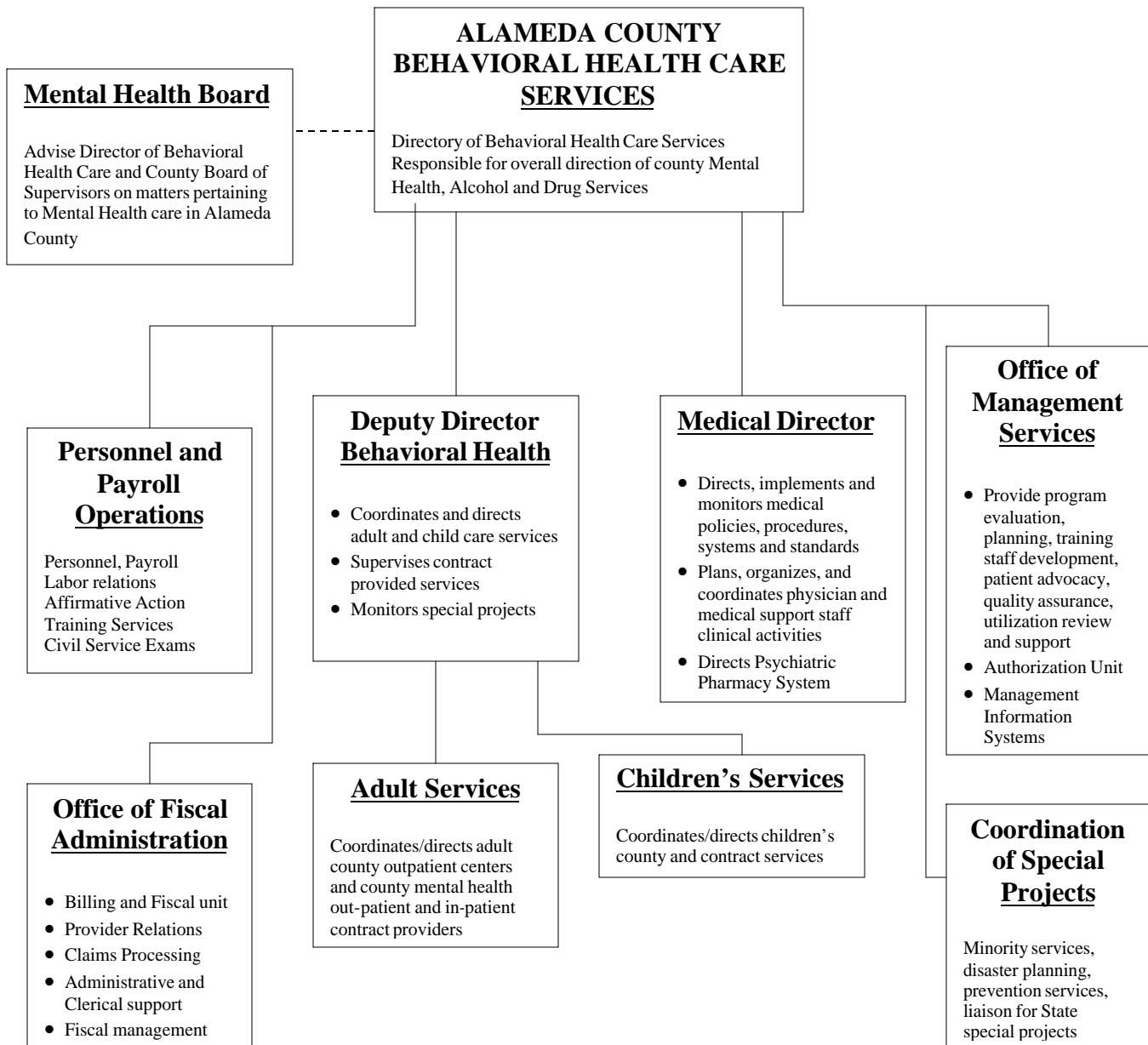
A California state ordinance mandates that Alameda County have a Mental Health Board appointed by the County Board of Supervisors. In Alameda County, each of the five supervisors appoints 3 members to the Mental Health board. Its purpose is to ensure that the County's BHCS provide quality care, and that it treats members of the community with dignity courtesy and respect. They accomplish this through advocacy, education, review and evaluation of Alameda County's mental health needs. The chair of the Alameda County Mental Health Board is J. Dennis Wolfe, the vice chair is Patti Hart, and the liaison from the BHCS is Thomas Walker.

**Federal Officials**

**Key Executive Branch Figures:**



# Organization Chart for Alameda County Behavioral Health Care Services



The bulk of the executive branch's responsibility for issues relating to mental health is not surprisingly in the Department of Health and Human Services (HHS) currently led by Donna Shalala. This is done by three agencies reporting to the Secretary of HHS. The US Department of Labor, currently led by Alexis Herman, handles issues related to employment and compensation of those with mental illness.

### **Key Congressional Figures:**

The Committees in Congress that initially handle legislation that affects those with mental illness are those that address Health, Finance/Appropriations, and Crime. The Senate and House committees are the following:

#### **Senate:**

Senate Committee on Health, Education, Labor and Pensions

Chair: James Jeffords (R-VT), Edward Kennedy (D-MA) ranking minority member

Senate Finance Committee:

Chair: William Roth (R-DE)

#### **House of Representatives:**

House Commerce Subcommittee on Health and the Environment

Chair: Michael Bilirakis (R-FL)

House Judiciary Subcommittee on Crime

Chair: Mitch McCollum (R-FL)

House Appropriations Subcommittee on Labor, Health and Human Services and Education

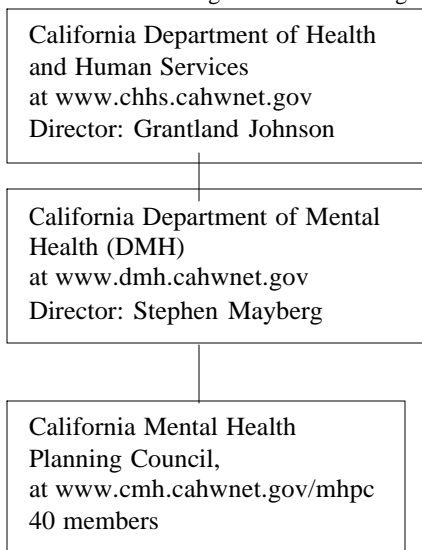
Chair: John Porter (R-IL)

### **California State Officials**

#### **California Executive Branch**

The California Department of Mental Health, directed by Stephen Mayberg, handles issues related to mental health for the executive branch. It is under the California Department of Health and Human Services.

Federal and state laws mandate that there be a council that advocates for people with serious mental illnesses and gives oversight of public mental health system. In California, this is the California Mental Health Planning Council, which has 40 members including family, clients, providers, and state employees balanced by geography, gender and ethnicity. The Director of the Department of Mental Health, Stephen Mayberg, appoints them for 3-year terms. They hold public meetings, have a number of committees and often present to other California State mental health organization's meetings.



The California Mental Health Director's Association consists of the directors of mental health services of each of the counties in California. For Alameda County, it is Marye Thomas.

#### **California Legislative Branch**

The following committees of the California legislature originate legislation having to do with mental health:

- **California Assembly:** The Select Committee on Mental Health, chaired by Helen Thomson
- **California Senate:** The Mental Health and Neurodevelopmental Disorders Subcommittee chaired by Martha Escutia. It is a subcommittee of the Health and Human Services Committee.
- **Joint Committee:** The Assembly and Senate have a Joint Committee on Mental Health Reform, co-chaired by Helen Thomson and Wesley Chesbro.

A key lobbyist for mental health issues in California is Rusty Selix of Sacramento. He lobbies on behalf of the California Coalition for Mental Health, the California Council of Mental Health Agencies, and the Mental Health Association of California.

## **1. Hospitals.**

### **Acute Psychiatric Hospitals**

These hospitals have a 24-hour a day inpatient facility, usually locked. Staff provides immediate therapeutic response to clients exhibiting acute symptoms of mental illness and related substance induced disorders particularly focusing on those who are a danger to themselves or others, or are gravely disabled. The goal is to stabilize and help the clients re-establish themselves in the community as quickly as possible. There are 4 such hospitals in Alameda County: Alta Bates/Herrick Medical Center, Eden Hospital, Fremont Hospital and John George Psychiatric Pavilion

### **Sub-Acute Hospitals**

Sub-acute facilities are 24-hour locked facilities providing intensive diagnostic evaluation and treatment services for severely impaired residents suffering from a psychiatric illness. Clients are referred from acute care facilities. There are 4 sub-acute care facilities in Alameda County: Gladman Mental Health Rehabilitation Center, Morton Bakar Center, S.T.A.R.S., and Villa Fairmont Hospital.

## **2. Other Social Service Agencies**

The *Alameda County Behavioral Health Care Services Resource Directory* has the following categories of services for those with mental illness. Each category has a number of different Alameda County agencies listed as providing services.

- Adjunct services – Services not directly related to treatment or prevention, but assist the client in maintaining the status achieved during treatment.
- Day Treatment – A structured therapeutic milieu to a group of clients who are at risk of psychiatric hospitalization.
- Medication support – Includes prescribing, administering, dispensing and monitoring of medications necessary for maintenance of an individual with symptoms of mental impairment.
- Self-Help/Peer Support – Staffed with persons whose qualifications are based primarily on personal experience. Sharing of experiences and support of peers are the key elements of these programs.
- Transitional Living – Serve clients transitioning from an institutional setting such as an acute or sub-acute hospital. Clients develop skills to live independently

## **3. Private psychiatrists, therapists**

There are literally hundreds of individual practitioners who provide psychotherapy, counseling and medication services for those with mental illness in Alameda County. The Behavioral Health Care Services has a network of 400 practitioners that it refers clients to. The availability of a particular practitioner to a client may depend on the mental health insurance coverage that the client has.

## **4. Independent non-profit mental health groups**

NAMI on-line at [www.nami.org](http://www.nami.org): With more than 200,000 members, NAMI is the nation's leading grassroots advocacy organization solely dedicated to improving the lives of persons with severe mental illnesses. NAMI's efforts focus on support to persons with serious brain disorders and to their families; advocacy for nondiscriminatory and equitable federal, state, and private-sector policies; research into the causes, symptoms and treatments for brain disorders; and education to eliminate the pervasive stigma surrounding severe mental illness. NAMI has more than 1,200 state and local affiliates in the United States and Canada. Parents of severely mentally ill children founded NAMI, and its focus tends to be support to families, although it has many client members. One of NAMI's services is an e-news service that sends e-mail to members when something of importance to NAMI occurs or needs attention. The following are issues featured in recent NAMI e-news:

**Mental Health Issues:** Mostly covered from the national point of view, but states who act on the issues are sometimes included as well.

- Mental health parity: Insurance, Medicare should cover mental illnesses at the same levels as physical illnesses.
- Vocational rehabilitation and employment of those with mental illness
- Restraint protections: Residents would be free from any restraints and involuntary seclusions imposed for purposes of discipline and convenience.
- Work incentives: make it easier for adults with severe disabilities to go to work without losing health care benefits under Medicare and Medicaid
- Doing away with criminalization of those with mental illness. Establishment of mental health courts.
- Treatment programs for people with co-occurring mental and addictive disorders
- Support for biomedical and other research on mental illness

**Mental Health Action Alerts:** Alerts include information on the issue, NAMI's position, who to write, call, fax, and email to make your opinion known.

- Federal and some State legislation affecting mentally ill

- Protest mental illness stigma in ABC's "Wonderland" new TV series. Result: ABC withdraws support for show after less than 3 weeks.
- Prescription drug benefit legislation: many mental health drugs are new and very expensive
- Candidate Questionnaire 2000: positions of candidates on issues of importance to those with mental illness.
- Prevent execution of mentally ill prisoners: Larry Robison in Texas and Alexander Williams in Georgia
- Shelter Plus Care program: Housing for formerly homeless individuals

#### **Mental Health Information Availability:**

- Where to find information about mental illnesses
- Television shows focusing on mental illness - the good and the bad
- Access to members of Congress and other government officials
- Results of White House conference on Mental Health
- Funding of mental health research and services

Family Alliance for the Mentally Ill is an organization of relatives of persons who have serious mental illness. The Family Alliance provides information, education, and mutual support to families in Alameda County. It operates 4 different support groups that meet regularly.

Other Family Support Groups: There are a number of groups that meet at Alameda County psychiatric hospitals for the families of patients or former patients. Some of them specialize on the needs of particular ethnic or age groups.

The California Coalition for Mental Health at [www.mhac.org](http://www.mhac.org) is made up of 32 organizations with a membership of 115,000 mental health professional health professionals, citizen advocates, clients and family members across the state. It is an advocacy alliance with the goal of attaining state of the art treatment and rehabilitation of people who have mental illness.

The following are other private, non-profit agencies serving those with mental illness in California:

- California Association of Social Rehabilitation Agencies (CASRA) online at [www.casra.org](http://www.casra.org): A statewide association of private, non-profit agencies providing rehabilitation and support services for clients of the public mental health system who have serious and/or persistent mental illness. Betty Dahlquist, Executive Director.
- California Institute for Mental Health (CIMH) online at [www.cimh.org](http://www.cimh.org): Promotes quality mental health services through training, technical assistance, research and policy development.
- National Mental Health Association (NMHA) online at [www.nmha.org](http://www.nmha.org): Promotes mental health, preventing mental disorders, and achieving victory over mental illnesses through advocacy, education, research and service.

#### **5. Client Groups**

There are a number of groups run by and for mental health clients. While they have many of the same goals as more broadly based groups, they sometimes have different positions on the issues. In particular, client groups will typically oppose any laws or policies imposing forced treatment of those with mental illness, while family groups may support it. The following is a list of some of the major client groups.

- Alameda County Network of Mental Health clients (ACNMHC) – Mission: Improve the quality of life of mental health clients within Alameda County by promoting freedom of choice, empowerment, economic security and independent living. Receives a contract from the county as part of BHCS public services. It operates several centers for mental health clients throughout the county, and has a program for visiting psychiatric hospitals and talking to patients about their rights.
- California Network of Mental Health Clients (CNMHC) online at [www.cnmhc.org](http://www.cnmhc.org) the first statewide client-run organization in the country, formed in 1983. Goals are to empower clients through development of self-help groups, to confront discriminating attitudes, to provide a strong voice for clients, and to promote the rights of clients in treatment situations. Takes positions on and sometimes sponsors state legislation.
- California Association of Mental Health Patients' Rights Advocates (CAMHPRA) online at [www.camhptra.org](http://www.camhptra.org) Promotes public policy furthering the rights and well being of mental health consumers.
- Mental Health Consumer Concerns (MHCC) online at [www.aesir.damerica.net/~mhcc](http://www.aesir.damerica.net/~mhcc) promotes rights of all clients, development of client-run alternatives to the traditional mental health system, to educate about "mental illness", to enhance self-esteem and dignity. It operates peer support programs in Contra Costa and Napa counties.
- National Association for Rights Protection and Advocacy (NARPA) online at [www.connix.com/~narpa](http://www.connix.com/~narpa) Advocates abolishing of all forced treatment laws and seeks to empower clients to independently exercise their rights.
- Recovery, Inc online at [www.recovery-inc.com](http://www.recovery-inc.com): An international, community-based, self-help organization, founded in 1937 by the late Abraham Low, a Chicago neuropsychiatrist. It has weekly group meetings in 700 locations in the US and Canada, including a meeting in Alameda County.

### **Current Problems and Issues Affecting Those with Mental Illness**

A recent report *Being There: Making a Commitment to Mental Health* by the Little Hoover Commission, a California state watchdog agency, begins: "A generation ago, California decided that people with mental illness should live in their



communities rather than locked in institutions. It was determined that they would benefit from community-based treatment. It is painfully clear that we have failed to follow through with all that was required by this noble decision. ... Those with mental illness are frequently on street corners, sleeping in parks, behind bars, and disproportionately among the poor, the victims of crime, the unemployed and the homeless". The chief recommendations of the report are that the State set a commitment to serve those with mental illness adequately, and that it provides levels of resources that make this happen. The existing community programs need to have adequate resources so that no one who needs mental health care is denied access to high quality, tailored services.

Looking at the situation in Alameda County, we see the following problems:

### **1. Entering the Mental Health System and Follow-up after Treatment**

Even though Alameda has a sophisticated and dedicated system of mental health services, there are problems for some clients in getting adequate care for their mental illness. A recent study by the Alameda County Mental Health Board called the "Front Door Project" sought to understand all the ways that individuals enter and receive psychiatric emergency services (PES), crisis and information referral services that are the entry points (or Front Door) into Behavioral Health Services. The conclusions found the following problems (in prioritized order):

1. Clients who visit PES receive symptom control instead of a comprehensive assessment that leads to an appropriate referral to an appropriate level of care.
2. Clients with substance abuse problems usually do not receive specialty substance abuse treatment.
3. Clients who are discharged from inpatient hospital care often do not receive appropriate follow-up services.
4. Clients who are frequent users of PES and other emergency/crisis services may not receive ongoing services and attention that would help minimize their crises and hospitalizations.
5. Clients who are detained on a 5150 (involuntary commitment) status by police often end up unnecessarily hospitalized.
6. Clients with a known history of mental illness may receive inappropriately coercive services for minor crises.
7. The police sometimes inappropriately put clients on 5150 status.
8. Clients in need of substance abuse detoxification often cannot get it unless they are sick enough to be admitted to a hospital.
9. Ethnic minority clients sometimes cannot obtain services.

Recommendations from the Front Door study for improving service include:

- Clients who visit PES should receive a comprehensive assessment that leads to an appropriate referral to an appropriate level of care instead of symptom control only.
- Clients with substance abuse problems should always receive specialty substance abuse treatment.
- Clients who are discharged from any inpatient psychiatric hospital, acute hospital psychiatric unit, or substance abuse unit should always receive prompt, appropriate, and documented outpatient follow-up services after discharge.
- Clients who are frequent users of PES should always receive ongoing services and attention that would help to minimize their crises and hospitalizations.
- Clients who are detained by police on 5150 (involuntary commitment) status should not be hospitalized unnecessarily.

One program has recently been put into place to help address this situation. In this program, a list of the most seriously mentally ill people was created and divided up by name among the 10 support centers. The assigned center is responsible for what happens to the individual 24 hours a day, 7 days a week. They find them homes, get them into jobs programs, and help to stabilize them. Because these people were formerly using many resources, this program has been cost effective to run.

### **2. Getting Access to Funding for Treatment**

Vivian Jackson of NAMI of Alameda County, the parent of a client, sees the following practical problems for mentally ill clients and their families with respect to getting funding for care and medications:

- Since Medi-Cal funding is allocated and administered by a County, a client must go to a clinic provided by the county where he/she lives. In the Bay Area, there are a number of counties very close to each other and this sometimes can lead to problems in getting care. Medicare (Federal medical funding) doesn't have this rule, but it doesn't cover medications.
- With new medications sometimes costing \$400/month, many clients can't afford to get them.
- Supplemental Security Income (SSI) has a means test such that you have no assets over \$2000 in order to qualify, which is an extreme hardship for many families.

### **3. Finding Adequate Housing**

Finding adequate housing is a critical problem throughout the Bay Area, and even more so for those with mental illness who typically have few resources to afford it. There are a number of board and care homes that provide services to those with mental illness, but a recent study has found that many of them now prefer to serve the developmentally disabled because they get a higher housing allowance payment from them from the state than for those with mental illness. This study concludes that this problem is in a state of emergency in Alameda County.

#### 4. **Criminalization of those with Mental Illness**

California's jails and prisons contain 30,000 seriously mentally ill inmates. Most are nonviolent, low-level offenders who landed in the criminal justice system in part because they didn't receive adequate community treatment. Many are behind bars on what officers call "mercy bookings" jailed for their protection, not the public. Law enforcement officials now see themselves as operating mental institutions without access to programs and treatment. Many of them are now advocating that jail and prison should not be used to house those who have not received adequate care from the mental health system. In addition, local and state agencies have failed to integrate and coordinate mental health and criminal justice services – and as a result people with mental health needs leaving jails and prisons do not receive adequate services and are too often rearrested.

#### 5. **Stigma**

Stereotypes characterize those with mental illness as dangerous, dirty, unpredictable and worthless. Even though these descriptions are not true of many, the stigma that they create make a double barrier for those with mental illness to overcome. They act to make it more difficult to find employment and housing from a society that believes the stereotypes, and they keep some people from asking for help, lest they be thought of, or think of themselves as, being "like those people".

#### 6. **Employment**

Many mental health consumer focus groups and surveys strongly indicate that mental health clients' desire normalized social roles, including access to meaningful employment opportunities. Unfortunately, getting meaningful employment this has often been very difficult to achieve due to stereotypes, previous incarceration, and not being able to achieve stability with therapists and medication. One program that is trying to fight this problem in Alameda County is a recent program called "Jobs Now".

### Legislation Addressing the Problems of Those with Mental Illness

#### 1. Federal Legislation in 106th Congress (1999-2000) affecting those with mental illness

The following chart gives a summary of the federal legislation in the 106<sup>th</sup> congress that affects those with mental illness. This information is from [www.congress.gov](http://www.congress.gov).

<b>Description</b>	<b>Legislation</b>	<b>Introduced by</b>	<b>Status</b>
<b>Mental health courts</b> for nonviolent offenders with severe mental illnesses and restraint protections.	S. 1865, America's Law Enforcement and Mental Health Project	Strickland, DeWine	Signed by Clinton Nov 2000, without funding.
<b>Children's health act</b> of 2000 to cover mental illness and substance abuse in children and restraint protections	HR 4365, Children's Health Act of 2000	Dodd, Lieberman, Harkin, Specter, Shays, DeGette, DeLauro, Stark	Signed by Clinton on October 2000
<b>Work Incentives</b> provisions in SSI, SSDI, Medicaid and Medicare programs to make it easier for adults with severe disabilities (including adults with severe mental illnesses) to go to work without losing health care benefits under Medicare and Medicaid .	S 331 / HR 1180 - Ticket to Work and Work Incentives Improvement Act	Jeffords , Kennedy , Roth, Moynihan, Lazio, Waxman	Signed by Clinton on December 1999
<b>Substance Abuse and Mental Health Service Administration (SAMHSA) Reauthorization</b>	Contains key provisions contained in S 2639 / HR 5091 - Mental Health Early Intervention, Treatment and Prevention Act of 2000	Kennedy, Domenici	Reauthorized
<b>Housing - HUD budget:</b> to include funding for housing of mentally ill. States and Localities apply for these funds from HUD	PL 106-377 Fiscal 2000 Funding Availability - Section 8 Vouchers for People With Disabilities		Signed by Clinton Oct 27, 2000
<b>Family Opportunity Act:</b> Positive provisions for people with severe mental illnesses and their families being included in the Family Opportunity Act. Ex: integrated treatment for co-occurring disorders, suicide prevention, and	S 2274 / HR 4825 Family Opportunity Act	Grassley, Kennedy, Barrett, Sessions, Upton, Waxman	Awaits funding as part of spending bills Nov 2000.

coordination of child welfare and mental health services.			
<b>Research</b> and services at National Institute of Mental Health (NIMH) and Center for Mental Health Services (CMHS)	Part of HR 4577 funding for Departments of Labor, HHS and Education		Unresolved Dec 2000.
<b>Mental Health Parity</b> Equal treatment of mental and physical illnesses in insurance.	S 796 - Mental Health Equitable Treatment Act S 3233 / HR 5434 - Medicare parity	Domenici, Wellstone  Wellstone, Roukema	In Committee  In Committee
<b>Patient Freedom from Restraint Act</b> Sets rules governing use of restraints in mental health facilities.	S 736, S 750, HR 1313	Lieberman, Dodd, DeGette, Stark, DeLauro	In Committee
<b>Juvenile Justice Act</b> addressing the horrendous conditions and the unmet treatment needs of juveniles brought into the system	S 464, Juvenile Justice Act	Wellstone	In Committee
<b>Youth Suicide</b> and Violence Act	S 1555 Youth Suicide and Violence Act	Domenici, Kennedy	In Committee
<b>Medical Access</b> - to contain provisions that ensure access to mental illness	HR 2723 Patient's Bill of Rights HR 4680 Medicare Prescription HR 5572 Medicaid Intensive Community Health Treatment Act	Dingell, Norwood  Thomas  Kaptur, Cubin	In Committee  Passed by House, not yet by Senate Just Introduced

**Legislators introducing legislation affecting mental health:** (note strong bipartisanship here)

**Senators:**

Mike DeWine (R-OH), Christopher Dodd (D-CT), Pete Domenici (R-NM), Charles Grassley (R-IA), Tom Harkin (D-IA), James Jeffords (R-VT), Edward Kennedy (D-MA), Daniel Patrick Moynihan (D-NY), William Roth, Jr., (R-DE), Arlen Specter (R-PA), Paul Wellstone (D-MN)

**Representatives:**

Tom Barrett (D-WI), Tom Bliley, Jr. (R-VA), Diana DeGette (D-CO), Rosa DeLauro (D-CT), John Dingell (D-MI), Kenny Hulshof (R-MO), Nancy Johnson (R-CT), Rick Lazio (R-NY), Robert Matsui (D-CA), Marge Roukema (R-NJ), Pete Sessions (R-TX), Chris Shays (R-CT), Pete Stark (D-CA), Ted Strickland (D-OH), Fred Upton (R-MI), Henry Waxman (D-CA), Heather Wilson (R-NM)

1. California State Legislation Affecting those with Mental Illness in 2000

The most significant increase of funding for programs benefiting mentally ill people in many years was AB 3034 introduced by Darrell Steinberg passed and signed by Governor Davis. It added significant funding, \$65 million, to the budget for counties to provide comprehensive mental health treatment to the homeless mentally ill. Unfortunately, the proposal from Alameda County to get funding under this bill in 2000 was not accepted.

The most controversial legislative bill in 2000 was AB 1800 introduced by Helen Thomson, which would have made it easier to commit patients to mental hospitals, and extended the length of time that people could be held involuntarily. It was strongly supported by family groups such as NAMI and vigorously opposed by patients' rights activists and client groups. The motivation of the family groups was to get help more quickly for their seriously ill family member, without having to wait until the person was in a critical situation. The motivation of client groups was against being arbitrarily forced into a hospital and given treatment against their will, a situation that they feared could be abused. Bill AB 1800 was not passed, but Helen Thomson vows to reintroduce some form of it in the next legislative year.

The following is a summary of the more important mental health legislation introduced in the California legislature. There are a number of bills vetoed by Governor Davis. His chief reason for giving vetoes was lack of adequate funds available, emphasizing that he did sign one important increase for mental health funding, AB 2034. On some of the veto messages, he acknowledged the merit of the legislation and suggested that it be reintroduced. This information is from [www.leginfo.ca.gov](http://www.leginfo.ca.gov).

DESCRIPTION	LEGISLATION	INTRODUCED BY	STATUS
<b>Involuntary Treatment –</b> Lengthens the time a person may be committed and broadens the criteria for involuntary treatment.	AB 1800	Thomson, Perata	Did not pass
<b>Facilities –</b> Requires California Department of Mental Health to create a report on nursing facilities and develop protocols for reviews.	AB 1969	Steinberg	Vetoed by Governor
<b>Dual Diagnosis –</b> Establishes Dual Diagnosis grant program to treat people with co-occurring disorders of mental illness and substance abuse.	SB 1623	Perata	In committee
<b>Decriminalization of Mental Illness –</b> Establishes mental health courts to divert mentally ill out of jails and into treatment.	SB 1769	Chesbro	Vetoed by Gov.
<b>Patient Rights –</b> Establishes patient advocacy program within the DMH.	SB 1534	Perata	Withdrawn after hostile amendments added
<b>Preventing Suicide –</b> Established a 24-hour crisis-line network for suicide prevention.	SB 405	Ortiz and Perata	In committee.
<b>Training –</b> Accepting workers licensed in other states. Training for police officers about mentally ill. Equal training required for those working in correctional facilities.	SB 1748 AB 1718 AB 1975	Perata Hertzberg Romero	Signed by Gov. Signed by Gov. Signed by Gov.
<b>Access to Treatment –</b> Healthcare service plans to provide coverage for treatment of mental illness. Help in filling mental illness prescriptions. Requires detailed treatment plan when mentally ill person is discharged from state hospitals. Discharge planning improvements.	SB 468 SB 745 SB 1770 SB 1858	Polanco Escutia Chesbro Escutia	Signed by Gov. Signed by Gov. Vetoed by Gov. “Has merit in 2001” In committee.
<b>Homeless Mentally Ill –</b> Expanded services to homeless mentally ill – housing, staffing, community services.	AB 2034	Steinberg	Signed by Gov.
<b>Children’s Mental Health –</b> Grants to reduce juvenile mentally ill offenders. Mental health workers in the Department of Youth Authority to be licensed for youth. Programs in schools to screen for mental illness. Help for mentally ill children in foster care. Expands criteria to fund early detection and prevention of mental health problems in primary sch.	SB 2062 SB 2098 AB 2068 AB 2706 AB 1980	Perata Hayden Steinberg Cunneen Aroner	Veto by Gov. Signed by Gov. Veto by Gov. “Has merit in 2001” Signed by Gov. In committee.

**Legislators introducing legislation affecting mental health:** (note that these are all Democrats)

**Senators:** Perata (D- Oakland), Escutia (D - Montebello), Chesbro (D-Arcata), Polanco (D – Los Angeles), Hayden (D – Santa Monica)

**Assembly members:** Steinberg (D - Sacramento), Thomson (D - Davis), Aroner (D – Berkeley), Cunneen (D – Campbell)

## Looking Toward the Future

Let us look at the vision and priorities that will help to build the future for those with mental illness.

### 1. Research priorities in the National Institute of Mental Health

The National Institute of Mental Health (NIMH), under the direction of Steven E. Hyman, MD, is the primary public research arm focused on understanding, treatment and prevention of mental disorders. It has established goals and a research plan to study issues related to those goals. The following are its current research priorities:

#### **Goal 1: Understand Mental Illness and Mental Health**

- Brain Function and Structure – how these go awry in mental illness and affected by treatment.
- Genes and Mental Illness – the role of genes in brain and behavior and vulnerability to mental illness
- Brain and Behavior – behavior and biological, social and developmental factors affecting mental health
- Mental Disorders – Tackling the Complexities of Co-Morbidity – mental illness and addiction
- Monitoring and Measuring Mental Illness – understand basis of disparities in mental health in different populations

#### **Goal 2: Understand How to Treat and Prevent Mental Illness**

- Improved Treatments for Mental Illness – translate biological research findings into useful applications
- Research Innovations in Design, Methods, and Assessment – examine the interplay between treatment, environment, provider and consumer.
- Prevention Strategies – understand how people learn and change behavior in order to prevent mental illness, and improve treatment outcomes.
- Mental Health Services – Impact of organization of services on outcomes to make for more cost-effective service delivery.

#### **Goal 3: Strengthen the Mental Research Platform**

- Researchers of the Future – ensure future research capacity through support of training and career development
- Research Utilization - educate public about mental illness to reduce stigma
- Enabling Research of the Future – ensure protection of human subjects in research

### 2. What the future will look like

NAMI's 10-year forecast of mental health trends includes the following predictions:

- With sophisticated electronic imaging techniques that allow researchers to see into the living brain, scientists can discern areas of the brain that malfunction during specific illnesses, and soon may enable treatments to be targeted more effectively.
- More effective treatment of severe depression, perhaps reducing the rising suicide rate.
- Better targeted treatment and a new generation of antipsychotic drugs offer major hope for better outcomes for people with schizophrenia.
- The new science will allow policy makers to prioritize between serious brain disorders and more ordinary mental health problems, such as stress.
- Policy makers will demand greater accountability for hundreds of millions of dollars that now support a fragmented, inadequate and failed public mental health care system.
- The Internet is helping to overcome the stigma of mental illness. It preserves anonymity while providing information about treatment options, current research, screening tests, and virtual support groups.
- New medications are being advertised directly to millions of potential consumers, further changing the balance of power in the physician-patient relationship.

## Next Steps

We need to continue my education about how the system works and doesn't work for those with mentally illness. This study has led me to make the following list of steps that we will pursue next.

- Meet with:
  - Rep. Pete Stark and wife Deborah about legislation and her work on mentally ill children
  - Rev. Nicholas Ristad, chaplain at Napa State Hospital
  - Rev. Chester (Chet) Watson, Board Member NAMI, California
  - Visit Life Reaching Across to Life Program in Fremont.

- Attend at least one meeting of each of the following organizations:
  - NAMI meeting 4<sup>th</sup> Web of every month at 7:30pm in Berkeley
  - Alameda Co Mental Health Board 3<sup>rd</sup> Wed of every month at Fairmont Hospital San Leandro 5:30-8:30
  - The California Mental Health Planning Council. 2001 meetings: January 18-19 in San Diego., April 19-20 in Los Angeles, June (date and place TBD), and September 20-21 in Oakland.
  - A meeting of the Berkeley Mental Health Commission, 4<sup>th</sup> Wednesdays at 6:30 at 2640 MLK at Derby.
- Classes to attend/consider attending:
  - UC Berkeley extension class X416: Critical Incident Stress Management: Basic Training, 1 unit, a 2-day class, Jan 8-9, 2001. Recommended by Nancy Fernandez for potentially working in/with one of the county centers.
  - UC Berkeley Extension Class: An Experiential Introduction to Art Therapy, 1 unit, May 19-20. Will help me in being able to work at a center with clients.
  - UC Berkeley Extension Class: Art Therapy with Groups, 2 units, Feb 10, 24, Marcy 10, 24 April. Will help me in being able to work at a center with clients.
- Consider forming a NAMI chapter in Fremont.
- Consider applying for a position on the California Mental Health Planning Council.

## References:

For this report, I interviewed the following people:

- Steve Bischoff, Executive Director of Alameda County Mental Health Association
- Nancy Fernandez, Special Projects Coordinator, Alameda County Behavioral Health Care Services
- Alane Friedrich, member of Alameda County Mental Health Board
- Vivian Jackson, a volunteer for NAMI, Alameda County
- Dan Jordan, Director of Eligibility, Mentally Ill Advocates, and Patients Rights Advocates.
- Jan Marinessin, a minister on leave of absence from Berkeley Mental Health Commission. Active in prisoner and mental health issues.
- Kathie Zatzkin, Alameda County Network of Mental Health Clients.

## Documents:

1. Alameda County Behavioral Health Care Services Resource Directory, 2000.
2. Alameda County Behavioral Health Plan Update, Volume 3, No 2.
3. Behavioral Health Care, Volume 4 No 2. Alameda County Behavioral Health Care Services.
4. Being There: Making a Commitment to Mental Health, Report #157, California Little Hoover Commission, November 2000.
5. The Diagnostic and Statistical Manual. 4th edition. Text Revision (DSM-IV-TR) contains a comprehensive list of mental illnesses and their symptoms.
6. Final Report, Front Door Project Ad Hoc Committee of the Alameda County Health Board, July 2000.
7. Going it Alone – The Struggle to Expand Housing Opportunities for People with Disabilities, the Technical Assistance Collaborative, Inc, and the Consortium for Citizens with Disabilities Housing Task Force.
8. Handbook of Rights for Mental Health Patients, Patients’ Rights Advocates, Oakland CA.
9. Medi-Cal Mental Health Service Delivery System, Chapter II, Alameda County, I.D.E.A Consulting, 1998.
10. NAMI information packet: including:
  - Mental Illness Is Everybody’s Business
  - Medications for Mental Health
  - The Families Advocate
  - Many other brochures on specific mental illnesses, treatments, family and mental health client support groups.
11. Reaching for the light – A Resource Guide for Coping with Mental Health Problems, Mental Health Association in California, 1998.

# Glossary

<b>affect</b>	Behavior that expresses an inner emotion such as sadness, elation, or anger. <i>Affect</i> refers to fluctuating emotions, whereas <i>mood</i> refers to sustained emotions.																		
<b>agnosia</b>	The failure to recognize objects despite having all senses intact.																		
<b>alogia</b>	Impoverishment in thinking that is inferred from observing speech and language behavior. Little information is conveyed.																		
<b>anxiety</b>	The apprehensive anticipation of future danger or misfortune accompanied by a feeling of tension.																		
<b>aphasia</b>	An impairment in the understanding or transmission of ideas by language that is due to injury or disease of the brain.																		
<b>aphonia</b>	An inability to produce speech sounds.																		
<b>avolition</b>	An inability to initiate and persist in goal-directed activities.																		
<b>catatonic behavior</b>	Marked motor abnormalities including rigid maintenance of a body position over an extended period of time, excessive motor agitation, being mute, and echoing the voices of others.																		
<b>compulsion</b>	A repetitive behavior that the person feels driven to perform in response to an obsession.																		
<b>conversion symptom</b>	A loss of, or alteration in, voluntary motor or sensory function that is not fully explained by a neurological or general medical condition.																		
<b>culture-bound syndrome</b>	Recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. These experiences are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for these experiences																		
<b>delusion</b>	<p>A false belief based on incorrect inference about external reality that is firmly sustained despite what constitutes incontrovertible and obvious proof or evidence to the contrary. These can be subdivided according to their content:</p> <table border="1"> <tr> <td><b>bizarre</b></td> <td>A delusion that involves a phenomenon that is very unlikely.</td> </tr> <tr> <td><b>jealous</b></td> <td>The delusion that one's sexual partner is unfaithful.</td> </tr> <tr> <td><b>erotomaniac</b></td> <td>A delusion that another person, usually of higher status, is in love with the individual</td> </tr> <tr> <td><b>grandiose</b></td> <td>A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.</td> </tr> <tr> <td><b>of being controlled</b></td> <td>A delusion in which feelings, impulses, thoughts or actions are experienced as being under the control of some external force rather than being under one's own control</td> </tr> <tr> <td><b>of reference</b></td> <td>A delusion whose theme is that events, objects or other persons in one's immediate environment have a particular and unusual significance.</td> </tr> <tr> <td><b>gustatory</b></td> <td>A hallucination involving the perception of taste.</td> </tr> <tr> <td><b>olfactory</b></td> <td>A hallucination involving the perception of odor.</td> </tr> <tr> <td><b>persecutory</b></td> <td>A delusion in which the central theme is that one is being attacked, harassed, cheated, persecuted or conspired against.</td> </tr> </table>	<b>bizarre</b>	A delusion that involves a phenomenon that is very unlikely.	<b>jealous</b>	The delusion that one's sexual partner is unfaithful.	<b>erotomaniac</b>	A delusion that another person, usually of higher status, is in love with the individual	<b>grandiose</b>	A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.	<b>of being controlled</b>	A delusion in which feelings, impulses, thoughts or actions are experienced as being under the control of some external force rather than being under one's own control	<b>of reference</b>	A delusion whose theme is that events, objects or other persons in one's immediate environment have a particular and unusual significance.	<b>gustatory</b>	A hallucination involving the perception of taste.	<b>olfactory</b>	A hallucination involving the perception of odor.	<b>persecutory</b>	A delusion in which the central theme is that one is being attacked, harassed, cheated, persecuted or conspired against.
<b>bizarre</b>	A delusion that involves a phenomenon that is very unlikely.																		
<b>jealous</b>	The delusion that one's sexual partner is unfaithful.																		
<b>erotomaniac</b>	A delusion that another person, usually of higher status, is in love with the individual																		
<b>grandiose</b>	A delusion of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.																		
<b>of being controlled</b>	A delusion in which feelings, impulses, thoughts or actions are experienced as being under the control of some external force rather than being under one's own control																		
<b>of reference</b>	A delusion whose theme is that events, objects or other persons in one's immediate environment have a particular and unusual significance.																		
<b>gustatory</b>	A hallucination involving the perception of taste.																		
<b>olfactory</b>	A hallucination involving the perception of odor.																		
<b>persecutory</b>	A delusion in which the central theme is that one is being attacked, harassed, cheated, persecuted or conspired against.																		

	<b>somatic</b>	A hallucination involving the perception of a physical bodily experience. It is distinguished from physical sensations from an as-yet undiagnosed general medical condition.
	<b>tactile</b>	A hallucination involving the perception of being touched, or of something being on or under one's skin.
	<b>visual</b>	A hallucination involving sight, which may consist of formed images, such as people, or of unformed images, such as flashes of light. It is distinguished from illusions, which are misperceptions of real external stimuli.
<b>depersonalization</b>	An alteration in perception so that one feels detached from, and as if one is an outside observer of, one's mental processes or body.	
<b>derailment</b>	A pattern of speech in which a person's ideas slip off one track onto another that is completely unrelated, or only obliquely related.	
<b>derealization</b>	An alteration in perception of the external world so that it seems strange or unreal.	
<b>disorganized speech</b>	A pattern of speaking that exhibits derailment or incoherence.	
<b>dyskinesia</b>	Distortion of voluntary movements with involuntary muscular activity.	
<b>egodystonic</b>	Maladaptive behavior that the patient recognizes as maladaptive and doesn't want to change. They believe that the thoughts and behavior aren't coming from the 'real me.'	
<b>egosentonic</b>	Maladaptive behavior that makes sense to the patient and that they don't want to change.	
<b>Electroconvulsive therapy (ECT)</b>	A treatment for severe depression. The therapy involves a series of mild electrical currents administered to a sedated patient that affects the part of the brain that regulates mood and helps stimulate the production of precursors to serotonin and norepinephrine.	
<b>etiology</b>	The origins of a disorder.	
<b>factitious disorders</b>	Conditions where patients feign physical or psychological symptoms with the sole intent of being a patient. This most severe form is known as the 'Munchausen' variant.	
<b>flashback</b>	A recurrence of a memory, feeling, or perceptual experience from the past.	
<b>flight of ideas</b>	A nearly continuous flow of accelerated speech with abrupt changes from topic to topic that are usually based on understandable associations.	
<b>grandiosity</b>	An inflated appraisal of one's worth, power, knowledge, importance or identity.	
<b>hallucination</b>	A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ.	
<b>ideas of reference</b>	The feeling that external events have a particular and unusual meaning that is specific to the person.	
<b>idiom of distress</b>	The way in which different cultures express, experience, and cope with feelings of distress.	
<b>illusion</b>	A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices.	
<b>incidence</b>	In epidemiology, the number of new cases of a disorder for a specific time interval.	
<b>incoherence</b>	Speech or thinking that is incomprehensible to others because words or phrases are joined together without a logical or meaningful connection. This is sometimes referred	



	to as “word salad.”
<b>malinger</b>	Voluntary and deliberate production of false or grossly exaggerated physical or psychological symptoms to achieve a goal.
<b>mood</b>	A pervasive and sustained emotion that colors the perception of the world. Examples are depression, elation, anger, and anxiety.
<b>NAMI</b>	Founded in 1979, a nonprofit, grassroots, self-help, support and advocacy organization of mental health clients, families, and friends of people with severe mental illnesses. Its full name used to be National Alliance for the Mentally Ill, but now, it is simply NAMI.
<b>neurotransmitter</b>	A chemical that the nerve cells themselves release to communicate with one another.
<b>norepinephrine</b>	A neurotransmitter that regulates alertness and arousal and is implicated in depression.
<b>obsession</b>	A persistent, disturbing, intrusive thought or impulse which the patient finds illogical but irresistible. Unlike a delusion, the patient finds it absurd and tries to resist it.
<b>panic attack</b>	A period of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During the attack there are symptoms such as shortness of breath, palpitations, pounding heart, accelerated heart rate, chest pain, choking, or fear of going crazy.
<b>paranoid ideation</b>	Ideation of less than delusional proportions, involving suspiciousness or the belief that one is being harassed, persecuted, or unfairly treated.
<b>personality</b>	Enduring patterns of perceiving, relating to, and thinking about the environment and oneself. Personality traits are prominent aspects of personality that are exhibited in a wide range of important social and personal contexts.
<b>phobia</b>	A persistent, irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid it.
<b>prevalence</b>	In epidemiology, the number of existing cases of a disorder.
<b>psychotic</b>	This term has historically received a number of different definitions, none of which has achieved universal acceptance. Here are the definitions used most often: <ul style="list-style-type: none"> <li>• Psychosis is restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature.</li> <li>• The above definition plus prominent hallucinations that the individual realizes are hallucinatory experiences.</li> <li>• The above definition plus other positive symptoms of schizophrenia (i.e. disorganized speech, grossly disorganized or catatonic behavior).</li> <li>• Psychosis has also been defined conceptually as a loss of ego boundaries or a gross impairment in reality testing.</li> </ul>
<b>religious or spiritual problem</b>	Distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of spiritual values that may not necessarily be related to an organized church or religious institution. This is not defined as a DSM ‘mental disorder,’ but a ‘condition that may be a focus of clinical attention.’
<b>sign</b>	An objective manifestation of a pathological condition. Signs are observed by the examiner rather than reported by the affected individual.
<b>serotonin</b>	A neurotransmitter implicated in depression. A serotonin deficiency may underlie the sleep problems, irritability, anxiety, and suicidal behavior associated with depression.

<b>symptom</b>	A subjective manifestation of a pathological condition. Symptoms are reported by the affected individual rather than observed by the examiner.
<b>syndrome</b>	A grouping of signs and symptoms.
<b>volition</b>	The act of willing.

Sources of definitions:

- *DSM IV-TR*
- *Essential Psychopathology and Its Treatment*, by Jerrold S. Maxmen and Nicholas G. Ward.
- *Helping Someone with Mental Illness – A Compassionate Guide for Family, Friends* by Rosalynn Carter with Susan K. Golant

# Resources

## Books and Documents

### Information about Mental Disorders and their Treatment

#### **General**

- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> Edition, Text Revision*, (DSM-IV-TR), Washington, D.C.: American Psychiatric Association, 2000.
- Greist, J.H., Jefferson, J.W. and Spitzer, R.L., editors. *Treatment of Mental Disorders*, New York: Oxford University Press, 1982.
- Maxmen, Jerrold S. and Ward, Nicholas G. *Essential Psychopathology and Its Treatment, Second Edition Revised for DSM-IV*, New York: W.W. Norton & Company, 1995.
- Robins, L.N. and Regier, D.A., editors. *Psychiatric Disorders in America – The Epidemiologic Catchment Area Study*, New York: Free Press, 1990.
- Schuster, Richard J MD, FACP. *The Textbook of Primary and Acute Care Medicine, 2<sup>nd</sup> Edition*, edited by Gideon Bosker, MD, FACEP, Editor-in-Chief of *Emergency Medicine Reports*. Connecticut: Thomson American Health Consultants, 2004, Part XVII, *Psychiatric Disorders*.
- Sue, David, Sue, Derald and Sue, Stanley. *Understanding Abnormal Behavior, 4<sup>th</sup> Edition*, Boston: Houghton Mifflin, 1994.
- Yalom, I.D. *The Theory and Practice of Group Psychotherapy, 4<sup>th</sup> edition*, New York: Basic Books, 1995.

#### **Mood Disorders**

- Arieti, Silvano and Bemporad, Jules. *Severe and Mild Depression – The Psychotherapeutic Approach*, New York: Basic Books, Inc, 1978.
- Emotions Anonymous. *Emotions Anonymous, Revised Edition*, St. Paul, Minnesota: Emotions Anonymous International Services, 1994.
- Fieve, Ronald. *Moodswing*, New York: Bantam Books, 1989.
- Goodwin, Frederick K. and Jamison, Kay Redfield. *Manic-Depressive Illness*, New York: Oxford University Press, 1990.
- Jamison, Kay Redfield. *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament*, New York: Free Press Paperbacks, 1994.
- McGrath, Ellen, et. al., editors. *Women and Depression – Risk Factors and Treatment Issues – Final Report of the American Psychological Association's National Task Force on Women and Depression*, Washington D.C.: American Psychological Association, 1990.
- Mountain, Jane. *Bipolar Disorder – Insights for Recovery*, Denver: Chapter One Press, 2003.
- Muller, Wayne. *Legacy of the Heart: The Spiritual Advantage of a Painful Childhood*, New York: Fireside, 1992.
- Solomon, Andrew. *The Noonday Demon: An Atlas of Depression*, New York: Simon & Schuster, 2001.
- Real, Terence. *I Don't Want to Talk about It – Overcoming the Secret Legacy of Male Depression*, New York: Scribner Book Co, 1997.

#### **Psychotic Disorders**

- Keefe, Richard S.E., and Harvey, Philip D. *Understanding Schizophrenia – A Guide to the New Research on Causes and Treatment*, New York: The Free Press, 1994.
- Robbins, Michael D. *Experiences of Schizophrenia: An Integration of the Personal, Scientific, and Therapeutic*, New York, Guilford Press, 1993.
- Torrey, E. Fuller. *Surviving Schizophrenia: A Manual for Families, Consumers and Providers*, Perennial, 1995.

#### **Anxiety Disorders**

- Baer, Lee. *Getting Control – Overcoming Your Obsessions and Compulsions, Revised Edition*, New York: Plume Books, 2000.
- Barlow, D.H. and Cerny, J.A. *Psychological Treatment of Panic*, New York: Guilford Press, 1988.
- Handly, Robert, with Pauline Neff. *Anxiety and Panic Attacks – Their Cause and Cure: The five-point Life-Plus Program for Conquering Fear*, New York: Rawson Associates, 1985.
- Kulk, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K., Marmon, C.R., and Weiss, D.S. *Trauma and the Vietnam War Generation - Report of Findings from the National Vietnam Veterans Readjustment Study*, New York: Brunner-Routledge, 1990.
- Rachman, Stanley, and De Silva, W.P., editors. *Obsessive-Compulsive Disorder – The Facts*, New York: Oxford

University Press, 1996.

- Rachman, Stanley, and De Silva, W.P., editors. *Panic Disorder – The Facts*, New York: Oxford University Press, 1996.
- Jerilyn Ross, *Triumph over Fear: A Book of Help and Hope for People with Anxiety, Panic Attacks, and Phobias*. New York: Bantam Books, 1994.
- Steketee, Gail and White, Kerrin. *When Once Is Not Enough – Help for Obsessive-Compulsives*, Oakland, California: New Harbinger Publications, 1990.

### **Eating Disorders**

- Hall, Lindsey Hall and Ostroff, Monika, *Anorexia Nervosa: A guide to recovery*, Carlsbad, California: Gurze Books, 1998.
- Hall, Lindsey and Cohn, Leigh, *Bulimia: A guide to recovery*, Carlsbad, California: Gurze Books, 1998.
- Siegel, Michelle, Ph.D., Brisman, Judith Ph.D. and Weinschel, Margot, Ph.D., *Surviving an Eating Disorder: Perspectives and strategies for family and friends*, New York: Perennial Currents, 1997.

### **Substance-Related Disorders**

- Alcoholics Anonymous. *Twelve Steps and Twelve Traditions*, New York: Alcoholics Anonymous World Services, 1996.
- Cothran, Helen, editor. *Heroin*, San Diego: Greenhaven Press, 2001.
- Evans, Katie, and Sullivan, J. Michael. *Dual Diagnosis, Second Edition – Counseling the Mentally Ill Substance Abuser*, New York: Guilford Press, 2000.
- McMaster, Curtis P. *The Tragedy of Heroin Addiction*, in Cothran, Helen, Editor, *Heroin*, San Diego: Greenhaven Press, 2001, pp 29-33. Originally published in *Professional Counselor*, June 1998.

### **Disorders usually first diagnosed in Childhood**

- Barkely, Russell. *Attention Deficit Hyperactivity Disorder; A Handbook for Diagnosis and Treatment, 2<sup>nd</sup> Edition*, New York: Guilford Press, 1998.
- Hallowell, Edward M. and Ratey, John J. *Driven to Distraction -Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood*, New York: Touchstone, 1995.
- Kervatt, Gail Goetze. *The Silence Within – A Teacher/Parent Guide to Helping Selectively Mute and Shy Children*, Oak Ridge, New Jersey: Gail Kervatt, 1999.

### **Dementia**

- Cummings, Jeffrey and Miller, Bruce L. *Alzheimer's Disease – Treatment and long-term Management*, New York: Dekker, 1990.
- Shenk, David. *The Forgetting: Alzheimer's, Portrait of an Epidemic*, New York: Bantam Doubleday Dell Publishing Group 2001.

### **Personality Disorders**

- Allen, David, M. *Psychotherapy with Borderline Patients – An Integrated Approach*, Mahwah New Jersey: Lawrence Erlbaum Associated Publishers, 2003.
- Bayer, Linda. *Personality Disorders, The Encyclopedia of Psychological Disorders*, Philadelphia: Chelsea House Publishers, 2000.
- Black, Donald W., M.D., with C. Lindon Larson. *Bad Boys, Bad Men – Confronting Antisocial Personality Disorder*, New York: Oxford University Press, 1999.
- Bornstein, Robert F. *The Dependent Personality*, New York: Guilford Press, 1993.
- Gunderson, John G., M.D. *Borderline Personality – A Clinical Guide*. Arlington, VA: American Psychiatric Publishing, Inc., March 2001.
- Hanson, Gary D. *Histrionic Personality Disorder (Formerly known as hysteria)*, on line at [narramore.gospelcom.net/bk\\_128\\_histrionic1.htm](http://narramore.gospelcom.net/bk_128_histrionic1.htm) and [narramore.gospelcom.net/bk\\_128\\_histrionic2.htm](http://narramore.gospelcom.net/bk_128_histrionic2.htm), Narramore Christian Foundation.
- Johnson, Stephen M. *Character Styles*, New York: W.W. Norton, 1994.
- Johnson, Stephen M. *Characterological Transformation- The Hard Work Miracle*, New York: W.W. Norton, 1985.
- Johnson, Stephen M. *Humanizing the Narcissistic Style*, New York: W.W. Norton, 1987.
- Linehan, M.M. *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, New York: Guilford Press, 1993.
- Kreisman, Jerold and Straus, Hal. *I Hate You, Don't Leave Me – Understanding Borderline Personality Disorder*, New York: Avon, 1991.
- Kraepelin, Emil, *Manic-Depressive Insanity and Paranoia*, New York: Arno Press, 1976

### **Suicide**

- Collins, Judy. *Sanity and Grace: A Journey of Suicide, Survival and Strength*, New York: Jeremy P. Tarcher,

2003.

- Ellis, Thomas and Newman, Cory. *Choosing to Live – How to Defeat Suicide through Cognitive Therapy*, Oakland, California: New Harbinger Publications, 1996.
- Grollman, Earl A. *Suicide: Prevention, Intervention, Postvention, Second Edition*, Boston: Beacon Press, 1988.
- Jamison, Kay Redfield. *Night Falls Fast – Understanding Suicide*, New York: Alfred A. Knopf, 1999.
- Quinnett, Paul. *Question Persuade Refer – Ask a Question Save a Life*, a booklet used for training for Certified QPR Gatekeeper Instructors by the QPR Institute, 1995.

### **Cultural Issues**

- Castillo, Richard. *Culture and Mental Illness – A Client-Centered Approach*, Pacific Grove: Brooks/Cole Publishers, 1997.

### **Alternate Views of Mental Illness**

- Foucault, Michel. *Folie et deraison - Histoire de la folie a l'age classique*, English Translation: *Madness and civilization – a history of insanity in the Age of Reason*, New York: Vintage Books, 1988, c. 1965.
- Kutchins, Herb, and Kirk, Stuart. *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders*, New York: The Free Press, 1997.
- Liang, R. D. *The Divided Self – An Existential Study in Sanity and Madness*, New York, Pantheon Books, 1969.
- Perry, John Weir. *The Far Side of Madness, Second Edition*, Putnam, Connecticut: Spring Publications, 2005.
- Scheff, Thomas J. *Being mentally ill – a sociological theory*, New York: Aldine Pub. Co, 1966.
- Scheff, Thomas J., editor. *Labeling Madness*, Englewood Cliffs, N.J.: Prentice-Hall, 1975.
- Szasz, Thomas. *The Myth of Mental Illness- foundations of a theory of personal conduct*, New York: Harper and Row, 1961.

## **Personal Stories**

### **Mood Disorders**

- Berger, Diane and Berger, Lisa. *We Heard the Angels of Madness – A Family Guide to Coping with Manic Depression*, New York: Quill - William Morrow, 1991.
- Cronkite, Kathy. *On the Edge of Darkness – Conversations about Conquering Depression*, New York: Dell Publishing, 1994.
- Duke, Patty and Gloria Hochman. *A Brilliant Madness – Living with Manic Depressive Illness*, New York: Bantam Books, 1993.
- Beers, Clifford W. *A Mind That Found Itself – An Autobiography*, Garden City, New York: Doubleday, 1953. Originally published in 1908.
- Castle, Lana R. *Bipolar Disorder Demystified – Mastering the Tightrope of Manic Depression*, New York: Marlowe and Company, 2003.
- Jamison, Kay Redfield. *An Unquiet Mind – A Memoir of Moods and Madness*, New York: Vintage Books, 1995.
- Manning, Martha. *Undercurrents – A Life Beneath the Surface*, San Francisco: HarperSanFrancisco, 1994.
- Slater, Lauren. *Prozac Diary*, New York: Random House, 1998.
- Styron, William. *Darkness Visible – A Memoir of Madness*, New York: Random House, 1990.
- Thompson, Tracy. *The Beast - A Journey Through Depression*, New York: Plume / Penguin, 1996.
- Thorne, Julia and Rothstein, Larry. *You are Not Alone – Words of experience and hope for the journey through depression*, New York: HarperPerennial, 1993.
- Wolfe, Thomas, Leslie Field, Ed. *The Autobiography of an American Novelist*, Cambridge, Mass.: Harvard University Press, 1983. Previously published as *The Story of a Novel*, New York: Charles Scribner's Sons, 1936. Originally published as two essays by The Saturday Review Co., 1935-36.
- Wootton, Tom. *The Bipolar Advantage*, Bipolar Advantage Publishers, 2005.

### **Anxiety Related Disorders**

- Robbins, Steven James. *The Long Journey Home*, on line at: [grunt.space.swri.edu/srjourne.htm](http://grunt.space.swri.edu/srjourne.htm)

### **Substance-Related Disorders**

- Hartigan, Francis. *Bill W. – A Biography of Alcoholics Anonymous Cofounder Bill Wilson*, New York: St Martin's Press, 2000.

### **Schizophrenia**

- Cadigan, John. *People Say I'm Crazy: The Real Life Story of an Artist's Struggle with Schizophrenia* (a documentary), [peoplesayimcrazy.org](http://peoplesayimcrazy.org), Palo Alto Pictures, 2005.
- Elgin Holley, Tara. *My Mother's Keeper: A Daughter's Memoir of Growing up in the Shadow of Schizophrenia*, New York: Avon Books, 1997.
- Hanson, Daniel S. *Room for J: A Family Struggles with Schizophrenia*, Edina, MN: Beaver's Pond Press, 2004.

- Margo, Margaret. *The Uninvited Guest – A Mother’s Story about Mental Illness*, self-published by the author Margaret Margo, who can be reached at: [margaret@listeningwell.net](mailto:margaret@listeningwell.net).
- Nasar, Sylvia. *A Beautiful Mind: The Life of Mathematical Genius and Nobel Laureate John Nash*, New York: Simon and Schuster, 2001.
- Perceval, John. *Perceval’s Narrative – A Patient’s Account of His Psychosis 1830-1832*, Gregory Bateson, Editor. New York: William Morrow & Company, Inc., New York, 1974.
- Schizophrenia.com. Personal stories of Schizophrenia on line at: [http://www.schizophrenia.com/sznews/archives/cat\\_schizophrenia\\_personal\\_story.html](http://www.schizophrenia.com/sznews/archives/cat_schizophrenia_personal_story.html)
- Wagner, Pamela and Spiro, Carolyn. *Divided Minds: Twin Sisters and Their Journey Through Schizophrenia*, New York: St. Martin's Press, 2005.

### **Autism**

- Greenfield, Josh. *A Place for Noah*, New York: Pocket Books, 1979.
- Park, Clara Claiborne. *The Siege – A Family’s Journey into the World of an Autistic Child*, New York: Little Brown & Co (Pap); © Clara Claiborne Park 1967, 1982, and © renewed 1995. Reissue edition (March 2001).
- Park, Clara Claiborne. *Exiting Nirvana: A Daughter’s Life with Autism*, New York: Little Brown & Co (Pap); March 2001. This book is a continuation of the family story begun in *The Siege*.

### **Attention Deficit Disorder**

- Joseph Brooks. *My Story: Joseph Brooks*, on line at <http://www.healthyplace.com/Communities/ADD/ask/stories/joseph.htm> .

### **Alzheimer’s**

- DeBaggio, Thomas. *Losing My Mind – An Intimate Look at Life with Alzheimer’s*, New York: The Free Press, 2002.
- Dodge, Tom. *Oedipus Road: Searching for a Father in a Mother’s Fading Memory*, Fort Worth: Texas Christian University Press, 1996.
- Knowles, Carrie. *The Last Childhood: A Family Story of Alzheimer’s*, New York: Three Rivers Press, 2000.
- Miller, Sue. *The Story of My Father – A Memoir*, New York: Alfred A. Knopf, 2003.
- Peterson, Betsy. *Voices of Alzheimer’s – Courage, Humor, Hope and Love in the Face of Dementia*, Cambridge, Mass: DaCapo Press, 2004.
- Snyder, Lisa. *Speaking Our Minds: Personal Reflections from Individuals with Alzheimer’s*, New York: W. H. Freeman & Co. 1999.

### **Borderline Personality Disorder**

- Walker, Anthony, M.D. *The Siren’s Dance: My Marriage to a Borderline: A Case Study*, New York: Rodale, 2003.

### **Stories of Mental Health Care Workers**

- Ackerman, Diane. *A Slender Thread: Rediscovering Hope at the Heart of Crisis*, New York: Random House, Inc., 1997.
- Field, Joanna. *A Life of One’s Own*, Los Angeles: J.P. Tarcher, Inc., 1936.
- Remen, Rachel Naomi. *Kitchen Table Wisdom – Stories That Heal*, New York: Riverhead Books, 1996.
- Rogers, Carl. *On Becoming a Person – A Therapist’s View of Psychotherapy*, Boston: Houghton Mifflin, 1961.
- Rubin, Lillian B. *The Man with the Beautiful Voice – and more stories from the other side of the couch*, Boston: Beacon Press, 2003.

## **History of Mental Illness**

### **Histories**

- Grob, Gerald N. *Mental Institutions in America – Social Policy to 1875*, New York: The Free Press, 1973.
- Grob, Gerald N. *Mental Illness and American Society, 1875-1940*, Princeton: Princeton University Press, 1983.
- Grob, Gerald N. *The Mad Among Us – A History of the Care of America’s Mentally Ill*, Cambridge, Massachusetts: Harvard University Press, 1994.
- Mora, George, M.D. “History of Psychiatry”, in *Comprehensive Textbook of Psychiatry*, Edited by A.M. Freedman and Harold Kaplan, Baltimore: Williams & Wilkins Co, 1967, pp 2-34.
- Stone, Michael, M.D. *Healing the Mind – A History of Psychiatry from Antiquity to the Present*, New York: W.W. Norton & Company, 1997.
- Whitaker, Robert. *Mad in America – Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*, Cambridge: Perseus Publishing, 2001.

### **Time Lines**

- Aetna IntelliHealth. *Mental Health Timeline*, online at their website: [www.intelihealth.com](http://www.intelihealth.com).

- International Society for Suicide Prevention. *Mental Health Timeline*, online at [www.suicide-parasuicide.rumos.com/en/articles/mental\\_health/mhtimeline.htm](http://www.suicide-parasuicide.rumos.com/en/articles/mental_health/mhtimeline.htm).
- Jessie. *History of the Conceptualizations of Mental Illness*, on-line at [www.geocities.com/Tokyo/Bay/9166/mihistory.htm](http://www.geocities.com/Tokyo/Bay/9166/mihistory.htm).
- Nursing and Midwifery History UK. *Mental Health History Timeline*, online at [www.shf.ac.uk/~nmhuk/mhnurs/timeline/mhtimeline.html](http://www.shf.ac.uk/~nmhuk/mhnurs/timeline/mhtimeline.html).
- PBS. *Timeline on Treatments for Mental Illness*, published online at [www.pbs.org/wgbh/amex/nash/timeline](http://www.pbs.org/wgbh/amex/nash/timeline).

### **Status Reports**

- U.S. Department of Health and Human Services. *Mental Health – A Report of the Surgeon General*, Center for Mental Health Services, Washington D.C.: U.S. Department of Health and Human Services, 1999.
- U.S. Department of Health and Human Services. *Mental Health – Culture, Race, and Ethnicity—A Supplement to Mental Health – A Report of the Surgeon General*, Center for Mental Health Services, Washington D.C.: U.S. Department of Health and Human Services, 2001.
- U.S. Department of Health and Human Services. *The President’s New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America*, Washington D.C.: U.S. Department of Health and Human Services, Publication No. SMA-03-3831, 2003.

### **Biographies**

- Brown, Thomas J. *Dorothea Dix, New England Reformer*, Cambridge, Massachusetts: Harvard University Press, 1998.
- Dane, Norman, *Clifford W. Beers – Advocate for the Insane*, Pittsburgh: University of Pittsburgh Press, 1980.
- Farr, Clifford B. “Benjamin Rush and American Psychiatry”, in *The American Journal of Psychiatry*, Centennial Anniversary Edition, 1944, pp. 3-15.
- Gollaher, David. *Voice for the Mad – The Life of Dorothea Dix*, New York: The Free Press, 1995.
- Goodman, Nathan G. *Benjamin Rush – Physician and Citizen 1746-1813*, Philadelphia: University of Pennsylvania Press, 1934.
- Johnston, Christine I.M. *The Father of Canadian Psychiatry Joseph Workman*, Victoria, Canada: Ogden Press, 2000.
- Messerli, Jonathan. *Horace Mann – A Biography*, New York: Alfred A. Knopf, 1972.
- Wilson, Dorothy Clarke. *Stranger and Traveler – The Story of Dorothea Dix, American Reformer*, New York: Little, Brown and Company, 1975.

### **Resources for Families**

- Amador, Xavier F. with Anna-Lica Johanson. *I Am Not Sick I Don’t Need Help!*, Vida Pr, 2000.
- Beard, Jean J. and Gillespie, Peggy, Interviewers. *Nothing to Hide – Mental Illness in the Family*, New York: The New Press, 2002.
- Berger, Diane and Berger, Lisa. *We Heard the Angels of Madness – A Family Guide to Coping with Manic Depression*, New York: Quill - William Morrow, 1991.
- 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.
- 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. *Coping with Schizophrenia – A Guide for Families*, Oakland, California: New Harbinger Publications, 1994.
- NAMI. *Family-to-Family Education Program*, 1998. Information about this program is online at: [www.nami.org/family](http://www.nami.org/family)
- Ozonoff, Sally, Dawson, Geraldine and McPartland, James. *A Parent’s Guide to Asperger Syndrome and High-Functioning Autism – How to Meet the Challenges and Help Your Child Thrive*, New York: Guilford Press, 2002.
- 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.
- Johnson, Julie T. *Hidden Victims – An Eight Stage Healing Process for Families and Friends of the Mentally Ill, 2<sup>nd</sup> Edition*, Edina, Minnesota: PEMA Publications, 1994.
- Woolis, Rebecca. *When Someone You Love Has a Mental Illness*, New York: Tarcher, 1992.

### **Resources for Mental Health Clients**

- Basco, Monica and Wright, Jesse. *Getting Your Life Back: The Complete Guide to Recovery from Depression*,

Carmichael, CA: Touchstone Books, 2002.

- Burns, David D. *Feeling Good: The New Mood Therapy*, New York: Avon Books, 1999.
- Burns, David D. *The Feeling Good Handbook*, New York: Plume, 1999.
- Canale, Andrew. *Beyond Depression – A Practical Guide for Healing Despair*, New York: HarperCollins, 1992.
- Chamberlin, Judi. *On Our Own – Patient-Controlled Alternatives to the Mental Health System*, available from the National Empowerment Center at [www.power2u.org](http://www.power2u.org), 2002. Originally published in 1977, copyright © 1977 Judi Chamberlin.
- Copeland, Mary Ellen. *Wellness Recovery Action Plan*, Berkeley: Peach Press, 1997, rev 2002.
- Copeland, Mary Ellen, McKay, Matthew and Riddle, Mary Liz. *The Depression Workbook 2<sup>nd</sup> Edition: A Guide for Living with Depression and Manic Depression*, Oakland, California: New Harbinger Publications, 2002.
- Corrigan, Patrick and Lundin, Robert. *Don't Call Me Nuts! – Coping with the Stigma of Mental Illness*, Chicago: Recovery Press, 2001.
- NAMI. *Peer-to-Peer Education Course*, an experimental program, 2001. Information about this program is online at: [web.nami.org/about/peer.html](http://web.nami.org/about/peer.html)
- Ragins, Mark. , *The Road to Recovery*, a book available on line at <http://www.village-isa.org/Ragins%20Papers/Road%20to%20Recovery.htm>.
- Wahl, Otto F. *Telling is Risky Business – Mental Health Consumers Confront Stigma*, New Brunswick, New Jersey: Rutgers University Press, 1999.

## Religion and Mental Illness

- Bender, Sue. *Everyday Sacred – A Woman's Journey Home*, San Francisco: HarperSanFrancisco, 1995.
- Boisen, Anton. *The Exploration of the Inner World – A Study of Mental Disorder and the Religious Experience*, Philadelphia: University of Pennsylvania Press, 1936.
- Carlson, Dwight L. *Why Do Christians Shoot Their Wounded?: Helping (Not Hurting) Those with Emotional Difficulties*, Downers Grove, IL: InterVarsity Press, 1994.
- Christiansen, Gunnar. "Successful Partnerships with Churches are built step by step – Don't 'dump and run' ", *NAMI California Connection*, Winter 2002, pp 14-15.
- Clinebell, Howard. *Well Being--A Personal Plan For Exploring & Enriching The 7 Dimensions Of Life--Mind, Body, Spirit, Relationships, Work, Play, Earth*, San Francisco: Harper, 1992.
- Elliott, William. *Tying Rocks to Clouds, Meetings and Conversations with Wise and Spiritual People*, Wheaton, Illinois: Quest Books, 1995.
- Fleischman, Paul R. *The Healing Spirit – Explorations in Religion and Psychotherapy*, Cleveland: Bonne Chance Press, 1994. Originally published as *The Healing Zone – Religious Issues in Psychotherapy* by Paragon House, 1989.
- Frankel, Estelle. *Sacred Therapy: Jewish Spiritual Teachings on Emotional Healing and Inner Wholeness*, Boston: Shambhala, 2004.
- Freud, Sigmund. *Future of an Illusion*, in *The standard edition of the complete psychological works*, vol. XIII (pp 1-162) London: Hogarth Press, 1955. Original work published in 1913.
- Govig, Stewart D. *In the Shadow of Our Steeples: Pastoral Presence for Families Coping with Mental Illness*, New York: Haworth Press, Inc., 1999.
- Gregg-Schroeder, Susan. *In the Shadow of God's Wings – Grace in the Midst of Depression*, Nashville: Upper Room Books, 1997. There is a study guide called *In the Shadow of God's Wings – Grace in the Midst of Depression – Group Study Guide*.
- Grof, Stanislav and Grof, Christina. *Spiritual Emergency – When Personal Transformation Becomes a Crisis*, Los Angeles: J. P. Tarcher, 1989.
- Horning, Crystal. *A Christian View of Mental Illness: Understanding and Response*, Goshen, Indiana: Mennonite Mutual Aid, 2001.
- James, William. *The Varieties of Religious Experience – A Study in Human Nature being the Gifford Lectures on Natural Religion Delivered at Edinburgh in 1901-1902*, New York: New American Library, 1958.
- Josephson, Allan M., and Peteet, John R. *Handbook of Spirituality and Worldview in Clinical Practice*, Washington, DC: American Psychiatric Publications, Inc., 2004.
- Jung, Carl G. *Collected Works*, Princeton: Princeton University Press, 1970. Originally published in 1958.
- Jung, Carl G. *Psychology and Religion*, Based on the Terry Lectures delivered at Yale University, New Haven: Yale University Press, 1938.
- Kahle, Peter A. *The Power of Spirituality in Therapy: Integrating Spiritual and Religious Beliefs in Mental Health Practice*, New York: The Haworth Pastoral Press, 2004.
- Liebman, Joshua. *Peace of Mind*, New York: Simon and Schuster, 1946.



- Loewenthal, Kate M. *The Psychology of Religion: A Short Introduction*, Oxford, England: Oneworld Publications, 2000.
- Kelsey, Morton. *Healing Christianity – A Classic Study*, Minneapolis: Augsburg, 1995.
- Malina, Bruce. *The New Testament World – Insights from Cultural Anthropology – Third Edition Revised and Expanded*, Louisville, Kentucky: Westminster John Knox Press, 2001.
- Martin, Philip. *The Zen Path through Depression*, New York: Harper San Francisco, 1999.
- Mohr, Sylvia and Huguélet, Philippe. “The Relationship between Schizophrenia and Religion and its Implications for Care,” *Swiss Medical Weekly*, 2004; 134:369-376.
- Muktananda, Swami. *Meditate- Happiness Lies Within You*, South Fallsburg, New York: Syda Foundation, 1999.
- Patton, Sally. *Welcoming Children With Special Needs: A Guidebook for Faith Communities*, Boston: Skinner House, 2004.
- Richards, P. Scott and Bergin, Allen E. *Casebook for A Spiritual Strategy in Counseling and Psychotherapy*. Washington, DC: American Psychological Association, 2004.
- Roukema, Richard W., M.D. *The Soul in Distress – What Every Pastoral Counselor Should Know About Emotional and Mental Illness*, New York: The Haworth Pastoral Press, 1997.
- Schumaker, J.F., editor. *Religion and Mental Health*, New York: Oxford University Press, 1992.
- Severino, Sally and Richard Liew, Editors. *Pastoral Care of the Mentally Disabled; Advancing Care of the Whole Person*, New York: Haworth Press, Inc., 1996.
- Shorto, Russell. *Saints and Madmen – Psychiatry Opens Its Doors to Religion*, New York: Henry Holt and Company, 1999.
- Sperry, Len and Shafranske, Edward P. *Spiritually Oriented Psychotherapy*, Washington, DC: American Psychological Association, 2005.
- Swinton, John. *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*, Nashville: Abingdon Press, 2000.
- Thomas, Leo and Alkire, Jan. *Healing Ministry – A Practical Guide*, Notre Dame: Ave Maria Press, 1992.
- Toews, John and Lowen, Eleanor. *No Longer Alone*, Scottdale, PA: Herald Press, 1995.
- Toth, J.C. “Faith in Recovery – Spiritual Support after an Acute Mental Illness”, *Journal of Christian Nursing*, Fall 1992, pp. 28-31.
- Ulanov, Ann and Barry. *Religion and the Unconscious*, Philadelphia: The Westminster Press, 1975.
- Waterhouse, Stephen. *Strength for His People: A Ministry for Families of the Mentally Ill*, Amarillo, TX: Westcliff Bible Press, 1994.
- Wuellner, Flora Slosson. *Prayer, Stress and Our Inner Wounds*, Nashville: Upper Room Books, 1985.
- Wulff, David. *Psychology of Religion – Classic and Contemporary Views*, New York: John Wiley and Sons, 1991.

## Curricula

- Shifrin, Jennifer. *Pathways to Understanding: Manuals and a Videotape on Ministry and Mental Illness*, St. Louis: Pathways to Promise.
- Strobel, Shirley. *Creating a Circle of Caring: The Church and the Mentally Ill*, Arlington, VA: National Alliance for the Mentally Ill, 2000.

## Unitarian Universalist Publications

- Parker, Rebecca. *A Theology of Religious Education*, LREDA Fall Conference, 2002, Asheville, North Carolina, published as a series of audio tapes by the Liberal Religious Educators Association of the Unitarian Universalist Association.
- Unitarian Universalist Association. *The Welcoming Congregation*, 2<sup>nd</sup> edition, Boston: Unitarian Universalist Association, 1999.
- Unitarian Universalist Association, *Singing the Living Tradition*, Beacon Press, 1993.
- Wilson, Pamela, *Training Manual for Our Whole Lives Sexuality Education, Implementation Workshop*, developed for UUA, July 1999.

## Mental Health Organizations on the World Wide Web

<b>General Mental Health Information</b>	
• <b>Internet Mental Health</b>	A free encyclopedia of mental health information created

www.mentalhealth.com	by a Canadian psychiatrist, Dr. Phillip Long.
· <b>Mental Health Matters</b> www.mental-health-matters.com	Mental health self help and psychology information and resources.
· <b>Mental Health Sanctuary</b> www.mhsanctuary.com	Information on mental disorders, suicide intervention, books, articles, and medication.
<b>Medical Information</b>	
· <b>Drug Information</b> www.drugs.com health.yahoo.com/drug	On line information on drugs
· <b>Health Library - Stanford</b> .healthlibrary.stanford.edu	Stanford's on line health library
· <b>Worst Pills</b> www.worstpills.org	Drug information from Public Citizen's Health Research Group
<b>Self-Help Groups and Therapies</b>	
· <b>Al-Anon / Alateen</b> www.al-anon.alateen.org	For families and teen-age children of alcoholics
· <b>Alcoholics Anonymous</b> www.alcoholics-anonymous.org	For alcohol addicts
· <b>Cocaine Anonymous</b> www.ca.org	For cocaine addicts
· <b>Emotions Anonymous</b> www.emotionsanonymous.org	For people with emotional problems
· <b>Mental Health Recovery</b> www.mentalhealthrecovery.com	Website of Mary Ellen Copeland, developer of WRAP, the Wellness Recovery Action Program™.
· <b>Narcotics Anonymous</b> www.na.org	For narcotics addicts
· <b>Recovery, Inc.</b> www.recovery-inc.com	Recovery from mental health problems founded by the neuropsychiatrist Abraham A. Low, M.D.
<b>Websites for Specific Disorders and Causes</b>	
· <b>Alzheimer's Association</b> www.alz.org	The first and largest organization dedicated to finding prevention methods, treatments and an eventual cure for Alzheimer's.
· <b>Anorexia Nervosa and Related Eating Disorders</b> www.anred.com	Information, self-help tips, recovery and prevention of anorexia nervosa, bulimia nervosa, bingeing and other eating disorders.
· <b>Anxiety Disorders Association of America</b> www.adaa.org	Promotes the prevention, treatment and cure of anxiety disorders and to improve the lives of all people who suffer from them.
· <b>Autism Society of America</b> www.autism-society.org	Promotes opportunity for all autistic individuals to be fully participating members of their community through education, advocacy at state and federal levels, active public awareness and the promotion of research.
· <b>Borderline Personality Disorder Resources</b> www.bpdresources.com	Geared for friends/family/loved ones of those with Borderline Personality Disorder
· <b>Borderline Personality Disorder Sanctuary</b> www.mhsanctuary.com/borderline	Education, communities, support, books, and resources for borderline personality disorder.
· <b>Children and Adults with Attention Deficit Disorders</b> www.chadd.org	Non-profit serving individuals with AD/HD through leadership, advocacy, research, education and support.
· <b>Depressive and Bipolar Support Alliance</b> www.dbsalliance.org	Organization with many self-help group chapters to improve the lives of people with mood disorders.
· <b>The Hoarding of Animals Research Coalition</b> www.tufts.edu/vet/cfa/hoarding/index.htm	A collection of resources to help better understand the phenomenon of animal hoarding
· <b>International Association for Suicide Prevention</b> www.med.uio.no/iasp	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.

· <b>Learning Disabilities Association of America</b> www.ldanatl.org	Education, advocacy, encourage research into learning disorders.
· <b>National Alliance for Research on Schizophrenia and Depression</b> www.narsad.org	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.
· <b>Oassis</b> www.oassis.org	Organization for Attempters and Survivors of Suicide works to prevent suicide, increase suicide awareness and remove the stigma on attempters and survivors.
· <b>Obsessive Compulsive Foundation</b> www.ocfoundation.org This website includes: · <b>Compulsive Hoarding</b> www.ocfoundation.org/1005/index.html	Information and resources, for people with obsessive compulsive disorder, their families, friends, professionals and other concerned individuals.
· <b>TARA</b> www.tara4bpd.org	Treatment and Research Advancements Association for Personality Disorders, including Borderline Personality Disorder. Supports research, education, and advocacy for personality disorders.
<b>Advocacy Organizations</b>	
· <b>Mad Nation</b> www.madnation.org	Mental health client advocacy group with many non-mainstream mental health links.
· <b>Mental Help Net</b> www.mentalhealth.net	Promotes mental health and wellness education and advocacy.
· <b>NAMI</b> www.nami.org	NAMI is a self-help, support and advocacy organization of mental health clients, families, and friends of people with severe mental illnesses. Local affiliates and state organizations identify and work on issues most important to their community.
· <b>NAMI Alameda County</b> www.nami-alamedacounty.org	Alameda County, California chapter of NAMI provides group support, education, and advocacy for people with mental illness and their families.
· <b>NAMI Santa Clara County</b> www.namisantaclara.org	Santa Clara County, California chapter of NAMI offers experience, support, comfort, and education for people with mental illness and their families.
· <b>NAMI Family-to-Family Education Program</b> www.nami.org/family	A 12-week course for family caregivers of individuals with severe brain disorders.
· <b>NAMI Peer-to-Peer Education Program</b> www.nami.org/about/peer.html	A program for people with any serious mental illness who are interested in establishing and maintaining their wellness and recovery.
· <b>National Mental Health Association</b> www.nmha.org	NMHA works to improve the mental health of people with mental disorders, through advocacy, education, research and service.
· <b>National Empowerment Center</b> www.power2u.org	Website has practical information that will help you recover if you have been labeled with a mental illness
· <b>National Mental Health Consumers' Self Help Clearing House</b> www.mhselfhelp.org	The nation's first national 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.
· <b>MindFreedom Support Coalition International</b> www.mindfreedom.org	Goal is to win campaigns for human rights of people diagnosed with psychiatric disabilities. Sign up for email alerts.
· <b>World Network of Users &amp; Survivors of Psychiatry</b> www.wnusp.org	An organization of users and survivors of psychiatry which advocates for human rights, promotes the user/survivor movement around the globe, and links user/survivor organizations and individuals throughout the world.
<b>Religious Resources</b>	
· <b>Congregational Resource Guide, NAMI Illinois</b> www.congregationalresources.org/mentalhealth.asp	An annotated collection of mental health ministry resources
· <b>FaithNet NAMI California</b> www.faithnetnami.org	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.
· <b>Mental Health Ministries</b> www.mentalhealthministries.net	Interfaith outreach to enable faith communities to provide compassionate care to those affected by mental illness.
· <b>Pathways to Promise</b> www.pathways2promise.org	Clergy Information: 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.
· <b>VICOMIM</b> www.vaumc.org/gm/micom.htm	Virginia Interfaith Committee on Mental Illness Ministries. Educates clergy and laity toward an awareness and sensitivity within the faith communities about mental illness.
<b>Denominational Mental Health Websites:</b> · <b>Anabaptist:</b> www.adnetonline.org · <b>Episcopal:</b> www.eminnews.org · <b>Evangelical Lutheran:</b> www.elca.org/disability/candlelighting · <b>Presbyterian:</b> www.pcusa.org/health/usa/resources/mental-illness.htm · <b>Unitarian Universalist:</b> www.uua.org/programs/idbm/accessibilities/disability8.htm www.uua.org/YRUU/resources/online/teensuicide.htm · <b>United Church of Christ:</b> www.min-ucc.org	Many religious denominations have information on line describing what they do in support of mental health issues.
<b>Government Websites</b>	
· <b>California Care Network</b> www.calcarenet.ca.gov/default.asp	Find California state-licensed health, social services, mental health, alcohol and other drug, disability and elder care services and facilities.
· <b>National Institute on Aging: Alzheimer's Education &amp; Referral</b> www.alzheimers.org	Compiles, archives, and disseminates information concerning Alzheimer's disease for health professionals, people with AD and their families, and the public. In the Department of Health and Human Services.
· <b>National Mental Health Information Center</b> www.mentalhealth.org	Substance Abuse and Mental Health Services Administration in US Department of Health and Human Services
· <b>National Institute on Alcohol Abuse and Alcoholism</b> www.niaaa.nih.gov	US government leadership in the effort to reduce alcohol-related problems.
· National Institute on Drug Abuse www.nida.nih.gov	Mission is to lead the nation in bringing the power of science to bear on drug abuse and addiction.
· <b>National Institute of Mental Health</b> www.nimh.nih.gov	The lead US governmental agency for research on mental and behavioral disorders.
· <b>U.S. Department of Veterans Affairs - Mental Health</b> www.mentalhealth.med.va.gov	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.
<b>Professional Organizations</b>	
· <b>American Association of Pastoral Counselors</b> www.aapc.org	Pastoral Counseling is a unique form of psychotherapy which uses spiritual resources as well as psychological understanding for healing and growth.
· <b>American Psychiatric Association</b> www.psych.org	A medical specialty society for psychiatrists. Members work together to ensure humane care and effective treatment for all persons with mental disorders.
· <b>Bazelon Center for Mental Health Law</b> www.bazelon.org	A national legal advocate for people with mental disabilities.

# INDEX

## A

Ackerman, Nathan, 88, 256  
Adler, Alfred, 86  
Affect, 64, 249  
Agnosia, 249  
Agoraphobia, 22, 52, 158, 187  
Aichhorn, August, 87  
Alogia, 57, 249  
Alzheimer's type Dementia, 100  
Amok, 94, 103  
Anorexia nervosa, 55  
Antisocial Personality Disorder, 64  
Anxiety Disorders, 22, 42, 52, 70, 158, 164, 187, 253, 260  
    Agoraphobia, 22, 52, 158, 187  
    Case Study of Agoraphobia, 53  
    Case study of Obsessive-Compulsive Disorder, 53  
    Case Study of Post Traumatic Stress Disorder, 54  
    Obsessive-Compulsive Disorder, 52, 187, 253  
    Panic Attack, 52, 253, 254, 268  
    Post Traumatic Stress Disorder, 52, 95, 104, 187, 188  
Aphasia, 249  
Aphonia, 62, 249  
Appendixes, 234  
Ataque de nervios, 94, 103  
Avolition, 57, 249

## B

Beers, Clifford, 83, 86, 255, 257  
Berger, Lisa and Berger, Diane, 132  
Bernstein, David, 68  
Bethlehem Hospital, 85  
Bill of Rights for mental health clients, 128  
Binet, Alfred, 86, 98  
Bipolar Disorder, 50, 51, 187, 253, 255  
Black, Donald, ii, 65, 254  
Bleuler, Eugen, 87  
Body Dysmorphic Disorder, 22, 62, 158  
Borderline Personality Disorder, 64, 65, 189, 254, 260, 261  
Boufée delirante, 94, 104  
Buehrens, John, 84  
Bulimia nervosa, 55

## C

Caring Congregation Program  
    Determining Congregational Priorities, 151  
    Other Program Ideas, 187  
    Participation Guidelines, 6  
    Steps to becoming a Caring Congregation, 3  
    Tailoring the Program to Your Congregation, 4  
    Training of leaders. *See* Leaders Workshop  
    What does it mean to be a Caring Congregation, 3  
Caring Congregation Workshops, 4  
    Adding Artistic, Literary and Musical Dimensions to the Workshops, 5, 198  
    Children's Workshop 1 - Introducing Mental Disorders to Children, 168

    Children's Workshop 2 - Recognizing Feelings, 170  
    Children's Workshop 3 - Being Compassionate to Someone with a Mental Disorder, 175  
    Children's Workshop 4 - Learning and practicing empathy and communication skills, 178  
    Lessons for Children, 165  
    Pastoral Care Workshop 1 - Mental Disorder and its Consequences and Treatment, 154  
    Pastoral Care Workshop 2 - Mental Disorders - Families, Religion and Pastoral Care, 159  
    Pastoral Care Workshops, 153  
    Workshop 1 - Mental Disorders and their Consequences, 8  
    Workshop 2 - Specific Mental Disorders and how they are Diagnosed, 39  
    Workshop 3  
        The History of Mental Disorders, 76  
    Workshop 4 - Mental Disorders in Special Populations, 89  
    Workshop 5 - Mental Health Treatment, 116  
    Workshop 6 - Families and Friends of those with Mental Disorders, 131  
    Workshop 7 - The Role of the Church, 149  
Case Studies  
    A Family's Story, 132  
    Agoraphobia, 53  
    Alcohol Dependence, 60  
    Alzheimer's type dementia, 101  
    Anorexia Nervosa, 56  
    Antisocial Personality Disorder, 65  
    Asperger's Disorder, 98  
    Attention Deficit Hyperactivity Disorder, 99  
    Autism, 98  
    Bipolar Disorder, 51  
    Borderline Personality Disorder, 65  
    Dependent Personality Disorder, 68  
    Family of Alzheimer's Patient, 101  
    Heroin Dependence, 61  
    Histrionic Personality Disorder, 67  
    Major Depressive Disorder, 51  
    Narcissistic Personality Disorder, 66  
    Obsessive-Compulsive Disorder, 53  
    Pain Disorder, 63  
    Paranoid Personality Disorder, 66  
    Post Traumatic Stress Disorder, 54  
    Schizophrenia, 58  
    Schizotypal Personality Disorder, 68  
Cassian, John, 82  
Catatonic behavior, 57, 249, 251  
Chamberlin, Judi, ii, 84, 88, 120, 258  
Childhood. *See* Infancy, Childhood and Youth Disorders  
Clinebell, Howard, 124, 258  
Coffee Hour Skit, 13  
Cole, T. L., ii, 65  
Compulsion, 52, 249, 253  
Conduct Disorder, 97, 190  
Consumer Movement, 119, 128  
Conversion Disorder, 22, 62, 158  
Conversion symptom, 249  
Copeland, Mary Ellen, ii, 128, 130, 260

Culture, 88, 94, 103, 104, 105, 109, 110, 255, 257  
Culture-bound syndrome, 94, 103, 105  
Cutting, 44

## D

Daun Gets Stuck, 178, 180  
Delusion, 249, 251  
    Bizarre, 249  
    Erotomanic, 249  
    Grandiose, 249  
    Jealous, 249  
    Of being controlled, 249  
    Of reference, 249  
    Persecutory, 249  
Delusional Disorder, 57  
Dementia. *See* Disorders of the Elderly  
Depersonalization, 250  
Depression, 22, 23, 34, 51, 70, 105, 147, 158, 164, 187, 188, 268  
Derailment, 57, 250  
Derealization, 250  
Dhat, 95, 104  
Disorders of the Elderly, 91, 100  
    Case Study of Alzheimer's patient, 101  
    Case Study of Family of Alzheimer's patient, 101  
    Dementia, 22, 34, 87, 91, 100, 158, 164, 189, 254, 256  
        Alzheimer's type, 100  
        Caused by a medical condition, 100  
        Substance-induced, 100  
        Vascular, 100  
    Disorders of Cognition, 100  
Disorganized speech, 22, 57, 158, 250, 251  
Dix, Dorothea, 72, 73, 83, 86, 257, 268  
Domrich, Otto, 86  
Duke, Patty, 255  
Dyskinesia, 250

## E

Eating Disorders, 42, 55, 188, 254, 260  
    Anorexia nervosa, 55  
    Bulimia nervosa, 55  
    Case Study of Anorexia Nervosa, 56  
ECT. *See* Electro-convulsive therapy  
Egodystonic, 250  
Egosentonic, 250  
Elderly. *See* Disorders of the Elderly  
Electro-convulsive therapy, 87, 120, 125, 128, 160, 250  
Electro-shock Therapy. *See* Electro-convulsive therapy  
Erikson, Eric, 88  
Ethnicity, 88, 94, 103, 104, 107, 257  
Etiology, 30, 250

## F

Factitious disorders, 250  
Families, 131  
    Adult Children, 137, 139  
    Case Study of A Family's Story, 132  
    Communication Guidelines, 141, 160  
    Coping Strategies for Mental Health Clients, 140  
    Coping with a Loved One's Mental Disorder, 138  
    Life Burdens, 137, 160  
    Primary Caretakers, 137

Siblings, 137, 139  
Spouses, 137  
Stages of Emotional Reactions among Family Members, 131, 136, 160

Feel and Speak Drama Game, 179, 184, 186  
Flashback, 187, 250  
Fleischman, Paul, ii, 145, 150, 152, 161, 162, 258  
Flight of ideas, 50, 250  
Franklin, Benjamin, 82  
Freud, Sigmund, 83, 86, 87, 145, 150, 258

## G

Gheel, 85  
Ghost sickness, 95, 104, 105  
Glossary, 157, 249  
Grandiosity, 50, 64, 250  
Gregg-Schroeder, Susan, ii, 8, 51, 146, 149, 150, 154, 199, 219, 258, 268

## H

Hallucination, 250  
    Gustatory, 249  
    Olfactory, 249  
    Somatic, 249  
    Tactile, 249  
    Visual, 249  
Handly, Robert, 53, 253, 268  
Hanson, Gary, ii, 67, 254, 268  
Hartigan, Francis, 60, 255, 268  
Hearing Voices Skit, 42, 45, 217  
Heinroth, Johann Christian, 86  
Hippocrates, 85  
History of Mental Disorders, 76  
    Historical Quotes, 81  
    Shamanism, 77, 80  
    Time Line, 85  
    Time Periods in Mental Health History, 79  
    Unitarians, Universalists and Mental Health Care, 72, 77  
Histrionic Personality Disorder, 64, 190, 254, 268  
Hwa-Byung, 95, 104, 105  
Hypochondria, 22, 62, 158  
Hysteria. *See* Histrionic Personality Disorder

## I

Ideas of reference, 250  
Idiom of distress, 94, 103, 104, 250  
Ilkka, Karen, ii, 44  
Illusion, 250  
Incidence, 250  
Incoherence, 57, 250  
Infancy, Childhood and Youth Disorders, 90  
    Autism, 97  
    Case Study of Asperger's Disorder, 98  
    Case study of Attention Deficit Hyperactivity Disorder, 99  
    Case Study of Autism, 98  
    Communication Disorders, 97  
    Conduct Disorder, 97, 190  
    Learning Disorders, 97  
    Mental Retardation, 97, 189, 190  
    Oppositional Defiant Disorder, 97

## J

James, William, 86, 144, 198  
Jamison, Kay Redfield, 51, 253, 255, 268  
Jung, Carl, 87, 144, 150, 162, 258

## K

Kallman, Franz, 87  
Kanner, Leo, 87  
Kinsey, Alfred, 87  
Kraepelin, Emil, 66, 86, 254, 268

## L

Leader's Workshop  
  Basic Facilitation Skills, 208  
  Caring Congregation Evaluation after Teaching, 231  
  Curriculum Treasure Hunt, 212, 213, 214  
  Curriculum Treasure Hunt Tasks, 212, 213  
  Curriculum Treasure Hunt Tasks Answers, 214  
  Demonstration of an Example Workshop Session, 207  
  Effective Group Facilitation Techniques, 209  
  Empathy, 217  
  Expectations of the Trainers and Attendees, 195, 203  
  Guidelines for Choosing Leaders, 192, 193  
  Handling Hot Potatoes, 210  
  Leadership Training Evaluation after Teaching, 230  
  Leadership Training Evaluation before Teaching, 229  
  Leading the Peer Teaching Assignments, 223  
  Line Dance, 204  
  Moving from Workshops to Congregational Action, 219  
  Opening Rituals, 198  
  Our Stories, 206  
  Peer Teaching Assignment Sheet, 222  
  Peer Teaching Assignments, 221  
  Sample Worship Service on Mental Health, 226  
  Suggested Weekend Training Agenda, 195  
  Training Lessons, 197  
  Training Service and Forms, 225  
  What would you do if...?, 218  
  Wrap Up and Closing Ritual, 224  
Learning Disorders, 97  
Lessons for Children, 165  
  Daun Gets Stuck, 178, 180  
  Feel and Speak Drama Game, 179, 184, 186  
  Feeling Faces Chart, 173  
  Guidelines for Class, 167  
  My Rainbow Song, 169  
  Template for Feelings Art Project, 170, 171, 174  
Lobotomy, 79, 87  
Luxenburger, H., 87

## M

Mal de ojo, 95, 104  
Malingering, 251  
Malleus Maleficarum, 82  
McMaster, Curtis, iii, 61, 254, 268  
Medications, 125  
  Anticycling agents, 125  
  Antidepressants, 125  
  Antipsychotics, 125  
  Common Psychiatric, 117, 126  
  Hypnoanxiolytics, 125

Stimulants, 125

Mental Disorder

Anxiety Disorders, 22, 42, 52, 70, 158, 164, 187, 253, 260  
Attention Deficit and Disruptive Behavior Disorders, 97  
Categories, 22, 155, 158  
Causes, 23  
Disorders of the Elderly, 100  
Disruptive, 22, 158, 210, 211  
Eating Disorders, 42, 55, 188, 254, 260  
Mood Disorders, 22, 41, 50, 70, 158, 187, 253, 255  
Myths and Stereotypes, 24, 156  
Personality Disorders, 22, 43, 64, 66, 70, 158, 164, 189, 254, 261, 268  
Psychotic Disorders, 22, 42, 57, 158, 164, 188, 253  
Somatoform Disorders, 22, 62, 158  
Stigma of Mental Disorders, 25  
Substance Related Disorders, 43, 59, 188  
Violence, 24

Mental Retardation, 97, 189, 190

Mesmer, Franz, 85

Meyers, Barbara F., ii, 58, 80, 237

Moniz, Egas, 87

Mood, 251

Mood Disorders, 22, 41, 50, 70, 158, 187, 253, 255

  Bipolar Disorder, 50, 51, 187, 253, 255

  Case Study Bipolar Disorder, 51

  Case Study Major Depressive Disorder, 51

  Depression, 22, 23, 34, 70, 105, 147, 158, 164, 187, 188, 268

  Depressive Episode, 50, 57

  Manic Episode, 50, 57

  Postpartum Depression, 50

  Myths and Stereotypes, 24, 156

## N

NAMI. *See* National Alliance on Mental Illness

Narcissistic Personality Disorder, 64, 189

National Alliance on Mental Illness (NAMI), iii, 42, 88, 92, 131, 134, 136, 137, 139, 141, 190, 217, 235, 236, 237, 241, 243, 245, 247, 248, 251, 257, 258, 261

  Family-to-Family, 42, 136, 137, 139, 257, 261

  Family-to-Family program, 142, 217

  Main Reference on NAMI, 142

  Peer-to-Peer, 258, 261

  Peer-to-Peer Program, 142

  Provider Education Program, 142

Neff, Pauline, 53, 253, 268

Neurotransmitter, 251

Norepinephrine, 251

## O

Obsession, 52, 251

Obsessive-Compulsive Disorder, 52, 187, 253

  Compulsions, 52, 253

  Obsessions, 52, 253

Oppositional Defiant Disorder, 97

Other Program Ideas, 187

  An Outside Speaker or Panel, 190

  Film Night or Film Series, 187

  Worship Service, 191

## P

Pain Disorder, 22, 62, 158  
Panic Attack, 52, 251, 253, 254, 268  
Paranoid ideation, 69, 251  
Paranoid Personality Disorder, 64, 190  
Park, Clara Claiborne, iii, 98, 256  
Pastoral Care Workshops, 153  
    Families, Religion and Pastoral Care, 159  
    Mental Disorder and its consequences and treatment, 154  
People Bingo, 9, 12  
Perceval, John, 256  
Personality, 251  
Personality Disorders, 22, 43, 64, 66, 70, 158, 164, 189, 254, 261, 268  
    Antisocial Personality Disorder, 64  
    Borderline Personality Disorder, 64, 65, 189, 254, 260, 261  
    Case study of Antisocial Personality Disorder, 65  
    Case study of Borderline Personality Disorder, 65  
    Case Study of Dependent Personality Disorder, 68  
    Case Study of Histrionic Personality Disorder, 67  
    Case Study of Narcissistic Personality Disorder, 66  
    Case study of Paranoid Personality Disorder, 66  
    Case Study of Schizotypal Personality Disorder, 68  
    Histrionic Personality Disorder, 64, 190, 254, 268  
    Narcissistic Personality Disorder, 64, 189  
    Paranoid Personality Disorder, 64, 190  
    Schizotypal Personality Disorder, 64, 268  
Pervasive Developmental Disorders, 97  
Phillips, Kevin, iii, 98  
Phobia, 251  
Pierce, Franklin, 86  
Pinel, Philippe, 85  
Planning  
    Building a Caring Congregation Plan, 235  
Post Traumatic Stress Disorder, 52, 95, 104, 187, 188  
Power Study, 237  
prevalence, 251  
Prevalence, 251  
Psychotic, 251  
Psychotic Disorders, 22, 42, 57, 158, 164, 188, 253  
    Case Study of Schizophrenia, 58  
    Delusional Disorder, 57  
    Schizoaffective Disorder, 57, 188  
    Schizophrenia, 22, 23, 33, 34, 57, 70, 105, 142, 158, 164, 188, 213, 253, 255, 256, 257, 261

## Q

Quotes, Historical. *See* History of Mental Disorders:  
    Historical Quotes

## R

Race, 88, 91, 94, 103, 104, 107, 257  
Race and Ethnicity in Mental Disorders, 91  
Ragins, Mark, 258  
Rahman, Peggy, iii, 169  
Recovery Model, 117, 123, 159  
    Stages of Recovery, 117, 123, 258  
Reil, Johann, 86  
Religious or spiritual problem, 251  
Resources, 253, 260, 261  
    Books and Documents, 253

    Curricula, 259  
    History of Mental Illness, 256  
    Information about Mental Disorders and their Treatment, 253  
    Personal Stories, 255  
    Religion and Mental Illness, 258  
    Resources for Families, 257  
    Resources for Mental Health Clients, 257  
    Unitarian Universalist Publications, 259  
Mental Health Organizations on the World Wide Web, 259  
Robbins, Stephen J., iii, 54, 253, 255, 268  
Rorschach, Herman, 87  
Rush, Benjamin, 73, 82, 85, 86, 257

## S

Schizoaffective Disorder, 57, 188  
Schizophrenia, 22, 23, 33, 34, 57, 70, 105, 142, 158, 164, 188, 213, 253, 255, 256, 257, 261  
Schizotypal Personality Disorder, 64, 268  
Serotonin, 250, 251  
Shamanism, 77, 80  
Shorto, Russell, 145, 162, 259  
Sign, 251  
Skinner, B.F., 87, 259  
Somatoform Disorders, 22, 62, 158  
    Body Dysmorphic Disorder, 22, 62, 158  
    Case Study of Pain Disorder, 63  
    Conversion Disorder, 22, 62, 158  
    Hypochondria, 22, 62, 158  
    Pain Disorder, 22, 62, 158  
Spirituality and Mental Disorders, 144, 150  
    Gifts of the Shadow, 146  
    Primary religious experience, 148  
    Religion and Mental Health, 147, 148, 150, 151, 160, 162, 163, 259  
    Religious Ideation and Mental Disorders, 146  
    Ritual, 104, 148, 198, 200  
    Spiritual Emergence, 146  
Stigma of Mental Disorders, 25  
Stone, Michael, 84, 88  
Substance Related Disorders, 43, 59, 188  
    Abuse, 22, 59, 70, 105, 158, 254, 262, 268  
    Case Study of Alcohol Dependence, 60  
    Case Study of Heroin Dependence, 61  
    Dependence, 22, 59, 158  
    Dual Diagnosis, 59, 254  
Suicide, 43, 44, 70, 88, 105, 147, 187, 189, 254, 255, 257, 260, 261  
    QPR Model, 70, 210  
    Suicide intent, 70  
Surgeon General's Report  
    Mental Health - Culture, Race, and Ethnicity - A Supplement to Mental Health - A Report of the Surgeon General on Mental Health, 106  
    On Mental Health - A Report of the Surgeon General on Mental Health, 26  
Susto, 95, 104  
Symptom, 251  
Syndrome, 252  
Szasz, Thomas, 83, 88, 120, 268



## T

Terminology, 1  
  Consumer, 1  
  Consumer movement, 1  
  Glossary, 249  
  Match-up Cards, 91, 94  
  Mental disorders, 1  
  Mental health client, 1  
  Metal illness, 1  
Therapies, 156  
Therapy, 117, 125, 156  
  Biofeedback, 125  
  Common Psychiatric Medications, 126  
  Couples and Family Therapy, 125  
  Family Therapy, 125  
  Group Therapy, 125  
  Individual Therapy, 125  
  Marriage counseling, 125  
  Medications, 125  
  Operant Conditioning, 125  
  Relaxation, 125  
Thorne, Julia, 255  
Tuke, William, 85  
Turkat, I.D., 68, 268

## U

Unitarian Universalist Association, 84, 88, 259, 268

Unitarians, Universalists and Mental Health Care, 72

## V

Volition, 252

## W

Wagner-Jauregg, Julius von, 87  
Wellness Recovery Action Plan (WRAP), 130, 258  
Weyer, Jonathan, 85  
Wilson Bill, 60, 255, 268  
Wolfe, Thomas, 43, 44, 69, 255, 268  
Wootton, Tom, 255  
Worcester State Lunatic Hospital, 73, 86  
Workman, Joseph, 74, 83, 257  
Worship Service on Mental Health, 226  
Wounded Spirit, 95

## Y

Youth. *See* Infancy, Childhood and Youth Disorders

## Z

Zacchia, Paolo, 85

# End Notes

---

<sup>1</sup> Wilson, Dorothy Clarke, *Stranger and Traveler – The Story of Dorothea Dix, American Reformer*, Little, Brown and Company, New York, 1975, p 95.

<sup>2</sup> We gratefully acknowledge the Unitarian Universalist Association's *Welcoming Congregation Program, Second Edition* that focuses on making congregations more intentionally inclusive towards bisexual, gay, lesbian, and/or transgender persons after which this program is patterned.

<sup>3</sup> This definition of "religion" is from Rev. Steven Edington from the UU Church of Nashua in a sermon entitled "You Call this a Religion?" on May 3, 1998.

<sup>4</sup> These names come from much longer lists in Appendix B of *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* by Kay Redfield Jamison, New York: Free Press Paperbacks, 1994.

<sup>5</sup> Adapted from Gregg-Schroeder, Susan. *In the Shadow of God's Wings – Grace in the Midst of Depression*, Upper Room Books, Nashville, 1997, p 14.

<sup>6</sup> U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General—Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. The entire report can be obtained at the web site of the Surgeon General [www.surgeongeneral.gov/library/mentalhealth/](http://www.surgeongeneral.gov/library/mentalhealth/)

<sup>7</sup> Ex: Kutchins, Herb, and Kirk, Stuart, "Pathologizing Every Day Behavior" ", Chapter 2 in *Making Us Crazy*

<sup>8</sup> For example: Michel Foucault in *Madness and Civilization*, Thomas Szasz in *The Myth of Mental Illness*, and Thomas J. Scheff in *Being Mentally Ill: a sociological theory*

<sup>9</sup> Wolfe, Thomas, Leslie Field, Ed. *The Autobiography of an American Novelist*, © Harvard University Press, Cambridge, Mass., 1983, p 62.

<sup>10</sup> Gregg-Schroeder, Susan. *In the Shadow of God's Wings – Grace in the Midst of Depression*, Upper Room Books, Nashville, 1997, pp 23-24.

<sup>11</sup> Jamison, Kay Redfield. *An Unquiet Mind – A Memoir of Moods and Madness*, Vintage Books, New York, 1995, pp 36-38.

<sup>12</sup> Goodwin, Frederick K. and Jamison, Kay Redfield. *Manic-Depressive Illness*, New York: Oxford University Press, 1990.

<sup>13</sup> This case history is based on an account in Handly, Robert, with Pauline Neff. *Anxiety and Panic Attacks – Their Cause and Cure: The five-point Life-Plus Program for Conquering Fear*, Rawson Associates, New York, 1985, pp 8-12.

<sup>14</sup> Robbins, Steven. *The Long Journey Home*, on line at: [grunt.space.swri.edu/srjourne.htm](http://grunt.space.swri.edu/srjourne.htm)

<sup>15</sup> *Battling Anorexia – The Story of Karen Carpenter* by Adena Young, on line at <http://atdpweb.soe.berkeley.edu/quest/Mind&Body/Carpenter.html> , which was written to acknowledge the importance of educating and empowering women.

<sup>16</sup> "Laura" is a pseudonym for a real-life woman who is living with schizophrenia.

<sup>17</sup> Hartigan, Francis. *Bill W. – A Biography of Alcoholics Anonymous Cofounder Bill Wilson*, St Martin's Press, New York, 2000, pp 29 - 60.

<sup>18</sup> McMaster, Curtis P. *The Tragedy of Heroin Addiction*, in Cothran, Helen, Editor, *Heroin*, Greenhaven Press, San Diego, 2001, pp 29-33.

<sup>19</sup> *The Textbook of Primary and Acute Care Medicine, 2<sup>nd</sup> Edition*, edited by Gideon Bosker, MD, FACEP, Editor-in-Chief of *Emergency Medicine Reports*. Thomson American Health Consultants, 2004. Part XVII, Psychiatric Disorders.

<sup>20</sup> From *Bad Boys, Bad Men – Confronting Antisocial Personality Disorder*, by Donald W. Black, M.D., with C. Lindon Larson, copyright © Oxford University Press, pp 2-4. Used by permission of Oxford University Press, Inc.

<sup>21</sup> Kraepelin, Emil, *Manic-Depressive Insanity and Paranoia*, Arno Press, New York, 1976, pp 227-228.

<sup>22</sup> Bayer, Linda, *Personality Disorders, The Encyclopedia of Psychological Disorders* Chelsea House Publishers, New York, 2000, pp 60-61.

<sup>23</sup> Hanson, Gary D. *Histrionic Personality Disorder (Formerly known as hysteria)*, on line at [narramore.gospelcom.net/bk\\_128\\_histrionic1.htm](http://narramore.gospelcom.net/bk_128_histrionic1.htm) and [narramore.gospelcom.net/bk\\_128\\_histrionic2.htm](http://narramore.gospelcom.net/bk_128_histrionic2.htm), copyright 2003 Narramore Christian Foundation.

<sup>24</sup> Bernstein, David, P., "Schizotypal Personality Disorder" in *Adult Psychopathology Case Studies*, Irving G. Weiner, ed., Hoboken, NJ: John Wiley & Sons, 2004, pp 75-77.

<sup>25</sup> Turkat, I.D., and Carlson, C.R. "Data-based vs. symptomatic formulation of treatment: The case of a dependent personality." *Journal of Behavior Therapy and Experimental Psychiatry*, Vol. 15, No 2, 1984 pp 154-157.

- <sup>26</sup> Rosenthal, Dr. David. "Was Thomas Wolfe a Borderline?" *Schizophrenia Bulletin*, v. 5 no. 1, 1979, pp 87-94. You may also want to see: Wolfe, Thomas, Leslie Field, Ed. *The Autobiography of an American Novelist*, Cambridge, Mass.: Harvard University Press, 1983.
- <sup>27</sup> This essay can be used as a sermon or a lecture on the subject of mental illness. See also the Sample order of service in the appendix.
- <sup>28</sup> Stone, Michael. *Healing the Mind: A History of Psychiatry from Antiquity to the Present*, W.W. Norton & Company, 1997, p. xi.
- <sup>29</sup> *Encyclopedia Britannica* article on Trepanation, 1990
- <sup>30</sup> Lisowski, F.P. *Prehistoric and Early Historic Trepanation*, 1947, available online at: [www.trepan.com/survey.html](http://www.trepan.com/survey.html).
- <sup>31</sup> *The Malleus Maleficarum*, Part I, Question 7, 1486, available on line at: [www.malleusmaleficarum.org/part\\_I/mm01\\_07a.html](http://www.malleusmaleficarum.org/part_I/mm01_07a.html)
- <sup>32</sup> *The Massachusetts Body of Liberties*, adopted as law by the General Court of the Commonwealth of Massachusetts Bay, December, 1641, Liberty 52, available online at: [www.winthropociety.org/liberties.php](http://www.winthropociety.org/liberties.php)
- <sup>33</sup> Quoted in David Braddock and Susan Parish, *An Institutional History of Disability*, 2000, p 32, available online at [www.aucd.org/conference/Institutional\\_History.wpd.pdf](http://www.aucd.org/conference/Institutional_History.wpd.pdf)
- <sup>34</sup> Quoted in Goodman, Nathan, *Benjamin Rush: Physician and Citizen 1746–1813*, University of Pennsylvania Press, 1934, p 256.
- <sup>35</sup> Dix, Dorothea. *Memorial to the Massachusetts Legislature*, 1843, available online at: [usinfo.state.gov/usa/infousa/facts/democrac/15.htm](http://usinfo.state.gov/usa/infousa/facts/democrac/15.htm)
- <sup>36</sup> Dr. Joseph Workman, *Annual Report – 1869*, quoted in Christine I.M. Johnston, *Joseph Workman – The Father of Canadian Psychiatry*, The Ogden Press, 2000, p 75.
- <sup>37</sup> Beers, Clifford. *A Mind that Found Itself*, 1905, republished University of Pittsburg Press, 1981, p 36.
- <sup>38</sup> Freud, Sigmund. *A General Introduction to Psychoanalysis*, available online at: [english.dc-marion.ohio-state.edu/modernismproject/oedipuscomplex.htm](http://english.dc-marion.ohio-state.edu/modernismproject/oedipuscomplex.htm)
- <sup>39</sup> A seminal text from 1960, prior to the publication of Szasz's well-known book with the same name, available on line at: [www.cyc-net.org/cyc-online/cyc01-0904-mentalillness.html](http://www.cyc-net.org/cyc-online/cyc01-0904-mentalillness.html)
- <sup>40</sup> Available online at: [www.uua.org/actions/health/61mental.html](http://www.uua.org/actions/health/61mental.html)
- <sup>41</sup> Chamberlin, Judi. *On Our Own – Patient-Controlled Alternatives to the Mental Health System*, available from the National Empowerment Center, 2002, pp xvi-xviii. Originally published in 1977.
- <sup>42</sup> Stone, Michael. *Healing the Mind: A History of Psychiatry from Antiquity to the Present*, W.W. Norton & Company, 1997, p 419.
- <sup>43</sup> Private communication to Barbara Meyers, writing of experiences in the 1980's
- <sup>44</sup> NAMI (National Alliance on Mental Illness, formerly called National Alliance for the Mentally Ill) is a major advocacy organization for mental health issues. It is discussed in workshop 6.
- <sup>45</sup> Maxmen, Jerrold S. and Ward, Nicholas G. *Essential Psychopathology and Its Treatment, Second Edition Revised for DSM-IV*, W.W. Norton & Company, New York, 1995, pp 420-421.
- <sup>46</sup> Park, Clara Claiborne, *The Siege: A Family's Journey into the World of an Autistic Child*, for a case study of a family with an autistic child, pp 3-5. © 1967, 1982 by Clara Claiborne Park. Copyright © renewed 1995 by Clara Claiborne Park. Used by Permission of Little, Brown and Co, Inc. For those who wish to learn more of the story of Clara Claiborne's autistic daughter as she grew into adulthood, Claiborne has written a sequel: *Exiting Nirvana: A Daughter's Life with Autism*, New York: Little Brown & Co (Pap); March 2001.
- <sup>47</sup> Phillips, Kevin, a 22-year-old man with Asperger's Disorder. On line at Kevin Phillips' website at: [www.angelfire.com/amiga/aut/index.html](http://www.angelfire.com/amiga/aut/index.html) and [www.angelfire.com/amiga/aut/belief.html](http://www.angelfire.com/amiga/aut/belief.html).
- <sup>48</sup> Brooks, Joseph. *My Story: Joseph Brooks* on line at [www.healthyplace.com/Communities/ADD/ask/stories/joseph.htm](http://www.healthyplace.com/Communities/ADD/ask/stories/joseph.htm) .
- <sup>49</sup> DeBaggio, Thomas. *Losing My Mind – An Intimate Look at Life with Alzheimer's*, The Free Press, New York, 2002.
- <sup>50</sup> Miller, Sue. *The Story of My Father – A Memoir*, Alfred A. Knopf, New York, 2003, excerpts from Chapter 8.
- <sup>51</sup> According to Bruce Malina in *The New Testament World* [Westminster John Knox Press, 2001] p 122-123, references to the phenomenon of evil eye in the Old Testament include: Proverbs 22:9, Proverbs 23:1-8, and Deut. 28:53-57. New Testament references include: Matt. 6:22-23, Luke 11: 34-36, Matt. 20: 1-16, Mark 7: 1-23, Mark 7:22, Mark 7:23, Gal. 3:1, Gal. 4:14, Gal. 4:15, Gal. 4:17-18, Gal. 5:20. And, references in the apocryphal literature include Sir. 14:8-10, Sir. 18:18, Tobit 4: 7, 17, and Wisdom of Sol. 4:12.
- <sup>52</sup> U.S. Department of Health and Human Services. *Mental Health: Culture, Race and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General – Executive Summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 2001.
- <sup>53</sup> Remen, Rachel Naomi. *Kitchen Table Wisdom – Stories That Heal*, Riverhead Books, New York, 1996, p 218.
- <sup>54</sup> *Ibid.*

---

<sup>55</sup> Ibid.

<sup>56</sup> Ibid, p 219.

<sup>57</sup> Chamberlin, Judi. *On Our Own – Patient-Controlled Alternatives to the Mental Health System*, available from the National Empowerment Center, 2002, pp 13-14, 17-18. Originally published in 1977.

<sup>58</sup> Rosenhan, S.L. ‘On Being Sane in Insane Places’, *Science* 179 (January 19, 1973), p 256.

<sup>59</sup> Ibid.

<sup>60</sup> This model is based on work by Dr. Mark Ragins discussed in his book *The Road to Recovery*.

<sup>61</sup> The Consumer-Operated Services Program Multi-site Research Initiative (COSP-MRI) funded by Substance Abuse and Mental Health Services Administration’s (part of the U.S. Department of Health and Human Services) Center for Mental Health Services from 1998-2004. It is the largest study of consumer-operated mental health services in history.

<sup>62</sup> David J. Miklowitz, PhD; Elizabeth L. George, PhD; Jeffrey A. Richards, MA; Teresa L. Simoneau, PhD; Richard L. Suddath, MD, “A Randomized Study of Family-Focused Psychoeducation and Pharmacotherapy in the Outpatient Management of Bipolar Disorder,” *Archives of General Psychiatry*, Vol. 60, No 9, Sept 2003, pp 904-912.

<sup>63</sup> This description of the Wellness Recovery Action Plan™ is written by Mary Ellen Copeland, MA, MS, author of *Wellness Recovery Action Plan*. Brattleboro, VT: Peach Press, 1997, rev. 2002 and other mental health recovery resources.

<sup>64</sup> Diane and Lisa Berger, *We Heard the Angels of Madness – A Family Guide to Coping with Manic Depression*, Quill - William Morrow, New York, 1991, pp 36-42.

<sup>65</sup> Schumaker, J.F., editor. *Religion and Mental Health*, New York: Oxford University Press, 1992.

<sup>66</sup> Adapted from Gregg-Schroeder, Susan. *In the Shadow of God’s Wings – Grace in the Midst of Depression*, Upper Room Books, Nashville, 1997, p 14.

<sup>67</sup> Fleischman, Paul R. *The Healing Spirit – Explorations in Religion and Psychotherapy*, Bonne Chance Press, Cleveland, 1994, p. 261.

<sup>68</sup> Gregg-Schroeder, Susan. *In the Shadow of God’s Wings – Grace in the Midst of Depression*, Upper Room Books, Nashville, 1997, p 14.

<sup>69</sup> These Choosing Leaders and Participation Guidelines closely follow those of *The Welcoming Congregation*.

<sup>70</sup> These names come from much longer lists in Appendix B of *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* by Kay Redfield Jamison, New York: Free Press Paperbacks, 1994.

<sup>71</sup> Gregg-Schroeder, Susan. *In the Shadow of God’s Wings – Grace in the Midst of Depression*, Upper Room Books, Nashville, 1997, p 14.

<sup>72</sup> Fleischman, Paul R. *The Healing Spirit – Explorations in Religion and Psychotherapy*, Bonne Chance Press, Cleveland, 1994, p. 261.