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A Manual for Pastoral Care of the Seriously Mentally Ill: A Lutheran Perspective

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A MANUAL FOR PASTORAL CARE OF THE SERIOUSLY MENTALLY ILL: A LUTHERAN PERSPECTIVE

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A MANUAL FOR PASTORAL CARE OF THE SERIOUSLY MENTALLY ILL: A LUTHERAN PERSPECTIVE

A MAJOR APPLIED PROJECT SUBMITTED TO
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BY

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PREFACE

Sixty years ago John H. C. Fritz in his Pastoral Theology penned these words on mental illness:

> Insanity , a morbid condition of the mind due to brain disease, is one of the saddest afflictions that can befall a man, especially a child of God, and it is one of the saddest and most difficult duties of a Christian pastor to minister to the insane. . . . Insane people, whatever their form of insanity may be, should never be kept at home, but, for their own protection and that of their family, be confined to an institution where special care and attention are given to such patients. Happily a pastor is not frequently called upon to minister to an insane person.[1]

That prevalent attitude of locking up the seriously mentally ill, throwing away the key, and attempting to forget about these hurting people was born and existed out of fear and ignorance. Unfortunately this same attitude exists today, even among clergy. However, mental illness cannot be locked away in a closet and forgotten. This "saddest affliction" has been let loose from the closet, from the state hospitals, and has been visiting every segment of society, even God's people in our local congregations. Current data from the U.S. National Institute of Mental Health state that one in five Americans has some form of mental illness in any given six months.[2] One in four American families have a

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[1]John H. C. Fritz, Pastoral Theology (St. Louis: Concordia Publishing House, 1932), 204-205.

[2]American Psychiatric Association Division of Public Affairs, A Mental Illnesses Awareness Guide For The Clergy: "Let's Talk About Mental Illness" (Washington, DC: American Psychiatric Press, 1990), 9.

family member who is affected by a serious mental illness. Mental illness affects five times as many people as multiple sclerosis, and six times as many people as diabetes. There are more hospital beds in America occupied by people who have a mental illness, than by people who have cancer, heart and lung disease combined.[3]

The pastor has no choice but to face this challenging person and attempt to minister, whenever and wherever this mysterious stranger makes his appearance. Fritz displayed remarkable pastoral insight when he stated:

> When it becomes necessary that he must do so, he ought to acquaint himself somewhat with the nature and cause of insanity and especially with the particular case which he must treat.[4]

That "acquainting time" has long been upon us, but there has been no definitive pastoral manual to assist the clergy in ministering to the modern-day "insane." Thus the impetus for this manual.

Alexander Pope's words, "fools rush in where angels fear to tread," accurately portray the deep fears and reservations this writer experiences as he begins the writing of this major project. Over a period of time the author has done much research on the related subjects of mental illness and pastoral care as well as dealing with many experiences of ministry to the mentally ill. The author has been at-

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[3]The Mental Health Association of Houston and Carris County, The Mental Health Association's Manual for the Clergy: Resources for Helping & Healing (Houston: n.p., 1991), v.

[4]Fritz, 205.

tempting to gain expert knowledge and skills in order to convey them to fellow clergy, assisting them in the pastoral care of this critical area of need. This writer points out that this illness is similar to any other medical disease and needs to be treated accordingly. The field of medical knowledge continues to expand and due to time considerations this author will never have a conclusive, all-encompassing grasp of this subject matter.

In the meantime state governments are closing down state hospitals in the name of budgetary concerns, leaving the displaced seriously mentally ill to knock on the doors of our churches and the homes of their families, relatives, and/or friends, seeking care and support. How does the Christian community respond? Dare the Church refuse to minister to these "crazy, mentally deranged" individuals whom society does not want or desire in public? It is hoped that this project, briefly but adequately, will address the issues and concerns in providing pastoral care to this critical population of hurting people. May God's Spirit move us to compassion and action.

To assist the reader, a glossary is provided in Appendix A. Also the third person masculine pronoun is often used in a generic sense to refer to both male and female. All Scripture quotations will be from the New International Version (NIV).

ABSTRACT

Persons with serious mental illness (schizophrenia, bipolar, unipolar depression) have often been seen as "strangers in our midst". Because state hospitals are relocating these patients into our communities (even though the community mental health resources may not be there) and because of stigma, persons with mental illness are coming in from the "cold" to our churches. Pastors and staff need assistance in ministering to this needy population. This project attempts to define mental illness, identify persons with mental illness, and demonstrate models of ministry. Specific guidelines, helpful suggestions, and supporting evidence (appendices) will address ministry issues and concerns as they pertain to the person with mental illness, his family, the congregation and the pastor himself.

CHAPTER I

UNDERSTANDING MENTAL ILLNESS

A major challenge in the discussion of mental illness is the use of language. The understanding of words varies tremendously. Nowhere is that more evident than in the terminology of mental illness. Certain schools of thought by definition would deny the existence of mental illness. Others may see all behavioral aberration as mental illness, totally denying any spiritual and/or moral dimensions of the individual's behavior.

"Mental" refers to the mind and "illness" suggests an absence of health. So "mental illness" is the lack of a healthy mind. If only this were the case. A brief reflection upon this definition instanteously reveals the inadequacies and limitations of words and concepts. Darkening the already murky waters of medical terminology, some professionals would delineate the difference between illness and disease:

> As described in medical, psychological and physiological theories, disease is an alteration in the structure or function of the body. Illness, on the other hand, is the person's experience of altered function or well-being; it is the phenomenal experience of sickness.[1]

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[1]Cathrine A. Chelsa, "Parents' Illness Models of Schizophrenia," Archives of Psychiatric Nursing 4 (August 1989): 218.

In the interest of saving time and energy, let us borrow Clark S. Aist's definition of mental illness:

> Mental illness refers to a variety of enduring or recurrent disturbances in patterns of an individual's thinking, mood or behavior that are typically associated with painful distress and/or impairment of social, occupational or leisure functioning. Severity of symptoms may range from mild annoyance to extreme discomfort, from little or no violation of conventional norms to floridly deviant behaviors, and from minor distortions of reality to significant impairment in reality testing.[2]

The above definition is based upon a common understanding of mental health from which any deviation (illness) can be measured. The previous writer would describe mental health as:

> a condition of well-being in relation to self and others characterized by such qualities as (a) positive self-acceptance, (b) acccurate perception of others and the world, (c) stability and purposiveness in behavior, (d) dependable sense of identity and values, (f) adaptability to one's environment, (g) ability to engage in productive work and fulfilling love, and (h) commitment to a source of devotion beyond oneself.[3]

In summary, mental illness is a term used for a group of disorders causing severe disturbance(s) in thinking, feeling, relating, and/or functioning. They result in substantially diminished capacity for coping with the ordinary demands of life. Also, mental illnesses can affect persons

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[2]Clark S. Aist, "Mental Health and Illness" in Dictionary of Pastoral Care and Counseling, ed. Rodney J. Hunter (Nashville: Abingdon Press, 1990), 711.

[3]Ibid.

of any age - infants, children, adolescents, adults, and the elderly - and they can occur in any family.

Mental illness is not the same as mental retardation. The mentally retarded (developmentally disabled) have a diminished intellectual capacity usually present since birth. Those with mental illnesses are usually of normal intelligence although they may have difficulty performing at a normal level due to their illness.

The focus of this project will be those specified mental illnesses which are usually labled chronic, prolonged, serious, or veteran. According to the Diagnostic and Statistical Manual, Third Edition, Revised (DSM-III-R) those are disorders that linger longer than six months. The focus of this project shall cover only the three most prevalent and serious mental illnesses: schizophrenia, manic-depression, and serious depression or dysthymia.

SCHIZOPHRENIA

Schizophrenia is one of the most serious and disabling of the mental illnesses. And like many of the mental illnesses, its definitions have developed over time. It is now definitely recognized as a brain disease, having a scientific and biological entity as clearly as diabetes, multiple sclerosis, cancer and other such diseases. This illness exhibits symptoms of brain disease, symptoms that include impairment in thinking, delusions, hallucinations, changes

in emotions and changes in behavior.[4] Medical professionals often see this illness in terms of a psychoneural biochemical deficiency in the brain. The diagnostic criteria from DSM-III-R explains schizophrenia as follows:

A. Presence of characteristic psychotic symptoms in the active phase: either (1), (2), or (3) for at least one week (unless the symptoms are successfully treated):

   (1) Two of the following:

      (a) delusions
      (b) prominent hallucinations (throughout the day for several days or several times a week for several weeks, each hallucinatory experience not being limited to a few brief moments)
      (c) incoherence or marked loosening of associations
      (d) catatonic behavior
      (e) flat or grossly inappropriate affect

   (2) Bizarre delusions (i.e., involving a phenomenon that the person's culture would regard as totally implausible, e.g., thought broadcasting, being controlled by a dead person)

   (3) Prominent hallucinations (as defined in [1b] above) of a voice with content having no apparent relation to depression or elation, or a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other

B. During the course of the disturbance, functioning in such areas as work, social relations, and self-care is markedly below the highest level achieved before onset of the disturbance (or, when the onset is in childhood or adolescence, failure to achieve expected level of social development).

C. Continuous signs of the disturbance for at least six months. The six-month period must include an active phase (of at least one week, or less if

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[4]E. Fuller Torrey, Surviving Schizophrenia: A Family Manual, Rev. ed. (New York: Harper & Row, 1988), 6.

symptoms have been successfully treated) during which there were psychotic symptoms characteristic of Schizophrenia (symptoms in A), with or without a prodromal or residual phase, as defined below.

Prodromal phase: A clear deterioration in functioning before the active phase of the disturbance that is not due to a disturbance in mood or to a Psychoactive Substance Use Disorder and that involves at least two of the symptoms listed below.

Residual phase: Following the active phase of the disturbance, persistence of at least two of the symptoms noted below, these not being due to a disturbance in mood or to a Psychoactive Substance Use Disorder.

Prodromal or Residual Symptoms:

(1) marked social isolation or withdrawal
(2) marked impairment in role functioning as wage-earner, student or homemaker
(3) markedly peculiar behavior (e.g., collecting garbage, talking to self in public, hoarding food)
(4) marked impairment in personal hygiene and grooming
(5) blunted or inappropriate affect
(6) digressive, vague, overelaborate, or circumstantial speech, or poverty of speech, or poverty of content of speech
(7) odd beliefs or magical thinking, influencing behavior and inconsistent with cultural norms, e.g. superstitiousness, belief in clairvoyance, telepathy, "sixth sense," "others can feel my feelings," overvalued ideas, ideas of reference
(8) unusual perceptual experiences, e.g., recurrent illusions, sensing the presence of a force of person not actually present
(9) marked lack of initiative, interests or energy

E. It cannot be established that an organic factor initiated and maintained the disturbance.

F. If there is a history of Autistic Disorder, the additional diagnosis of Schizophrenia is made only

if prominent delusions or hallucinations are also present.[5]

DSM-III-R may further subdivide schizophrenia into five types, depending on the criteria: Catatonic, Disorganized, Paranoid, Undifferentiated or Residual types. Please see Glossary.

CASE STUDY:
Three months after its initial contact with the patient, a 26 yr. old male migratory farm worker, a community mental health team was contacted by the city police. The patient, who had been maintained in an outpatient clinic for the past few months, had suddenly appeared in a judge's chamber and demanded to be put to death because he felt he was responsible for the production of evil and violence in the world. When team members reached the jail, they found the patient agitated, easily angered, suspicious, and guarded. His speech was disorganized and often incoherent. He stated that he could not eat meat or terrible violence and evil would be unleashed on the world. He also described a plot by the California Mafia to keep him from working, and he spoke of voices that told him what to do and that "must be obeyed." Past history included similar episodes over the previous five years, resulting in several year-long periods of inpatient hospitalization. At no time did he exhibit a full manic or depressive syndrome. Between hospitalizations the patient lived in hobo jungles, flophouses, and gospel missions; rode freight trains from town to town; and worked, picking fruit, for only a few days at a time. Since adolescence he has lived the life of a drifting loner. DSM-III-R Diagnosis: Schizophrenia, Paranoid Type, Chronic with Acute Exacerbation.[6]

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[5]The American Psychiatric Association, Diagnostic Criteria From DSM-III-R (Washington, DC: American Psychiatric Association, 1987), 113-115.

[6]Robert Spitzer and others, eds., DSM-III Diagnostic and Statistical Manual of Mental Disorder (Third Edition) Case Book, First Edition. (Washington, DC: American Psychiatric Association, 1981), 254-255.

Studies indicate that schizophrenia is more common than people realize. Approximately one out of every hundred persons in the United States will be diagnosed with schizophrenia during his lifetime. It is conservatively estimated that there are 1.2 million persons in the United States with schizophrenia today. It should be noted that this refers only to schizophrenia and not to other related disorders such as bipolar disorder, or schizoaffective disorder. Of the 1.2 million persons with schizophrenia, 31,000 are in jails and prisons, 87,000 are in public shelters and streets, 85,000 are in hospitals, 250,000 in foster and/or group homes, 165,000 are in nursing homes, 100,000 live by themselves, and 482,000 live with their families.[7] Just the economic cost of this illness is tremendous. One U.S government official conservatively estimated the cost for this illness to be $36 billion in 1986.[8] This figure includes costs for hospitalization, social security disability, welfare payments, and lost wages.

It is estimated that three-quarters of persons with schizophrenia develop the disease between 16 and 25 years of age.[9] Studies also indicate an earlier and more severe

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[7]Torrey, 8.

[8]Ibid., 11.

[9]Alliance for the Mentally Ill of Michigan - Oakland County, What is Schizophrenia? (n.p., n.d.) 2.

onset of the illness for males; also the males respond less well to treatment.[10]

Although the full-blown symptoms (auditory hallucinations and/or delusional thinking) are easy to diagnose, finding a good doctor is critical for the treatment of schizophrenia. The best way to find a good doctor is to ask others in the medical profession to whom they would send their own family member if they had a similar problem. It is also advisable to contact other families who have a schizophrenic family member. The local chapter of the Alliance for the Mentally Ill (AMI) can be immensely helpful in providing these data.

The treating psychiatrist should do a diagnostic workup which ideally would include the following: history and mental status examination, physical and neurological examination, basic laboratory work (blood count, blood chemical screen, and urinalysis), psychological tests, CT scan, lumbar puncture and an electroencephalogram (EEG).

Usually persons acutely ill with schizophrenia need to be hospitalized. This is often necessary to protect the patient while enabling the mental health professional to observe the person in a controlled setting. However, getting the mentally ill loved one into the hospital may prove to be a major undertaking as commitment procedures are technical and may require the services of the police and the courts.

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[10]Torrey, Ibid., 83.

Most initial hospitalizations, as well as secondary (relapse) hospitalizations are involuntary. The emergency and the long-term commitment procedures vary from state to state, and even from community to community. An intervention for the person with schizophrenia must be well planned with the medical and mental health authorities. Treatment primarily focuses on medications (psychoactive drugs) and psychotherapy, usually in the form of group therapy. Psychoanalysis and insight-oriented psychotherapy is obviously ineffective; in fact, research indicates that these therapies may even aggravate the illness.[11] Electroconvulsive therapy (ECT), diets, and other treatment procedures are still considered controversial.

The prognosis of schizophrenia can be positive depending on various factors: (1) Mentally ill patients who are more likely to have a good outcome are those who were considered to be relatively normal prior to getting sick. (2) Women have a more favorable outcome than men. (3) A poor outcome is suggested by a family history of schizophrenia. (4) The later the age of onset, the more likely there will be a positive outcome. (5) The best outcomes occur in those patients whose onset is most sudden. (6) A multitude of stressful events immediately preceding the psychotic break often indicate a positive outcome. (7) A normal CT scan is also a good sign. (8) The better the initial response to the

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[11]Ibid., 220-222.

antipsychotic medication, the better the outcome is likely to be.[12] It is estimated that 25% of those patients with symptoms of schizophrenia will recover completely; another 25% will be much improved and be relatively independent; another 25% will be somewhat improved but require extensive support network. The remaining 25% are unimproved and tragically 10% of these will commit suicide.

Although the exact cause of schizophrenia remains unknown, because of research, considerable knowledge has been accumulated. First, based on studies of gross pathology, microscopic pathology, neurochemistry, cerebral blood flow and metabolism, as well as electrical, neurological and neuropsychological measures, schizophrenia has been clearly established to be a brain disease, similar to the organic disorders of Alzheimer's, or Parkinson's disease.[13]

Secondly, the limbic system and its connections are primarily affected. The limbic system is that strategic area of the brain which translates various sensory stimulations into neuroelectrical activity. The precise dynamics of this critical area are being researched. Thirdly, it is known that schizophrenia runs in families.

Lastly, is seems that brain damage resulting in schizophrenia may occur very early in childhood, maybe even while the child is in the uterus. Other theories that address the

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[12]Ibid., 114-116.

[13]Ibid., 138.

cause of this illness, such as genetics, nutrition, immune deficiency, stress, and others are unsupported by research and remain as speculations, interesting and often damaging to those whose lives are afflicted by this mental disease.

BI-POLAR DISORDER (MANIC DEPRESSION)

Manic depression is the most dramatic and distinct of the affective disorders. The chief characteristic of this illness is the mood swings. The distinction between bipolar illness and other depressive disorders is that patients switch or swing from depression to mania (or vice-versa) generally with periods of normal moods in between the two extremes. This mental illness generally strikes before the age of 35. Similar to schizophrenia, nearly one out of every hundred people will suffer from this disorder sometime during his life.[14]

Symptoms of the manic phase may include the following: (1) A mood that seems excessively good, euphoric, or expansive. (2) Expressions of unwarranted optimism and lack of judgment. (3) Hyperactivity and excessive plans or participation in numerous activities that have a good chance for painful results. (4) Flight of ideas. (5) Decreased need for sleep, allowing the patient to go with little or no sleep for days without feeling tired. (6) Distractibility in which the patient's attention is easily diverted to inconsequen-

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[14]American Psychiatric Association, Let's Talk Facts About Manic-Depressive Disorder (Washington, DC: American Psychiatric Association, 1988), 1.

tial or unimportant details. (7) Sudden irritability, rage or paranoia when the person's grandiose plans are thwarted or his excessive social overtures are refused.

Symptoms of the depressive phase may include the following: (1) Feelings of worthlessness, hopelessness, helplessness, total indifference and/or inappropriate guilt, prolonged sadness or unexplained crying spells, jumpiness or irritability, withdrawal from formerly enjoyable activities, social contacts, work or sex. (2) Inability to concentrate or remember details. (3) Thoughts of death or suicide attempts. (4) Loss of appetite or noticeable increase in appetite, persistent fatigue and lethargy, insomnia or noticeable increase in the amount of sleep needed. (5) Aches and pains, constipation, or other physical ailments that cannot be otherwise explained.[15] It should be noted that the above symptoms are identical to those of major or unipolar depression.

The diagnostic criteria from DSM-III-R explain the manic as follows:

A. A distinct period of abnormally and persistently elevated, expansive or irritable mood.

B. During the period of mood disturbance, at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity
(2) decreased need for sleep, e.g., feels rested after only three hours of sleep

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[15]Ibid., 2-3.

(3) more talkative than usual or pressure to keep talking
(4) flight of ideas or subjective experience that thoughts are racing
(5) distractibility, i.e., attention too easily drawn to unimportant or irrelevant external stimuli
(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
(7) excessive involvement in pleasurable activities which have a high potential for painful consequences, e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments

C. Mood disturbance sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others.

D. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).

[Criterion D helps distinquish between a manic episode and schizophrenia. Patients in a manic state may act bizarrely and suffer delusions and hallucinations but once the manic episode passes, these symptoms disappear. Schizophrenic patients, on the other hand, may be preoccupied with delusional thoughts before and after an acute episode of illness.][16]

E. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder or Psychotic Disorder NOS.

F. It cannot be established that an organic factor initiated and maintained the disturbance. Note: Somatic antidepressant treatment (e.g., drugs, ECT) that apparently precipitates a mood distur-

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[16]Demitri F. and Janice Papolos, Overcoming Depression (New York: Harper & Row, 1987), 31.

bance should not be considered an etiologic organic factor.[17]

CASE STUDY:
B.B., a 39-year-old Hungarian opera singer, is readmitted to a psychiatric hospital after keeping family awake for several nights with a prayer and song marathon. She is flamboyantly dressed in a floor-length red skirt and peasant blouse, and is adorned with heavy earrings, numerous necklaces and bracelets and medals pinned to her bosom. She speaks very rapidly and is difficult to interrupt as she talks about her intimate relationship with God. She often breaks into song, explaining that her beautiful singing voice is a special gift that God has given her to compensate for her insanity. She uses it to share the joy she feels with others who are less fortunate.

B.B. has had at least ten admissions to this hospital in the past 20 years, some because of serious suicide attempts made when she was depressed, some because she was manic, and some, in her words, "just because I was crazy." Although she does have a lovely voice, she has not been able to organize herself to work professionally during the past 15 years, and has spent much of her time at the local community mental health center. She has seen the same therapist weekly for many years and believes that he communicates with her through a local radio station, giving her instructions on how to conduct her life between therapy sessions. She also receives illuminations from Kahlil Gibran and Adele Davis, whose conversations she is able to overhear. DSM-III-R Diagnosis: Bipolar Disorder, Manic, with Psychotic Features[18]

The other half of the disorder, a major depressive episode, is described by DSM-III-R as follows:

A. At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical

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[17]Ibid., DSM-III-R, 125-126.

[18]Robert Spitzer and others, eds., 98-99.

condition, mood-incongruent delusions, or hallucinations, incoherence, or marked loosening of associations.)

(1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observations by others
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day, (as indicated either by subjective account or observation by others of apathy most of the time)
(3) significant weight loss or weight gain when not dieting (i.e., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains)
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness, or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may not be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. (1) It cannot be established that an organic factor initiated and maintained the disturbance.
(2) The disturbance is not a normal reaction to the death of a loved one (Uncomplicated Bereavement)

C. At no time during the disturbance have there been delusions or hallucinations for as long as two weeks in the absence of prominent mood symptoms (i.e., before the mood symptoms developed or after they have remitted).

D. Not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder NOS.[19]

CASE STUDY:

A 38-year-old married woman came to a mental health clinic with the chief complaint of depression. In the last month she has been feeling depressed, suffering from insomnia, crying and has been aware of poor concentration and diminished interest in activities. She relates that she was sickly as a child and has been depressed since childhood because her father deserted the family when she was approximately ten. Apparently she was taken to a doctor for this, and the family doctor recommended that her mother give the patient a little wine before each meal. Her adolescence was unremarkable, although she describes herself as having been shy. She graduated from high school at age 17 and began working as a clerk and bookkeeper at a local department store. She married at about the same age, but the marriage was not a success: she had frequent arguments with her husband, in part related to her sexual indifference and pain during sexual intercourse.

At age 19 she began to drink heavily, a behavior pattern she claims started after the desertion by her father. With the heavy drinking she went on benders, had morning shakes, and had guilt feelings because she was not caring well for her children. At 21 she was admitted to a local mental hospital, where she was diagnosed as having alcoholism and depression. She was treated with antidepressants. After discharge she continued to drink almost continually up until age 29; she did have a 1-year period of abstinence in this time. At 29 she was again hospitalized, this time in an alcohol treatment unit. Since that time she has remained abstinent. She has subsequently been admitted to psychiatric hospitals for a mixture of hysterical and depressive symptoms, and she has been treated with electroconvulsive therapy (ECT), without much relief.

She describes nervousness since childhood; she also spontaneously admits to being sickly since her youth with a succession of physical problems doctors often indicated were due to her nerves or depression. She, however, believes that she has a physical problem that has not yet been discovered by the doctors. Beside nervousness, she has chest pain, and has been told by a

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[19]DSM-III-R, 128-127.

> variety of medical consultants that she has a "nervous heart." She also goes to doctors for abdominal pain, and has been diagnosed as having a "spastic colon." She has seen chiropractors and osteopaths for backaches, for pains in the extremities, and for anesthesia of her fingertips. Three months ago she had vomiting, chest pain, and abdominal pain, and was admitted to a hospital for a hysterectomy. Since the hysterectomy she has had repeated anxiety attacks, fainting spells that she claims are associated with unconsciousness that last more than thirty minutes, vomiting, food intolerance, weakness and fatigue. She has had several medical hospitalizations for workups of vomiting, colitis, vomiting blood, and chest pain. She has had a surgical procedure for an abcess of the throat.
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> The patient is one of five children. She was reared by her mother after her father left. Her father was said to be an alcoholic who died at age 53 of liver cancer. Despite a difficult childhood financially, the patient graduated from high schol and worked 2 years. She tried to work a second time, but was forced to quit because of her sickliness. She married her present husband at 17 and has remained married. Her husband is said to be an alcoholic who has some period of work instability. They have argued over sex and finances. She has five children, ranging in age from 2 to 20. She currently admits to feeling depressed, but thinks that it is all because her "hormones were not straightened out." She is still looking for a medical explanation for her physical and psychological problems. Diagnosis: Major Depression, Recurrent, without Melancholia; Somatization Disorder; Alcohol Dependence, in Remission.[20]

The diagnosis of the affective disorders is obviously a very technical and complicated process. Essentially diagnosis occurs over an extended period of time and often happens on the basis of elimination of other affective disorders; also responses to medications serve as diagnostic markers.

Refocusing on manic-depression, scientist have long known that the risk for this disease runs in families. In February 1987, scientists reported that they had located a

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[20]Robert Spitzer and others, eds., 184-185.

genetic marker among members of the Old Order Amish. This meant that an aberrant gene on certain chromosomes appeared to make the person predisposed to having the manic-depression. These studies show that close relatives of people suffering from bipolar illness are 10 to 20 times more likely to develop either depression or manic-depression than the general population.

However genetics is not the only component of this illness. Studies indicate, similar to schizophrenia, that the limbic system of the brain is somehow affected: neurotransmitters are affected by various hormone secretions. Studies also indicate that the human circadian system (body's biological clock) is also involved in this disorder.[21] In summary, nobody is medically certain as to the etiology of this disease; much more research is required.

Treatment of the bipolar disorder is encouraging. To begin, a complete physical is necessary in order to rule out other causes. The most common medication, lithium carbonate, successfully reduces the number and intensity of manic episodes for 70% of those who take the medication. Like all medications, lithium has side effects and must be very closely monitored by a psychiatrist; blood tests to determine lithium level are critical. Tegretol is often given bipolar patients who are unresponsive to lithium. As with almost all mental illnesses, the person's self-esteem and

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[21]Papolos, 73-84.

relationships with others have been affected; thus supportive psychotherapy is encouraged.

DYSTHYMIC DISORDER

The previously mentioned, chronic depressive disorders are associated with manic-depression, also known as bipolar disorder - so named because of the mood swings from mania to depression (or vice-versa). Dysthymia is described as chronic depression or unipolar depression. The depressive qualities are listed on pages 14-16 of this chapter.

Major depression is the illness that underlies the majority of suicides. This "cloud of despair" that doesn't seem to leave can appear at any age. In any six-month period, 9.4 million Americans suffer from this illness. One in four women and one in ten men can expect to develop it during their lifetime. Fortunately, 80 to 90 percent of those who suffer from chronic depression (dysthymia) can be effectively treated.[22]

The first step in treatment for major depression is to have a complete physical examination in order to rule out other causes. Medication is always the first line of treatment upon diagnosis. The physician or psychiatrist usually prescribes an antidepressant, or a monoamine oxidase inhibitor (MAOI), and/or, as last resort, electroconvolusive therapy (ECT). Some of the trade names of the more popular tri-

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[22]American Psychiatric Association, "Let's Talk Facts About Depression" (n.p., 1988), 1.

cyclics are Elavil, Endep, Amitid, Asendin, Norpramin, Pertofrane, Adapin, Sinequan, Tofranil, Aventyl and Pamelor, while some of the more popular MAOI's are Marplan, Nardil and Parnate.

The latest "miracle drug" in the antidepressant market is Prozac (fluoxetine) which makers claim have long-lasting therapeutic value with minimal side effects. Most of the antidepressants can cause side effects which fall into three categories: (1) sedation, (2) anticholinergic effects [dry mouth, constipation, etc.] and (3) orthostatic hypotension [dizziness when rising quickly from a lying position, etc.][23] Appendix B lists some of the medications commonly prescribed .

Strange as it may seem, electroconvulsive therapy (ECT) is the treatment of choice for people suffering from psychotic depression or intractable mania, those suffering from other health considerations and are unable to take antidepressants, or those patients who are intent on suicide and cannot wait for the three weeks that it takes for antidepressant medication to work.[24] Contrary to the movie "One Flew Over the Cuckoo's Nest", ECT once was inhumane but has been changed to use a series of small jolts and thus is a very effective treatment. The major side effect of concern is the short-term memory loss, which eventually returns.

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[23]Papolos, 105-113.

[24]Ibid., 116-117.

Surveys indicate that a majority of patients treated with ECT would recommend it for others with similar symptoms.[25]

Along with medication psychotherapy is also encouraged in the treatment of depression. Psychotherapy involves the verbal interaction between a trained professional and a patient with emotional or behavioral problems. The therapist applies techniques based on established psychological principles to help the patient gain insights about himself and thus change his maladaptive thoughts, feelings, and behavior. Interpersonal and cognitive/behavior therapies are seen to be the most beneficial.

Due to the limited amount of health care dollars, there is controversy in public health circles over the definition of serious mental illness. For example, withdrawal from cigarette smoking would qualify as a serious mental illness. The National Alliance for the Mentally Ill (NAMI) has proposed these definitions:

> Adults with a serious mental illness are persons age 18 and over who have a severe and persistent disability, whether or not they are in psychiatric treatment, and who meet the following criteria.
>
> **A. Have a primary psychiatric diagnosis, as rendered by a qualified practitioner, of:**
> -schizophrenia
> -bipolar disorder/major depression
> -schizoaffective disorder
> -panic disorder
> -obsessive-compulsive disorder
> -borderline personality disorder
> or

[25]Ibid., 118.

Any other brain disorders which according to prevailing scientific judgement are neurobiological and defined in DSM-III-R. Regardless of any secondary diagnosis, the primary psychiatric diagnosis takes precedence.

Additionally, individuals with one of these diagnoses would have to meet the criteria in either B or C.

B. Treatment History:

-Inpatient or outpatient treatment within the past three years; or
-Participation within the last three years in a community mental health center, psychosocial rehabilitation program, or other setting which provides community support services to individuals with serious mental illness; or
-Involvement in the criminal justice system in the last three years as a result of mental illness.

C. Functional Impairment:

-Are significantly functionally impaired-or without treatment they would have been or would be significantly functionally impaired-in at least two of the following areas:
1. Activities of daily living such as maintaining a household, using public transportation, money management, and accessing community services.
2. Social functioning such as developing and maintaining friendships, interpersonal communications, and accessing and maintaining support systems.
3. Task performance in work, work-like, or educational settings.
4. Adaptation in work, work-like, or educational settings, e.g. coping with stress in these environments.
5. Task performance in non-salaried work environments such as in the home or in the community.
-Individuals who qualify for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) shall be deemed to automatically meet the functional criteria of this definition.

Children with serious emotional disturbance are children from birth to 18 years of age whose disabilities have lasted, or are expected to last, one year or more and have:

(1) Disorders that have a known neurobiological etiology. These include:

-schizophrenia
-bipolar disorder/major depression

-obsessive compulsive disorder
-attention deficit hyperactivity disorder
-anxiety disorders
-autism and other pervasive developmental disorders
-Tourette's Syndrome
-other disorders which according to prevailing scientific judgement have a neurobiological etiology

or

(2) Disorders with an unknown etiology that manifest themselves as emotional, mental health or psychological problems, such as severe behavioral disorders, adjustment disorders;

or

(3) Disorders with both elements of both (1) and (2).[26]

In summary, the major mental illnesses have been defined, described and illustrated. It must be emphasized that serious mental illness is a no-fault brain disease. Contrary to much popular thinking, prolonged mental illness is not caused by poor parents or dysfunctional family dynamics. Although the exact cause remains hidden at the present moment, the good news is that it is manageable (psychoactive drugs, psychotherapy) if diagnosed early.

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[26]Ron Honberg and Fred Fedeli, "NAMI Defines 'Serious Mental Illness,'" NAMI Advocate, January-February 1993, 1, 4.

CHAPTER 2

THE BIBLE AND MENTAL ILLNESS

As one surveys the biblical literature on such topics as mental illness, healing, demonism, and exorcism, one immediately becomes conscious of certain critical issues as illustrated in selected excerpts from "Chronic Mental Illness: A Congregational Challenge". (This paper was issued by the Standing Committee for Church in Society, the American Lutheran Church, as a stimulus to thought and action within ALC congregations.)

> The Bible, although it does not pretend to be a technical manual on mental health or illness, does describe a number of incidents involving unusual behavior patterns. Because these stories appear in our Scriptures, we have been shaped by them and by what they seem to say about mental illness, whether or not the stories represent people who are mentally ill in our present-day sense of the term. While we offer these examples, we by no means intend to imply that the characters named were actually mentally ill, only that the behaviors described might be interpreted that way by some readers of the Bible. . . . Traces of the belief in the existence of evil spirits, suggested in the Old Testament, did not reach full development until after the Exile. This belief then developed into the conviction that evil spirits could "invade human bodies and personalities and cause mental illness, physical disease". . . . Not only was there a New Testament belief in demon possession, but Jesus became known as the one who exorcised demons, and thus the one who instantly

> healed mental illness as well as physical illness.[1]

These excerpts strongly suggest that demon possession is synonymous to mental illness; the people of the Scriptures did not have the medical and scientific knowledge of illness and disease that modern day society possesses. Careful assessment of the above article reveals other serious issues, namely hermeneutics and theology.

Theodor Gaster's extensive article on "Demon, Demonology" accurately reflects current thought on this interesting topic:

> In considering the question of demonology in the Bible, it must be borne in mind at the outset that the modern definition of a demon as a devil or malign spirit, is the result only of a long development. As used by ancient writers, the word often means something different; while on the other hand, many of the figures of ancient belief that are today blanketed by this general designation actually bore quite distinctive character. . . . From the standpoint of religious psychology, daimonism represents an externalization of human experiences. Feelings and sensations, moods and impulses, even physical conditions, which might otherwise be described as obtaining autonomously within a man, are portrayed, on this basis, as outer forces working upon him. Aspiriation becomes inspiration; ecstasy, rapture (i.e., a state of being "seized"); insight, revelation. Emotion becomes, so to speak, immotion; that which is projected out of the self, that which is injected into it; the flight of inward, not outward, an invasion rather than an escape. In the language of daimonism, therefore, all such experiences are represented as visitations-i.e., as actions of an external power, rather than as internal psychic

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[1]Standing Committee for Church in Society, The American Lutheran Church, Chronic Mental Illness: A Congregational Challenge (Minneapolis: Office of Church in Society, The American Lutheran Church, n.d.), 1.

> states . . . . Basically, of course, this distinction between the objective and the subjective approaches to experience amounts only to looking at the same thing from opposite ends of the mental telescope. It is a formal, rather than a substantive, distinction; and the primitive mind is, indeed, by no means unable to turn the telescope the other way around. Accordingly, there is often a perceptible undercurrent of ambiguity in speaking of spirits, and, with the progressive refinement of religious thought and psychological insight, these tend more and more to be transformed from outright external agents to mere personifications of inward psychic states. In other words, men begin to speak of the troubled spirit, rather than of the spirit that troubles.[2]

The phrases, "the primitive mind" and "the progressive refinement of religious thought and psychological insight", indicate this scholar's hermeneutical principles. One of the underlying questions that challenge modern biblical scholarship is the existence of demons and their ability to influence human behavior. Unavoidably and intricately related is the basic Scriptural teaching of Satan as the person or personification of evil. The above article masterfully demonstrates historical critical methodology, the hermeneutical approach of modern comtemporary religious thought. In this instance the above example is a rational approach to addressing the question of evil and its existence in this world.

The evangelical, confessional Lutheran pastor and layperson would find the above scholarship unacceptable. Three theological principles must be addressed: (1) the authority,

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[2]Theodor Gaster, "Demon, Demonology" in The Interpreter's Dictionary of the Bible, Vol. 1, ed. George Buttrick (Nashville: Abingdon, 1962), 817-818.

the inspiration, and integrity (inerrancy) of the Scriptures, (2) the doctrine of sin and evil, and (3) interpretation of the Holy Scriptures.

The purpose of this chapter is not to write a theological treatise on the doctrine of Scripture as confessed by The Lutheran Church - Missouri Synod. The Commission on Theology and Church Relations during the 1970s and 1980s produced numerous statements and literature on the topic of Scripture. These documents often addressed the critical issues of inspiration, inerrancy, and history. For example, selected excerpts from CTCR's The Inspiration of Scripture address the concerns of Scripture being used as an accurate historical document:

> Even though there are differences and variety in the Sacred Writings which sometimes perplex us because we can find no harmonization for them that satisfies human reason, faith confesses the Bible to be the inerrant Word of God. Since the inerrancy of the Scriptures is a matter of faith, it is by definition a doctrine which is believed solely on the basis of the witness of the Scriptures concerning themselves and not on the basis of empirical verification. . .
>
> Faith affirms that God could speak His Word of Truth even though men whose knowledge of nature and history apart from direct revelation was partial and limited. Faith affirms that even in the presence of difficulties which human reason may regard as deficiencies, we have, nevertheless, in the Scriptures God's totally reliable Word which cannot mislead and deceive us.
>
> "None of the natural limitations which belong to the human mind even when under the inspiration of the Holy Ghost can impair the authority of the Bible or the inerrancy of the Word of God; for Holy Scripture is the book of divine truth which transcends everything called truth by the wise men

> of this world (I Cor.1:17ff., Col.2:8) and is therefore able to make us 'wise unto salvation' (2 Tim.3:15)". . .
>
> The Bible, however, was written to bear witness to the action of God in human history to accomplish the redemption of fallen mankind. If Biblical historical records are unreliable or even false, then God's saving actions in history are called into question too. The Christian faith rests so squarely on God's actions in human history, centering in the incarnation, death, and resurrection of His Son, Jesus Christ, that if Biblical historical records are false, our faith is left without a foundation. (I Cor. 15:17).[3]

The Bible is replete with references that speak of Satan and his demons (cohorts). The selected verses illustrate this fact:

> He who does what is sinful is of the devil, because the devil has been sinning since the beginning. The reason the Son of God appeared was to destroy the devil's work. (I Jn.3:8)
>
> Put on the full armor of God so that you can take your stand against the devil's scheme. For our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms. (Eph. 6:11-12).

A brief comment on hermeneutics is in order. The Commission on Theology and Church Relatiions, The Lutheran Church - Missouri Synod has authored two reports on this critical topic: (1) "A Lutheran Stance Toward Contemporary Biblical Studies" and (2) "A Comparative Study Of Varying Contemporary Approaches To Biblical Interpretation." These

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[3]The Inspiration of Scripture: A Report of the Commission on Theology and Church Relations, The Lutheran Church Missouri Synod (n.p.: March 1975), 10-11.

studies discuss the dangers of historical (higher) critical methodology and espouse the careful, professional use of historical-grammatical scholarship. This writer shall attempt to utilize the latter as various Scriptures are studied. Various passages indicate the existence of mental illness.

Deuteronomy 28:28 illustrates why higher critics prefer to use a developmental model approach as this passage speaks of mental illness being a curse from God. But this passage must be placed within the context of the covenant: blessings to those who obeyed and curses upon those who disobeyed.

> However, if you do not obey the Lord Your God and do not carefully follow all his commands and decrees I am giving you today, all these curses will come upon you and overtake you: (28:15). The Lord will afflict you with madness, blindness and confusion of mind. (v.28)

Even in this contemporary culture and society a person with mental illness will testify without hesitation that this illness is the worst of all illnesses: the stigma, the suffering, and the pain (mental pain is real pain to the person experiencing it) is not only indescribable but also intolerable. The afflicted person often feels accursed by God and unwanted even by the devil. (See appendix D.)

King Saul suffered from what appears to have been manic-depressive psychotic episodes:

> Now the Spirit of the Lord had departed from Saul, and an evil spirit from the Lord tormented him. Saul's attendants said to him, "See, an evil spirit from God is tormenting you. Let our lord command his servants here to search for someone who

> can play the harp. He will play when the evil spirit from God comes upon you, and you will feel better." . . . Whenever the spirit from God came upon Saul, David would take his harp and play. Then relief would come to Saul; he would feel better, and the evil spirit would leave him (I Sam. 16:15-19, 23).
>
> The next day an evil spirit from God came forcefully upon Saul. He was prophesying in his house, while David was playing his harp, as he usually did. Saul had a spear in his hand and he hurled it, saying to himself, "I'll pin David to the wall," But David eluded him twice. (I Sam. 18:10-11; also 19:9-10).

This pericope illustrates the manic behavior of the bipolar cycle. Interestingly, the prescription for controlling this erratic behavior was music therapy! What is most troublesome about this account is the words which ascribe an evil spirit from the Lord coming upon Saul and causing the mental illness. Is the Lord God really responsible for this horrible illness? The text seems to indicate so.

In reflecting upon the Old Testament cases of persistent disobedience to God, Pharaoh and the plagues come to mind. During the first few plagues we read of Pharaoh repenting, agreeing to let the Israelites leave Egypt, but then he would change his mind. Note carefully these words from Exodus 8:32: "But this time also Pharaoh hardened his heart and would not let the people go." Shortly thereafter came the plague of boils; again Pharaoh changes his mind. Only this time the passage states: "But the Lord hardened Pharaoh's heart and he would not listen to Moses and Aaron, just as the Lord had said to Moses." (Ex. 9:12) Is it pos-

sible to refuse and refute God's grace to such an extent that God's anger and judgment is immediately visited in the form of some disease or tragedy? Is this what the Apostle Paul had in mind when he describes people who "did not think it worthwhile to retain the knowledge of God, (so) he gave them over to a depraved mind"? (Rom. 1:28) Or is there some other adequate explanation for God's action?

Another interesting case of mental illness is King Nebuchadnezzar.

> The words were still on his lips when a voice came from heaven, "This is what is decreed for you, King Nebuchadnezzar: Your royal authority has been taken from you. You will be driven away from people and will live with the wild animals; you will eat grass like cattle. Seven times will pass by for you until you acknowledge that the Most High is sovereign over the Kingdoms of men and gives them to anyone he wishes.
>
> Immediately what had been said about Nebuchadnezzar was fulfilled. He was driven away from people and ate grass like cattle. His body was drenched with the dew of heaven until his hair grew like feathers of an eagle and his nails like the claws of a bird.
>
> At the end of that time, I, Nebuchadnezzar, raised my eyes toward heaven, and my sanity was restored. Then I praised the Most High; I honored and glorified him who lives forever. (Daniel 4:31-34)

After quoting from secular sources to indicate historical verification of this bizarre event, Old Testament scholar Edward Young shares these remarks:

> The disease which came upon the king is known technically as Lycanthropy, in which the sufferer imagines himself to be changed into an animal and, to a certain extent, acts like that animal. Apparently Neb. had that form of disease which would be

> called Boanthropy, i.e., he thought himself to be an ox, and so ate grass like an ox.[4]

Elijah is another well-known Old Testament prophet who appears to have suffered from mental illness, mainly manic depression or the bipolar depressive disorder. I Kings 18 and 19 describe the various stages of this illness. Elijah had just finished praying fire down from heaven to burn the sacrifice; this resulted in the slaughter of the priests of Baal as well as the destruction of heathen altars. High on the success of the moment and knowing that God was breaking the drought in response to his prayer, he outran the rain-clouds and King Ahab's chariot from Mount Carmel to Jezreel (19:45-46). This spiritual and moral victory quickly collapsed under the words of Queen Jebebel's threats to destroy him. Elijah's depressed reaction is described:

> Elijah was afraid and ran for his life. When he came to Beersheba in Judah, he left his servant there while he went a day's journey into the desert. He came to a broom tree, sat down under it and prayed that he might die. "I have had enough, Lord," he said. "Take my life; I am no better than my ancesters." Then he lay down under the tree and fell asleep.
>
> All at once an angel touched him and said, "Get up and eat." He looked around, and there by his head was a cake of bread baked over hot coals, and a jar of water. He ate and drank and then lay down again.
>
> The angel of the Lord came back a second time and touched him and said, "Get up and eat, for the journey is too much for you." So he got up and ate and drank. Strengthened by that food, he traveled

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[4]Edward J, Young, The Prophecy of Daniel (Grand Rapids, MI: Eerdmans Publishing Co., 1949), 112.

> forty days and forty nights until he reached Horeb, the mountain of God. I Kings 19:3-8)

Note God's treatment for depression: a short vacation, good food and rest. Later in this account, the Lord gave Elijah some very dynamic supportive psychotherapy as well as providing him with peer support.

Allusions to acute mental illness can also be found in the Wisdom literature. For example, Psalm 42 echoes feelings of depression: "My tears have been my food day and night" (3) and "Why are you downcast, O my soul? Why so disturbed within me?"(5) Stewart Govig, a contemporary ELCA Lutheran theologian who has written on persons with disabilities, discusses Jack Kahn, a London psychiatrist's research on Job:

> In his book Job's Illness, Kahn distinquishes three clincial syndromes in the account of Job's suffering: obsessional neurosis (16:15-17; 17:13-16), depression (3:20-21), and paranoia (10:13-17; 16:10-11). Kahn links each to an underlying psychopathology. But he insists, Job achieves a more mature personality through all this.[5]

Other Old Testament passages can be located which may suggest mental illness, especially the behavior of certain prophets. Although not explicitly stated, illness is presented as originating from two sources: Satan (the account of Job, for example) and man's own sinful behavior. It must be remembered that the Old Testament paints a picture of

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[5]Stewart D. Govig, Strong At The Broken Places: Persons With Disabilities And The Church (Louisville: Westminister/John Knox Press, 1989), 56.

broken, sinful people needing and awaiting a Deliverer. Mental illness was a part of and also a result of the sin and brokenness of mankind; deliverance by the Savior meant restoration and healing of the body and soul as well as that of the mind.

A study of health and healing in the Gospels necessitates a careful discussion of demon-possession and its relationship to mental illness. To no one's surprise, an abundance of literature exists on this topic, much of which is written from a pragmatic perspective. Well-done exegetical and theological treatises appear scarce, namely because of the difficult nature of the subject matter. Yet this sensitive and critical area must be addressed.

To begin, the Gospel writers continue the same perspective as the Old Testament writers regarding disease. Jesus himself upon healing the individual party would instruct them to present themselves to the priests; the ten lepers of Luke 17 were to go to the priests, similar to the Levitical ordinances established under Moses and Aaron (Lev. 13 et al). More importantly, Jesus himself upon healing the individual party would use the appropriate "method", depending upon the source of the illness. If the illness was caused by demons, then the demons were cast out. If the illness was caused by natural causes, then these causes, not the demons, were addressed. (See Mark 1:32, 34; Matt. 8:16.) Please note that not all diseases were caused by demons. In fact, Mat-

thew precisely distinquishes between demon possession and epilepsy or those having seizures:

> News about him spread all over Syria and people brought to him all who were ill with various diseases, those suffering sever pain, the demon-possessed, those having seizures, and the paralyzed, and he healed them. (4:24).

The word for "seizures" or epilepsy is from the cognate verb "seleniazomai" which means to be affected by the moon. From the Latin the word "lunatick" is derived. Although the word describes seizures, unfortunately the literature is scarce and inconclusive in determining if this word also applies to mental illness, as its present-day derivations would seem to imply. Nevertheless, it should be noted how symptom-specific the Gospel writers were as they attempted to describe the healing ministry of Jesus.

Yet it must be acknowledged that the common New Testament perception of madness or mental illness was related to demon possession. The unbelieving Jews reacted to Jesus' message by saying, "He is demon-possessed and raving mad." (John 10:20) Again, this is the only instance of the cognate "mainomai" (to be mad, to be out of one's mind) being used in the Gospels.

A typical example of demon-possession and deliverance is the account, mentioned in all the synoptic Gospels, of the demoniacs in the country of the Gadarenes:

> When he (Jesus) arrived at the other side in the region of the Gadarenes, two demon-possessed men coming from the tombs met him. They were so violent that no one could pass that way. "What do you

> want with us, Son of God?" they shouted. "Have you come here to torture us before the appointed time?"
>
> Some distance from them a large herd of pigs was feeding. The demons begged Jesus, "If you drive us out, send us into the herd of pigs."
>
> He said to them, "Go!" So they came out and went into the pigs, and the whole herd rushed down the steep bank into the lake and died in the water. Those tending the pigs ran off, went into the town and reported all this, including what had happened to the demon possessed men. Then the whole town went out to meet Jesus. And when they saw him, they pleaded with him to leave their region. (Matt. 8:28-34)

Reformed theologian Frederick S. Leahy has studied this and other passages regarding the nature of New Testament demon-possession. He gives these general impressions:

(1) Demon-possession may be voluntary or involuntary.
(2) There is no essential link between the character of the victim and his possession.
(3) Possession may be permanent or spasmodic, the former case being illustrated by Luke 11:26 where the word translated 'dwell' indicates permanent residence.
(4) Body and mind alike are affected. There is either a general suppression of the personality, or the emergence of a kind of double personality. In either case, the victim becomes the instrument of the demon. Consequently it is the demon who speaks through the instrumentality of the person possessed.
(5) Symptoms vary greatly, but frequently include, especially in cases of involuntary possession, mental abnormality, epileptic or similar fits, superhuman strength, suicidal tendencies and a malignant attitude towards others. Sometimes there is an uncanny recognition of the presence of Christ and an acute awareness of His Person and authority.

(6) Deliverance, when it comes, is sudden.[6]

In surveying and studying the literature and various reports of demon-possession from New Testament times to the present, Professor Leahy observes these common marks of possession:

(1) Speaking in a voice not that of the victim.
(2) Unusual physical strength.
(3) Obvious conflict within the person.
(4) Hostility and fear in the presence of Christ when proclaimed in His Word.
(5) Greatly heightened insight and sensitivity.
(6) Speaking in tongues.
(7) In cases of involuntary possession the same physical and mental disturbances as are described in the New Testament are observed.
(8) Voluntary possession, as with sorcerers and spiritist mediums, is often employed to effect healing, sometimes with phenomenal results.[7]

Although mental illness and demon-possession would appear, at first glance, to be identical in the New Testament, there are significant differances. Most demon-possessed people exhibit symptoms of mental illness, but most mentally ill people are NOT demon-possessed. Please note that demon-possession is not synonymous with mental illness!

That raises the question of the relationship of demons to believers, which is an area of great controversy in protestant and evangelical church circles today. The late Mer-

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[6]Frederick S. Leahy, Satan Cast Out: A Study in Biblical Demonology (Carlisle, PA: The Banner of Truth Trust, 1975), 90-91.

[7]Ibid., 128.

rill Unger enumerates three positions within the Christian church today:

> (1) Many Christians naively assume that the potential of satanic power in the life of the regenerated is practically nil. They live in a sort of fool's paradise, imagining that becoming Christians magically shields them from satanic attack or demonic invasion.
>
> (2) Other believers maintain a more realistic view. They are fully convinced that satanic powers may not only tempt and attack but that, if they are not repulsed, they may affect the saint's life and do serious harm in his experience. They may influence him, delude him, despoil him. Always, however, they attack the saint from without, but never exercising total control over him. To such people the possibility of a born-again believer being invaded by one or more demons is preposterous and, in their view, unbiblical.
>
> (3) A third class of believers hold to what seems to me the most realistic view. Grievously sinning saints (and such there are) may go beyond the old nature. In cases of serious, persistent, scandalous sin, such as gross immorality or participation in occultism or occult religionism, demons may exercise control over the believer for a time until his sin is confessed and forsaken and deliverance from evil powers is gained.[8]

Although it is often assumed that the Lutheran dogmaticians never spoke directly to the subject of demonology, Francis Pieper addressing the topic of "Angelology" wrote these startling words:

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[8]Merrill F. Unger, What Demons Can Do To Saints (Chicago: Moody Press, 1991), 55.

> It is Scriptural to describe the status of all those who do not believe that the blood of Jesus Christ cleanses us from all sins as "Obsessio spiritualis". . . . Bodily possession ("obsessio corporalis") presents an entirely different case. Also children of God may suffer this affliction (Mark 5:6, 18, 19; Luke 8:28, 38, 39); by it the devil, under God's sufferance, takes possession of a man by personally (kat' ousian) dwelling in him, so that the demoniac, bereft of the use of his reason and will, becomes the involuntary instrument of Satan. The human personality no longer functions; the devil in person (autoprosopos) becomes the acting subject. The demoniac is no longer responsible for his actions.[9]

Pieper does not treat the subject of pastoral care for those who are demon-possessed, but in a footnote defers to John H. C. Fritz's Pastoral Theology. (Fritz does make a sharp distinction between those afflicted with insanity versus those who are afflicted with demon possession.)[10]

Various Scripture passages also indicate that believers are subject to the attacks and manipulations of Satan and his demons:

> Put on the full armor of God so that you can take your stand against the devil's schemes. For our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms. (Ephesians 6: 11-12)
>
> Submit yourselves, then to God. Resist the devil, and he will flee from you. (James 4:7)
>
> Be self-controlled and alert. Your enemy the devil prowls around like a roaring lion looking for

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[9]Francis Pieper, "Angelology" in Christian Dogmatics, Volume 1 (St. Louis: Concordia Publishing House, 1950), 509-510.

[10]Fritz, 204-211.

> someone to devour. Resist him, standing firm in the faith . . . (I Peter 5:8-9)

The following two texts exemplify Satan's activities in the life of that most colorful and outspoken apostle, Peter:

> Simon, Simon, Satan has asked to sift you as wheat. But I have prayed for you, Simon, that your faith may not fail. And when you have turned back, strengthen your brothers. (Luke 22:31-32)

> From that time on Jesus began to explain to his disciples that he must go to Jerusalem and suffer many things at the hands of the elders, chief priests, and teachers of the law, and that he must be killed and on the third day be raised to life. Peter took him aside and began to rebuke him. "Never, Lord!" he said. "This shall never happen to you!" Jesus turned and said to Peter, "Out of my sight, Satan! you are a stumbling block to me; you do not have in mind the things of God, but the things of men." (Matthew 16:21-23)

Commentators have written volumes on the above passages. Without saying that a believer can become demon-possessed, R. C. H. Lenski cautiously suggests the possibility as he elucidates on this latter text:

> Unwittingly and though moved by the best intentions Peter had made himself an agent of Satan. What a warning to watch our love, our good intentions, our best acts, lest, perhaps after all, they agree with Satan and not with Christ.[11]

The contemporary evangelical protestant church would tend to see demon-possession in terms of degrees or a process. This is the perspective of C. Fred Dickason, Merrill Unger, and Jerry Johnson, just to name a few writers on this subject. Lutheran scholars, by contrast, focus on the doc-

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[11]R. C. H. Lenski, The Interpretation of St. Matthew's Gospel (Minneapolis: Augsburg Publishing House, 1943), 640.

trine of sanctification, not demonology. Lutheran theologians would address the work of the Holy Spirit as He continuously reveals sin in the Christian's life and works repentance and faith in the Gospel; opposing this process would be the devil, the world, and our own flesh. Having demonstrated that demon-possession of Christians is a contemporary possibility, one must also allow that mental illness can be demonically induced. Even as it was in the times of Jesus, so it must be noted again: mental illness due to demon-possession describes only a minority of cases. How does one distinguish between mental illness and demon-possession?

Let's begin by examining a "typical" demon-possession case; specifically let us review the account of the demon-possessed man on pages 33-34, found in Matthew 8. The gospel writer Mark's account contains this interesting dialogue from the same incident:

> When he saw Jesus from a distance, he ran and fell on his knees in front of him. He shouted at the top of his voice, "What do you want with me, Jesus, Son the Most High God? Swear to God that you won't torture me!" For Jesus was saying to him, "Come out of this man, you evil spirit!" Then Jesus asked him, "What is your name?" "My name is Legion," he replied, "for we are many." (Mark 5:6-9)

Some modern day psychiatrists would diagnose the above case as that of a Dissociative Personality Disorder. Most Christian counselors dealing with counselees involved in the occult would concur. The difference between the Christian

counselor and the secular psychiatrist would be the method of treatment. The Christian therapist would use Scripture and prayer whereas most likely the psychiatrist would prescribe medication.

Samuel Southard of Fuller Theological Seminary was requested by students, particularly students from the Far East, to teach a course on demonizing and deliverance. Consequently this professor researched the topic, designed a curriculum, and published it in Pastoral Psychology under the title: "Demonizing and Mental Illness: the Problem of Identification." Unfortunately his approach was a pragmatic one based upon case studies developed by his students who had very little, if any, formal training in psychology. He concluded that most of the students accepted a multiple causation for psychological/spiritual disorder instead of a fixed unitary explanation.[12] Demonizing and mental illness usually went together.

In addition to adopting a symptom-association approach versus a symptom specific approach, the students generally preferred a dynamic approach instead of a behavioral approach. The students tended not to focus on certain behaviors such as frenzy or foaming at the mouth, but tended to investigate the "possessed" background.[13]

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[12]Samuel Southard, "Demonizing and Mental Illness (2) The Problem of Assessment: Los Angeles," Pastoral Psychology 34 (Summer 1986): 285.

[13]Ibid., 286.

Kurt Koch, a German theologian who has studied demonology, describes eight distinct symptoms of possession, using the account of the Gadarene demoniac in Mark 5:

Mark 5:2	The demoniac had an unclean spirit. In other words, he was indwelt by another being.
Mark 5:3	The possessed man exhibited unusual powers of physical strength. No one could bind him any more.
Mark 5:4	The third characteristic was the paroxysms (the fits of rage). He had wrenched chains apart and broken his fetters in pieces.
Mark 5:7	The fourth sign in one of disintegration, splitting of the personality. The demoniac runs to Jesus for help, yet cries out in fear.
Mark 5:7	The fifth sign is that of resistance, an opposition to the Christian faith and spiritual things. He tells Jesus to leave him alone. One meets this resistance to spiritual help quite often in counselling subjected people.
Mark 5:7	The sixth symptom is hyperaesthesia, an excessive sensibility. The Gadarene had clairvoyant powers. He knew immediately who Jesus really was.
Mark 5:9	The seventh sign is seen in the variation or alteration of voice. A 'legion' of demons spoke out of him.
Mark 5:13	The eighth characteristic is occult transference. The demons left the man and entered into the swine.

Koch states that the second, third and fourth characteristics are similar in many respects to the symptoms of certain mental illnesses. The remaining five characteristics are not to be found within any psychiatric classification. For example, clairvoyance itself is never a sign of mental illness, and a mentally ill patient will never be able to

speak in a voice or a language he has previously not learned.[14]

To assist in distinquishing between mental illness and demon-possession, Jerry Johnston recounts this interesting story of Christian counselor Robert Karman:

> Robert's first lesson occurred in the very room in which we sat when a patient said in characteristically schizoid fashion, "I hear voices most of the time."
>
> Robert said that his usual response as a therapist was to ask if can talk with these voices. The schizophrenic will then have to admit that no one else can hear them - which is a step in confirming to the patient that the voices are only auditory hallucinations.
>
> He had asked the patient, "Well, can I speak with these voices?"
>
> Surprisingly, the patient had said, "Of course."
>
> The psychologist had then groped for words to tell me how he felt the patient "retreating" somehow and another being altogether stating in another voice, "Well, shall we talk?"[15]

Thus demon-possession is most often associated with the multiple personality disorder or dissociative state, not the serious mental illnesses of schizophrenia, manic depression, or chronic depression.

T. Craig Isaacs, researching the phenomena of possession, concluded that possessions do exist as a phenomena independent of current commonly accepted forms of psychopa-

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[14]Kurt Koch, Occult Bondage And Deliverance (Grand Rapids: Kregel Publications, 1970), 57-58.

[15]Jerry Johnston, The Edge Of Evil: The Rise of Satanism in North America (Dallas: Word Publishing, 1989), 200.

thology. He then developed a Possessive States Disorder category, similar to the present categories of DSM-III-R. The diagnostic criteria for the Possessive States Disorder would be:

A. The experience of being controlled by someone, or something, other than oneself, with a subsequent loss of self-control in one of the four areas: thinking, anger or profanity, impulsivity, or physical functioning.

B. A sense of self which fluctuates between periods of emptiness and periods of inflation, though one period may predominate. This fluctuation is not due to external circumstances, but corresponds to whether the person is feeling in control of him or herself, or is feeling out of control.

C. At least one of the following is present:

1) The person experiences visions of dark figures or apparitions and/or the person has coherent voices which have a real, and not a dream-like quality.
2) Trances, or the presence of more than one personality. If more than one personality, these are either obseved during the trance, or if present in normal consciousness, the person is able to maintain an independent sense of reality respective to the other personality. Also there may be variations in voice or the ability to speak or understand a previously unknown language.
3) Revulsive religious reactions, such as extreme negative reactions to prayer, or to religious objects. The inability to articulate the name Jesus, or the destruction of religious objects.
4) Some form of paranormal phenomena, such as poltergeist-type phenomena, telepathy, levitation, or strength out of proportion to age or situation.
5) There is an impact on others: Paranormal phenomena, stench, coldness or the feeling of an alien presence or that the patient has lost a human quality, is experienced by someone other than the patient.

A, B, and C, must be present.[16]

This researcher's attempt is noble although misguided. The research model starts with demon possession, not serious mental illness, as is evidenced by the author's discussion. Although he quickly addresses cultural and historic facets of this tension, the theological issues are skirted; for example, are demonizing and demon possession synonymous? Also, would the American Psychiatric Association ever place a category in DSM-IV for which they would have no treatment protocal?

Refocusing upon the Mark 5:1-20 account of the Gerasene demoniac, the following homilectical treatment may prove helpful:

> Jesus approaches a man cast out by society because of his "demons." Jesus, unafraid, identifies the demon, "Thy name is Legion" (meaning "many"). Once named, the demon loses its power to cause fear. It becomes a knowable, understandable and thus, treatable entity.
>
> By identifying the man's demon for what it is, Jesus is able to exercise authority over it, heal the man and restore him to his community.
>
> Modern men and women rarely think in terms of demons. Yet, we are still afraid of what we do not understand. Once mental illnesses are understood (named) we no longer need fear it or shun those who suffer. As did Jesus, our compassion, understanding, and recognition that the person and the disease are separate are powerful indications of

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[16]T. Craig Isaacs, "The Possessive States Disorder: The Diagnosis of Demonic Possession," Pastoral Psychology 35 (Summer 1987): 272.

> God's loving grace and are instrumental in the treatment of persons suffering mental illness.[17]

In summary, Jesus and the New Testament writers underscored the difference between demonically caused and non-demonically caused illness in their discussion of healing. Both kinds of illnesses were healed but by different means. No matter what the cause was, Jesus healed them. Jesus became known as the one who exorcised demons, and thus the one who instantly healed illness, both physical and mental. Most importantly, Jesus did not avoid people who had symptoms of mental illness, but had compassion on them, and wished them to be freed from their distress. His calls of mercy and grace such as "Come unto me, all you who are weary and burdened and I will give you rest" (Matt. 11:28) were not only extended to assuage the spiritual burdens of sin and guilt, but also the burdens caused by original sin: sickness, disease, pain and suffering. How appropriate that the last pages of Scripture close with these words:

> And I heard a loud voice from the throne saying, "Now the dwelling of God is with men, and he will live with them. They will be his people and God himself will be with them and be their God. He will wipe every tear from their eyes. There will be no more death or mourning or crying or pain, for the older order of things has passed away." (Revelation 21: 3-4)

Even as God in His Son visited the earth the first time and touched and healed the sick, here is a final picture of

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[17]American Psychiatric Association. A Mental Illnesses Awareness Guide for the Clergy. Walter Hill, ed. (Washington, D.C.: American Psychiatric Press, 1990). 5.

healing, of God wiping away all tears, removing all pain, even the tears, the pain and suffering of the mentally ill as well as that of their families and loved ones.

CHAPTER 3

IDENTIFYING THE MENTALLY ILL WITHIN THE CHURCH

INTRODUCTION

The initial reaction of the typical Lutheran pastor serving an average size congregation of a couple hundred communicant members may be: "Outside of Ol' Aunt Suzie who is a little demented or may be suffering from Alzheimer's, I don't know of anybody with serious mental illness and even if there is somebody with mental illness, he doesn't show up in church and thus it is of no concern to me." This tragic but all too frequent attitude needs to be addressed on several fronts. Statistics indicate that mental illness is all too common, afflicting men and women of all ages, races, and economic status. At any given time 25 million adult Americans and 8 million children suffer a mental illness, while it is estimated that one in five persons will suffer a mental disorder during his lifetime.[1] One out of five families is affected by mental illness is the often quoted number among professionals and family members associated with the National Alliance for the Mentally Ill (NAMI), a

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[1]American Psychiatric Association, An Educator's Guide To Mental Illness Awareness Programs: "Let's Talk About It" (Washington, D.C.: American Psychiatric Press, 1991), 13.

support and informational network composed of family and friends of those afflicted with mental illness. Thus the laws of statistical probability almost necessitate that there will be persons with mental illness within the average congregation.

The average pastor is accustomed to encountering marriage and family conflict situations that may require his counseling skills and expertise. Usually these acute crises can be pastorally addressed and managed. However, if the situation requires more time, energy and/or counseling skills, the pastor may refer to another Christian mental health setting.[2]

However, ministering to the seriously mentally ill and their families and their loved ones is another matter, usually one which the pastor is ill-equipped to handle. First, it should be noted that most families initially turn to their clergy as their first line of assistance in dealing with a mental health crisis. Studies indicate that 40% of church members seek help from their pastor or rabbi.[3] Surprisingly, clergy refer only one to ten per cent for more

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[2]John L. Young and Ezra E. H. Griffith, "The Development and Practice of Pastoral Counseling," Hospital and Community Psychiatry 40:3 (March 1989): 271-274.

[3]J. Veroff, R. A. Kulka, and E. Douvan, Mental Health in America (New York: Basic Books, 1981), 121.

specialized care.[4] Explanations for this low referral rate include: (1) Because of professional training, pastors are not familiar with psychopathology and symptoms of mental illness; (2) Emotional difficulties are primarily perceived in purely spiritual terms; (3) Clergy tend to be skeptical of psychology and/or psychiatry, feeling that treatment protocols may be antithetical to Christian faith and behavior; and/or (4) Clergy lack knowledge of available psychiatric resources.[5] The difficulties faced by families is further documented by a survey done in 1986 by the California Alliance for the Mentally Ill (CAMI). This survey reported that although 40% of CAMI families sought the help of clergy, when faced with mental illness, clergy were found to be last in being helpful and supportive.[6] Who are the mentally ill persons that the pastor and/or his staff are mostly likely to encounter?

THE HOMELESS

On a cold December Friday afternoon, the pastor is hurriedly completing last minute details for the Sunday morning worship service when he hears the church office

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[4]John F. Gottlieb and Mark Olfson, "Current Referral Practices of Mental Health Care Providers," Hospital and Community Psychiatry 38:11 (November 1987): 1172.

[5]Ibid.

[6]Patricia Williams, William A. Williams, Robert Sommer, and Barbara Sommer, "A Survey of the California Alliance for the Mentally Ill," Hospital and Community Psychiatry 37:3 (March 1986): 255.

doorbell ring. Because the church staff has already left for the day, the pastor rushes to unlock the door, imagining the party at the door to be a church member who also has some last minute errands to complete at the church. To his surprise, the pastor opens the door to an unknown stranger dressed in ill-fitting clothes. The man explains that he is hungry and needs some food for himself and his family. The person's unkempt appearance and pleading eyes create a churning of various internal emotions. His first impulse is to shout at him: "Go away, mister. Can't you see that you have come at a most inopportune time. I am busy in my office and there's nobody else to help you. Besides we have various community social agencies that you should solicit first." On the other hand, the pastor recalls the Lord's words from the Olivet Discourse of Matthew 25: "I was a stanger and you took me in." Also the admonition from Hebrews 13: "Do not forget to entertain strangers, for by so doing some people have entertained angels without knowing it," echoes within the chambers of his sensitive heart. What should he do?

The above scenario is not unusual. Upon further questioning the pastor would learn that the stranger was homeless. And homelessness is a major social problem, particularly in the larger cities. The number of the homeless is difficult to estimate. Homeless advocates place the number over one million while the government estimates that there

are 600,000 homeless people.[7] Both parties would agree that over a third of the homeless are mentally ill. Where have the homeless mentally ill come from and why are they knocking on church doors?

Rael Jean Isaac and Virginia C. Armat have written a brilliant but scathing expose entitled Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill. Briefly the story goes like this. With the advent of psychotrophic drugs came the deinstitutionalization movement of the 1960s which released mentally ill patients from the state hospitals into the care of community health centers. There were many glitches with this program, the greatest problem being the community mental health centers that were not in place. If they were operating, they were more interested in treating the "worried well" rather than the chronically mentally ill. Consequently the majority of state hospital patients ended up moving home with family members who were ill-equipped to handle such illnesses. In more recent times the emptying of state hospitals has accelerated because of declining operating revenues for national and state governments. Often seriously mentally ill patients, lacking the necessary care and support systems, become noncompliant with their medications, relapse, and ultimately

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[7]"A Blueprint for Helping the Homeless Mentally Ill," NAMI Advocate 13:3 (March/April 1992), 3.

end up on the streets.[8] Also homeless persons with mental illness self-medicate and substance abuse becomes an additional treatment concern. Consequently the homeless are turning to anyone, anything that can offer some form of assistance, particularly on a cold winter night. Ideally the pastor in the above example had a social ministry program in place and he "referred" the homeless person to the proper resource person or party.

THE DUAL DIAGNOSIS PATIENT

The typical pastor may dismiss the concerns of the homeless mentally ill as a "concern that generally lies outside the purview of the congregation" and thus mental illness is not an issue of immediate concern. However, every pastor and congregation is faced with the unavoidable scourge of alcoholism and its heinous effects.

Dual diagnosis or dual disorder simply means that the individual has both the illness of alcoholism and mental illness simultaneously; note that both illnesses are chronic, have a high rate of relapse, and entail family systems. How common is this disorder? An initial paragraph from the The Harvard Mental Health Letter defines the affected population.

> The prevalence of dual diagnosis is firmly established by the Epidemiologic Catchment Area study, a recent survey of more than 20,000 Americans by

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[8]H. Richard and Doris M. Lamb, "Factors Contributing to Homelessness Among the Chronically and Severely Mentally Ill," Hospital and Community Psychiatry 41:3 (March 1990): 303-04.

> the National Institute of Mental Health. Researchers conducted a standard diagnostic interview with residents of five cities and with a separate group of people living in prisons, nursing homes, and mental hospitals. They found lifetime rates of 13.5 percent for alcohol abuse or dependence, 6 percent for other drug abuse or dependence, and 22.5 percent for other psychiatric disorders. Among people with other psychiatric disorders, 22 percent also had an alcohol problem and 15 percent had another drug problem. Having another psychiatric disorder nearly tripled the risk of an alcohol or other drug problem. The lifetime rate of substance abuse in antisocial personalities was 84 percent; in schizophrenics, 47 percent; in people with bipolar disorder, 61 percent; and in people with panic disorder 25 percent.
>
> Examined from the other side, the pattern was similar. Thirty-nine percent of alcoholics and 53 percent of persons with drug problems had another psychiatric diagnosis.[9]

Other studies have come to similar conclusions, showing approximately from 30 to 60 percent of all alcoholics suffer from a primary psychiatric diagnosis. (Experts in alcohol treatment programs generally use a baseline figure of 1:10 adults suffers from alcoholism). Thus by inference one out of every three alcoholics in the church is also experiencing serious mental illness.

There exists much debate regarding cause and effect in these difficult cases. Experts postulate three possibilities: (1) The psychiatric symptoms and the substance abuse have common causes, biological, psychological, or social. The risk factors for drug abuse are similar to those for depression and other disorders: low self-esteem, limited

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[9]"Dual Diagnosis: Part I," The Harvard Mental Health Letter 8:2 (August 1991): 1.

skills for coping with changing circumstances, and lack of friends and family support. (2) Drug abuse causes acute and chronic psychiatric symptoms. Acute psychotic symptoms from intoxication by various drugs and depression during withdrawal are examples of this thesis. Surprisingly what appears as serious depression in an alcoholic or heroin addict often clears up after several weeks of abstinence. (3) Psychiatric disorders produce drug abuse and dependence.[10] This is the self-medication concept and is widely accepted in treatment circles. The stigma, cost, and limited accessibility to psychiatric services allow for the person with mental illness to compensate by substituting alcohol and street drugs for psychotrophic medications.

Treatment resources and programs for the dual diagnosis patient are almost non-existent. Usually this kind of patient is admitted to a substance abuse treatment program for alcoholism. The patient is "dried out", taken off all medications, including neuroleptics which are necessary for controlling the mental illness. The mental illness, which may have been the cause of the alcoholism (self-medicating) is not addressed and the patient returns home only to relapse. Likewise the alcoholism of a person with mental illness is often ignored in the psychiatric hospital and the patient often relapses upon dismissal from the treatment center.

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[10]Ibid., 2.

The ideal model of treatment will treat both chemical dependency and the mental health disorder concurrently. The most successful substance abuse recovery programs includes the following elements: (1) Abstinence; (2) Regular attendance at Alcoholics Anonymous or Narcotics Anonymous meetings; 90 meetings in 90 days is a common suggestion for newly recovering persons; (3) Working the steps of the Twelve-Step program; (4) Securing and working with a sponsor who serves as a guide and mentor; and (5) Meditation and prayer to develop one's spirituality.[11] (Please notice the spiritual components of this recovery program.)

Successful mental illness interventions would include the following strategies:

1. Correcting physiological deficiencies through such approaches as medication, nutritional supplements, and even exercise.

2. Building social support systems through case management, attendance at support groups, and mobilization of friendship networks.

3. Improving family functioning through such means as education about the disorder, communication skills training, and negotiation of contracts regarding roles, boundaries, and consequences for specified behaviors.

4. Prompting and reinforcing positive behavior through such tools as reminder cards, behavior checklists, and point systems.

5. Increasing the client's functional abilities through the teaching of such skills as assertion, stress management, or activities of daily living.

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[11]Katie Evans and J. Michael Sullivan, Dual Diagnosis: Counseling the Mentally Ill Substance Abuser (New York: The Guilford Press, 1990), 20-21.

6. Encouraging productive thinking patterns through such things as education about the nature of the disorder, using positive self-talk and imagery, or examining faulty assumptions about self and others.

7. Increasing client awareness of feelings, thoughts, and behaviors and their interrelationship through such methods as exploring the relationship between family of origin issues and current behavior, commenting on the here-and-now behavior in group therapy, and keeping journals.[12]

These interventions are ideal at best. Persons with schizophrenia and antisocial and borderline personality disorders would have extreme difficulty with this program.

An integrated program would include the previously mentioned strategies. It contains the following components: (1) Concurrent treatment of both disorders; (2) Psychotropic medications; (3) Disease process abstinence labeling; (4) A.A./N.A. involvement; (5) Stepwork (working through a modified twelve-step program); and (6) a supportive approach.[13]

What can the pastor do when he encounters a person with both the chemical dependency and the mental illness symptoms? (Because alcohol is the most common substance to be abused, the discussion will focus on this drug.) First, the minister must keep current his knowledge and ministry skills in the area of substance abuse. As Conrad Bergendoff points out, "The first and perhaps most important task of the

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[12]Ibid., 22-23.

[13]Ibid., 23-33.

pastor is accurate knowledge of the nature of alcoholism and the alcoholic."[14] This means continous reviewing of Howard Clinebell's classic Understanding & Counseling the Alcoholic. A competent pastor will also keep abreast with the latest developments pertaining to the disease, including such items as Fetal Alcoholic Syndrome (FAS), the search for the alcoholic genome, adult children of alcoholics, the increase in substance abuse among adolescents and the elderly, recent research on addictive behaviors and therapies and local treatment centers, as well as other issues. The pastor will also be involved in recognizing the problem, confronting the problem, assisting family and/or friends to develop a plan of action (intervention) as well as providing care and support for the alcoholic member and his/her family.[15]

The pastor ideally will be involved in aftercare so that a relapse can be prevented. At the community level the pastor can offer meaning and guidance, develop drug-free alternatives for social interactions, provide effective role models, and link together with other community resources in preventing drug and alcohol abuse.[16]

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[14]Conrad Bergendoff, Pastoral Care for Alcoholism: An Introduction (Center City, MN: Hazelden Foundation, 1981), 10.

[15]Agnes B. Hatfield, Dual Diagnosis: Substance Abuse and Mental Illness (Arlington, VA: National Alliance for the Mentally Ill, n.d.) 4-8.

[16]The Mental Health Association's Manual for the Clergy: Resources for Helping & Healing (Houston: The Mental Health Association of Houston and Harris County, 1991), 18.

Obviously volumes could be written on this topic, but the above items present a brief overview of pastoral care practices. The mental illness component of the dual disorder will be addressed later in this document.

MENTAL ILLNESS IN CHILDREN

For whatever reason society has traditionally and perhaps conveniently assumed that prolonged mental illnesses afflicted only older teenagers and adults. However, research indicates that because severe mental illness by definition is also a neurobiological disorder in form and function, it is also diagnosable in children and adolescents.

Parents of a child who has an attention deficit disorder (ADD), will readily affirm that it is not only theory, but reality. Furthermore, educators, psychologists, pediatricians, social workers, and many others are recognizing the onset of serious mental illness in early childhood. The science of genetics argues the high probability of a mentally ill parent having a seriously mentally ill child with a comparable diagnosis. If mental health professionals are cognizant of these data, the pastor as a spiritual health professional must also be knowledgeable.

Recent epidemiological studies indicate that about 20 percent of the 25 million Americans between ages 12 and 18 (adolescents and teens) will require mental health care.[17]

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[17]Aaron H. Esman, M.D., "Treatment and Services for Adolescents: An Introduction," Hospital and Community Psychiatry 43:6 (June 1992): 616.

The recent development of assessment instruments is enabling medical scientists to detect neurobiological disorders at earlier ages. Already it is estimated that by the age of 3 years, 10% to 15% of children will have some type of behavior problem.[18] Inevitably as the pastor encounters hyperactive children as he makes home visits, counsels Sunday School teachers about a disruptive child, teaches confirmation class to an inattentive child and/or is called upon to discuss a discipline case in the day school program, in all likelihood he is dealing with a child with mental illness. It is extremely important that the pastor is alert to this possibility as early detection of this critical illness can also mean early treatment.

Although the focus of this project is the major serious mental illnesses of schizophrenia and the depressive disorders, the most common childhood disorders are the attention deficit disorder (ADD) and the conduct disorder (CD). In fact, many experts believe these two disorders go hand-in-hand, in that CD is a continuation of ADD. Studies of prisoners with CD have verified this. Numerically it is estimated that approximately 3 to 10 percent of all children have ADD.[19] It is thought to be ten times more common in boys

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[18]Jody Zylke, M.D., "Psychiatrists Increasingly Able to Assess, Treat Mental Health Problems of the Very Young," JAMA 264:19 (November 21, 1990): 2491-2.

[19]Glenn Hunsucker, Attention Deficit Disorder (Ft. Worth, TX: Forrest Publishing, 1988), 10.

than girls. This disorder often develops before the age of seven, but is usually diagnosed between the ages of 8 and 10.[20] Typically the child with ADD:

1. Has difficulty finishing any activity that requires concentration at home, school, or play; shifts from one activity to another.

2. Doesn't seem to listen to anything said to him or her.

3. Acts before thinking, is excessively active and runs or climbs nearly all the time; often is very restless even during sleep.

4. Requires close and constant supervision, frequently calls out in class, and has serious difficulty waiting his or her turn in games or groups.[21]

To further complicate the picture, many ADD children are not hyperactive and may exhibit the following symptoms:

1. They have trouble concentrating on things for a long period of time.

2. Easily distracted.

3. They have trouble following directions.

4. They do not finish what they start (although they may try harder than those who are hyperactive.)

5. They may lose things (i.e., school work, books, etc.)

6. Overall disorganization or overly organized.

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[20]American Psychiatric Association, Let's Talk Facts About Childhood Disorders (Washington, DC: American Psychiatric Press, 1988), 6.

[21]Ibid.

7. Seem to be depressed and daydream a great deal.

8. May be meek and not speak out in defense of themselves as their hyperactive counterparts might.[22]

It should be noted that physically these children may be thinner, more uncoordinated, more suspectible to infectous diseases, and maybe even more prone to bed-wetting than normal children their age. Because of their short attention span these children may fare poor academically, sometimess failing to graduate from high school. Behaviorally speaking, impulsiveness and aggression characterize their actions. Socially these children appear immature and often fail to realize the social and relational consequences of their misbehaviors.[23]

A parent/teacher questionnaire, a medical/social history of the child, a history of the parents, observation of the child, occasional neurological screening and educational testing are the usual procedures for determining ADD.[24] Appendix C contains a parent/teacher questionnaire that the pastor can adapt for professional use.

As with any psychoneurobiological disorder, treatment consists of medication and psychotherapy. It is not unusual for parents and other caregivers initially to be in a state

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[22]Hunsucker, 14.

[23]Ibid., 21-31.

[24]Ibid., 80.

of denial when a chronic diagnosis is made for presenting mental illness. With children the problem is often compounded by the parent's sense of shame and guilt for his offspring having this terrible brain disease.

The immediate and primary focus must be on getting the child/adolescent into medical treatment. Ritalin, dexedrine or cylert is the medication of choice for children while tofranil is often prescribed for adolescents.[25]

It cannot be emphasized enough the critical importance of the parent's monitoring the medication, noting changes in behavior, side effects, etc. Psychotherapy is also essential in assisting the ADD patient and his family in accepting, understanding, and coping with the illness. Behavioral therapy may also assist the child in rehabiliation.

Conduct disorder (CD) is a persistent pattern of behavior that violates the community's norms as it pertains to aggression and trustworthiness. Persistent (6 months or more) misbehaviors include stealing, running away, lying, fire setting, truancy from school or work, breaking into cars or buildings, deliberate destruction of property, cruelty to animals, forced sexual activity, using a weapon in fights, frequently initiating fights, stealing with confrontation, and physical cruelty to animals.[26] Medical

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[25]Ibid., 87.

[26]Barry Garfinkel, Gabrielle Carlson, and Elizabeth Weller, Psychiatric Disorders in Children and Adolescents, (Philadelphia: W.B. Saunders Co., 1990), 194-194.

authorities are reluctant to make a CD diagnosis because the misbehavior may be related to social, economic, cultural, and/or other psychiatric conditions, just to name a few possible explanations. Yet research has demonstrated that CD and ADD often coexist.[27] Thus in treating CD stimulants must be used to treat the ADD first. Research seems to indicate that lithium may be effective in treating CD.[28]

Like adults, children also experience depression. In fact, studies of children aged six to 12 have shown that as many as one out of ten suffer from depression.[29] Similar to adults, treatment consists of medication (antidepressants) and psychotherapy. It should be noted that many children also experience anxiety disorders, including phobias, separation anxiety, just to name a few. School and law enforcement authorities are alarmed at the recent increase in substance abuse among children and adolescents.

Pervasive developmental disorders such as autism could also be addressed in this section. Obviously, the church and its ministers need to listen to the pain and suffering, both physical, emotional, and mental, of its youngest members: infants, children and adolescents.

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[27]Arthur Rifkin, "Pharmacological Treatment of Conduct Disorder," in Neurobiological Disorders in Children and Adolescents, eds. Enid Peschel, Richard Peschel, Carol Howe, and James Howe (San Francisco: Jossey-Bass Publishers, 1992), 60.

[28]Ibid., 61.

[29]American Psychiatric Association, Ibid. 2-3.

MENTAL ILLNESS AMONG SENIOR ADULTS

The elderly are an important part of every church and every pastor's ministry. There are over thirty million people in the United States who are 65 and older, of which it is estimated that 15 to 25 percent suffer from significant symptoms of mental illness.[30] This group has the highest suicide rate in America. Other impressive statistics could be given, but the tragic aspect of these data is that very few elderly seek medical treatment. Only four percent of patients in a community mental health center are elderly.[31] Often the elderly are not aware services exist for the treatment of depression and dementia. They may be ignorant as the symptoms of mental illness, presuming that he is only experiencing the typical signs of old age.

The most common mental disorder among the geriatric population is depression, affecting from 15 to 20 percent of the elderly.[32] Many researchers feel that the above number is low as depression often mimics dementia. The reader is familiar with the symptoms of depression: feelings of worthlessness, hopelessness, and helplessness; thoughts of death and/or suicide. Treatment includes drug therapy (antidepres-

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[30]American Psychiatric Association, Let's talk Facts About Mental Health of the Elderly (Washington, D.C.: American Psychiatric Press, 1988), 1.

[31]Ibid., 2.

[32]Papolos, 129.

sants) that is carefully monitored because of the metabolism and other health risk factors in the elderly.

The most dreaded mental illness of old age is dementia which is characterized by confusion, memory loss, and disorientation. Fifteen percent of older Americans suffer from dementia, while 60 percent of these suffer from Alzheimer's disease, a progressive mental deterioration for which there has been found no cause nor cure.[33]

Since the elderly are usually involved in various congregational activities, the pastor may be the first to notice that a parishioner appears to be experiencing a short-term memory loss, not remembering whether she turned off the stove or whether she took her medications that day. The need for pastoral intervention and care becomes obvious.

There is no doubt that mental illness exists among the elderly. It is interesting to observe that families with loved ones experiencing Alzheimer's will vehemently deny that their family member is mentally ill, only sick with Alzheimer's. This denial appears to be fueled by the fear and stigma of mental illness, a sad social commentary of modern day culture's attitude toward the mentally disabled.

In summary, it has been suggested that the typical pastor will inevitably encounter a person with mental illness in the daily ministry to people with emotional and

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[33]Judah Ronch, Alzheimer's Disease: A Practical Guide for Families and Other Caregivers (New York: Contininuum Publishing Co., 1991), 181.

spiritual needs. It should be observed that the anxiety disorders, which afflict from eight to ten percent of our American society,[34] has not even been mentioned. Truly, persons with mental illness are in the church and the community, often asking the pastor and the church for help.

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[34]American Psychiatric Association, Let's Talk Facts About Anxiety Disorders (Washington, D.C.: American Psychiatric Press, 1990), 1.

CHAPTER 4

Pastoral Care Guidelines: The Mentally Ill Person

DIAGNOSTIC-ASSESSMENT STAGE:

For the pastor and his staff to minister in a professional manner to persons with mental illness, certain requirements must be addressed. The pastor must familiarize himself with the etiologies and symptoms of mental illness as described in Chapter 1. If a church member complains of hearing voices or feels that his thoughts are broadcasted to neighbors and friends, the pastor should immediately recognize the person as displaying schizophrenic behavior and needing medical treatment such as hospitalization and psychotrophic drugs.

Of paramount importance is understanding mental illness to be a medical illness. Much ignorance and misinformation exists in this area, even among psychiatrists and other mental health professionals, to say nothing of the many gross distortions that often exist in the church and similar arenas. The temptation to ignore the person with mental illness and refer him to some other mental health professional is realistic and must be confronted. The fear to become involved with persons suffering from mental illness appears to stem from these expressed and sometimes unspoken

concerns: (1) There appears to be a fine line between mental illness and spirituality. Often at the height of a psychotic crisis, persons with mental illness will acknowledge that they have no control over their thoughts, moods, and/or behaviors. What happens during a crisis? Does an "alien power" possess this person? Who or what is this "alien force"? Is it Satan? This is a "grey area" of practical theology. Lutheran clergy are more comfortable when the boundaries are well defined, in black and white and can be addressed in terms of the Scriptures and the Lutheran Confessions. (2). If mental illness is defined in terms of a psychosocial neurobiological disorder, at what point is the person with mental illness responsible for his thoughts, words, and/or behaviors?

In ministering to persons suffering from illness and/or disease this author has noted that strictly speaking, having the illness in itself is not sinful, but how the individual, the family, and the community (church) respond to the illness/disease determines a moral judgment of right or wrong. In other words, using the model of John 9, particularly verses 1-5, does the afflicted individual and concerned parties focus on illness/disease or on one's response to the situation? Does one attempt to affix cause/blame or does one use the situation as a faith-growth experience? Can the pastor be comfortable with ambiguity or does he feel compelled to offer a theological discourse and treatise on

illness, suffering, and/or pain? (3). When a person with schizophrenia hears a voice speaking and claims that voice is God, how does the pastor respond? Does the person with mental illness have the charismata? Must the pastor vehemently defend the doctrines of revelation and inspiration of the Scriptures? (4). Because mental illness often affects a person during childhood and adolescence, a time of learning personal and social behaviors, persons with mental illness will often have poor personal hygiene as well as poor relational skills. Thus it will require more time and energy in ministering to persons with mental illness. In the present day society where productivity is measured and rewarded, it is not unusual for a pastor to feel that his time and effort are better invested in ministering to "normal" people. Continuous self-examination and reflection is essential as a pastor ministers to persons with serious mental illness.

Not only must the pastor be knowledgeable about the various mental illnesses, he must also create an atmosphere of acceptance, understanding, and support. A mental disability should be treated no differently than a physical disability. As with other friends and colleagues, he must treat the individual with mental illness the way he would want to be treated, with dignity and respect. **This means that when a person**

with mental illness:	**He needs to:**
is withdrawn,	initiate relevant conversation.

is overstimulated,	limit imput, do not force discussion.
becomes insecure,	be accepting.
is fearful,	stay calm.

When symptoms or medications cause behaviors such as:	**He needs to:**
disorientation or preoccupation,	keep a known, structured routine.
difficulty with concentration,	slow down, and perhaps repeat; use simple, short sentences.
stress in ordinary situations,	create an uncomplicated, predictable environment.
trouble remembering,	help the person record information.
unsound judgement,	remain rational and reinforce common sense.

Some symptoms of mental illness may be unlike anything he has ever encountered. He cannot change that but must be very sensitive and refrain from further destroying the person's integrity.

When a person with mental illness:	**He needs to:**
is not grounded in reality,	listen for kernels of truth, or wait for a better time.
believes delusions,	avoid arguing.
displays little empathy,	recognize this as a symptom; try not to respond in kind.
has difficulty making contact,	make direct contact and keep the initiative.
seems totally lack-	affirm the person's value; treat

ing self-esteem and motivation,	accomplishments positively.

It must be remembered that fine inner qualities often remain and develop in spite of mental illness. A pastor and/or church staff should not do "for" persons with mental illness; instead he should do "with them", as he would with other persons with disabilities. **When a person with mental illness:**

	He can:
shows a talent such as music, writing or art;	be open to the person sharing this with him.
retains an inborn generosity,	acknowledge the gifts (which may not always be monetary).
expresses an interest in his or her illness and its consequences,	learn together.
wants to have a serious discussion,	remember, even the most severely ill are rational as much of the time as they are psychotic.
wants to help,	give them a task and let them do it.[1]

Under normal circumstances the brain is designed to absorb various stimuli such as sound, sight, smell, and touch. A healthy brain, similar to a computer, is continuously receiving input (stimuli), screening imput, processing the data, and acting on it (responses). Serious mental illness affects the screening mechanism so that the

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[1]Jennifer Shifrin, "Reaching Out To Someone Who Has A Mental Illness," chap. in Pathways to Partnership: An Awareness & Resource Guide on Mental Illness (St. Louis: Pathways to Promise, 1990), 7-8.

"brain filters" are incapable of screening or are overwhelmed by external stimuli. For example, an average teenager may have the TV and CD player going continuously while eating and talking on the phone at the same time. By contrast, the person with mental illness would feel distracted, overwhelmed and unable to cope with such stimulation. The brain's systems would be overloaded, almost to the point of suffocating the brain's cognitive and other functions.

In other words, the stimulus windows (parameters) for persons with mental illness are severely restricted; this phenomenon must be recognized and allowed for in relational and other behaviors. Overstimulation (particular to each individual) becomes stressful and may trigger anger and/or psychotic-like responses.[2] Medication appears to aid in controlling the rate and amount of stimulation received by the brain.

Consequently, communication with persons with mental illness must be deliberate, concrete, and concentrated. One must keep the communication simple, short, slow, specific, singular and soft. Repetition may be necessary. Communication is a skill that is learned and must be continously practiced.[3]

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[2]Agnes B. Hatfield, Coping With Mental Illness In The Family: A Family Guide (Arlington, VA: National Alliance For the Mentally, 1991), 28.

[3]Ibid., 29-30.

Perhaps the greatest gift the pastor and/or staff can give a person with mental illness is acceptance, support, and friendship. One of the greatest barriers a person with mental illness and his family must overcome is the acceptance of the illness. The emotional, social and spiritual stigma of this illness makes for the worst kind pain, torture, and suffering imaginable. Jennifer Shifrin of Pathways to Promise ministry quotes this U.S. government report:

> For example, research studies have found that most Americans think the two worst things that can happen to a person are leprosy and insanity. In American society, ex-convicts stand higher on the ladder of acceptance than former mental patients. Asked to rank 21 categories of disability from the least offensive to the most, respondents place mental illness at the bottom of the list. . . . People continue to discriminate against the mentally ill, although it may be less socially acceptable to admit it openly. Discrimination crosses all boundaries of society and exists among people of all ages, socioeconomic levels, intelligence, education, and places. Nearly everyone, it seems, regards victims of mental disorders as "fundamentally tainted and degraded."[4]

A person may be tempted to defensively respond by suggesting that no such discrimination exists within The Lutheran Church-Missouri Synod. Unfortunately the evidence indicates otherwise.

Serious mental illness does exist among LCMS clergy and their family. In 1992 the Concordia Health Plan under the recommendations of Preferred Healthcare Providers reduced the lifetime ceiling benefits for mental illness from

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[4]Shifrin, intro. n.p.

$500,000 to $50,000. One hospitalization for mental illness and most of that $50,000 is gone. It appears that the church has concurred with the prevailing attitudes and practices of contemporary society and agrees that anyone with serious mental illness should be punished by restricting the amount of medical care that can be received.

What the pastor must tell the person with mental illness is: "Even though your brain is sick (broken, diseased, whatever adjective he may select), you are still God's child; you are okay." Not only must the pastor articulate these words, he must demonstrate it in his attitude and actions. This is a challenge of the greatest magnitude! The Savior's words from Matthew 25 must continuously echo as he ministers to people with mental illness:

> Then the King will say to those on his right, 'Come, you who are blessed by my Father, take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was in prison and you came to visit me.'
>
> Then the righteous will answer him, 'Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in, or needing clothes and clothe you? When did we see you sick or in prison and go to visit you?'
>
> The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.' (Matthew 25:34-40)

In this pericope, could the "stranger" or "one who is sick" or the "one who is in prison" refer to persons with mental

illness? Obviously persons with mental illness account for a large number of prisoners and the homeless. But persons with serious mental illness may describe their condition as being hostage to the prison of diseased brain. See Appendix D.

Another gift that the pastor can share with persons with mental illness is concern for their life of faith, the state of their relationship with God, their spirituality. Tragically the church and its clergy often subscribe to the thinking of the secular world who feel that it is dangerous to introduce religious issues to those suffering from mental illness. They might rationalize: "It will only contribute to their delusional thinking;" "Their minds are too clouded to discuss religion;" "You will only confuse them."[5]

Ed Cooper, who has vividly portrayed with words the experiences of a person suffering from serious mental illness, vehemently disagrees. He acknowledges that the pastor must be sensitive to the appropriate timing for religious discussion. It could possibly exacerbate the illness. He then adds:

> It doesn't make any sense to ignore us (persons with mental illness) or our souls. I do not believe I was ever harmed by being told the Gospel story. To be exposed to the grace of God through word and deed can only be a help in dealing with the pain of this illness. Being introduced to the real Jesus will not harm or impede my recovery. In fact, I find it a source of comfort and strength that helps me in my struggle. In my view only real

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[5]Ed Cooper, When Even The Devil Deserts You (Fort Lauderdale, FL: Dream Again Press, 1992), 96.

good can come from being included in the circle of God's children.[6]

If the person with mental illness is on medication, the pastor should inquire as to the patient's compliance status. The writer recognizes this as an area of controversy as some mental health authorities may see this as infringing upon the privacy of the person with mental illness. Ideally the people with mental illness will be monitoring their medication and its effects, chronicling the course of the illness and its symptoms in terms of sleep, appetite, excercise, or affect. Most mental health authorities concede that this is only an ideal! In reality, the illness leaves the individual so emotionally, psychologically, and mentally impaired that self-monitoring seems to be the exception rather than the rule.

On the other hand, it must be remembered that there is no "perfect pill" for controlling mental illness, much less curing it! Every medication has its limitations and its side effects. (Please check chart in appendix B for medication and its side effects.) Consequently the temptation for persons with mental illness to terminate or regulate/ moderate their medication is real and on-going. Ideally, these persons should be in contact with their psychiatrist and/or case manager. Ordinarily persons with mental illness will visit their doctor once a month. Yet many physical, emotion-

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[6]Ibid., 97.

al, psychological and/or mental changes can transpire in that time period. It should also be remembered that the person with mental illness usually receives little or no support from the nonmedical community to continue on medication. In fact certain church and/or denominations that stress faith healing often encourage people who have chronic illness and are medication dependent to discard medication and trust God alone for restoration of body and mind, all of which leads to a patient's relapse.

It is important that the pastor be cognizant of relapse warning symptoms. Again, not all will be seen in any one person's case. Each person typically develops a set of early warning symptoms that will be seen each time the person relapses. These include:

1. Changes in usual sleep pattern.
2. Changes in activity levels; for example, becoming tense, nervous, pacing, restless.
3. Changes in appetite; for example, becoming less interested in eating.
4. Changes in sexual activity; for example, becoming preoccupied with masturbation.
5. Changes in social activity: for example, withdrawing, refusing to see friends.
6. Changes in the intensity of sounds; for example, needing to play the record player much softer or louder.
7. Changes in expression of feelings; for example, hostility or periods of euphoria increase.
8. Changes in bodily sensations; for example, pains or aches.

9. Change in personal care; for example, no bathing or changing clothes.

10. Can no longer concentrate well, as when listening to the radio, watching television or reading.

11. Becomes preoccupied with one or two ideas so that much of the day is spent thinking about this.

12. Some personal "redflag". (One patient always goes on a diet right away as she is getting sick. Another patient always get sick when a particular kind of sensational news story happens and gets a lot of coverage, etc.)[7]

It is not unusual for bi-polar (manic-depressive) patients to feel so in control, so recovered, so "good", that they dispose of their lithium, only at a later date to end up in crisis, in an hospital emergency room, wondering what happened. A recent study reports that more than 50 percent of bipolar patients stabilized on lithium for an average of 30 months experienced another manic episode within ten weeks after discontinuing lithium. The monthly risk of another episode was 28 times higher than when the patient was continued on lithium.[8] The pastor and church staff must continuously encourage the person with mental illness to stick with the medical regiment. In the event that the medication dosage needs to be adjusted, the pastor should encourage, and if necessary assist, in the process of contacting the responsible medical authorities.

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[7]Kay McCrary. Handout notes from Pathways to Promise workshop, "Mental Illness: Myth & Reality" Oct. 25, 1992.

[8]Trisha Suppes, "Rapid Recurrence of Mania In Bipolar Patients Who Stop Lithium." Life in Balance 10:1 (January 1993), 6.

INTERVENTION-TREATMENT

When a person with mental illness becomes symptomatic and dysfunctional, the pastor and staff must encourage this person to seek treatment. It is not unusual for persons with mental illness to be so depressed, delusional, psychotic, ill, and/or symptomatic that they are unable to seek medical treatment. It is important that the responsible party (parent, sibling, child, spouse, case manager) for the person with mental illness be contacted and informed of patient's mental and medical status. Ideally the responsible party will intervene and the proper medical care and attention will be received.

However, the pastor knows from his theological studies on the doctrines of man and sin that this world and its human institutions are far from ideal. Not only will the responsible parties fail to respond, but as the pastor begins to encounter the public mental health system, he will engage a cumbersome bureaucracy that responds to mental health crisis with the speed and compassion of an immovable mountain.

To facilitate the process of receiving treatment for a person with mental illness who is in crisis, it is advisable that the pastor have a referral guide published by the local mental health association. Usually the local Alliance for the Mentally Ill (AMI) affiliate will have published its own referral guide. The AMI referral guides tend to contain more

information and are normally "user-friendly", having been written and published by families who have had first hand experience with mental illness. This referral guide will frequently contain the following information: description of the illness, crisis intervention, hospitalization and commitment procedures, medications, public and private resources for care, coping strategies of friends and family members, advocacy and support groups for family, descriptions of the community mental health system, housing, rehabiliation, support groups for persons with mental illness, financial considerations (social security programs, medicaid, and medicare), just to name a few topics.

At this point it is necessary to emphasize the importance of keeping records and documentation. This is true for whoever the caregiving party may be: family, friend, and/or pastor. Records must include previous medical history, medication record, date and time of present symptoms. The intervention process will not be described here in detail but will be discussed in the next chapter. Normally the pastor does not initiate the intervention process, but provides a supportive role to the person with mental illness, the person's friends and family, and/or to the responsible caregiving party or agency.

Once the person with mental illness is hospitalized, it is important that the pastor see this illness as if it were comparable in terms of other medical illness, such as heart

disease, surgery, cancer, and others. The pastor must be sensitive both to the patient's and the family's needs for spiritual care and support. Just because the patient happens to be in a psychiatric treatment center the pastor and staff should not alter their crisis visitation protocol. The visiting hours and the accessibility to the patient may be different, but the needs and concerns of the patient and family remain the same.

Unless the patient requests differently, the pastor should wait a day or so before making a hospital call. This will allow a patient to stabilize and become comfortable with his environment. The pastor should always phone ahead and speak to the head nurse of the patient's unit before making the visit. The pastor should check on the patient's condition and the advisability of making such a visit. If the pastor is a friend of the patient and is comfortable with the patient's delusional and/or psychotic state, the pastor should inform the nurse of this. Although it is assumed that the patient will receive pastoral care from the institutional staff (not always a valid assumption), the pastor should inform the nurse of his close relationship to the patient and of his pastoral resources (presence, Word, Sacrament, and prayer). Ideally permission for a visit will be granted.

The initial visit should be short. The pastor should seek out a quiet spot without too many distractions in order

to focus on the patient and his emotional, psychological and spiritual needs (assessment). Sometimes the patient is too tired and/or lethargic from the illness and medication to engage in a meaningful conversation. Sometimes the patient may be angry and/or confused. It may be difficult to engage the patient in a meaningful conversation. Consequently Scripture reading and prayer may not always be possible nor appropriate. The pastor should remember that the purpose of his visit is to bring God's love and presence to bear upon this hospitalization. The pastor should regularly, one to two times per week, visit the patient. As the patient's condition progresses, pastoral care could include sharing the Lord's Supper and bringing appropriate literature.

Professional clergy working within an institutional setting may incorporate a spiritual assessment treatment protocal in working with the mentally ill person. Based upon the pioneering work of Paul Pruyser, James Fowler, Stephen Ivy, and Wayne Oates, this spiritual analysis seeks to diagnose (assess) and prescribe a course of treatment. Often the evaluative measurement has been constructed to fit the needs of the "pastoral technician" at a particular setting. The following instrument describes styles or stages of consciousness that may be correlated with the faith-growth process.

1. **Pleasure** - normal for ages 0-2. Characterized by drive-gratification. Communication is affective rather than verbal. This stage will rarely be seen in association with adult patients in the mental health

facility except in conjunction with some who may be suffering from extreme dementia or profound developmental disability.

2. **Magical** - normal for ages 2-6 years. Characterized by an inability to reflect, reliance on intuition and fantasy to interpret reality and affective liability. It is characteristic of the adult patient who is acutely psychotic and in need of external controls on behavior. Diagnostic criteria will include evidence of impulsive, even violent behavior, emotional lability, intrusiveness and misinterpretation of environmental stimuli, including hallucinations or delusions. Thinking will be concrete and possibly ritualistic.

3. **Literalizing** - normal for ages 6-12 years. Characterized by concrete thinking or by a "non-reflective orthodoxy." The individual at this stage is particularly self-interested and manipulative. A primary issue is the development of competence and self-esteem. Seen in adult psychiatric patient, this may indicate a moderate-to-severe level of personality disturbance and may require institutionalization. Compared to the earlier stage, thinking is concrete, but more accurate and there may be diminished evidence of hallucinations or delusions. Ritualism and religiosity at this stage are often fixed in many patients.

4. **Interpersonal** - normal for ages 12-18 years. Characterized by a need for association and conformity, as well as an increasing capacity for abstraction. Primary issues here are acceptance, belonging and seeing one's identity as a reflection of others'. In adult patients, it may reflect a resolving crisis of mental health in which there is a reliance on group process and support. Diagnostic criteria will reflect evidence of increased social participation, appropriate interaction, improved insight, stronger ego functioning, and increased respect for rules and limits. Tolerance for ambiguity, spiritual reflection, and abstract thinking about spiritual themes become more evident at this stage.

5. **Idealizing** - normal for ages 18-24 years. Characterized by an increased need for individuation and a critical review of one's beliefs. Independence, objectivity, and commitment to task, idea or group are features of this stage. In the adult psychiatric patient, it may indicate the status of a nominally higher-functioning person in a transitional period prior to discharge from the institution. Diagnostic criteria in-

> clude evidence of increased commitment to a healthy set of moral and spiritual ideals, a desire for healthy autonomy, creative problem-solving ability with reliance on a trustworthy Higher Power and a healthy assertiveness.[9]

Obviously other critical data are considered when assessing a person with mental illness. The above material was presented to acquaint the pastor with various pastoral care practices within professional health care institutions.

The pastor should monitor the patient's progress by communicating with the head nurse and the social worker. As the patient's discharge date approaches, the pastor should request an audience with the discharge planner, emphasizing the need for spiritual care and support which the church and the religious community can offer. If the discharge planner is unresponsive to these overtures, then the pastor should initiate meetings with both the patient and family to discuss the plan for spiritual care and follow-up for both the patient and the family.

DISCHARGE-FOLLOW UP-CONTINUING CARE:

Upon discharge the pastor and church staff should in whatever way possible encourage and support the patients as they are integrated back into society. This is especially needed if the patient is living away from home in a community mental housing complex. Oftentimes the person with mental illness will feel alone and unsupported. Usually a telephone

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[9]Frederic S. Weiss, "Pastoral Care Planning: A Process-Oriented Approach for Mental Health Ministry," Journal of Pastoral Care XLV (Fall 1991), 271-272.

call is sufficient to inform the person with mental illness that Christ and His people care about each other, including those who are mentally disabled. Again, the pastor should inquire about the patient's medical compliance. If the person is participating in an out-patient follow-up program, the pastor should inquire about this. The pastor and staff should be sensitive to and inasmuch as possible, participating in the patient's rehabilitation program.

As the person with mental illness is hospitalized and discharged, the pastor and church staff need to understand that the patient continuously is experiencing loss and grief. The patient lost control of his mind and its processes which necessitated the hospitalization. Frequently the person with mental illness will feel ashamed and guilty for not having the moral fortitude and the spiritual strength to control his thoughts, mood, and/or behaviors. The person with mental illness may feel that he is a very weak Christian and has committed a very grievous sin.

The pastor must be sensitive to the uniqueness of this illness. When a person experiences a chronic physical illness such as multiple sclerosis, cancer or heart disease, there is usually some physical, outward symptom such as changes in blood pressure, pulse, and respiration to measure the intensity and direction of illness; all changes and signs that the average person may not understand, but accepts as part of the course of the illness.

The emotional, mental, psychological and often spiritual pain that a person with chronic mental illness experiences is not scientifically measurable and thus is often rejected by family and friends as imaginery and/or delusional. Thus the loss of trust and understanding by others is continual, and usually results in a loss of self-esteem and integrity. The pastor and the church can address this critical loss by reminding the person with mental illness of his baptism. Our Savior in holy baptism adopts the individual person, regardless of age, sex, ability or disability (including mental illness), into His holy family as a full-fledged son or daughter.

Another loss that the person with mental illness experiences is the actual loss of mental powers due to the neurobiological dysfunctioning of the brain itself. Although the person may have above average intellectual powers, the schizophenia and the prescribed medication may slow down the response time so that the person with schizophrenia may almost appear to be retarded. Highly coordinated reflex skills observed in athletes and others often disappear when mental illness strikes.

Persons with manic-depression may have highly creative artistic skills, but these are often lost when the person is treated with lithium and other medications. Electro-convulsive therapy (ECT) often results in memory loss, usually short term. Thus a person with mental illness not only

experiences a loss of the present, but also a loss of the past! Please read Ed Cooper's personal description of mental illness (See Appendix D.)

The inability or extreme difficulty to form relationships is another immeasurable loss to cope with. As mentioned earlier, this illness often strikes a person during his adolescent and teenage years, normally a time when a person is developing relational and social skills. It is also not unusual for a person with schizophrenia to be preoccupied with voices and other mental distractions to the extent that neither the time nor the energy is available to form normal, healthy relationships. Thus, the mental illness has either robbed the person of the ability to form healthy relationships or by uncontrollable symptoms has destroyed existing relationships. Thus the person with mental illness is usually a loner, with the radio or television serving to fill the empty vacuum. If a person with mental illness is lucky, he may have a pet such as dog or cat. If the person with mental illness is extremely blessed, he may have a caring family (parents, siblings, children, spouse) and friend. What an opportunity exists for the Christian church to minister to hurting people!

Other secondary losses from serious mental illness are the normal loss of dignity, control, privacy, and time that every patient experiences when he enters the hospital. Perhaps the most critical and detrimental loss experienced

by people with serious mental illnes is the loss of hope and the loss of a future. Most persons with serious mental illness have lost the ability and the skill necessary to hold a job. People with mental illness can function fairly well in a stress-free environment, but such jobs are far and few between. Although they may be receiving social security disability, welfare, and/or other entitlements, they often feel as if they are a burden to society. Tragically, much of society, including the church, often expresses similar feelings. American society has emphasized that a individual's worth is based upon his ability to be a productive citizen. Even to the present day American inclusion and acceptance of the disabled as full fledged citizens has been an on-going battle. With the enactment of the Title I of the Americans With Disabilities Act the opportunities for jobs for persons with serious mental illness should greatly improve.[10]

Research into brain diseases and the development of new medications is cause for hope for families, friends and persons with mental illness. Studies with identical twins and genetic tracing seem to indicate the possible existence of a genetic marker. In other words, there appears to be a tendancy for schizophrenia to run in families, similar to

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[10]Ron Honbery, "Law Protects Mentally Disabled Workers," NAMI Advocate, July/August 1992, 1 & 3.

the disease of alcoholism.[11] Abnormalities within the temporal lobes, enlargement of the inferior horns of the lateral ventricles and decrease in the size of the hippocampus, parahippoacampalgyrus, and amygdala of brains of schizophrenic patients has been observed in neuroimaging studies that use computerized tomography (CT), and magnetic resonance imaging (MRI), and in postmortem research.[12] Other researchers believe that serious mental illness is caused by an undiscoverd virus. This hypothesis is based on such factors as seasonality, urbanity, still-births, geography, influenza and medication.[13] Research in recent years has just begun to examine the brain closely. There is hope within the medical and scientific communities that the key to understanding the mysterious illnesses of the brain will soon be discovered and utilized, giving millions of sufferers hope and a new lease on life.

In the early 1960s, it was the discovery of the antipsychotic drugs that ushered in a new wave of optimism in the treatment of serious mental illness. Thousands of patients were released from state hospitals as they were given these new miracle drugs. Unfortunately, these neuroleptic

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[11]Samuel Barondes, "Genetics of Mental Illness: Problems and Promise," The Journal of the California Alliance for the Mentally Ill 2:4 (Summer 1991), 19-22.

[12]Lori Altshuler, "Neuroanatomy in Schizophrenia and Affective Disorder," Ibid., 27-30.

[13]"Researchers Wrestle With Theories of Mental Illness", NAMI Advocate 13:7 (November-December 1992), 14.

medications had side effects and unless monitored closely, the patients became non-compliant and ultimately symptomatic. In other words, the "cure" (medication) was almost as bad as the illness. Research over the years has developed different drugs. Recently clozaril was developed and released for persons with schizophrenia that were considered treatment resistant.[14] Likewise for the treatment of chronic depression a new and better antidepressant has become available: prozac, a drug with greater strength and fewer side effects.[15] It is anticipated that with additional research and development that there will be more effective medications to the handle the various symptoms of the serious mental illnesses.

As important as research is to understanding the causes of mental illness and to developing better medication, research does not provide the hope and future that persons need in order to cope with their tragic disease. It is the pastor with the message of the Gospel that can bridge this spiritual vacuum and create hope and a future. The message of God's love and forgiveness as seen in Jesus Christ, God in human flesh coming and minstering to those who had broken bodies and brains, brings acceptance and peace. Furthermore,

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[14]Claudia Wallis and James Willwerth, "Awakenings: Schizophrenia - A New Drug Brings Patients Back To Life," Time (July 6, 1992), 52-57.

[15]Philip Elmer-Dewitt, "Depression: The Growing Role Of Drug Therapies," Ibid., 57-60.

seeing Jesus Christ die and rise again with a new body, guaranteeing replacement of these mortal bodies with immortal (disease-free) bodies brings joy, hope, and comfort to those afflicted with the scourge of serious mental illness. The pastor does have a valid and a much needed ministry to those suffering from mental illness. The Christian pastor is a purveyor of hope, both in the present and in the future.

CHAPTER 5

Pastoral Care Guidelines: Ministering to the Family of the Person with Mental Illness

INTRODUCTION

This is one of the most important chapters because the pastor's ministry will be targeted to both the person with mental illness and his family. Statistics indicate that nearly two-thirds of all persons with mental illness live at home with their families. In all likelihood it will be a family member seeking intervention on behalf of his affected loved one, and one of the places he often turns to for support and guidance is the church.

This chapter could be easily summarized with two pieces of advice: First, encourage the family members to purchase a notebook and to chronicle every behavior of the mentally ill family member; also log the interventions such as time, place, and name, of the person giving advice. Secondly, contact your local affiliate of the Alliance for the Mentally Ill and ask for information on mental illness, describing in detail the symptoms of the person with mental illness. These two cardinal rubrics will serve the pastor well in advising families experiencing mental illness.

However, these two suggestions have not been readily available to pastors until recent times. Also further discussion is necessary in order to explain the rationale of previously mentioned advice.

NINE PHASES IN COPING WITH MENTAL ILLNESS

Dr. Kenneth Terkelsen delineates nine phases or responses to mental illness that families will experience. Phase one is ignoring what is coming. The family members react by minimizing the early changes, often treating the unusual behavior as a manifestation of temporary destabilization rather than as the first sign of an enduring condition. Phase two is the first shock of recognition. The mentally ill person begins to act out and is observable to both family and non-family to the extent that further action is advised. Advice may be sought from professional sources, but often the affected person is encouraged to get "his act to together."

Phase three is stalemate. The affected person is recalcitrant, not cooperating in the family's efforts to seek assistance. The family members become polarized on the necessity of seeking treatment, often stalled because the family member's behavior is seen as problematic. The family finds itself divided while increasing attention is given to the affected person.

Phase four is containing the implications of illness. As the affected loved one continues to decline, various

family members and maybe even certain mental health professionals will attempt to circumscribe the implications of the decline in functioning. Phase five is transformation to official patienthood. Eventually something very compelling or disasterous occurs in which the affected person becomes impaired, such as threatening suicide. The resulting intervention is a hospitalization at a psychiatric facility. The family becomes painfully aware that the patient has a life-threatening emotional illness that will not go away.

Phase six is the search for causes. Because the affected loved one has a diagnosis and since our society operates with the "cause and effect" model of interpreting illness, the search begins in an attempt to locate the cause for this crippling disease. The direction of the search will depend on the family's preexisting beliefs about the nature of mental illness. Some will look at the family and its dynamics, an interpersonal view, assessing the quality of family life and analyzing various factors that may attribute to the loved one's illness.

Other families seek a biological explanation. No matter which direction the search takes, the family will be confused and frustrated by the absence of definitive answers and the resulting controversy among professionals regarding the etiology of mental illness.

Phase seven is the search for treatment. As key family members accept the illness and realize the need for inter-

vention, the search for effective treatment commences. Three factors determine the direction of the search: (1) the family's acceptance of the presence of illness, (2) the family's perception of causes, and (3) the profile of treatment services available to the family. Phase seven entails an educational process for the family as they become acquainted with the various therapeutic and institutional environments available for treatment.

Phase eight is the collapse of optimism. As treatment progresses it becomes increasingly apparent to the family that the affected person is not returning to his previous level of identification. As time passes the symptomology may change but does not disappear. The family eventually comes to acceptance and attempts to make some accommodation for the prolonged, possibly permanent incapacitation of the affected person. The family dynamics are restructured and readjusted (often dramatically) for continuing care of the mentally ill loved one.

Phase nine is surrendering the dream. Eventually the collapse of optimism activates another process: mourning the loss of idealized internal images of the affected member. It should be noted that this kind of grieving does not follow the usual loss and mourning process because of the following factors. First, it is often several years before the family realizes that the illness is prolonged in nature, and no matter how long they wait, total remission is unlikely.

Secondly, mental illness is typically an invisible illness, making it difficult to accept the permanency of the disability. Thirdly, the typical course of mental illness entails a series of fluctuations in the level of functioning and thus a person does not want prematurely to write off the future of the affected loved one.

Finally, upon the family's acceptance of the prognosis, the affected loved one may feel a release from pressure and tension to perform and function at a prescribed level, and in fact, may function at a higher level. Unlike other losses, the loss due to mental illness is continuous and unending.

Phase ten is picking up the pieces. Here the family attempts to compartmentalize the illness and its accompanying concerns, putting it into such a perspective that life among family members may resume as it was before the illness occurred.[1]

INITIAL INTERVENTION

The consultation role is a familiar one for the pastor. As the affected family member becomes more symptomatic, that is, the loved one's behavior is out of control and the person is hallucinating, hearing voices, or the person may be talking about suicide, a family member will often contact

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[1]Kenneth Terkelsen,"The Evolution of Family Responses to Mental Illness through Time," in Families of the Mentally Ill: Coping and Adaption, ed. Agnes Hatfield and Harriet Lefley (New York: The Guilford Press, 1987), 152-165.

the pastor for advice. The pastor should strongly encourage immediate intervention. The intervention process itself may be quite complicated and the pastor may be asked to participate, particularly if the affected family member is hesitant to seek treatment, feeling that he is not sick.

Planning is absolutely critical in obtaining treatment for an affected family member. A phone call to the police will not necessarily secure treatment for the person with mental illness who is psychotic. In fact, requesting police assistance may result with the affected family member in the local jail, making the situation even more traumatic.

The obvious first step entails planning. It is necessary for the concerned family member and the pastor to learn the details of the commitment process. This information can be found by contacting a crisis intervention hotline, a community mental health representative, school nurse or social worker if the child is under eighteen, or the local Alliance for the Mentally Ill (AMI) affiliate. AMI is usually the most helpful, accurate, reliable and "user-friendly" resource.

The commitment procedures vary from state to state, and may change over a period of time. Accurate information is necessary to assure that the affected family member receives proper treatment. Questions to be addressed include:

1. Will the admission for treatment be voluntary or involuntary?

2. If an involuntary commitment is needed, what are the necessary steps?

3. Will patient be admitted to a private or a public hospital?

4. What are the patient's financial resources: private pay insurance or public assistance (medicaid, etc.)?

5. What is the physician's treatment model of mental illness? Is the illness biologically based or due to the dysfunctional dynamics of the family, etc.?

6. If possible, learn about the treatment facility's attitude toward the family. Do they perceive the family to be a part of the treatment team or part of the problem contributing to the illness?

It is always better for someone to be hospitalized voluntarily if possible. The reasoning ability of a mentally ill person in crisis is frequently impaired. It is often not possible to convince the person of the need for hospitalization. In such cases it is necessary to initiate commitment proceedings.

Commitment or involuntary hospitalization is always a very difficult process. A person may be clearly in need of treatment and still not satisfy the state Mental Health Code as a "person requiring treatment." To be committable a person must be mentally ill and:

1. Be a danger to himself (suicidal) or others (homicidal), or

2. Be unable to attend to his basic physical needs, or

3. Have judgment so impaired that he is unable to understand the need for treatment, and if untreat-

ed his behavior is likely to result in significant harm to himself or others.[2]

In Michigan, for example, a concerned relative or friend may initiate the involuntary admission process by medical certification or by a probate petition.

1. **Admission by Medical Certification.** Any person, 18 years of age or over, may initiate the process of commitment. Check with Community Mental Health first as procedures vary from county to county.

   Two medical certificates are required; one may be completed by a PhD psychologist, but one must be completed by a physician. One certificate may be completed by a doctor in the community, or both may be completed at the hospital. The person bringing the individual to the hospital or to the Community Mental Health Center will be asked to complete an application for hospitalization. The application should include direct observation of behavior which demonstrates the person satisfies code requirements for a "person requiring treatment." If the person meets the admission criteria, he or she will be admitted to the hospital. Within 72 hours following admission, excluding Sundays and holidays, the person will have a deferment meeting in the hospital, at which he will be represented by a lawyer. The patient may designate a friend or a relative to also be in attendance. At this meeting a representative of community mental health and a representative of the hospital will present a proposed treatment plan. If the person agrees to cooperate with this plan the individual is allowed to sign a voluntary admission form. If at any time in the course of treatment, the person refuses to accept the agreed-upon treatment, the hospital director may notify the court and a hearing on the original commitment petition will be held.

   If the person does not agree to the treatment plan at the deferment meeting, a full court hearing on the petition will be held within 7 days. Again, the patient will be represented by a lawyer. It will be necessary for the individual who signed

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[2]State Alliance for the Mentally Ill of Michigan, Mental illness: A Family Resource Guide (np, nd), 5.

the petition to be in Court in order to testify about the person's behavior.

2. **Admission by Petition.** If the mentally ill person is uncooperative with efforts to have him examined by a doctor, a petition for hospitalization may be filed directly with the probate court by a friend or relative. The petiton must include facts which demonstrate that the person requires treatment, names and addresses of witnesses to the facts or events mentioned and the names and addresses of the person's nearest relative or guardian, or if none, a friend. The probate court will make arrangements to have the individual examined by a physician and hospitalized if necessary. (Hospitalization may be necessary in the family's opinion but not in the opinion of the court.) A court hearing will be scheduled within 7 days to determine whether the person will remain in the hospital.[3]

Some states like Maryland, allow for the relative of the mentally ill person to go to the police station and fill out an emergency petition for hospitalization.[4] Other states such as Missouri have a Mental Health Coordinator who oversees and coordinates the involuntary commitment processes for each mentally ill person refusing hospitalization.[5]

If a mentally ill person who signed himself in as a voluntary patient suddenly decides to leave the hospital a.m.a. (against medical advice), the family may have several options including community placement and/or appplying for guardianship.

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[3]Ibid., 5-6.

[4]Agnes Hatfield, Coping with Mental Illness in the Family: A Family Guide (Arlington, VA: National Alliance for the Mentally Ill, 1991), 55.

[5]Alliance for the Mentally Ill, Referral Guide for the Mentally Ill (St. Louis: np, nd), 26.

Guardianship is the designation by the Probate Court of a person to make personal decisions on behalf of an individual who is judged to be incapacitated. The guardian makes decisions regarding personal care but is not financially responsible for the care. Conservatorship is the designation by the Probate Court of an individual to assume financial management of income or property. It is highly advisable to consult the local mental health authorities and the local AMI affiliate when considering this legal recourse.[6]

As a person begins the process of seeking treatment for an affected loved one, he will immediately recognize that the mental health system is designed to protect the rights of the patient. Thus the concerned family member may become frustrated. He must deal with a psychotic, uncooperative mentally ill loved one. And he must also engage a cumbersome bureaucracy that ofttimes seems indifferent to the pain and suffering experienced by the mentally ill person and his family.

In order to facilitate the communication process with the treatment team, it is helpful and often necessary that a release of information be signed by the mentally ill person. This can be accomplished while still respecting the patient's right of confidentiality. The family member should not be intimidated by medical authorities who use patient

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[6]Ibid., 30-31.

confidentiality as an excuse not to communicate with the family.

COPING SKILLS AND ADAPTATION

The Appraisal Process

The appraisal process is the identification, either consciously or unconsciously, of the source of threat. The threat of mental illness is determined by the meaning and value that family members have attached to the illness.

There appears to be at least five relevant variables in evaluating this threat. The first and most powerful is the extent of the family member's involvement in the daily life of the client. There are risks associated with prolonged, intimate exposure to the daily life, personal habits, and preoccupations of a relative with mental illness. The models of causation, symptoms, and outcomes that are assumed by the family members is the second factor. The third factor is the phenomenology and natural history of the illness, including memories of the premorbid personality, the presence of specific illness-related behaviors, the course of the illness, the affected loved one's cooperativeness with treatment, the family's mutual caregiving patterns, and the affected love one's inability to respond appropriately.

Fourthly, there is a cluster of variables: the individual family member's personality and life history, life cycle issues, generic responses to hardship, and prior experience with mental illness. The last variable is the social network

which is often disrupted by the presence of mental illness.[7] The appraisal process is complex and dynamic, often changing over the course of a lifetime.

Stages of Adaptation

The earlier part of this chapter, "Nine Phases in Coping With Mental Illness" carefully delineated the stages the average family encounters in dealing with mental illness. They could be summarized into four multifaceted stages: (1) denial, (2) recognition, (3) coping, and (4) advocacy.

The table below lists those adaptational attributes of families who have a member with mental illness:

Adaptational Attributes

1. **Cognitive attributes:**

   Understanding of mental illness and its treatment

   Understanding of caregiving and management issues

   Understanding of mental health system and community resources

   Accurate appraisal of the mental illness and its consequences

   Realistic expectations for the family member and the family

   Understanding of the process of personal and family adaptation

2. **Behavioral attributes:**

   Communication skills

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[7]Diane T. Marsh, Families and Mental Illness: New Directions in Professional Practice (New York: Praeger Publishers, 1992), 145-146.

Conflict resolution skills

Problem-solving skills

Assertiveness skills

Behavioral management skills

Stress management skills

3. **Emotional attributes:**

Employment of relatively mature defenses

Resolution of the emotional burden

Maintenance of a satisfactory emotional climate within the family

4. **Social attributes:**

Assumption of a constructive role within the family

Achievement of a balance that meets needs of all family members

Utilization of the informal support network

Involvement with other families

Development of outlets outside of the family

Establishment of collaborative relationships with professionals

Movement into advocacy roles[8]

It should be noted that all the above listed attributes are in a state of flux. For example, it would be easy to assume that the family is adequately coping with the illness in the cognitive areas. However, the mental health system may change or the understanding of mental illness may change because of the latest advances in technology and research.

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[8]Ibid., 53.

As the pastor well knows, every change brings with it an accompanying set of stresses. The pastor should study this chart carefully to assess the adaptational health and well-being of those families experiencing mental illness. Specific pastoral care may address those areas of obvious need.

Coping Strategies

As mental health professionals study the effects of mental illness on the family, researchers have recognized four categories of coping responses or strategies. Problem-oriented strategies include getting and using practical advice, developing tangible supports and resources, learning coping skills, and becoming involved in advocacy.

Emotional strategies include sharing problems and feelings with others, joining a support group, making time for oneself, and enhancing spirituality. Cognitive strategies include recognizing the long-term and serious nature of the illness, recognizing the limits of mental health interventions, recognizing the possibility of personal life under these circumstances, and gathering information.

Finally, physical strategies include exercising, maintaining proper diet and nutrition, getting sufficient sleep and relaxation, and meditating.[9] The overriding focus of caregivers must be not only on the affected loved one, but also on themselves. In order to be an effective caregiver, one must be healthy and able to give care to others. This

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[9]Ibid., 148.

means taking care of oneself first; this is a continuous challenge for the family of mentally ill. These coping strategies would also apply to other chronic diseases, not just serious mental illness.

In summary, research indicates the following behaviors to be most effective as individual and familial coping stratgies:

1. Accepting the mental illness and its consequences for the family.
2. Reframing to focus on individual and family capabilities rather than limitations.
3. Seeking information about mental illness, services, and resources.
4. Developing skills related to mental illness.
5. Assuming an active and constructive role within the family and the social system.
6. Understanding the cognitive, behavioral, emotional, and social components of the process of family adaptation.
7. Developing realistic expectations for the family member and for the family.
8. Achieving a balance that meets the needs of all family members.
9. Maintaining cognitive and behavioral flexibility.
10. Striving to maintain a normal family lifestyle.
11. Understanding and strengthening the family system.
12. Improving communication, conflict resolution, problem solving, assertiveness, behavior management, and stress management skills.
13. Seeking informal and formal sources of social support.
14. Seeking feelings and coping strategies with other families.

15. Seeking outlets outside of the family.

16. Developing collaborative relationships with professionals.

17. Seeking professional counseling when appropriate.

18. Moving into advocacy roles.[10]

SPECIAL CARE-GIVING CONSIDERATIONS

Serious mental illness is so unpredictable, debilitating, misunderstood, and stigmatizing. It is not unusual for the onset of mental illness by a family member to trigger all kinds of unhealthy dynamics within the family structure and system. In coping with the mental illness, most often family members and friends will either become a caretaker or an escape artist, not the caregivers that they assume to be.

Caretakers are those family members who put others' wants and needs before their own. They receive their love and nurturing by rescuing or caring for others because that is when they feel appreciated. Caretakers neglect their own needs at the expense of meeting others' requests. They have difficulty saying no to others. In fact, they often feel guilty or selfish when meeting their own personal needs.

Caretakers feel responsible for the failings and troubles of others; they also find it difficult to end destructive and abusive relationships as they often empathize with the problems of the abuser. Caretakers are often people

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[10]Ibid., 154.

pleasers and value the opinions and feelings of others more than their own.

Caretakers also will foster codependency. While not intending to "enable" the mental illness itself, caretakers do enable dependency by an unwillingness to set limits on their caretaking.[11] The caretaker will often be manipulated by the threats of a mentally ill person. They will often mistake guilt and worry for compassion, not realizing that true compassion is accepting the mentally ill person, but not suffering because of him or his behavior. The caretaker may experience the following feelings:

1. Fear because they do not understand that there are alternatives to the presenting problems. They often are distrustful, lacking faith, and skeptical, having a distorted view of the world and relationships.

2. Guilt because they cannot deal with others disappointment nor do they want to experience rejection. They often live by "shoulds" or "should nots" and are manipulated or manipulative.

3. Insecurity because they are worried about the future. They do not trust themselves or others and are dependent upon others to make them happy.

4. Hopelessness because they believe they have lost control over life and relationships. They blame others and circumstances for their problems; they have a difficult time coping with change.

5. Loneliness because they do not trust others and consequently they do not risk sharing their thoughts and feelings with others.

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[11]Julie Tallard Johnson, Hidden Victims: An Eight-Stage Healing Process for Families and Friends of the Mentally Ill (New York: Doubleday, 1988), 51.

6. Anger because they do not forgive themselves or others for failing to live up to their expectations.

7. Resentment because they are doing something they do not want to do, yet feel they must.

8. Self-pity because they take life too seriously and personally. They often feel that they and their family are being punished and are enduring life, not enjoying it.[12]

Escape artists have learned to deal with the stresses in their lives by avoidance or escape. They often feel lonely but will cover their feelings by acting happy and secure. Escape artists become comfortable by being detached and uninvolved. Unfortunately, they develop a pattern and a behavior that carries into relationships and other areas of living.

Because of their inability to take care of themselves, escape artists are often victims, feeling abused and misunderstood by others. Abuse and neglect are normative for them and they are unable to develop skills to meet their basic social and psychological needs.

Like the caretakers, escape artists also foster codependency, often feeling trapped in fixed roles and behaviors, but unwilling to take the risk to make the necessary changes. Escape artists live in a world of denial, participating in a silent agreement not to think, not to ask questions, not to feel. The escape artists tend to reinforce this denial by often engaging in addictive behaviors.

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[12]Ibid., 54-55.

By contrast, caregivers will take care of themselves first even while they are providing support and nurturing to others. The following qualities define healthy caregivers:

1. Are aware that the family's problems have an influence on them, but they have separated themselves enough to meet their own needs.
2. Experience a variety of emotions with which they are comfortable, sharing them with close friends.
3. Understand and experience mutual, loving, and supportive relationships with friends and others.
4. Continually do a personal inventory of their feelings, thoughts, and behaviors and allow others to do their own inventories.
5. Are honest with themselves and others and invite others to treat them in the same fashion.
6. Do not attempt to control or manipulate others' behaviors.
7. Set realistic goals for themselves.
8. Are comfortable saying no.
9. Do not blame others for their troubles.
10. Have a positive view of the future.[13]

There are more attitudes and behaviors that could be listed. The healthy caregiver has an objective perspective of the mental illness and is able to feel in control of himself and the situation, rather than losing control to the problem illness or behavior.

It is important for the pastor and the professional church worker to be sensitive to and cognizant of these dysfunctional coping behaviors as he visits the parish

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[13]Ibid., 41.

families and their affected loved ones. Although the primary focus of a pastoral visit is to offer support and understanding, the pastor can also bring healing by recognizing a deficient and ineffective coping and care-giving behavior and recommending changes.

Julie Tallard Johnson, a psychotherapist who specializes in assisting family and friends of the mentally ill, has developed an eight stage self-help program for caregivers to remain healthy while caring for their mentally ill loved one. In order for this eight-stage program to be successful, the caregiver needs to regularly participate in a support group and keep a journal. **The Eight Stages** are:

1. **AWARENESS:** I explore the ways in which the relationship has affected my life.

2. **VALIDATION:** I identify my feelings about this relationship and share those feelings with others.

3. **ACCEPTANCE:** I accept that I cannot control any other person's behavior and that I am ultimately responsible only for my own emotional well-being.

4. **CHALLENGE:** I examine my expectations of myself and others and make a commitment to challenge any negative expectations.

5. **RELEASING GUILT:** I recognize mental illness as a disease for which no one is to blame.

6. **FORGIVENESS:** I forgive myself for any mistakes I have made. I forgive and release those who have harmed me.

7. **SELF-ESTEEM:** I return the focus of my life to myself by appreciating my own worth, despite what may be going on around me.

8. **GROWTH:** I reaffirm my accomplishments and set daily, monthly, and yearly goals.[14]

COMMUNICATION GUIDELINES

In understanding and communicating with a person who is hallucinating a caregiver must recognize:

A. Stages of Hallucinations:

Stage 1: (Comforting) The person experiencing anxiety, stress, feelings of estrangement, and loneliness may daydream or focus on comforting thoughts to relieve the anxiety and stress.

Stage 2: (Condemning) Anxiety connected with the internal and external experience increases. The individual put himself in a "listening state" for the hallucination. Hallucinatory images, voices, and sensations may be only vague whispers. The individual becomes fearful that others may notice them and feels ineffective in controlling these thoughts. Terror may occur as anxiety escalates. The individual attempts to put distance between self and the hallucination by projecting the experience outward as if the hallucination were coming from another person or place.

Stage 3: (Controlling) The hallucination becomes more prominent, authoritative and controlling. The person becomes accustomed to it and "gives in" to it. Often the hallucination affords the person a sense of temporary security.

Stage 4: (Conquering) The individual becomes increasingly preoccupied with the hallucination and feels helpless to escape from the control it exerts. Not uncommonly, a formerly comforting hallucination becomes menacing, commanding and berating. The person becomes increasingly involved with the hallucination and feels unable to form meaningful relationships. As anxiety continues to rise, the hallucination becomes more elaborate in an unsuccessful effort to satisfy the needs it is serving. The individual may dwell in a terror-stricken world, in fleeting moments, or for hours on end.

B. Intervention Techniques

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[14]Ibid., 142.

1. Establish a trusting relationship.

2. Look and listen for symptoms of a hallucination.

3. Focus on the hallucinatory symptom and ask for the person's description of the symptoms.

4. Determine if the hallucination is emotional or toxic-based (from drug or alcohol use).

5. If asked, point out that you are not experiencing the hallucination.

6. Help the person observe and describe the present and recently past hallucinatory experience.

7. Ask the person to describe any past hallucinations.

8. Encourage the person to observe and describe thoughts, feelings and actions, both present and past, as they relate to the hallucination.

9. Help the person to observe and describe the needs underlying the hallucination.

10. Help the person to see the connection between the hallucinatory experience and the needs it is serving.

11. Suggest or reinforce the person's use of increased interpersonal relationships and other ways of meeting the persisting needs.

12. Focus on other or related aspects of the person's psychopathological behavior.[15]

It is not unusual for a pastor or any professional mental health worker to feel uncomfortable with a person who is hallucinating. However, many hallucinations are filled with religious imagery: cross, fire, angels, and Jesus Christ. As the pastor gains the confidence of the affected person, he can offer spiritual guidance and understanding so

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[15]St. Louis Metro Alliance for the Mentally Ill Newsletter, January-February 1990, 3.

that the person with mental illness will not feel threatened by a perceived Satanic attack or other inappropriate and misconstrued religious thoughts, feelings, and/or behaviors. Although it may take much time and effort, a pastor can build a caring relationship so that the mentally ill person will feel comfortable and safe sharing his or her hallucinations as well as their feelings and other thoughts.

C. Normative Communication Guidelines

In communicating with a mentally ill person the following guidelines are helpful:

Making positive requests: Making positive requests in a direct, pleasant and honest way help one to get what he wants and needs from others. Requests are different from demands. Demands annoy people. Requests made in a positive way help one build cooperative relationships in which each person's contributions are respected and valued.

1. Look at the person.
2. Say exactly what you would like them to do.
3. Tell how it would make you feel.
4. Use such phrases as:
   "I would like you to . . "
   "I would really appreciate if you would . . ."
   "It would make me feel good if you would . . ."
   "It's very important to me that you help me with the . . "

Expressing negative feelings: Highly emotional expressions, blaming threats (especially of withdrawal of love), and character assassination are damaging to all, but especially detrimental to mentally ill persons. Research links such communications to rehospitalization.

The goal is to state calmly the behavior that one is unhappy about, giving an acceptable alternative, and communicating acceptance of the person.

1. Look at the person. Speak firmly.
2. Saying exactly what they did that upset you.
3. Tell them how it made you feel.

4. Suggest how the person might prevent this from happening in the future.
5. Use such phrases as:
"I feel angry that you shouted at me, Tom. I'd like it if you spoke more quietly next time."
"I am very sad that you did not get that job. I'd like to sit down and discuss some other possibilities with you after dinner."
"I feel very anxious when you tell me I should get a job; it would help me a lot if you didn't nag me about it."

Setting limits: One should be clear, specific, and firm about stating what is acceptable versus unacceptable behavior. Remaining calm but firm increases the chances that the person will comply and not simply become more upset.

Sometimes one would make calm, clear demands such as: "Put down the knife" or, "to live at home you must take your medication."

One should use this technique very rarely and only in situations which are very important. One only has a certain number of limits he can set. He must learn to use them wisely and appropriately.

Praising: The mentally ill person selectively forgets positives and remembers negatives. Furthermore, a person with mental illness is often poorly motivated.

One should use praise to encourage any progress, no matter how small. Praise can be attention, physical affection, expression of interest, and commendation.

One should notice any improvement or effort. One should be specific about what he likes or what he does not like. One should use phrases like:
"Thanks for doing the dishes, but there are spots on the glasses."
"Thanks for putting the plates away, but this time you put them in the wrong place."[16]

In summary, one should always be sensitive to the fact the mental illness is a neurobiological brain disease with the brain itself affected by malfunctioning neurotransmitters.

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[16]Alliance for the Mentally Ill Newsletter (St. Louis), December 1985, 3-4.

Thus one should speak slower, using simple words and simple sentences. Accordingly one should allow the mentally ill person longer time to receive, process, and respond to the auditory stimulations. Because the memory mechanism of the brain has been affected by the mental illness, it may be necessary to repeat the sentence. Remember that the affected person feels frustration at the inability to recall details from an earlier encounter. A response of annoyance, anger, or frustration to the affected family member only exacerbates an already painful event.

CREATING A SUPPORTIVE ENVIRONMENT

The purpose of this section is to assist families in developing the kind of environment that will be conducive to and supportive of the affected member's recovery. Mentally ill people function better in environments where stress and tension have been reduced. Most families are willing to adapt and make as many life style changes as possible to assist in the patient's recovery. The family members must be sensitive to the painful and disorganizing effects of mental illness on the life of their affected loved one. Due to the nature of the illness these patients will experience many of these challenges:

1. Sensory overload and confusion.
2. Difficulties in focusing attention and in concentration.
3. Strange and unpredictable perceptions.
4. Intense, changing, unpredictable moods.

5. Feelings of helplessness, incompetence, and dependence.

6. Difficulty in accepting the mental illness and in coming to terms with the limitations it imposes.[17]

By making some adjustments in their own behavior and environment families can make it easier for their relative to cope with the illness. The pastor should be cognizant of these issues and assist the family in making the adjustment whenever possible. Families can help their relative in the following ways:

Families can reduce stimulation.

When there are too many people present, too much noise, and too much activity, people with serious mental illness become more confused and stressed. It is as though the brain's filtering system breaks down. Not only the amount of stimulation, but also the intensity may prove difficult, if not painful for the coping systems of the affected person. Holidays and other gala events may present difficulty for the affected relative. Families are also encouraged to keep family conflicts away from the patient as much as they can, especially during the vulnerable stages of the illness. Families need to be sensitive to the overstimulation they may be creating by just hovering and being excessively involved with the patient's care.

All people need a certain degree of structure and predictability in their lives to function. For the mentally ill

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[17]Hatfield, 27.

person whose inner world is anything but predictable, it is crucial that the outer world be as structured and predictable as possible. When the patients' moods, thoughts and behaviors fluctuate without warning, they find comfort and security in an environment that has stability and structure. In addition to being consistent and predictable, families will need to establish routines and schedules for such activities as meals, bedtimes, and daily tasks. Also if changes are to be made in the environment, the relative must be given time and space to make the necessary accommodations.

Families must use words carefully.

A patient who has difficulty handling information and focusing attention is greatly helped if family members adjust some of their habits of talking together. As mentioned earlier, simple, clear statements help the patient understand what is said and provide a model for the patient to follow. Loud, high-pitched, rapid speech may be harsh and grating while slow, quiet and low-pitched voices may help the person with mental illness to remain comfortable.

Some families feel that no matter what they say or how they present it, the patient flares up and an argument results. They may resent giving in to the patient, yet continuing a prolonged argument serves no purpose. Such situations can be best handled by suggesting to the patient that the present is not a good time to pursue the subject and

expressing a willingness to discuss the matter further when tempers are cooler. Beginning another activity or leaving the room reinforces this point to the patient. A highly aroused patient can be calmed by an attentive listener using active listening skills.[18]

Families must support the growth of the family member's self-confidence and self-esteem.

Understanding the effects of the mental illness upon a person emotionally, psychologically, mentally and spiritually, is difficult for families to comprehend. Even the most simple household task may prove to be extremely stressful for the patient. Many families fail to understand that recuperation from a major breakdown is a slow process.

Families can facilitate a patient's rehabilitation by helping the patient to set up short-term goals that are readily attainable. They can assist the patient to locate a vocational training and rehabilitation program that will suit the patient's needs. The patient should be encouraged to take responsibility for his life, behaviors, and relationships. The family can assist in these endeavors by being accepting of the patient. Regaining self-confidence and self-esteem is a slow but painful process. Positive reinforcement for even the smallest of activities will produce self-growth and development.

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[18]Ibid., 30.

Families can help the patient to come to terms with his or her illness.

Patients with serious mental illness have the awesome task of deciding how to come to terms with the many facets of their lives that will be different because of the illness. People deal with this situation in varying ways, often depending on the situation and the people present.

The most difficult step is for the patient to reconcile himself to the illness. Denial is the number one coping mechanism in dealing with any crisis or major disaster. Experiencing a major chronic illness triggers all kinds of denial-linked responses: anger, projection, guilt, shame, and jealousy, just to name some of the responses.

Critical to the patient's acceptance of the illness is the medical model used to present the illness to the affected loved one. If the disease is seen using a medical model such as comparing the illness to diabetes (chemical imbalance - insulin), then acceptance of the illness is more palatable. If the illness is accepted by the patient, then treatment is possible. (Note: treatment, not cure!) If the mental illness is denied by the family members and the patient, then the family will exhibit dysfunctional, circular behaviors of managing from one crisis to another.

The pastor can play an important role in providing care and support for the patient and the patient's family as they deal with acceptance and treatment issues. Although this

topic will be treated more extensively later, the pastor can point out that it is not wrong or evil to have a sickness; often that is unavoidable and not a matter of choice. However, one can choose how one responds to the illness. The responses to the illness by family and the affected member will vary over the course and lifetime of the illness. Psychotherapy may be valuable in assisting the family to accept and cope with this chronic illness.

COPING WITH CRISIS SITUATIONS

Living with mental illness means living on the edge of crises that could happen at any time. "We live in dread that something terrible is about to happen," or "We're always expecting the unexpected with our mentally ill son (daughter)" is not an uncommon response among the families of the mentally ill. Tragically, when crises do arise, families often face them alone. This section will address some of the usual crises family encounter.

Medical Noncompliance

Most patients respond well to psychotropic medications, but a sizable percentage of patients fail to follow the prescribed medication regimens. This is one of the most frustrating problems that families encounter as invariably the patient will become psychotic, a crisis will arise and the patient will need hospitalization. The following steps for increasing compliance may be helpful:

1. Put the medication in context of the patient's life. Most patients realize the need for medica-

tions to assist them in gaining control of their lives. The negative side-effects must be weighed and discussed against these overall benefits.

2. Be concerned about compliance, asking the patient when and how much medication the patient takes. It is important to know what adjustments patients are making and why. The medication needs to be taken on a regular basis, the same amount at the same time everyday.

3. Make sure that the patient, the family, and other agencies of the mental health team are all informed about the medication. All parties need to know in order to combat erroneous biases that may be held by some in the patient's network.

4. Involve patients as much as possible in their own medications. It is important for patients to be involved in the decisions about their medications.

5. Be willing to be assertive if all else fails and use whatever tactics are available.[19]

Use and Abuse of Alcohol and Drugs

Alcohol and other recreational drugs will always create complications for the mentally ill person who is taking medication. The full potential effect of the psychotropic drugs will be affected if not negated by the use of alcohol. Most experts believe that due to the stigma and the side-effects from the neuroleptics, many patients substitute alcohol and street drugs for medications. The homeless mentally ill are the most obvious example of this. A substance abuse consultation and intervention is often necessary to deal with these situations.

Violence and Destruction

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[19]Agnes Hatfield, Family Education in Mental Illness (New York: Guilford Press, 1991), 121-22.

Although the mass media do not hesitate to link violence to mental illness, it has been vehemently argued that the mentally ill person is no more likely to display violent behavior than the average person in life. Researchers believe that there may be more violence in the familiies of the mentally ill, only that it is underreported. In those cases where it occurs, families need to assess the violent behavior and the circumstances surrounding it. The following questions should help families understand the reasons for the aggression, the purposes it serves and the factors perpetuating it:

1. Is this a real confrontation? Is there a real issue at stake? Legitimate expressions of anger might be mistaken for verbal aggressiveness or attack.

2. Is violence or threat of violence an expression of psychotic thought? Is the person under a delusion that someone is out to get her or him and that she or he must attack in self-defence, or does the patient hear voices urging her or him to do destructive things? If the violence reflects psychotic symptoms, then prompt medical intervention is necessary.

3. Does the person use aggression deliberately as a threatening tactic to get what he or she wants, in other words for nonpsychotic reasons, thus taking revenge for what are considered wrongs, such as involuntary hospitalization?

4. Does aggression occur because of the patient's tenuous control under stress? Does the patient become highly agitated when he or she feels cornered or under threat?[20]

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[20]Ibid., 124.

In the case where the patient is obviously nonpsychotic and actively aggressive, the family will at some point need to actively intervene. The family members will need to come together during a period of calm and formulate a plan of action, deciding which patient demands and behaviors will not be tolerated.

The next step is to convey to the patient in a non-threatening way the plan of action and the consequences, should the plan be tested. When the confrontation occurs, the family must be prepared to follow through on the consequences of the agreed plan. Families will then evaluate the plan of action and revise their strategies if necessary.

On the other hand, in the event that the patient becomes violent because the person has lost control over himself, families may also be forced to intervene. Families will need to be attuned to clues that their relative is beginning to lose control. Such clues may include agitation, disorganization in thinking or behavior, suspiciousness, or argumentativeness.

As the family observes the clues, they are urged to stay calm which may be reassuring for the patient. The family must also give the patient physical and emotional space. The safety of everyone must be addressed; don't stay behind closed doors with an agitated person. When things become calmer, family members may want to discuss the issue

with the patient and make it a learning experience for everyone involved.

Suicidal Threats

One of the most anxiety producing situations for the families of the mentally ill is when the affected family member threatens suicide. Families need to know the warning signs:

1. Expressions of personal worthlessness or concerns about having committed an unpardonable sin.
2. Expressions of hopelessness about the future.
3. Preoccupation with morbid thoughts of death.
4. The presence of hallucinatory voices that instruct the person to hurt or kill him- or herself.
5. Increased risk-taking behavior (driving too fast, drinking heavily, handling guns, etc.)
6. A sudden, unexplainable brightening of mood in a person who has been chronically depressed.
7. Indications that the patient is getting her or his affairs in order.
8. Discussion of concrete, specific suicidal plans.[21]

Family members must call the treating psychiatrist (or crisis hotline) immediately if they suspect that their affected loved one is contemplating suicide. It is also recommended that potentially lethal weapons be removed. The patient's medication should be monitored to guard against overdosing. One should allow the patient to talk about the suicidal thoughts without expressing shock or condemnation.

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[21]Ibid., 126-127.

An intervention plan should always be in place when dealing with a suicidal patient.

PLANNING FOR THE FUTURE

As treatment for the person with mental illness progresses, the family needs to address seriously rehabilitation and plans for the future. When a person is seriously impaired as a result of mental illness, it is necessary to find the best rehabilitative resources available. Resources may be scarce in their area, there may be long waiting lists, or the mentally ill member may refuse to attend vocational-rehabilitation programs or community social centers. In any event families do play an important transitional and supplemental role. Actually, much resocialization can occur in the everyday context of family living. Family members should intentionally find ways to help their relative become more competent and independent.

Family's Role in Rehabilitation Activities

Families can enlarge the patient's experiences. Persons with mental illness are often withdrawn and prefer restricted, almost isolated living. A primary consideration for families is to find an avenue out of such impoverished existence by recalling earlier interests the patient enjoyed before the illness and by attempting to re-establish them or open new avenues of interest. The well-known principle of building on strengths should serve as a guide as families encourage their ill relative to take responsibility for

ongoing family life. He needs to feel like a contributing member of the family and should be expected to do his best, obviously doing only what he is capable of doing. The family always needs to be sensitive to the temptation to do for the mentally ill person. One should always remember that the family member is only ill, not disabled or retarded!

The lack of motivation is one of the most common complaints that family members have about their affected loved one. The mentally ill person's lack of drive, lethargy, and general disinterest in the surrounding world often anger and frustrate families. It should be remembered that low motivation and other accompanying behaviors are a part of the illness of schizophrenia and that these behaviors are not alleviated by the neuroleptic medications. Thus, psychosocial treatments are most effective for countering these negative symptoms. Persistence, encouragement and gentle nudging may be necessary to inform the patient of expectations and responsibilities that he has. The patient may complain of anxiety or fatigue. However the patient can not be allowed to withdraw to avoid the pain and stress. Instead the family must encourage new experiences and give support to the affected family member. Positive feedback to each new attempted activity will increase the patient's self confidence and self-esteem. It will also give the patient more control of his life and the future.

The family should encourage independent living skills. The primary goal of rehabilitation is to help the patient to become as independent as possible, ultimately learning how to draw on the wider community to meet various needs. The dangers of codependencey have been discussed earlier. The degree to which people can live independently in the community will depend upon the degree to which they are able to handle money, maintain acceptable appearance and hygiene, keep living quarters clean and orderly, cook and shop.[22] The family must always be alert to the patient's readiness to learn any of these tasks and should be prepared to teach them.

Mentally ill persons often are lonely and bored because they have difficulty establishing a social life for themselves. Many authorities feel that because mental illness often strikes during adolescence, the person's social skills are severely affected and must be relearned. Family members can assist by learning what is available in the community: support groups, social clubs, drop-in centers. Family members can also help the family member to learn what is the appropriate social behavior for various situations as well as encouraging the patient to develop interpersonal relating knowledge and skills.

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[22]Hatfield, 52.

Community Treatment Resources

Every state has Community Mental Health Centers (CMHC) which are responsible for the mentally ill after discharge from the hospital. CMHC provides emergency assessment and services, community placement, medical supervision and treatment and case management services for persons with mental illness. They also provide information and services to family. Each CMHC has a psychosocial rehabilitation program to assist the mentally ill person in developing coping skills for successful community living.

Housing options for the mentally ill

Although most persons with mental illness live at home with a family member, mental health experts strongly encourage that alternative living arrangements be considered. Some options are:

1. Contract Homes: These are privately own homes with which the local CMHC contracts. They are generally for short-term placement with a program aimed at helping the individual move on to more independent living after 6 months to a year.

2. Community living facilities and apartments managed by state hospitals. These are similar to CMHC contract homes, but are supervised by the hospital rather than by CMHC.

3. Adult Foster Care Homes. These homes provide 24-hour supervision and care but generally no psychosocial rehabilitation or other services. Cost is covered by SSI or SSDI payments. There are far fewer foster care homes available in most states than are needed.

4. Independent living with supervision. There are a limited number of shared living arrangements, generally apartments, with intermittent supervision by a CMHC case manager.

5. Independent living; alone or with family members. This is generally a satisfactory arrangement only for persons who are fairly self-sufficient. Living with family members is not usually a good solution. If there is a Center for Independent Living in one's community, they may be helpful in making housing arrangements or in providing assistance that may aid in achieving independence.

6. Homes for the aged (62 or over), licensed by the State Department of Social Services.

7. Nursing homes which take persons with mental illness as well as medical problems.[23]

Rehabilitation Services

Patients with severe mental illness often have some impairment in several aspects of their lives even when their symptoms are well controlled by medication. Well-designed rehabilitation programs may help them acquire the skills they have missed or lost. These rehabilitation programs can take place in a variety of settings: hospital wards, psychiatric day treatment programs, sheltered workshops, CMHCs, and vocational rehabilitation centers. Most states have CMHCs that usually provide a wide spectrum of services, including the learning of social skills, developing friendships, and acquiring job skills. Often a CMHC takes on the character of a club, where former patients are considered members and the center serves as a clubhouse. Social expectations for members are gradually increased. The ultimate

[23]State Alliance for the Mentally Ill of Michigan, 16-17.

goal is independent living and competitive employment for those who can reach that level.[24]

Financial Considerations

People with mental illness who are unable to work may be entitled to either Social Security Disability Insurance (SSDI) or to Supplementary Security Income (SSI). SSDI is for disabled workers who have previously paid into the Social Security system through payroll deductions from their earnings. Monthly benefit payments are based on past earnings. Some people who become disabled before the age of 22 may collect SSDI under a parent's account if the parent is retired, disabled, or deceased. Medicare provides health insurance to disabled people who have been entitled to Social Security benefits for two consecutive years or more. Applications are made at a local Social Security office. Clients need to bring Social Security number, birth certificate or other proof of age, proof of citizenship, information about any sources of financial support, financial documents, and a list of doctors, hospitals or clinics where diagnosis and treatment were received.[25]

SSI is a federal-state program to provide monthly income to individuals who have very little income and who are aged, blind or disabled. Anyone who is eligible for SSI is automatically eligible for Medicaid. The amount of SSI

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[24]Hatfield, 47.

[25]State Alliance for the Mentally Ill of Michigan, 18.

benefits is less if the mentally ill person lives at home rather than independently. Each state will have its own guidelines for eligibility in terms of definition of illness, disability, assets, and part-time income limits.

If benefits are denied, the ruling may be appealed by:

1. Asking for reconsideration of the ruling.
2. Asking for a hearing before an administrative law judge.
3. Asking for a review of the decision by the Appeals Council.
4. Bringing civil action in federal court.[26]

Each state may or may not offer public assistance to people who are unemployed due to illness or disability and either ineligible for SSI or waiting to hear about SSI after having applied for it. Information and applications are available at a county Social Service office. Food stamps and pharmacy assistance programs may also be available to low-income people.

If the mentally ill person qualifies for SSI benefits, it is very important for the family to plan ahead so that the SSI payments and Medicaid will not be lost through inadequate estate planning. By inheriting property or money, the mentally ill person may be disqualified for these entitlements, which cover the cost of residential and medical care. Some families have drawn up a will which disqualifies the mentally ill relative; others have set up a trust fund

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[26]Ibid.

with another relative as trustee on behalf of the mentally ill person. The trust fund must be restricted so that it cannot be used for support and maintenance; a lawyer who specializes in this estate planning should be consulted.

In some communities, families have formed a corporation which handles trust funds and may also support personal advocacy services after the parents or family members are no longer living. One such example is called PLAN (Planned Lifetime Assistance Network) in Virginia.[27]

GRIEF AND LOSS DYNAMICS

Although grief and loss issues for the person with mental illness were addressed in the previous chapter, this section will address the topic from the care-giver's perspective. Mental health professionals are beginning to understand the burden the family experiences when a loved one becomes mentally ill. The grieving and loss dynamic must also be addressed by the pastor. T. Rando identifies three phases or stages that characterize the grieving process: (1) the avoidance phase, (2) the confrontation phase, and (3) the reestablishment phase. Feelings of shock, denial and disbelief describe the avoidance phase. Confusion, disorganization, and "emotional anesthesia" are common during this period. The confrontation phase is described as a time of "angry sadness," which may include a range of such emotions as anger, guilt, depression and despair. Individuals may be

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[27]Ibid., 19.

preoccupied with the loss as well as experiencing "grief attacks." Reestablishment entails the gradual decline of grief during the process of emotional and social reentry. While the loss is not forgotten, there is reinvestment of emotional energy in new persons, things and/or ideas.[28]

While the above model is helpful in understanding the grieving process, the loss and grieving dynamics for families with mental illness is unique. While a wake and funeral provide some form of closure for physical death, no such mechanism exists for the family experiencing chronic mental illness. The grief and loss is continuous. Parents will not only remember the premorbid personality and activities of their affected child, they will also experience the loss of present and future independence, being forced to be a continuous caregiver to their mentally ill loved one.

Mental illness also entails symbolic loss and actual loss, complicating the grieving dynamics. Thus the pastor and mental health professionals may often encounter dynamics of "unfinished business" as they work with families. The need for pastoral care and support is obvious.

Mental illness also creates a loss of relationships, not only for the parents, but also for the siblings. Some helpful suggestions for parents in dealing with the siblings are (seen in terms of what parents can or cannot do):

1. What parents can't do:

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[28]Marsh, 90.

a. Can't take away the fact that mental illness has an impact on their other children.

b. Can't lessen the impact by not talking about it.

c. Can't shield the other children from their own feelings about it.

d. Can't determine the coping style each child may adopt.

e. Can't go through the grieving process for them. This involves denial, sadness, anger, and finally, acceptance. Each person goes through this process in his/her individual way, at his/her own pace.

f. Can't make them seek help while they are in the denial phase.

g. Can't take away peer and societal stigma.

h. Can't expect they will not have a variety of negative emotions such as guilt, fear, grief, resentment, and jealousy.

i. Don't make the illness and that child the center of the family's attention.

2. What parents can do:

a. Be aware that all family members are profoundly affected.

b. Be aware of the coping stance their well children adopt, i.e., estrangement, enmeshment, etc.

c. Talk about your feelings and encourage them to do the same.

d. Learn about the illness in order to control family anxiety.

e. Work to improve aftercare options through the mental health system.

f. Read literature on siblings of the mentally ill to gain insight into the sibling experience.

g. Find out more about the Sibling/Adult Children's Network of NAMI and introduce to your children when they are emotionally ready.[29]

Often the psycho-social-spiritual needs of the spouse of a mentally ill person are overlooked. Certain mental health experts have described the unique problems spouses face: the feeling that they are no longer married to the same individual. Some losses include the sharing of events, household tasks, financial responsibility, parenting, intimacy, confidences, and decision making. Also included are the experiences of grief, anger, depression, frustration, and exhaustion. The inevitable conflict between caregiving responsibilities and personal needs along with the disruption of normal social life may result in grief and anger. Consideration of separation or divorce is likely to result in additional guilt and conflict.[30] The conflict caused by the interchanging of roles between caregiver (parent) and spouse when patient becomes symptomatic is rarely addressed. Special support groups for spouses of the mentally ill are becoming more popular.

CONCLUSION

In summary, researchers have determined the needs of families who have a member with mental illness to be the following:

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[29]Alliance for the Mentally Ill St. Louis Affiliate Newsletter, "What Parents Can and Can't Do for Siblings" (June-July 1989), 5.

[30]Marsh, 133.

A. A comprehensive system of mental health care.

   1. Functional components: adequate and accessible services.
   2. Structural interconnections: service coordination and integration.

B. Information: About mental illness and its treatment; about services and resources; and about the process of family adaptation.

C. Skills: For coping with the mental illness of a relative; with the mental health system; and with the personal and familial consequences of the mental illness.

D. Support:

   1. The informal support network: the nuclear family, the extended family, friends and acquaintances, neighbors, coworkers, and other families.
   2. The formal support network: professional and service providers, social institutions, and the government.

E. Meaningful involvement in the treatment and rehabilitation of their relative.

F. Managing the process of individual and familial adaptation: Resolving the emotional burden; resolving family problems and conflicts: managing the emotional climate in the home; and achieving a balance that meets the needs of all family members.

G. Contact with other families.

H. Assistance in handling problems in the larger society.[31]

Obviously the church and its people can do much to assist in meeting the needs of the mentally ill and their family members. This topic will be addressed in the next chapter.

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[31]Ibid., 164.

CHAPTER 6

PASTORAL CARE GUIDELINES: THE CONGREGATION

THE CHURCH IN HEALING AND CARING MINISTRY

Every Lutheran congregation is engaged in healing and caring ministry is an assumption that would seem appropriate and unquestionable. However, there seems to be a trend in many churches to separate ministry into primary emphasis, preaching the Word and administering the Sacraments, and secondary emphasis: evangelism, caring and other such ministries. This dangerous division tends to conveniently neglect the secondary emphasis because of time and energy commitments. It should be noted as one layman vividly stated: "The Gospel has legs and arms as it reaches out in love to those who are hurting!" (Please read appendices E and F.)

The church throughout the ages has recognized the healing ministry of Jesus. As the Body of Christ in the world today the church continues the ministry of healing to those who are breaking and broken, physically, emotionally and spiritually.[1] The Lutheran Church-Missouri Synod has seen

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[1]Charles Knippel, "Congregational Ministry With Mentally Ill Persons and Their Families: A Theological Perspective" in A Stranger In Our Midst: A Congregational Study on Prolonged Mental Illness, Ruth Fowler, Ed. (St. Louis: Pathways to Promise, 1987). 103-106.

itself as being a part of that healing ministry. Many examples and documents illustrate this fact. The opening paragraphs from the Leader's Manual for Project Compassion state:

> The Christian Church has always-like Jesus-been concerned about the whole person. Therefore, while we seek to bring a person to the saving knowledge of our Lord Jesus Christ, we also do all in our power to help others enjoy good physical, mental, and emotional health. Our Savior ministered through preaching and teaching, but also through acts of mercy. His loving heart was always filled with compassion for those in need. He healed the sick, comforted the sorrowing, forgave the erring, strengthened the weak, and supported the burdened. In short, "He went about doing good."
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> We, as members of Christ's body, the church, seek to carry on His compassionate preaching, teaching, healing minstry to others. And we need not search far in any community to find those people who need this ministry. People, who, because of age or illness, can no longer function normally, desperately need the friendship and help of Christians who are seeking to follow the example and command of their Savior. Whether confined to their own home, to a hospital, to a nursing home, or to another institution, these people depend on others for their physical, psychological, and spiritual needs.[2]

The congregation with all its various ministries cannot forget the words of our Savior:

> "Then the King will say to those on his right, 'Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came to visit me.'

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[2]Project Compassion: Leaders Guide, Annette Schroeder, editor (Board for Social Ministry Services, The Lutheran Church Missouri Synod: n.p. 1985), 7.

> "Then the righteous will answer him, 'Lord, when did we see you hungry and feed you, or thirsty and give you something to drink? When did we see you a stranger and invite you in or needing clothes and clothe you? When did we see you sick or in prison and go to visit you?'
>
> The King will reply, 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.' (Matthew 25: 34-40)

Truly the seriously mentally ill could be described as "one of the least of these brothers of mine." Let us not neglect to minister to persons with mental illness, who are often the strangers in our midst.

A scenario frequently encountered by mental health professionals is: Mr. D, diagnosed with paranoid schizophrenia, was recently admitted to the hospital's psychiatric ward because he suffered an acute psychotic episode due to the ineffectiveness of his medication. This was caused by accommodatation to the psychotrophic medications over a period of time which may occur if the patient is unable to maintain regular office visits to monitor medication. Because of Mr. D's occasional violent outbursts, he has been disowned by his family and friends. On the patient data base Mr. D. indicates that he considers himself a Lutheran.

Upon further questioning the social worker learns that Mr. D. was baptized and confirmed in Zion Lutheran Church. In his late teens he dropped out of youth group and the church as the symptoms of his mental illness forced him to socially isolate himself. Now the social worker phones your church, Zion Lutheran, and asks your church to be a part of

his community rehabilitation. What can the congregation do, not only for Mr. D., but for other mentally ill persons who may not be hospitalized?

BEING A FRIEND

As stated earlier, prolonged mental illness tends to isolate people. The people of the church can be a friend to those who may have no other friends or support systems. Befriending persons with mental illness is putting the agape love of I Corinthians 13 into practice.

Persons with mental illness often have poor social skills, low self-esteem, low self-worth, and may be experiencing side effects from the medication such as thirstiness, uncontrollable shaking, and/or delayed reaction/responses to conversation. It will take much perseverance and patience for caring people to initiate and build friendships. This can be done by being accepting, friendly, understanding, and genuine. It is important to stay in contact with the mentally ill person by telephoning or writing, sending cards appropriate to the occasion (birthday, Christmas). A church member should visit the mentally ill person in his home or living set-up.

If the living situation is inadequate, then this need should be addressed. Likewise if the person is not receiving adequate nutrition, medication, exercise, and other basic living supplies, the church member may need to contact the

social worker, case manager or make a referral to the proper mental health authority.

Friendship is living and sharing agape love. St. Paul would define this as being accepting without being judgmental. As a person with mental illness may be delusional or experiencing hallucinations, this may prove difficult, especially when the mentally ill person may request the friend to affirm the validity of a delusion based on paranoia. For example, the mentally ill person may demand that one tell them what the mentally person is thinking, assuming that the person has powers of mental telepathy. It is most helpful to be honest, firm and reality based. A friend can assist the mentally ill person in processing the feelings he is experiencing while delusional or while hallucinating. "From the way you describe it, it really sounds frightening", is one example of an appropriate response.

One of the most important actions a friend can bring is to give the mentally ill person permission to be sick. As stated before, mental illness is a no-fault disease. The person did not ask to be born with it nor to be afflicted with this cross. Yet it is often the church and its people who suggest that the mental illness is a symptom of little or no faith.

One of the greatest tragedies that the church can perpetuate is the myth that if a mentally ill person would confess some secret sin, renounce some Satanic alliance, get

things right with God, start praying and reading the Bible on a more regular basis, then God would heal him. On the other hand, it demonstrates Christian care and friendship to tactfully and appropriately inquire about medication compliance.

INFORMING THE PERSON THAT HE IS NOT ALONE

The Christian church always recognizes the work of the Holy Spirit whom the Lord sent so that His people would not be left alone. The message of the Gospel is not only that God loves and has died for us, but that He is with us now in the Person of his Holy Spirit. As is customary in some other aspects of God's Kingdom, He uses physical means to carry out His program. In this case He uses Christian brothers and sisters to create the Christian family in which ideally each member is present for the other. This means welcoming the person with mental illness into the faith community, not shunning them and reinforcing the stigma that coincides with the disease. This means accepting and loving the mentally ill persons for who they are, even as God has loved them. The members of the church, recognizing their social needs, not only befriend them, but encourage them to join support groups, social clubs and/or advocacy group.

INTEGRATING THE PERSON INTO THE CHURCH COMMUNITY

Often the disadvantaged people (poor, homeless, mentally disabled) are remembered during the holidays with food baskets and the like. In fact, the church in conjunction with a neighboring congregation may even host a special dinner or program for a Community Mental Health Center Day program. Integrating the person into the church, however, means more than token friendly relationships. It means treating the mentally ill person as a regular member of the congregation who participates actively and regularly in the worship service, receiving the sacrament of the Lord Supper. It is also allowing him to vote in the congregational business meetings, have his own offering envelope, and participate in various church tasks such as ushering, and altar guild. The mentally ill person should be allowed to engage in whatever other volunteer activities or services that other church members participate in. Obviously there are limitations; but given the stress level of the position, it is unlikely that a mentally ill person will accept nomination for the office of church president.

INTENTIONALLY OPENING THE CHURCH TO REHABILITATION AND SUPPORT GROUPS FOR PERSONS WITH MENTAL ILLNESS

Many community mental health centers (CMHC) and mental health agencies are seeking locations for a drop-in center for persons with mental illness. Likewise many support groups that service the mentally ill and/or their families

and friends are looking for meeting facilities. Examples and ministry models for congregations include:

1. **One-To-One Pastoral Ministries:**

Worship and other social group situations can be very stressful for a person who has been recently released from a psychiatric treatment setting. A congregation can respond with a one-to-one ministry for that patient and his family. Church Releasee Sponsorship Program, (CRSP), provides an emotional-social support system for people discharged from the Middle Tennessee Mental Health Institute. The program's goal is to provide a supporting relationship to recently discharged patients who are making the transition to community living. Volunteers visit the patient a minimum of once every other week over a period of ninety days at which time the relationship is reviewed and continues if both parties agree. CRSP matches congregations with patients prior to discharge as a support group to help those people make a successful transition. Volunteers receive orientation and support during the tenure of the relationship from the Pastoral Services and Volunteer Services of the Mental Health Institute.[3]

Housing continues to remain one of the primary needs for persons with mental illness. Some mentally ill persons will always require a supportive living arrangement while

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[3]Melodee Lane, Models of Care: For Persons with a Prolonged Mental Illness (St. Louis: Pathways to Promise, 1988), 1.

others will move on to a completely independent living arrangement. In many cases a congregation has cooperated with a housing agency that administrates placement programs for mentally ill persons needing housing.

2. **Adult Foster Care** is a living arrangement in which the mentally ill person becomes an integral part of an existing family unit. He has a bedroom, shares in the meals and activities with the family, learns appropriate behaviors, and gradually becomes a family member in the sense of forming affective bonds as he learns to adapt to the reality demands of the family. The Adult Family Living Program developed by Lutheran Social Services of Wisconsin and Upper Michigan (Superior, WI) is an example. The congregation provides the families as well as providing the support systems for the mentally ill person making the transition.[4]

3. **Board and Care Homes** provide long-term care and supervision for those unable to care for themselves. Besides board and room, meals, some degree of supervision and structure and medication monitoring is provided. The medical, rehabilitative and social needs of the residents are provided outside the facility. Bethel Outreach of Bethel Lutheran Church, Madison, Wisconsin, has the Johnson Street House which provides a permanent home to four men with a history of prolonged mental illness.[5]

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[4]Ibid., 4.

[5]Ibid.

4. **Halfway Houses**, as the name implies, is a transitional rehabilitation program between the hospital and the community. They provide a group living experience which is designed to produce changes in social behavior and in the ability to function independently in the community. Juniper House, St. Louis, MO, is a temporary housing project for young men who have mental illness and are homeless. The program's mission and intent is to provide holistic care so that these men can move into a supportive apartment setting rather than be on the streets. The program targets the homeless and those who are facing imminent release from a mental hospital. Besides providing a living arrangement, meals and clothing, this program also attempts to socially and spiritually rehabilitate the person so that he can function productively in the community.[6]

5. **Satellite Housing** may be apartments, duplexes or single-family dwellings in which mentally ill people are placed in small groups of two to five in order to live semi-independently. There is no live-in staff, but professional supervison is available to provide guidance and counseling as needed. The residents shop, cook and/or do housework either independently or in a shared arrangement. The resident is usually involved in an outside rehabilitative program or may hold a job.

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[6]Ibid., 6.

Cooperative Apartment Living Program, CALP, is a tranitional housing project developed by the Lutheran Church of the Good Shepherd (Cleveland, OH). A collaborating agency works with the church in locating an apartment and in prescreening and selecting the program's mentally ill participants. The church helps locate an apartment, furnishes it, and covers the initial expenses for two or three persons. The church also serves as practical, supportive friends to the residents, assisting them in their adjustment towards independence.[7]

6. **Shelter Care** is a means of responding to the homeless by making space available for overnight shelter and daytime food programs. This kind of program can entail laying mattresses down in part of the church building to the actual purchase of additional buildings to provide adequate shelter space. Usually volunteers from the congregation staff these programs while a paid director is usually needed to administer the overall program. Almost every major U.S. city has a homeless shelter that is administered by a religious group or organization.

The Shamrock Club in St. Louis, MO is noteworthy as it entails a committed effort to get the homeless off the streets and into some kind of treatment or assistance program (government or private.) Located at St. Patrick Center in downtown St. Louis, volunteers and supporting congre-

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[7]Ibid., 7.

gations assist by providing manpower and needed funds. A congregation takes responsibility for meals for the day. In addition to hot lunches, showers, laundry facilities, clothing, medical care, counseling, a mailing address and telephones are available on site.[8]

7. **Drop-In Centers** provide opportunities for socialization which are critically important for patients recovering from mental illness. One of the ways churches can serve is to make available their facilities for weekly or daily drop-in centers. These are frequently consumer operated and take minimal administration from the host congregation. Funding can come from various sources, both within and outside the congregation.

The Drop-In Club at Holy Trinity Lutheran Church (Red Bank, NJ) operates one night per week and offers a variety of social opportunities for the members. Members using The Drop-In Club are from nearby boarding homes. Two or three volunteers from the host congregation and a staff person from a local mental health agency which cooperates in this venture, are also members. The group meets in a church-owned house next to the church. The church is responsible for recruitment and scheduling of volunteer participants in the program. The Church's Social Concerns Committee is respon-

[8]Ibid., 9.

sible for the liaison between the church and the mental health agency.[9]

8. **Social Club and Support Programs** are usually inter-organizational in design with the cooperating partners being the church and a mental health agency. A minister and an outpatient staff person usually lead the activity group or club which meets on a regular weekly basis in a church facility, while the parishioners serve as volunteers. The clientele are persons with mental illness who are receiving clinical treatment and are utilizing the church as part of the social, emotional and spiritual rehabilitation program.

An interesting example is The Sunday Club, a program of the South Highland Presbyterian Church (Birmingham, AL). The congregation became aware of the number of boarding homes and half-way houses in their community. A church committee made an intensive study, hearing from local mental health organizations, consumers, family members and boarding home representatives. After studying the needs of the community, the church recognized that the people were not able to afford meals on some days of the week, nor were there appropriate places in the neighborhood to socialize. In order to help meet this need, the church has a program each Sunday afternoon beginning at 2:30 p.m. After a time of sharing and blessing, a hot meal is served followed by a social time. Volunteers from the congregation (women's groups, Sunday

[9]Ibid., 11.

School classes) are involved in serving meals and in conversation with those attending the club. The congregation finances the program.[10]

Self-help groups are also included in this category. Most groups are formed based on a common problem, need, and/or concern (alcoholism, over-eating, gambling, mental illness, or schizophrenia). The dynamic of support created by the sharing of experiences and information makes for a caring community. The 12-step approach is often utilized by consumers and family and friends. Some of the more common self-help and/or mutual support groups are:

a. National Alliance for the Mentally Ill
2101 Wilson Blvd., Suite 302
Arlington, VA 22201

National coalition of self-help group for the relatives and friends of the seriously mentally ill. Also provides both local and national means to advocate for better mental health services.

b. Depressive and Manic Depressive Association
222 S. Riverside Plaza, Suite 2812
Chicago, IL 60606

Mutual support for manic depressives, depressives, and friends and families. Similar to NAMI.

c. Recovery, Inc.
802 N. Dearborn Street
Chicago, IL 60610

Offers a self-help method of mental health through "will-training." Primarily for individuals with nervous or depressive disorders.

d. Emotions Anonymous
P.O. Box 4245
St. Paul, MN 55104

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[10]Ibid., 13.

> A fellowship sharing experiences, hopes, and strengths, using a twelve-step program in order to gain better emotional health.[11]

Obviously included in the above list would be Alcoholics Anonymous (AA) and Al-Anon since a majority of alcoholics are also mentally ill (dual diagnosis). This subject was discussed briefly in chapter three.

9. **Vocational Rehabilitation.**

CIRCLE, (Consumer Interface with Religious Communities for Learning about Employment), provides a self-help program for persons with mental illness, (Philadelphia Project SHARE/MAINSTREAM) with a congregation (Old Pine Street Presbyterian Church) to help persons with mental illness. They develop employment related skills by utilizing, among other things, the church's skills and resources. SHARE/MAINSTREAM provides the people to train, the training design and supervisor for CIRCLE. Old Pine Street Presbyterian Church provides members of the congregation who will train participants in the project, sponsors, office space and training space.[12]

10. **Interfaith Support Services and Programs**

Collaborative Association of Support Programs, CASP, (Asbury Park, NJ) is a coalition of clergy, laity, mental health and human service providers, people with mental

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[11]Johnson, 188-189.

[12]Lane, 14.

illness and their families coming together for two functions:

1. It sponsors several community support programs that are volunteer based.

2. It convenes monthly to evaluate the needs of those with mental illness in the community.

CASP was developed at a time when a number of people with mental illness began returning to the community, having been discharged from institutions. Programs currently sponsored by CASP include:

1. Eight bi-weekly social clubs that meet in participating churches.

2. A client "bank" which allows people with mental illness to deposit their government check and, with the supervision of another person, keep an accurate accounting of their expenses.

3. An annual dinner dance for persons with mental illness, with area businesses donating money, clothing and time or services.

4. Provision of housing for four clients in a house leased by CASP.[13]

Although The Lutheran Church - Missouri Synod has demonstrated a concern and a commitment to the care of the mentally retarded or developmentally disabled as seen in the Bethesda Homes ministry of Watertown, WI, and in similar ministries, tragically the church body has often ignored the needs of the mentally ill.

By contrast, the Mennonites have established a care and treatment model that deserves special attention. Because of

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[13]Ibid., 15.

the denomination's conscientious objection position during the world war II, Mennonite men were given alternate public detention assignments in government facilities such as prisons, sanitariums, and mental health hospitals. Their caring presence and advocacy for humane treatment of the violent mentally ill drastically altered the mental health hospitals in which they worked. The Mennonites were honored by the U.S. government for their involvement. But the Mennonite ministry didn't stop with the war. After the war the church set up five mental hospitals of its own, which in turn expanded into community mental health centers. Mennocare residential program, community home program, friendship / host family program, day care / friendship club, cell group and support groups are just a few of the current programs that have resulted from this denomination's concern for the mentally ill.[14]

Not only can the church open its facilities for various programs to serve the mentally ill and their loved ones, but the church can also open its caring heart to address specifically the emotional and spiritual needs of the mentally ill. An example of this ministry is the Stephen's Ministry in which volunteer lay people are trained to be caregivers: supportive, empathetic listeners who help people in crisis by assisting them to draw upon their spiritual resources.

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[14]Arthur Jost, "Mennonites And Mental Illness - A Fifty Year History," The Journal of the California Alliance for the Mentally Ill 3:4, 27-28.

Even as Stephen's ministers are effectively trained to handle hospice-like situations, divorce, death of family member, and similar events, so these same ministers are trained to assist the family in coping with mental illness. Although the pastor may not have the time and energy to devote to ministering to persons with mental illness, Stephen's ministers can serve as an effective back-up.

EDUCATING THE MEMBERS AND STAFF ABOUT MENTAL ILLNESS

The National Alliance for the Mentally Ill (NAMI) with its Religious Outreach Network (2101 Wilson Blvd., Suite 302 Arlington, VA 22201) and Pathways to Promise (5400 Arsenal Street, St. Louis, MO 63139) are two reputable organizations that can provide accurate, user-friendly resources for training the congregation, lay staff, and clergy about mental illness. In fact, both organizations meet annually, providing seminars on pertinent ministry topics and issues as well as helpful literature. It would be advisable that every church judicatory (Synod, District, local congregation) appoint/send delegate(s) to these conferences.

At the local level community mental health centers, hospitals and medical center, and/or state mental hospitals usually offer community information and awareness programs/seminars. A professional church worker can gather much information from these local resources. Local Alliance for the Mentally Ill (AMI) groups exist in most community. These groups are more than willing to provide information, assis-

tance, support, etc. to the local pastor and the congregation. The congregaton can also raise awareness by adding materials about mental illness to the congregation's library.

The first week of October is usually Mental Illness Awareness week. Although Lutheran clergy usually adhere to the appointed pericopes for the church year, special attention can be focused on the mentally ill: the illness, the family, and/or the patient. An excellent resource for this purpose is Pathways to Partnership: An Awareness & Resource Guide on Mental Illness.[15] This manual provides sermon topics, texts, hymns, and suggested prayers as well as various education programs for religious groups and organizations. Special bulletin inserts are also available through this resource.

Pastors should always include the hospitalized mentally ill in the congregational prayers for the sick and the hospitalized. Because of the stigma factor, the pastor should confer with the hospitalized person or person's family and/or friends to receive authorization, whether the hospitalization be for acute or chronic mental illness. On Mental Illness Awareness Sunday, the prayers listed in Appendix H are appropriate and may be included as a part of the liturgy. (Note: Not only should the pastor pray for the hospitalized mentally ill, but because this illness is a

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[15]Shifrin, 13-15.

medical illness, the pastor should visit the patient as he would any other ill church member or friend.)

ADVOCACY IN THE CHURCH AND THE COMMUNITY FOR PERSONS WITH MENTAL ILLNESS

Advocacy is a buzzword that tends to make many LC-MS clergy uncomfortable. Yet the congregation's name and public identity in the local community already suggest a ministry of advocacy. Typically a LC-MS congregation will be known for its pro-life and homosexuality position which is advocacy that coincides with confessionalism. The average congregation's arena of advocacy needs to be intentionally broadened. Simply speaking, advocacy means speaking on behalf of those who are unable to speak for themselves: the unborn, the elderly, the physically disabled, and the chronically mentally ill. Passages from the Old Testament prophets are often quoted (Cf: Amos 2,5, etc.) to support advocacy type ministries.

There are many ways in which a congregation can advocate. Ideally the pastor and the members of the congregation will become acquainted with the chronically mentally ill persons and will be sensitive to their needs. The need for care, support, adequate medical services, appropriate affordable housing and jobs is continuous. Usually the congregation will be unable to meet these needs by itself. It may need to form a coalition or working relationship with other congregations (Lutheran or non-Lutheran) in the community or

district to advocate effectively for persons with serious mental illness.

Pathways to Partnership: An Awareness & Resource Guide on Mental Illness offers the following suggestions for getting started at the congregational level:

1. Organize a leadership group. Identify and convene members of the congregation who have personal or professional concern and knowledge about mental illness.

2. Establish the group's identity. Agree on terminology, basic theological perspectives, and focus.

3. Assess needs and catalogue strengths of your congregation.
   a. Have clergy and lay staff had the opportunity to develop the knowledge and skills necessary to implement congregational efforts to respond pastorally to issues raised by mental illness?
   b. Does a caring community exist within the congregation where acceptance is possible?
   c. Has a support system been established for members, including families, who are returning to the congregation after treatment for mental illness or remaining in the congregation while receiving therapy?
   d. Has a survey been made of available resources, treatment programs, and self-help organizations?

4. Establish connections and begin building relationships with community agencies, self-help organizations, religious outreach networks, interfaith coalitions, denominational resource persons, etc.

5. Formulate long-term goals and objectives.
   a. Determine strategies, such as continuing education for pastors, etc.; integrating advocacy for persons with mental illness into the overall mission program of the congregation; and establishing programs of direct service for persons with mental illness and their families.
   b. Establish a time-line for action.
   c. Designate spokesperson(s) for public relations; assign other necessary tasks.

6. Decide what is "do-able" this year. Plan and present to your congregation's governing board a start-up proposal.

7. Continue implementation; give particular attention to recommendations in policy statement(s) of your denomination.[16]

Having conferred with several knowledgeable persons in the LC-MS and inter-Lutheran agencies, the writer is unaware of any congregation or district where a task force on ministry to persons with mental illness and their families exists. In keeping with the design of this graduate project and also out of the writer's own sense of pastoral need and care for those persons experiencing chronic mental illness, the writer met with the Michigan District (LC-MS) Board of Christian Care (Social Ministry) to establish a task force on mental illness. The following summary describes the establishment of this task force:

1. Fall 1991 - spring 1992, the writer researched various religious groups (Detroit Catholic Archdiocese) to study ministry models to the seriously mentally ill.

2. Spring and summer 1992, the writer met with executive director of Board of Christian Care and formulated a proposal for the establishment of Task Force on Mental Illness.

3. Summer 1992, the Board of Christian Care revised and adopted proposal. See Appendix I. The Board also authorized writer to implement proposal.

4. Fall 1992, Board of Christian Care approves funding and press release. See Appendix J.

5. Press release distributed at Michigan District Pastors' Conference, Lansing, MI, Oct. 20-22,

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[16]Shifrin, 16-17.

1992; also printed in December 1992 Michigan District Newsletter and January 1993 Michigan Lutheran. 34 responses received.

6. February 1993, Board of Christian Care approved questionnaire (Appendix K) and cover-letter (Appendix L). Also designated board member to work with writer and requested writer to meet with Board to develop screening process, etc.

The writer intends to follow the process outlined in Pathways to Partnership: An Awareness & Resource Guide on Mental Illness. In addition to meeting the goals outlined in the founding proposal (Appendix I), ultimately the Task Force on Mental Illness may introduce to Synod a resolution comparable to that modeled in Appendix M.

Other advocacy activities include objecting to false, stigmatizing statements made about mental illness. Although the news media often portrays mentally ill persons as "crazy" or violent, the clergy, through ignorance, also adds to the stigma of the mentally ill. When describing the dilemma of sanctification, "simul iustus et peccator", the pastor will often refer to the person as being "schizophrenic", referring spiritually to the tension of the dual natures of man in and of himself. The Apostle Paul's writing in Romans 7: 13-25 is a classic description of this difficult continuous struggle. The misinformed pastor needs to be reminded that schizophrenia is a perceptive disorder, a brain disease, not a person with a split personality. Indeed, there are many and various ways in which the congregation can minister to the person with mental illness and to his family

and friends.

CHAPTER 7

PASTORAL CARE GUIDELINES: THE PASTOR HIMSELF

Initially, a chapter concerning pastoral care guidelines for the pastor seemed unnecessary and almost superfluous. After all, the average Lutheran pastor has been professionally and academically trained in the care of souls (Seelsorger) and has much experience "under his belt." Does not the typical pastor visit the sick, minister to the dying, in addition to his other responsibilities of preaching and teaching? As a pastor, is he not a faithful shepherd to all the flock that the Lord has placed under his care? Whether the sheep be young or old, sick or healthy, he is usually there for them, ministering to their every spiritual need. What more can be asked or expected from a hard-working, diligent, conscientious servant of God?

This chapter addresses a number of rejoinders to clerical attitudes toward "doing ministry". First, it should be noted pastoral care has usually been defined and limited to those situations where there has been some sense of individual need and a willingness to accept help. Also from a historic perspective pastoral care included matters of "ultimate concern," that is, the troubles must be meaningful in relation to Christian faith in that they foster a deeper

faith and relation to God.[1] The dynamics of offering pastoral care to those with acute illnesses are easily understood and practiced. It is relatively easy to offer care, support, and hope to those whose pain, misery, and/or suffering is temporary. Moreover, the dynamics of pastoral care often change dramatically when the patient is experiencing a chronic, disabling, terminal illness or disease such as cancer, heart disease, or AIDS. In these specific situations the pastor recognizes these ministries as opportunities for offering support, care, and hope to a person whose pain and suffering also is temporary. However, the care-receiver in the end will leave this life and exchange this mortal body for an immortal one and will be forever with the Lord.

The most difficult kind of ministry is to those with a chronic, disabling condition for which medical science offers no cure or hope. Sometimes the symptoms of multiple sclerosis (MS), ALS, or lupus may go into remission. If the symptoms do not respond to treatment, then the patient and his family and friends are in for "a long haul!" Serious mental illness is the most disabling disease of all as it severely impairs the patient's ability to respond positively to pastoral care. The person with chronic mental illness may welcome the opportunity to address a topic of ultimate concern, but this crippling brain disease may severely

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[1]Rodney J. Hunter, ed. Dictionary of Pastoral Care and Counseling (Nashville: Abingdon Press, 1990), s.v. "Pastoral Care," by L. O. Mills.

impair the individual's abilty to appropriately respond. After all, who enjoys ministering to a blank wall? Yet such a description may be accurate of a patient in a catatonic state. Does severe brain disease preclude a pastoral ministry?

Another concern to be addressed is the fact that pastoral care is often defined in terms of activity. Clebsch and Jaekle suggest that the content of care include the functions of healing, sustaining, guiding, and reconciling.[2] Although pastoral theology textbooks commonly used in Lutheran seminaries stress the character of the pastor-to-be and recognize that character is an inward quality, yet even these qualities are defined in terms of activities.[3] The end result is that ministry is seen in terms of quantity as opposed to quality; form verses content. The emphasis in contemporary religious circles is on numbers, motion, and noise, whereas spirituality is more than the extrinsic; it deals with concerns and issues that start with the intrinsic.

Effective pastoral care is defined not only in terms of activity or ministry situations, but in terms of the personhood of the caregiver. Simply stated, ministry is not only sharing the Good News of God's love, it is also the

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[2]William Clebsch and Charles Jaekle, Pastoral Care In Historical Perspective (New York: Jason Aronson, 1983), 32-66.

[3]Armin Schuetze and Irwin Habeck, The Shepherd Under Christ (Milwaukee: Norwestern Publishing House, 1974), 1-6, 11-20.

vehicle through which the Good News comes. Authentic pastoral care entails the vehicle (person) understanding and accepting himself. This also includes the recognition and acceptance of one's humanness: limitations, finiteness, weakness, ability to feel pain as well as joy and happiness. This self-acceptance and understanding will eventuate in formation of basic, agape level human relationships. Henri Nouwen's image of the wounded healer vividly portrays and summarizes this concept.

How does this concept model itself in terms of pastoral care to the seriously mentally ill? The pastor will realize that a ministry of presence and acceptance is in fact a genuine ministry. It may be a ministry that requires much time with minimal (if any) response or feedback from the care-receiver. The pastor will also allow the mentally ill person to remain in a diseased state, realizing that care, not cure, is the therapeutic goal. Furthermore, the pastor will recognize and understand the pain of a person with a diseased brain and will minister to that person with the same skill and confidence that he would demonstrate to a person with acute illness. And not only would he minister to the person with mental illness, but also to the family and friends of the afflicted person. An effective pastoral caregiver will understand the emotions conjured in this poem by Ed Cooper:

WILL YOU?

Will you
Look for me in the swamp
As you rush to the mall to shop?

Will you
Have time to listen to me
Before you rush off to work?

Will you
Seek me out to befriend,
Even though I am bizarre and afraid?

Will you
Help me find a home for my head
And a sense of solidarity for my soul?

Will you?[4]

Thus an effective pastor will continually evaluate his understanding of Scripture and theology regarding pain, suffering, sickness, healing, wholeness, etc. He will address such questions as: (1) Is this illness the result of the sins of the fathers visited upon the children? (2) How does the theology of the cross relate to the theology of glory in this situation, if at all? The effective pastor will constantly monitor his pastoral care to those in crisis. He will attempt to assess his comfort level when ministering to those who are in pain, and dying by the use of peer groups. He will also recognize the limitations of his pastoral counseling skills. He will not provide counseling or therapy for chronically mentally ill persons. He will continually educate and upgrade his knowledge and ministry skills in this critical area of need.

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[4]Cooper, 84.

To summarize, the qualities that make for a good pastor have often been described by quoting Luther's axiom: "Oratio, meditatio, tentatio faciunt theologum." Indeed prayer and meditation upon God's Word make for an effective pastor. But so does the "angst" and tension of ministering to God's difficult people (those persons with serious mental illness), which is part of that "tentatio" that Dr. Luther knew so well.

CHAPTER 8

THEOLOGICAL CONCERNS AND REFLECTIONS

The aim of this pastoral care manual was to acquaint the reader with serious mental illness and all of its various dimensions. Because chronic mental illness remains a subject that is undergoing continuous research, one's knowledge of this medical disease will change. The human temptation to avoid what one does not fully understand or feel comfortable with is overwhelming, even among the mental health professionals. God's people, by contrast, have wrestled with the intangibles of faith, hope, love, belief, heaven, sacraments, just to name a few of the many everyday Christian terms. To further complicate the picture, the Prophet Jeremiah proclaims, "The heart is deceitful above all things and beyond cure. Who can understand it? (17:9). Thus the pastor already faces the double challenge of proclaiming foolishness to those who do not fully understand themselves. Ministering to a person with a diseased brain muddies the already murky waters.

In earlier times it was believed that the heart was the organ that controlled the body, giving it life. In more recent times it is understood that it is the brain which is the controlling mechanism of the body. Thus the brain may be dead (brain death) while the heart and lungs are still

active, a concept that the average layperson has difficulty comprehending. In similar fashion many clergy have associated the soul with the heart, but the spiritual dimension of a person obviously lies within the brain. That raises a great dilemma for those who enjoy operating within the arenas of firm and fixed structures. "Where does the physical end and the spiritual begin?" is a question that defies easy and simplistic answers. In fact, the question may be unanswerable. That, however, does not stop philosophers, psychiatrists, psychologists, ethicists, theologians and many others attempting to discover manageable "answers."

In the meantime, persons afflicted with serious mental illness are in desperate need of care, support, understanding, acceptance, and love, as are their families and friends. The church cannot sit around and refer or defer these hurting sheep to those whom the clergy may deem more qualified (professionals). The Lutheran church, its pastor, staff, and lay people must "roll up their sleeves" and become involved in ministry to the seriously mentally ill, even though they do not understand the illness.

Along with any active, effective ministry, the church will always be taking risks. (Experts will recognize risk as a sign of growth!) One of the greatest risks is to avoid the seriously mentally ill because of the time involved in this kind of ministry. Because the brain of the person with mental illness is damaged, it will take more time and energy

to process, relate, and communicate than it would with the average "normal" person. Whereas a pastor normally can make a statement once and it will be understood by almost everybody, often he will need to repeat it slowly to the person with mental illness.

It should be noted that because of the fine line between serious mental illness and spirituality (it is widely recognized throughout church history that various leaders such as Joan of Arc and others who claimed to hear God's voice were schizophrenic) there will be <u>many</u> mentally ill people in the average parish or congregation. Sad to say, they will often be in positions of leadership. Many church conflicts will result.

Remember, most serious mental illnesses are also a <u>perceptive</u> disorder. Thus the person with chronic depression will mostly likely be conservative, resisting change of any kind. A typical response from an older church member may be: "If the old Lutheran Hymnal was good enough for our parents, it is good enough for us today!" The normal response is to reply in kind (negatively), which often may polarize the meeting (and even the congregation.) The solution is for the pastor to be well acquainted with his parishioners, so well that he recognizes when Martha in one of her overzealous outbursts is in reality experiencing the "high" end of a mood swing, or that she is manic and can sooner or later be expected to have a low.

Another area in which serious mental illness will raise its ugly head is in the areas of family relationships. The male or female with serious mental illness will often be so socially impaired that the normal give-and-take verbal exchanges of everyday relationships of business, school, families, and/or marriage are nearly impossible. (See Appendix D and G.) The mental illness has not only made the family member dysfunctional, but it has impacted upon primary and secondary relationships. Thus the pastor should not be surprised if the healthy(?) spouse requests a divorce from an abusive marriage.

Serious mental illness may be the underlying cause of other abusive family relationships as well. To further complicate the dysfunctional relationship, it should be remembered that serious mental illness does not respond well to pastoral counseling and/or psychotherapy. In fact, it is highly improbable that the afflicted family member will consent to any kind of intervention, be it social, psychological or spiritual. As mentioned before, the mentally ill person and his family must be the continual focus of prayer. And the pastor must always have his crisis management skills handy and in good form!

Finally, the issue of pain and suffering must be addressed. It is an ageless, universal topic upon which countless men and women have pondered, writing tomes and giving discourses. The question, why bad things happen to good

people, is as old as the book of Job and continues to defy simple explanation. Because pages could be written about this subject, the writer will restrict his remarks as much as possible to that which pertains to serious mental illness. Obviously what relates to mental illness also may be descriptive of other diseases and tragedies.

Traditional Judeo-Christian monotheistic approaches have asked the question: "Why do the righteous suffer?" and have usually received refined answers such as "suffering is punishment (the consequences) for sin" and/or "suffering is due to evil, a privation of good, not a force of itself." These formulations assumed that God existed beyond suffering. Lutheran christology has focused upon the incarnate Christ, the God-man, suffering the pain, agony, and affliction of death and dying. Thus God does not remain remote from pain and suffering.

Much contemporary thought has viewed suffering in terms of loss and grief. The Kubler-Ross "five stages of dying" (denial, anger, bargaining, depression, and acceptance), paradigm has been adapted to see the experiences of loss as normal and the goal is acceptance which is better than denial. In this model loss is an interpsychic process (journey) in which the individual integrates the grief experience with reality. The learning that humans are finite beings and that loss is intrinsic to finitude is realized. Furthermore human beings experience loss as real as well as the suffer-

ing it creates.[1] In other words, suffering is a part of the loss experience and must be processed as any other grief experience.

Erika Schuchardt has studied the process of suffering and has creatively adapted the Kubler-Ross paradigm. Using a vertical screw as a model with three distinct stages (initial, transit, and target) and eight interwoven steps.[2] The first stage is the initial stage, compromising the cognitive dimension or "the head dimension" which is an externally directed reaction. The first step in this stage is the uncertainty which asks, "What is really going on?" Ignorance, insecurity and inability characterize this stage. This step is followed by the next step (second), certainty. The typical response is, "Yes, but it still cannot be true?"

The next major category or stage is the transit stage which is the emotional or heart dimension, the non-directed reaction. The third step, aggression, is seen in the question, "Why me . . ?" This is followed by the next step (4) of negotiation. The typical response is "but if . . then. ." This is followed by the next step (5) of depression which is seen in the expression of "what for . . . it's all pointless . . ."

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[1]L. Bregman, "Suffering, in Dictionary of Pastoral Care and Counseling, ed. Rodney J. Hunter. (Nashville: Abingdon Press, 1990), 1231.

[2]Erika Schuchardt, Why is This Happening to Me? (Minneapolis: Augsburg Publishing House, 1989), 39.

The final category or stage is the target stage which is the hand dimension or the dimension of activity, consisting of intentional interaction. The step (6) of acceptance is characterized by "Now I begin to realize . . . ." thoughts. The next step (7) is activity, characterized by the phrase, "I'll handle it!" The final step (8) is solidarity which suggests some social interacting and is characterized by the words, "We're handling it together!"

The Kubler-Ross model may prove helpful if you're working with the average pain, loss, and suffering of everyday living. As the concept of "average" cannot be strictly defined, neither can persons with severe mental illness be expected to subscribe to the above model of pain and suffering.

Eric Cassell, an ethicist, has carefully and thoughtfully studied the subject of suffering. He describes suffering as the distress brought about by the actual or perceived impending threat to the integrity or continued existence of the whole person.[3] The wholeness of a person necessitates that the person not only has a sense of the past, but also a sense of future with all its aims and purposes. Cassell poignantly details the dynamic of suffering:

> In suffering, what can be seen is the loss of central purpose, marked by an aimlessness of be-

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[3]Eric J. Cassell, "Recognizing Suffering," Hastings Center Report 21:3 (May-June 1991): 24.

> havior or reversion to behaviors that are primarily responses to immediate needs, no matter how conflicting the responses may be. Purposefulness, necessarily cohesive, fades. Suffering is the enemy of purpose, and the loss of central purpose is frequently seen in the suffering individual.[4]

The person with serious mental illness experiences the worst kind of pain and suffering imaginable. As Mr. Cassell points out, mental illness by the nature of the disease itself, robs an individual of identity, purpose, and sense of worth. Prolonged mental illness destroys, either partially or totally, the mechanism in the brain controlling feelings, thoughts, volition, and behaviors. What remains is an indescribable morass of a person within a body that is perceived by others to be fully human and responsible. Also, the emotional and mental pain of a diseased brain is as real as the physical pain of end-stage cancer.

To such a suffering individual comes the Good News of God's love, an unconditional accepting agape-type love, which states that God in Christ Jesus has created the person with mental illness, has redeemed this same person, and is present with this very same individual in the person of the Holy Spirit. All of this inspite of the fact that the person with mental illness is often incapable of responding appropriately in public or private. God declares to the person with serious mental illness that in baptism he has become a member of His Family and that His People, the Christian

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[4]Ibid., 30.

Church, will care and support these, the least of these His brothers, using Matthew 25 language. Is that actually happening in the Lutheran church today? It is hoped that this manual will facilitate the process of ministering to the seriously mentally ill and enabling them to be full and participating members of the local congregation.

As stated earlier, the pastor needs to remember that the person with serious mental illness is usually a person in continuing crisis. The ministry plan could be: (1) debriefing, (2) Scripture (23rd Psalm is always appropriate), and (3) a simple, brief prayer followed by praying the Lord's prayer together. As St. Paul instructs us, "Carry each other's burdens and in this way you will fulfill the law of Christ (Galatians 6:2)." May God help us to better understand the burdens of the seriously mentally ill and to assist them in their burden-bearing, in their service to the Lord.

APPENDIX A

GLOSSARY

AFFECT - How a person feels at a particular time. Anger, sadness, elation, and depression are all examples of affects. Another word for affect is mood. The type of affect, its appropriateness to the situation, and its persistence are important patterns that help determine a diagnosis.

AFFECTIVE DISORDERS - Mental illnesses characterized primarily by abnormalities in mood. The two principal classes are mania and depression. Manic disorder is characterized by euphoria, accompanied by other symptoms such as decreased need for sleep, pressured speech, racing thoughts, grandiosity and poor judgment. Depressive disorders are characterized by low mood, usually accompanied by insomnia, decreased appetite, poor concentration, loss of interest, and diminished ability to experience pleasure.

AFFERENT NEURON - A nerve cell designed to carry messages into the brain from various kind various kinds of sensory receptors, such as those in the ears or the eyes. An efferent neuron is designed to carry messages out of the brain in order to command parts of the body to perform some action, such as commands to muscles to move.

AKATHISIA - A side effect of neuroleptics characterized by an unpleasant sensation of internal restlessness and physical manifestations such as pacing or restless movement of the legs.

AKINESIA - Diminished motor activity. This symptom is common in schizophrenia and in disorders affecting the basal ganglia, such as Parkinson's disease, as well as injuries to some parts of the frontal system.

ALOGIA - Diminished capacity to think or to express thoughts. This is a common symptom of schizophrenia. It expresses itself clinically through a tendency to speak very little or, even when speech is relatively normal in amount, to say little in terms of content. The speech tends to be over-abstract or over-concrete.

AMBIVALENCE - Holding two opposing ideas or feelings at the same time which may hinder sound decision making.

ANHEDONIA - The inability of the person to find and experience pleasure in situations or areas that were normally pleasurable or rewarding.

ANTIPSYCHOTIC DRUGS - Drugs designed to diminish psychotic symptoms, such as delusions or hallucinations. These drugs are also referred to as neuroleptics.

ANXIETY - As a mood, anxiety is a state of tension, inner unrest, apprehension, uneasiness, or a temporary psychological imbalance.

APHASIA - Impairment of the ability to communicate verbally, caused by damage to the language centers located in the left hemisphere.

ATTENTION - The ability to concentrate on a task.

ATTENTION DEFICITY HYPERACTIVITY DISORDER - Behavior characterized by inappropriate degrees of inattention, impulsiveness, hyperactivity.

AUTISTIC - Thinking that disregards the environment in a pervasive way and constructs views of the world from internal fantasies rather than on external realities.

AVOLITION - A symptom of mental illness that is particularly common in schizophrenia. This symptom is expressed as extreme apathy and loss of normal drive and interest.

AXON - The part of the neuron that carries messages from the cell body to nerve terminals or synapses.

BLOCKING - Unexpected disruptions of one's train of thought.

BIPOLAR DISORDER - A type of affective disorder characterized by episodes of mania, most often referred to as manic depression.

CATATONIA - This can be either a state of extreme agitation and oveactivity referred to as catatonic excitement or motionless behavior often termed catatonic negativism.

COMPULSIONS - The repeated, senseless performance of actions accompanied by the feeling of not being able to stop the behaviors. It is thought that these actions are performed to prevent anxiety.

CONDUCT DISORDERS - Behavioral patterns in which the basic rights of others are violated.In addition, age appropriate norms for behaving and rules are often disregarded. Agression is common.

CONFABULATION - Inventing facts which usually cannot be systematically remembered to cover up impairments with thinking or performance.

CONFLICT - A clash between emotion or thoughts.

CONFUSION - A disturbance in orientation.

CT SCAN - Computerized tomographic scan (also referred to as CAT scan, or computerized axial tomographic scan). This is one of several "brain imaging" procedures used to study brain structure to observe existence of abnormalities.

DELUSIONS - These are fixed, false ideas or beliefs that are made from incorrect inferences about reality.

DENIAL - Rejection of reality.

DEPERSONALIZATION - The perception that something has happened to a person's body that results in feelings of change or sensations that his body or parts of are dead or altered.

DEPRESSION - A severe or major depression is characterized by such symptoms as: feelings of worthlessness, loss of energy and motivation, eating and sleeping disturbances, a sense of hopelessness, and recurrent thoughts of death or suicidal thoughts or attempts.

DEVELOPMENTAL DISABILITY - A handicap or impairment originating before the age of eighteen which may be expected to continue indefinitely and which constitutes a substantial disability.

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM III-R) - The American Psychiatric Association (APA) publishes this manual which describes all of the diagnostic criteria and the systematic descriptions of the various disorders.

DISORGANIZED - Any profound change in the tissues of an organ or structure that causes the loss of most or all of its proper characteristics.

DISORIENTATION - The inability to accurately identify the time, place and name of the person being interviewed.

DISTRACTIBILITY - The mind is easily diverted from the conversation by unimportant detail.

DIURESIS - The production and elimination of large amounts of urine.

D.S.S. - Department of Social Services.

D.V.R. - Department of Vocational Services.

DYSPHORIA - An unpleasant or uncomfortable mood state, such as depression or anxiety, contrasted with euphoria, the mood that characterizes manic disorder.

DYSTONIA - Acute muscular spasms, often of the tongue, jaw, eyes, neck and sometimes of the entire body.

ECT - Electroconvulsive therapy. This form of treatment involves applying a small amount of electrical current to the patient's temples, after the patient has been put to sleep and given a muscular relaxant. The electrical current produces a seizure which somehow alleviates deep seated depression.

EUPHORIA - Exaggerated sense of well being.

EXTRAPYRAMIDAL SYNDROME - A variety of signs and symptoms, including muscular rigidity, tremors, drooling, shuffling gait (parkinsonism); restlessness (akathesia); peculiar involuntary postures (dystonias); motor inertia (akinesia), and many other neurological disorders.

FANTASY - Imagined thoughts to gratify wishes.

GENERALIZED ANXIETY DISORDER - A disorder characterized primarily by free-floating anxiety.

GUILT - A distressing emotion that is felt when someone has violated his values; such a person may feel worthless and seek punishment.

HALLUCINATION - The perception of a sensory stimulus in the absence of such a stimulus. These false perceptions in the senses are not based on reality.

HYPERACTIVITY - Excessive activity which is generally purposeful.

HYPERKINETIC SYNDROME - This disorder is referred to as Attention Deficit Hyperactivity Disorder (ADHD). Such persons often are inattentive, impulsive, and hyperactive in comparison to persons of similar ages.

HYPOMANIA - Excitement that is "greater than average" but less that a full blown disorganized manic episode.

IATROGENIC - Distress or illness created by a physician.

ILLUSIONS - Misperceptions of real sensory stimuli.

INFORMED CONSENT - Permission for treatment based on an understanding of the purpose of treatment, common side effects or risks, consequences of withholding treatment permission, approximate length of treatment, and alternate treatment modalities.

IRRITABILITY - An inner feeling or tension or disequilibrium often communicated to others as annoyance, anger or frustration.

LABILE - Unstable emotions.

MANIA - A mood characterized by such symptoms as rapid or unpredictable emotional changes, high energy level, feelings of grandiosity, extreme irritability, and excessive involvement in activities that have high potential for painful consequences which are not recognized during the manic period.

MANIC-DEPRESSIVE - An older term now rarely used, but approximately equivalent to bipolar.

MENTAL RETARDATION - Below average general intellectual functioning which coexists with deficits in adaptive behavior.

MOOD - Pervasive feeling states that are experienced subjectively.

MRI - Magnetic Resonance Imaging, a technique involving exact measurements of brain structures based on the effects of a magnetic field on various substances in the brain.

NEUROANATOMY - The study of brain structure.

NEUROLEPTIC DRUGS - Drugs used principally to regulate the symptoms of psychosis. They are also known as antipsychotic drugs.

NEUROPHARMACOLOGY - The study of the way that various drugs may affect neuronal and brain functions.

NEUROPSYCHOLOGY - The study of cognitive, perceptual and volitional systems in the brain, with an attempt to localize these functions as precisely as possible.

NEUROSIS - In classic psychodynamic theory, a disorder caused by psychic conflict. In more recent times, term refers to milder disorders such as the anxiety disorders or mild depression.

NEUROTRANSMITTER - A chemical messenger that one neuron uses to communicate with another. Some of the best known are dopamine, norepinephrine, serotonin, acetylcholine and GABA.

OBSESSIONS - Ideas or thoughts that persistently intrude into consciousness.

PANIC DISORDER - A type of anxiety disorder characterized by panic attacks-sudden bursts of anxiety accompanied by a sense of impending doom and a variety of physical symptoms such as a pounding heart and shortness of breath.

PARANOIA - A mental disorder featuring delusions of persecution and suspiciousness.

PERSONALITY DISORDER - Persistent, characteristic, maladaptive ways of behaving.

PET SCAN - Positron emission tomographic scan. A brain imaging procedure that involves the use of positron-emitting substances that are injected into the body and taken up by the brain. The radiation that they emit is measured and used to construct a picture of the brain.

PHOBIA - An irrational fear. When this irrational fear is excessive or incapacitating, a person is usually said to have a phobic disorder.

PHOTOSENSITIVITY - Increased sensitivity of the skin to the sun leading to sunburning more easily than usual. Some psychoactive medications increase this likelihood.

POST-TRAUMATIC STRESS DISORDER - A type of mental disorder occurring in people who have experienced a stressor outside the normal human experience, such as death camps, natural disasters, or mass catastrophes. Symptoms include persistent reliving of the experience, a feeling of psychological numbness and prominent symptoms of anxiety and depression.

PREMORBID - Original, before onset of illness or disease.

PSYCHOSIS - This term usually means that a person is out of touch with reality and cannot distinguish fact from fantasy.

PSYCHOTROPIC DRUG - a drug that has an effect on psychic functions, behavior or experience.

REALITY TESTING - The ability to accurately distinguish fact from fantasy. To make sense of one's environment.

RESIDUAL - Remaining or left behind, symptoms that remain after a crisis resolves.

SCHIZOPHRENIA - A major psychiatric disorder, probably with multiple causes, characterized by disturbances in content and form of thought, perception, affect, sense of self, volition, relationship to the external world and psychomotor behavior.

TARDIVE DYSKINESIA - Involuntary movements of the mouth, tongue, and lips can occur and may be associated with choreo-atheroid (purposeless, quick, jerky movements that occur suddenly) movements of the trunk and limbs. Psychotropic medication contributes to the development of this condition.

TRICYCLIC ANTIDEPRESSANT A type of medication used principally for treating depressive illnesses. There are many different types of tricyclics. Some of the more common are Elavil, Tofranil, Norpramin, Aventyl, Vivactyl and Sinequan.

UNDIFFERENTIATED - Not differentiated, primitive.

APPENDIX B

MEDICATIONS

ANTIPSYCHOTICS:
(Phenothiazines)

Generic Name:	Trade Name:	Usual Adult Dossage:
chlorpromazine	thorazine chloramead chlorprom chlorpromanyl largactil promachlor promapar promosol terpium sonazine	200-600 mgs. initial 500-1400 mgs main.
promazine	sparine	
thioridazine	mellaril novoridazine	50-100 mg initial to 800 mg main.
mesoridazine	serentil	
fluphenazine decanoate	prolixin (inject.) permitil	.5-10 mg initial to 20 mg main.
trifluoperazine	stelazine pentazine clinazine novoflurazine solazine terfluzine triflurin tripazine	1-2 mg initial to 40mg main.
perphenazine	trilafon phenazine	8-16 mg initial to 64 mg main.

ANTIPSYCHOTICS (other)

haliperidol decanoate	haldol (inject.)	.5-5 mg initial to 100 mg main.
chlorprothixene	taractan	10 mg initial to 600 mg main.

thiothixene	navane	4-30 mg initial 16-60 mg main.
loxapine	loxitane	
molindone	moban	
clozapine	clozaril	25-300 mg initial 300-600 mg main.

SIDE EFFECTS:

1. Dystonic reactions. These are involuntary muscle contractions that cause bizarre and uncontrolled movements of the face, neck, tongue and back and an uncontrolled rollings of the eyes (counteracted by the antiparkison agents such as artane or cogentin).
2. Akinesia. This is characterized by stiffness and diminshed spontaneity of gestures, physical movement and speech (counteracted by artane or cogentin).
3. Akathisia. This is a feeling of internal restlessness-inability to sit still, as well as subjective sensation of discomfort often described as anxiety (counteracted by propranolol).
4. Tardive dyskinesia. See glossary.
5. Some other side effects may be menstrual changes, changes in sexual functioning, tendency to gain weight, and a sensitivity to sun.

ANTIDEPRESSANTS (tricyclic)

Generic Name:	Trade Name:	Usual Adult Dossage:
amitriptyline	endep elavil amitid	50-75 mg initial 150-300 mg main.
amoxapine	asendin	50-150 mg initial 150-400 mg main.
clomipramine	anafranil	25 mg initial 100-250 mg main.
desipramine	norpramin pertofrane	75-150 mg initial 100-300 mg main.
doxepin	adapin sinequan	25-50 mg initial 75-300 mg main.
imipramine	janimine sk-pramine tofranil	75 mg initial 150-300 mg main.
nortriptyline	aventyl pamelor	50 mg initial 50-100 mg main.
trimipramine	surmontil	75 mg initial to 200 mg main.

ANTIDEPRESSANTS (monoamine oxidase inhibitors)

isocarboxazid	marplan	30-50 mg initial 10-20 mg main.
phenelzine	nardil	15 mg inital to 90 mg main.
tranylcypromine	parnate	10 mg initial to 30 mg main.

ANTIDEPRESSANTS (other)

bupropion	wellbutrin	200 mg initial 300-450 mg main.
fluoxetine	prozac	20 mg initial 20-80 mg main.
trazodone	dysyrel	150 mg initial 150-400 mg main.
maprotiline	ludiomil	75 mg initial 125-225 mg main.

SIDE EFFECTS:

1. Sedation (drowsiness or sleepiness)
2. Anticholinergic effects (dry mouth, blurred vision, constipation, difficulty urinating, increased heart rate)
3. Orthostatic hypotension (light-headedness or dizziness when rising quickly from a sitting or lying position)
4. Other side effects may be: skin rash, sweating, tremors, altered orgasmic function and weight gain
5. With monoamine oxidase inhibitors (MAOI's) certain foods and beverages are to be avoided.

ANTIMANICS

Generic Name:	Trade Name:	Usual Adult Dossage:
lithium carbonate	eskalith lithane eskalith cr lithobid	300-600 mg initial 300-1200 mg main.
lithium citrate	cibalith-s	
carbamazepine	tegretol	
valproic acid	depakene	

SIDE EFFECTS:

1. Early side effects: gastrointestinal symptoms such as nausea, vomiting, diarrhea, stomach ache; fine tremor of the hands at rest; thirst and frequent urination; and fatigue
2. Persistent, continuing side effects: hand tremor; and severe thirst and frequent urination

3. Other side effects: increase in weight and hypothyroidism
4. SIGNS OF IMPENDING LITHIUM TOXICITY: fatigue, sleepiness, confusion, muscle weakness, heaviness of limbs, slurred speech, coarse hand tremor, unsteady gait, tremor of the lower jaw, muscle twitches, nausea, stomach ache, diarrhea, and tinnitus (ringing in the ears)

ANTIANXIETY MEDICATIONS:

Generic Name:	Trade Name:	Usual Adult Dossage:
(BARBITUATES)		
pentobarbital	nembutal	20 mg initial to 100 mg main.
phenobarbital	barbita	30-120 mg main.
(BENZODIAZEPINES)		
alprazolam	xanax	.025-.5 mg initial to 4 mg main.
chlorazepate	tranxene	15-60 mg main.
chlordiazepoxide hydrochloride	librium	5-25 mg initial 50-300 mg main.
clonazepam	klonopin	1.5-10 mg main.
diazepam	valium	2-5 mg initial 10-30 mg main.
halazepam	paxipam	20-40 mg initial 80-160 mg main.
oxazepam	serax	20 120 mg main.
prazepam	centrax	to 30 mg main.
BUSPIRONE	buspar	5-10 mg initial to 80 mg main.

SEDATIVE, HYPNOTIC MEDICATIONS:

(BARBITURATES)		
amobarbital	amytal	60-200 mg main.
aprobarbital	alurate	40-160 mg main.
mephobarbital	mebaral	32-100 mg main.
pentobarbital	nembutal	20-200 mg main.
phenobarbital	barbita	15-300 mg main.
secobarbital	seconal	30-200 mg main.
(BENZODIAZEPINES)		
estazolam	prosom	1-2 mg main.
flurazepam	dalmane	15-30 mg main.
lorazepam	ativan	.05 to 4 mg main.
quazepam	doral	15-7.5 mg main.
temazepam	restoril	15-30 mg main.

triazolam	halcion	.125-.25 mg main.

(NONBENZODIAZEPINES-
NONBARBITURATES)

chloral hydrate	noctec	.5-1 g main.
ethchlorvynol	placidyl	.2-1 g main.
glutethimide	doriden	250-500 mg main.
methyprylon	nodudar	200-400 mg main.
paraldehyde	paral	5-30 ml main.

ANTIPARKINSONIAN MEDICATIONS:

Generic Name:	Trade Name:	Usual Adult Dossage:
amantadine	symmetrel	100-300 mg main
benztropine	cogentin	1-8 mg main.
biperidin	akineton	2-6 mg main.
diphenhydramine	benedryl	25-200 mg main.
procyclidine	kemadrin	2-20 mg main.
trihexyphenidyl	artane	5-15 mg main.

NOTE:

1. These drugs are often given to counteract the side effects of antipsychotic medications.
2. Common side effects: blurred vision, restlessness, dry mouth, and constipation.

STIMULANTS:

methylphenidate	ritalin	5-10 mg initial 10-40 mg main.
dextroamphetamine	dexedrine	5-15 mg main.
magnesium pemoline	cylert	37.5 mg initial 56-75 mg main.
imipramine	tofranil	25 mg initial 75-150 mg main.

NOTE:

1. These drugs are often prescribed for children who suffer from attention deficit disorder with or without hyperactivity.
2. Side effects may be: anorexia, irritability/headache, variable blood pressure response, heart changes, occasionally will overstimulate, weight loss and/or abdominal pain.

REFERENCES:

1. Evelyn McElroy, Children and Adolescents with Mental Illness: A Parents Guide

2. Susan Krupnick & Andrew Wade, Psychiatric Care Planning
3. Demitri and Janice Papolos, Overcoming Depression
4. Patricia Scheifler-Roberts and Robert Mullaly, Medication Maze

APPENDIX C

ATTENTION DEFICIT DISORDER QUESTIONNAIRE FOR TEACHERS/PASTORS

NOTE: Four columns to the left of the questions should be allowed for the following responses: (1) Not at all; (2) Just a little; (3) Pretty much; (4) very much.

QUESTIONS: **RESPONSES: 1 2 3 4**

1. Restless in the "squirmy" sense.
2. Makes inappropriate noises when he shouldn't.
3. Demands must be met immediately.
4. Acts "smart" (impudent or sassy).
5. Temper outbursts and unpredictable behavior.
6. Overly sensitive to criticism.
7. Distractibility or attention span a problem.
8. Disturbs other children.
9. Daydreams.
10. Pouts and sulks.
11. Mood changes quickly and drastically.
12. Quarrelsome.
13. Submissive attitude toward authority.
14. Restless, always "up and on the go."
15. Excitable, impulsive.
16. Excessive demands for teacher's attention.
17. Appears to be unaccepted by group.
18. Appears to be easily lead by other children.
19. No sense of fair play.
20 Appears to lack leadership.
21. Fails to finish things that he starts.
22. Childish and immature.
23. Denies mistakes or blames others.
24. Does not get along well with other children.
25. Uncooperative with classmates.
26. Easily frustrated in efforts.
27. Uncooperative with teacher.
28. Difficulty in learning.

SCORING: A parent takes a similar inventory. The numerical value of the scores from questions 15, 28, 1, 14, 21, 22, 7, 26, 8, and 3 from the teachers questionnaire are tabulated and added to the score of parent's questionnaire. If the score is 36 or above, there is a high probability that the child has ADD and could benefit from treatment. See Glenn

Hunsucker's ADD:Attention Deficit Disorder (61-72) for details.

APPENDIX D

"WHEN EVEN THE DEVIL DESERTS YOU"

"I have a thousand faces and I am found in all races. Sometimes rich, sometimes poor, sometimes young, sometimes old. I am a person with the disabling pain of a broken brain.

You have names for my pain like schizophrenia, bipolar disorder, and major depression. Some of you refer to me as crazy or insane. The real fact is most of you don't refer to me at all. You want me locked away out of sight, but my only crime is my shattered mind. I understand why you don't want to look into a darkened soul because I cry when I am forced to make the journey.

Do you know the hurt I feel when I look into my family's faces and see their fear? Fear of me and what I have become. I try to tell them I will not hurt them and to explain it is not their fault. I try to reach out to them to ease their sorrow, but I fail to be a comfort because I cannot hide the agony of my soul.

I fight the demons of depression and despair. I search for a solace for my soul. I want my mind mended, but you must understand that a broken brain is more than mere mechanical failure. It has many causes, I am told. It may be hereditary, biological, or environmental. I don't know for sure what causes it, but I know what it causes.

It causes the total destruction of your inner self. It fragments you. It makes you seek an end even if that means death. You seek the end because you see not only what it has done to you, but also what it is doing to the ones you love. The fear of death fades because to a large degree you already feel dead. You are not able to interact with others, nor are people willing to interact with you as they once did. In fact, it feels like you have fallen so low even the devil has deserted you.

I ask you, where do you turn when even the devil deserts you? To therapy? It helps, but only touches part of me. To drugs? They help, but only touch part of me. Is there a path to a place that will touch all of me and not just mend my broken brain, but touch the untouchable?

I once heard of such a path. It was written about, but my mind wanders so much I find it hard to read. It has been spoken of, but I hear so many voices I don't know which to

follow. If you know the path, would you please find me? I may be in a hospital. I may be on the streets. I may be at home. Please find me and take me into your arms. Hold me there until we find the path that leads into the arms of the One not afraid to touch the untouchable. Find my family too. I may not be able to understand the written word or the words spoken to me. I may not even seem to know where I am, but I will know the warmth I feel when you gently put your arms around me. I will once again know I am loved."[1]

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[1]Ed Cooper, "When Even the Devil Deserts You," Church & Society: The Church and Serious Mental Illness (LXXXI:3 January/February 1991), 44-45.

APPENDIX E

ACCEPTING THE CHALLENGE TO CARE: THE RELIGIOUS COMMUNITY AND THE MENTALLY ILL

"Who are the mentally ill" and "what are their needs?" In an effort to answer these questions I am not going to discuss the mentally ill in clinical terms by referring to such things as faulty transmitters. A person cannot be reduced to a broken brain. A broken brain does not experience needs. I am also not going to discuss mental illness in terms of its effects. A person is more than a set of symptoms which require treatment. A person's needs cannot be entirely addressed through psycho-social treatment programs.

Yes, the illness has biological aspects. Yes it has psychological aspects. But beyond neurotransmitters, a broken brain, symptoms and psychology there is a person who lives the hell which we call mental illness. Long after medications have improved the brain's ability to process information and long after disturbing behaviors have been modified through psycho-social treatment, there lingers a spiritual/existential void. . . . a soul sickness. The spiritual disease of the long term mentally ill can only be understood if we put aside the word "treatment" and speak in human terms. I will put aside the word "treatment" and instead talk about "healing". I will not speak of pathology but will rather try to discern the logos of pathos. I will not speak of pain but rather of suffering. I will not speak of illness but rather of woundedness. I will not speak of depression but rather of anguish. It is only in wholly human terms that one can understand the death and renewal of the sprit which is lived experience of the long term mentally ill.

"Who are the mentally ill?" We are, above all, simply human being.

In our prime we were stricken by something that had no name, that came out of nowhere. In the dark it came and it shattered out lives. It was a thief who robbed us of our dreams, our plans, our futures.

When it first struck we were terrified and frightened of this thing with no name. At that moment, when we most needed to be close to the ones we loved, we were taken away

to a far off place. We were told that we were sick. We were told we were mentally ill. At the age of 14 or 17 or 22 we were told that we had an illness with no cure. We were told to take medications that made us slur and drool, that robbed our bodies of energy and made us walk stiffly like zombies. We were told to share our secrets. We were told that, in time, we could go home. But in those first few nights home seemed so very far away and the road back was not clear. Even to walk that length of the corridor on the ward seemed too much at first.

At night in the darkness of our beds, the lights from the houses in the community shone through windows of the hospital. Life still went on out there while ours crumbled around us. The lights in the houses seemed very, very far away. It was very lonely. It was a very long way home.

In time we left the hospital. We stood on the steps with our suitcases in hand. This was courage. This was such a tremendous beginning but our hopes were raised high. We were going to make it. Some did make it and never returned to the hospital. Many, many others returned home and found nothing was the same. Our friends were frightened of us or were strangely absent or were overly careful when near us. Our families were distraught and torn by guilt. Their eyes were still swollen with tears. And we? We were exhausted but we were willing to try to rebuild our lives. With all the ear-nestness at our command we followed our treatment. We tried to return to work and to school. We tried to pick up the pieces. We prayed for the strength and courage to keep trying. But, it seemed that God had turned a deaf ear to our prayers. The disease came again in the night and our lives were once again shattered.

This happened over and over again. In time we grew older. Our aging was no longer marked by the milestones of a year's accomplishments but rather by the numbing pain of the successive failures. If felt like we would never catch up. Our friends finished high school and college. They were married. They had children or careers. We had nothing. Slowly our friends left us because we had become someone else. Now we were mental patients, chronics. It gets hard to still care about anything when you've lost evrything. We didn't even dare to remember who we once had been. The memory of all we had lost was too much to bear. Being unable to look back, we also were unable to look forward. With each failure our hopes were shattered again. We came to believe that the future held nothing but an endless progression of meaningless days and nights in a world in which we had no use, no purpose, no reason to be.

Who are the long term mentally ill? They are human beings who live in great anguish, who suffer the pain of isolation, who feel as if God has forsaken them, who ask why did this happen to me? They are human beings whose needs are as simple as yours and mine. They need to belong. They need to live in the community. They need to worship their God within a community that does not exclude them because they are poorly dressed. They need a friend. They need to have someone who cares enough to stop by their home. They need to feel welcome within a fellowship. They need to come to terms with their lives and seek reconciliation with their God. They need to find meaning in their suffering. They need to be consoled. They need to dare to hope again. You and I can nurture that hope if we accept the challenge to care.

The religious community can plan an important role in the lives of the long term mentally ill. Do not try to be the psychiatrists. Do not try to be the psychologists. Let the spirit of the spiritual community embrace those forsaken ones. Take the time to know them and to frequent their homes. Console them and their families. Don't do things <u>for</u> the mentally ill. Do things <u>with</u> them.Invite them into the life of the community. Help them find a place where they belong and are truly useful and valued. Be leaders. Stand in support for programs and housing for the mentally ill. Teach your congregations through your words and example.

When your congregation asks: "Who are the mentally ill?" Tell them, "above all, they are simply human beings."

When your congregation asks: "How might we serve the mentally ill?" Tell them, "for God's sake, love them."

(Patricia E. Deegan, Ph.D. is Assistant Clinical Director for Continuing Care at the Center for Individual and Family Services of Cape Cod in Hyannis, MA. She has suffered from mental illness. This article and speech was delivered at Pathways to Promise Conference, Sept. 17, 1989, St. Louis, MO. The article was also printed in <u>The Caregiver Journal</u>, 8:2, 3-4.)

APPENDIX F

IF THE CHURCH WANTS TO BE THE CHURCH

In 1985 I retired from active service in the United Methodist Church after almost fifty years. Not long after my retirement I began working as chaplain at the Timberlawn Psychiatric Hospital in Dallas, Texas. Although I work only part time, I find the work most rewarding and fulfilling. To be very honest, I believe that I have found this work the most meaningful of my entire ministry. My only concern is the need is so great and I am able to touch only a portion of it.

Like most of us, I did not realize the extent of mental illness in our society. I now know one out of every four families is affected by mental illness. In many cases, the sick family member is "closeted" from sight of the community and even from the church. Unfortunately not only is the sick family member hidden from sight but family members also tend to withdraw from church and community activities. The family carries with them hurt, guilt, embarrassment, and so many times, hostility. "Why should we have to suffer a sick mother, father, daughter, son?" The weight is very heavy on them. As a congregation we too often have looked from a distance at such families. "They are peculiar; they have a child who is not quite right; the mother is strange." We keep our distance from them!

The truth is, these people are ill. They are ill with a sickness that has attacked the brain. Their families feel the pangs of isolation, aloneness. They feel no one cares.

I can walk across the beautiful grounds of Timberlawn Hospital and see young adults walking with each other or alone. If I did not know better, I would think that I was on the campus of a university. But, when I look into their eyes, I see sadness, loneliness, fear, and wonder. These are human beings, a part of a family just like my own. Part of a family who is out there somewhere grieving and wondering why this has happened to their loved one. Night and day their struggle goes on, wrestling with problems and trying to make some sense out of life.

I want to share some of the situations I have observed during my time at Timberlawn. These encounters could be doubled over and over again.

There is the young wife and mother. She said, "My marriage of twelve years is on the rocks. Not only am I losing my husband, but the courts have awarded our child to my husband, because I am in a mental hospital. It's hell to see all that I ever dreamed of go down the drain. It just is not fair."

There is Jack, a fine looking young man about twenty years old. He came to Timberlawn from another hospital where he had been treated for five years. "I'm scared to death," he said. "I have hallucinations day and night. I see things that are not real! And then there are the terrible nightmares. I am so nervous. I smoke incessantly to try to calm down. I know it isn't good for me. I wonder what is going to happen to me. Will this be my life forever?"

There was a unit meeting with a group of young adults. Because many of them were new patients, they were introducing themselves. They gave their first names and the reason for being in the hospital. Around the circle I heard:

> I am Helen, I am depressed.
> I am John, I have schizophrenia.
> I am Tom, they have diagnosed me as having manic depression.

Almost every Sunday, one of the patients will say to me:

> I am being released from the hospital next week. I am scared to death. I don't know whether my friends back home will understand where I have been and the new commitments I have made for myself. I am not sure my family will accept me and understand. Could you help me find a church that has a singles Sunday School class? Are there people in a church who understand something about mental illness? Will they care? Will they support a person who is mentally ill"

Another will say to me:

> Reverend, do you know of a pastor who will understand? Would it be safe to go to him? Where can I find a person who will accept me and support me in time of need?

I believe that the **door is wide open for the church to be the church.** This is the case if the church truly wants to be something more than a well oiled organizational structure. I

believe that the church can be a caring fellowship that will open wide its doors to those who suffer and who are struggling to make some meaning out of their lives.

Let me suggest some things I believe the church can do if it really wants to be the church:

A church can intentionally educate its members about mental illness. It can teach what mental illness is; what the characteristics of mental illness are; how mental illness can be treated; and how to eliminate myths about mental illness.

A church can form "caring groups" where the mentally ill may feel accepted and loved.

A local church can create a fellowship of mentally ill persons. Such fellowship will be a supportive group for each other.

A church can create a fellowship with families who have a member who is mentally ill. Such a fellowship would help families to know that they are not alone, that there are people who are walking down similar paths.

THE CHURCH IS NOT A HOUSE FOR SAINTS SHIELDED FROM HUMAN SUFFERING. RATHER THE CHURCH IS A HOSPITAL WHERE BROKEN LIVES CAN BE HEALED.

(S. Duane Bruce has served the United Methodist Church as a local church pastor, a district superintendent, an annual conference program director, and the executive director of the South Central Jurisdiction. He retired from active service in 1985 and is currently chaplain at the Timberlake Psychiatric Hospital in Dallas, Texas. He shared this paper at the Pathways to Promise Conference, September 18, 1989, St. Louis, MO. This article appeared in The Caregiver Journal, 8:2, 1-2.)

APPENDIX G

RECENT LETTER TO A CONGRESSMAN FROM A MICHIGAN LUTHERAN MOTHER OF MENTALLY ILL PERSON

I listen, and I hear Mr. Haveman (reader's note: Mr. Haveman is the MI State Mental Health Director) expound the virtue of community placement for our chronically mentally ill. The problem is that there doesn't seem to be any community services available for them.

Our daughter has battled mental illness since the age of fourteen. She is twenty-three years old now, the age when a normal young person is launching out to new horizons in a challenging world. Today my daughter is unsucessfully trying to cope with life in a society that has no tolerance for someone who is different, who has low self esteem, who cannot hold a job, who has few friends, who has no concept of money management, who vacillates between sleeping the day and night away and not sleeping at all, who gorges on hugh amounts of food or eats nothing at all.

Our daughter has been hospitalized for her mental illness seven times over the past nine years. In each instance, her discharge from the hospital was determined by insurance providers, not the physician. In 1988, she was hospitalized three times in rapid succession. Barely a week passed between discharge and admission. Obviously, she wasn't well enough to be discharged. However, the insurance company made the decision to discharge her.

Hospitalized as recently as November 1991, our daughter was discharged because the doctor claimed he could not justify to Medicaid keeping her in the hospital after the suicidal/homicidal crises passed. Mentally ill people are still mentally ill even though they may not be suicidal or homicidal for the moment!

As a concerned parent searching for help, it becomes readily apparent that there is no place in the community for help. Community placement translates to back home with the family. Well, let me tell you what it is like for a family to live with a mentally ill person.

The atmosphere in the family home of a mentally ill person is one of tension and anxiety as family members assume the posture known as "walking on eggs". No one wants to be the one to "set off" the ill family member. When speaking around this person, one must choose words carefully. Instead of the home being a haven where the family can relax and "be themselves", everyone begins to unconsciously assume responsibility for maintaining the stability of the ill person. As the situation progresses, anger and frustration rear their ugly heads, as family members quarrel and blame each other when the ill member acts out. Daughter seems to "dance to a different drummer". Sleeping and eating habits do not coincide with the family. How impossibly difficult it is to sleep when an ill person is up most of the night pacing the floor. The whole family is suffering.

Making long term plans becomes a dreaded event. We can never be sure daughter will participate in family events. If she does attend family or social gatherings, she often causes embarrassment by acting inappropriately. If she stays home, will someone else stay home too, or will everyone go to the function, fearful of what might happen while they are gone? Therapists tell us to live our own lives, to go out socially. So, we go out, sadly observing daughter in a fetal position staring at the wall, with a knot in our stomachs, wondering if she'll hurt herself while we are away.

As time goes on, social contacts and friends begin to avoid our family. If mom and dad venture to invite friends over after months of no guests in the home, that is the night daughter decides to take an overdose of sleeping pills and the evening comes to an abrupt halt with a trip to the emergency room. (That is what happened to me after having no guests in my home for eighteen months.) Our family is becoming isolated, this marriage is beginning to show signs of trouble. The family who started out as a loving, smooth functioning entity is rapidly becoming a dysfunctional family.

We realize our family is in trouble. We need help. The endless appointments for therapy begin. What is the resounding advice that emerges from the lips of the experts? Daughter is chronically ill, she will not get better, get on with your life. Your ill person is making your family sick. Ah, that is the problem. THERE IS NO PLACE TO PUT OUR SICK PERSON!

The hospitals won't keep the mentally ill. Our daughter has Medicaid, yet there are no psychiatrists who will see a Medicaid patient. There are pitifully few adult foster homes in Macomb county. If we parents took the advice of experts and "disengaged ourselves" from our ill sons and daughters,

our loved ones would be joining the growing ranks of the homeless, a population that is already unmanageable.

Community mental health services have closed their doors to new patients. We need help now. We need supervised housing for our sick people. It is unconscionable that patients are released from hospitals because insurance providers say it is time for discharge because a certain number of days have passed. Regulating psychiatric medications takes time. It takes time to regulate dosage to minimize side effects.

It is time to recognize that mental illness is just that, an ILLNESS. A hug and a warm environment (as Mr. Haveman recommends) does not make illness go away. Rather than closing research centers such as Lafayette Clinic, we need to increase these facilities.

Community services must be increased and supervised housing must be provided NOW. It is a disgrace when mentally ill patients must get medications through emergency rooms rather than have consistent medical follow-up with a regular physician.

Workers in our hospitals and group homes must be trained and educated concerning this illness. The length of hospital stays must be determined by the medical and mental condition of the patient, NOT some arbitrary number the insurance company decided upon. Physicians and psychiatrists must communicate and cooperate with one another in treating our mentally ill.

We are generating sick families. The thrust of health care today seems to be to live a healthy life style. Reduce all the stress in our lives we are told and our health will improve. The result of a mentally ill person living with the family appears to be creating stress related illnesses. Ask the family members of the mentally ill, and you will hear about high blood pressure, hives, ulcers, chest pains and any number of stress related disorders. The result of living with family seems to be that the family is getting sick and the mentally ill person is not improving either.

Mr. Haveman is replacing existing programs with words - a vision statement. Words don't house people, supervise people or provide treatment and medication. We need hospitals, doctors, community mental health clinics, housing and insurance guidelines and therapists to treat our mentally ill now.

Reform is certainly needed, but surely new measures must be in place <u>before</u> old ones are cancelled.

Sincerely,

(recent letter sent to author)

APPENDIX H

OPTIONAL PUBLIC PRAYERS

I. A Prayer by John Baggett

O God, who cares about the suffering of your children, grant us the gift of acceptance that we might find serenity and courage this day faithfully to cope with the mental illness in our midst. Teach us patience and understanding our mentally ill brothers and sisters need from us. Help us not to victimize with uninformed and uncaring attitudes those who suffer, but strengthen us with the love and understanding we receive from you to care and nurture. Enable us with wisdom and guidance to do your will in all our opportunities to serve those who suffer. AMEN.[1]

II. A Responsive Prayer by Walter S. Hill

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

Hear our prayer, O Lord.

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

Hear our prayer, O Lord.

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

Hear our prayer, O Lord.

Grant us courage and wisdom to remove the stigma of mental illness from those who suffer. Open our eyes to the need all around us. Enable us to recognize those who hurt and welcome them with the open arms of your

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[1]Shifrin, 13.

love into the fellowship of faith, that all might find a place in the midst of your congregation.

Hear our prayer, O Lord.

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

Hear our prayer, O Lord. Grant us this ministry of service, nurture and witness in Your Hold Name. AMEN.[2]

III. Prayers from the NAMI Religious Outreach Network interfaith Worship Service

Prayers of the People
The prayers are read by representatives of the client, family, professional and advocacy groups. Each petition end "Lord, in your mercy"; the people respond: **"Hear our prayer".**

The Prayer of the Consumer:
Lord, I turn to you, because You are always beside me. You created the healing powers within me and the strength and courage of my spirit. They are your gifts to carry me from fear to confidence. Thank you for the skill of my doctors and therapists, for the love of my family, for the support I receive from the network of my brother and sister consumers, and from my advocates. They are your helpers in the work of recovery. "In your hands I place my soul, when I sleep, and when I wake. You are with me, I shall not fear." Lord, in your mercy, **hear our prayer.**

The Prayer of the Families and Friends:
Dear God, you know how hard it has been. Sometimes we feel that we can take it no longer; this illness is so hard to understand; the system is so confusing and cold. We thank you that the one we love is alive and trying. We thank you for science, which has removed the guilt from our backs. We thank you for our support groups and for friends who are unafraid to ask "how is he doing this week?" Grant us wisdom, patience, and understanding, O Lord, and to you be glory and praise forever. Lord, in your mercy, **hear our prayer.**

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[2]Ibid.

The Prayer of Doctors and Nurses:
Strengthen all of us, O Lord, who treat and care for your children who have mental illness. Guide our hands, and our decisions. Enable us to always see the person beyond the diagnosis, the hope beyond the confusion and despair. Open our ears and hearts, and renew us in compassion and courage. "Blessed are you Lord, the faithful and merciful healer!" Lord, in your mercy, **hear our prayer.**

The Prayer of the Social Worker, Therapist, Case Manager:
O God, you have prepared us to be your partners in caring for the poor, sick and neglected persons, whom it would be easy to forget. Help us to bring light where there is confusion, healing where there is pain, and confidence where there is self-doubt. Let the fire of your love burn into the hardened heart of our society, so that there may be adequate resources, facilities and services for those whom you love above all others. Lord, in your mercy, **hear our prayer.**

The Prayer of the Clergy:
Blessed are you, O Lord God, who called us to the cure of souls in your Name. Forgive us for neglecting those with mental illnesses, who have souls too. Help us to bring mental illness "out of the closet" into the pew.

Dispel our fears and timidity. Open our ears to the voices and needs of the ill ones and their families, and to the gifts they have to offer your household of faith. Thank you for calling us to be advocates with you. Lord, in your mercy, **hear our prayer.**

The Prayer of the Advocate:
O God of justice, look with compassion upon the homeless and mentally ill people of our land. Defend them from those who neglect, exploit and stigmatize them.

Empower us to be the voices of those who cannot advocate for themselves. Save us from making any peace with injustice or with incompetence.

For those in authority, who profession is called "compromise", show them those things which cannot be negotiated. Give them hearts of flesh for hearts of stone. Inspire them with distrust of their advisors, and disarm their stingy greed with the power of your love. Lord, in your mercy, **hear our prayer.**

The Prayer of the Bereaved:

O Lord, we commend to your mercy all those, known to us and unknown, who have died from mental illness (especially we remember _____). We thank you for all the love and special gifts they have given us. May your will for them be fulfilled and may they share in the joys of your eternal kingdom. Lord, in your mercy, **hear our prayer.**

Unison Prayer: Prayer of St. Francis
"Lord, make us instruments of your peace."[3]

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[3]Lumen, 2:2 (November 1991), 6-7.

EXHIBIT I

July 28, 1992
(Revised)

PROPOSAL FOR THE ESTABLISHMENT OF A

TASK FORCE ON MENTAL ILLNESS

STATEMENT OF PURPOSE:

To address the needs of persons with mental illness and their significant others.

To equip professional church workers and congregations with resources in their ministries to and with persons with mental illness.

To enable persons with mental illness to full participation in the life of the congregation.

DEFINITION OF DISABILITY:

Disability concerning this Task Force is serious mental illness, which is defined as schizophrenia, manic-depression and chronic depression. (Related mental diseases and etiologies such as dual diagnosis [alcoholism], Alzheimer's, mental illness in children, etc. will also be addressed.)

GOALS:

A. To facilitate congregational awareness and education

B. To encourage congregations to develop and provide support systems for individuals and families with mental illness

C. To facilitate the networking of congregational programs

D. To develop an educational module to offer our professional church workers.

E. To encourage congregations to designate a Health Care Committee, possibly coordinated by the Parish Nurse, to assist the pastor in attending to the issues and concerns of the mentally ill within the congregation.

STRUCTURE:

A. The Task Force on Mental Illness shall be under the guidance and supervision of the Michigan District Board of Christian Care.

B. The Board of Christian Care shall be responsible for an adequate annual budget and the appointment of Task Force members.

C. Members may include: persons with mental illness (consumers), family and significant others, church-related professionals and agencies, District representatives, and significant others.

RESPONSIBILITIES:

A. The Task Force would be responsible for the development of presentations providing ministry-skilled education for professional church workers.

B. The Task Force would be responsible for the collection and dissemination of informational packets on mental illness to the congregations.

C. The Task Force would be responsible for program modules and ideas for congregational activities.

D. The Task Force would be responsible for providing news releases, seminars, and workshops for congregations and professional church workers relative to legal requirements pertaining to persons with mental illness.

Adopted as revised by the Board of Christian Care
Henry Pickelmann, Chairman
Thursday, September 10, 1992

EXHIBIT J

PRESS RELEASE:

The Board of Christian Care (MI Dist.) has authorized Chaplain Tom Oie (Henry Ford Hospital, Detroit) to set up a Task Force on Mental Illness. This task force, consisting of mental health professionals, church workers, as well as the mentally ill and their loved ones, will address the needs of the mentally ill and their families and will equip church workers and congregations with resources for ministry to the mentally ill. If you would like more information or would be interested in serving on the task force or know of someone in your congregation who would be interested, please contact Chaplain Tom Oie, 14166 Westgate Dr., Redford, MI 48239 or phone 313-876-2860 (d) or 313-255-6546 (n).

EXHIBIT K

QUESTIONNAIRE (TASK FORCE ON MENTAL ILLNESS)

NAME:_____PHONE NUMBER:_____
ADDRESS:_____

1. Explain your interest in serving on this task force. What are your experiences with mental illness, etc.? Describe affected family member/friend, etc.

2. What special concerns, needs, interests, abilities, etc. do you bring or can you contribute to this task force?

3. Briefly describe your vision for this task force: what should be its primary focus/function?

4. Briefly describe your involvement in your local congregation.

5. What is a convenient time and where would be a convenient location to meet?

Time (Day, Hours)
1. First Choice:
2. Second Choice:

Location (City, Site)
1. First Choice:
2. Second Choice:

EXHIBIT L

Chaplain Thomas Oie
14166 Westgate Drive
Redford, MI 48239
February 3, 1993

Dear Friends,

Thanks for your interest in The Task Force On Mental Illness and/or for requesting more information about this task force. Some of you may be surprised to receive this letter and packet. I have received 29 replies or inquiries about serving on this task force from three sources. First, at the MI Dist. Pastors' Conference Oct. 20-22, 1992, in Lansing I made a brief announcement and asked interested parties to contact me. I received names from the family itself or from a friend who knew that the family was experiencing mental illness. Secondly, I put a press release in the December 1992 Michigan District Newsletter. And I placed another press release in the January 1993 Michigan Lutheran.

Let me also introduce myself. I have been the chaplain at Henry Ford Hospital in Detroit for two and a half years. I am also a part-time assistant pastor at Christ Our Savior Lutheran Church in Livonia. My wife Darlene has mental illness and I am active in a local Alliance for the Mentally Ill affiliate.

Please study the enclosed materials: Questionnaire, "Proposal for the Establishment of a Task Force on Mental Illness" and Pathways to Partnership: An Awareness & Resource Guide on Mental Illness. Carefully read the proposal by the Michigan District Board of Christian Care. The Board of Christian Care determined that the Task Force should consist of five to eight members, consisting of affected family members (both clergy and laypeople), mental health professionals, and mentally ill persons (consumers). The Board has also authorized $500 to start up the Task Force.

Let me briefly explain the process. Please complete the questionnaire; give accurate and concise answers. If you need additional space, please use the back side. The information will be confidential, seen only by members of the screening committee. (Some of you have already shared your personal story and other pertinent data with me.) Return in

the enclosed stamped envelope by March 1st. The screening committee will "process" the questionnaires and present their recommendations to the Board of Christian Care who will officially appoint the task force members at their March 11th meeting. Hopefully the Task Force on Mental Illness will hold its first meeting in Lansing on a Saturday morning in May or June, 10 a.m. - 3:00 p.m.

If you have any questions, please write me or phone me at (313) 876-2860 (office) or 255-6546 (home). Thanks for yours continuing cooperation.

Yours in His Service,

EXHIBIT M

Resolution on the Church's Ministry among the Mentally Ill

WHEREAS, approximately 30 million adult Americans suffer from one or more mental disorders, and of these as many as 10 million are afflicted with chronic or prolonged mental illness; and

WHEREAS, approximately 1 percent of this country's population (about 2.5 million) have or will have the disease of schizophrenia, and about 6 percent have or will have a major affective disorder (major depression or manic depression); and

WHEREAS, as many as 12 million children suffer from some form of mental disorder, approximately 3 million of whom have a serious mental illness; and

WHEREAS, approximately 269,300 people within the geographical area served by the Diocese of California suffer or will suffer from a major mental illness; and

WHEREAS, persons with severe mental illness account for between 40-50 of the nation's homeless, and occupy 25 percent of all the hospital beds in the country; and

WHEREAS, the total economic cost to society of the disease of schizophrenia is approximately $61.9 billion, of which $14.4 billion is for direct treatment and support costs; and

WHEREAS, because of ignorance, fear and the perpetuation of myths, mentally ill persons are often stigmatized and discriminated against, in housing, medical insurance and employment opportunitites, and are denied adequately funded community treatment and support services; and

WHEREAS, the families of mentally ill persons are frequently burdened by these illnesses and often serve as the primary caretakers of their loved ones, need-

ing the support and love of friends and church, and yet often feeling abandoned and shunned; and

WHEREAS, the Church is called to engage in Christ's ministry of healing and advocacy on behalf of those who are ill in body, mind and spirit, and those who are discriminated against, lonely unaccepted and neglected; therefore be it

RESOLVED, that this Convention of the Diocese of California calls upon the clergy and people of the Diocese to make themselves knowledgeable of the latest medical and scientific research into mental illness; and be it further

RESOLVED, that the congregations, program groups, and institutions of the Diocese evaluate their ministry among the mentally ill and seek, in ways appropriate to each, a more full and imaginative ministry among this sizable segment of our society; and be it further

RESOLVED, that the Bishop appoint a committee to investigate and assist in supplementing a relevant response on the part of the units of the Diocese to this pressing problem.[1]

Adopted by the 139th Convention of the Episcopal Diocese of California, October 21, 1988. The Bishop has initiated a standing Commission on Mental Illness. The Rev. Richard L. York, 1801 Adeline Street, #203, Oakland, CA 94607 is chairman of this commission.

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[1]"Article #9", NAMI Religious Outreach Network Resource Materials, (np:nd).

SELECTED BIBLIOGRAPHY

I. BOOKS

A. General Reference:

American Psychiatric Association. Diagnostic Criteria from DSM-III-R. Washington, D.C.: American Psychiatric Press, 1987.

Benner, David G., ed. Baker Encyclopedia of Psychology. Grand Rapids: Baker Book House, 1985.

Register, Cheri. Living with Chronic Illness: Days of Patience and Passion. New York: Bantam Books, 1987.

Spitzer, Robert L., Andrew E. Skodol, Miriam Gibbon, and Jane B. W. Williams. DSM-III Casebook: A Learning Companion to the Diagnostic and Statistical Manual of Mental Disorders (Third Edition). Washington, D.C.: American Psychiatric Press, 1981.

Strong, Maggie. Mainstay: For the Well Spouse of the Chronically Ill. New York: Penquin Books, 1988.

Schmidt, Stephen A. Living with Chronic Illness: The Challenge of Adjustment. Minneapolis: Augsburg Publishing House, 1989.

Turnbull, H. Rutherford III, Ann P. Turnbull, G. J. Bronicki, Jean Ann Summers, and Constance Roeder-Gordon. Disability and the Family: A Guide to Decisions for Adulthood. Baltimore: Paul H. Brookes Publishing Co., 1989.

B. Theology:

Bromiley, Geoffrey W., ed. The International Standard Bible Encyclopedia, Vol. 1 & 2. Grand Rapids: William B. Eerdmans Publishing Co., 1979.

Buttrick, George Arthur, ed. The Interpreter's Dictionary of the Bible, Vol. 1. Nashville: Abingdon, 1962.

Dickason, C. Fred. Demon Possession & the Christian. Westchester, IL: Crossway Books, 1987.

Eliade, Mircea, ed. The Encyclopedia of Religion, Vol. 4. New York: Macmillan Publishing Co., 1987.

Geisler, Norman L. The Roots of Evil. Dallas: Probe Books, 1978.

Johnston, Jerry. The Edge of Evil: The Rise of Satanism in North America. Dallas: Word Publishing, 1989,

Koch, Kurt. Occult Bondage and Deliverance. Grand Rapids: Kregel Publications, 1970.

Leahy, Frederick S. Satan Cast Out: A Study in Biblical Demonology. Carlisle, PA: The Banner of Truth Trust, 1975.

Lenski, R. C. H. The Interpretation of St. Matthew's Gospel. Minneapolis: Augsburg Publishing House, 1943.

Lutheran Church Missouri Synod, Board of Social Ministry. Social Ministry Planning Manual. St. Louis: n.p., 1985.

McNeill, John T. A History of the Cure of Souls. New York: Harper and Row, 1951.

Marty, Martin E. Health and Medicine in the Lutheran Tradition. New York: Crossroad, 1983.

Pieper, Francis. Christian Dogmatics, Vol. 1. St. Louis: Concordia Publishing House, 1950.

Scharlemann, Martin H. Healing and Redemption. St. Louis: Concordia Publishing House, 1965.

Schuchardt, Erika. Why Is This Happening to Me? Minneapolis: Augsburg Publishing House, 1989.

Sumrall, Lester. Exorcism: The Reality of Evil and Your Power Over It. Green Forest, AR: New Leaf Press, 1991.

Unger, Merrill F. What Demons Can Do To Saints. Chicago: Moody Press, 1977.

C. Pastoral Care:

Ahlem, Lloyd. Help for Families of the Mentally Ill. St. Louis: Concordia Publishing House, 1983.

American Psychiatric Association. A Mental Illnesses Awareness Guide for Clergy. Washington, D.C.: American Psychiatric Press, 1990.

Bergendoff, Conrad. Pastoral Care for Alcoholism: An Introduction. Center City, MN: Hazelden, 1981.

Bufford, Rodger K. Counseling and the Demonic. Resources for Christian Counseling, ed. Gary Collins, no. 17. Dallas: Word Books, 1988.

Campbell, Alastar V., ed. A Dictionary of Pastoral Care. New York: Crossroad Publishing Co., 1987.

Clebsch, William and Charles Jaekle. Pastoral Care in Historical Perspective. New York: Jason Aronson, 1983.

Clinebell, Howard Jr., ed. Community Mental Health: The Role of Church and Temple. Nashville: Abingdon Press, 1970.

_____. The Mental Health Ministry of the Local Church. Nashville: Abingdon Press, 1972.

_____. Understanding & Counseling the Alcoholic. Nashville: Abingdon, 1968.

Colston, Lowell G. Pastoral Care with Handicapped Persons. Creative Pastoral Care and Counseling Series, ed. Howard J. Clinebell. Philadelphia: Fortress Press, 1978.

Cooper, Ed. When Even The Devil Deserts You. Fort Lauderdale, FL: Dream Again Press, 1992.

Fowler, Ruth. A Stranger in Our Midst: A Congregational Study on Prolnged Mental Illness. St. Louis: Pathways to Promise, 1988.

Friesen, James G. Uncovering the Mystery of MPD. San Bernardino, CA: Here's Life Publishers, 1991.

Fritz, John H. C. Pastoral Theology. St. Louis: Concordia Publishing House, 1945.

Govig, Stewart D. Strong at the Broken Places: Persons with Disabilities and the Church. Louisville: Westminister/John Knox Press, 1989.

Holinger, Paul C. Emotional Disorders: Principles of Diagnosis and Treatment. New York: Irvington Publishers, Inc., 1985.

Hosmer, Jeffrey, and Ruth Drescher. With Cords of Compasssion: Ministry with Persons Affected by Serious Mental Illness. Pittsburg: The Religious Advisory Committee, United Mental Health, Inc. 1992.

Hunter, Rodney J., ed. Dictionary of Pastoral Care and Counseling. Nashville: Abingdon Press, 1990.

Jacobson-Wolf, Joan E. When to Counsel, When to Refer: A Diagnostic Manual for Clergy on Mental Health Referral. Lima, OH: C.S.S. Publishing Co., 1989.

Lane, Melodee. Models of Care: For Persons with a Prolonged Mental Illness. St. Louis: Pathways to Promise, 1988.

Mueller, Norbert H. and George Kraus, eds. Pastoral Theology. St. Louis: Concordia Publishing House, 1990.

Neufeldt, Alfred H., ed. Celebrating Differences. Newton, KS: Faith and Life Press, 1984.

Oates, Wayne E. The Religious Care of the Psychiatric Patient. Philadelphia: Westminister Press, 1978.

Pruyser, Paul W. The Minister As Diagnostician: Personal Problems in Pastoral Perspective. Philadelphia: Westminister Press, 1976.

Schuetze, Armin W. and Irwin J. Habeck. The Shepherd under Christ: A Textbook for Pastoral Theology. Milwaukee: Northwestern Publishing House, 1974.

Shelly, Judith Allen, Sandra D. John and others. Spiritual Dimensions of Mental Health. Downers Grove, IL: InterVarsity Press, 1983.

Shifrin, Jennifer. Developing a Service Project for Persons with Prolonged Mental Illness: a Workbook for Congregations. St. Louis: Pathways to Promise, 1988.

_____. Pathways to Partnership: An Awareness & Resource Guide on Mental Illness. St. Louis: Pathways to Promise, 1990.

The Mental Health Association of Houston and Harris County. The Mental Health Association's Manual for the Clergy: Resources for Helping & Healing. Houston: n.p., 1991.

Welch, Edward T. Counselor's Guide to the Brain and Its Disorders: Knowing the Difference Between Disease and Sin. Grand Rapids: Zondervan Publishing House, 1991.

D. Mental Illness (general):

Alvarado, Yolanda. Mental Illness: A Family Resource Guide. n.p.: State Alliance for the Mentally Ill of Michigan, 1988.

American Psychiatric Association. An Educator's Guide to Mental Illnesses Awareness Programs. Washington, D.C.: American Psychiatric Press, 1991.

AMI-Region II. Word Explosion: Treasures in Poetry & Verse by the Mentally Ill and Their Family Members, Friends, and Professionals. Glenview, IL: AMI-Region II Art Project Committee, 1989.

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

Esser, Aristide H. and Sylvia D. Lacey. Mental Illness: A Homecare Guide. New York: John Wiley & Sons, 1989.

Evans, Katie and J. Michael Sullivan. Dual Diagnosis: Counseling the Mentally Ill Substance Abuser. New York: Guilford Press, 1990.

Garson, Sascha. Out of Our Minds: How to Cope with the Everyday Problems of the Mentallly Ill - A Guide for Patient and Their Families. Buffalo: Prometheus Books, 1986.

Group for the Advancement of Psychiatry, Resident's Guide to Treatment of People With Chronic Mental Illness. Washington, DC: American Psychiatric Press, 1993.

Hatfield, Agnes B. Coping with Mental Illness in the Family. Arlington, VA: National Alliance for the Mentally Ill, 1991.

_____. Family Education in Mental Illness. New York: Guilford Press, 1990.

Hatfield, Agnes B. and Harriet P. Lefley, eds. Families of the Mentally Ill: Coping and Adaption. New York: Guilford Press, 1987.

Isaac, Rael Jean and Virginia C. Armat. Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill. New York: Free Press, 1990.

Johnson, Julie Tallard. Hidden Victims: An Eight-Stage Healing Process for Families and Friends of the Mentally Ill. New York: Doubleday, 1988.

Kalvelage, Joan. Questions & Answers about Tardive Dyskinesia. Arlington, VA: National Alliance for the Mentally Ill, 1981.

Krupnick, Susan L. W. and Andrew J. Wade. Psychiatric Care Planning. Springhouse, PA: Springhouse Corp., 1993.

Liberman, Robert Paul, ed. Psychiatric Rehabilitation of Chronic Mental Patients. Washington, D.C.: American Psychiatric Press, Inc., 1988.

Mace, Nancy L. and Peter V. Rabins. The 36-Hour Day (Revised Edition). Baltimore: Johns Hopkins University Press, 1991.

Marsh, Diane T. Families and Mental Illness: New Directions in Professional Practice. New York: Praeger Publishers, 1992.

Missouri Alliance for the Mentally Ill. Referral Guide for the Mentally Ill. St. Louis: Alliance for the Mentally Ill, n.d.

National Alliance for the Mentally Ill (NAMI). Annotated Reading List, NAMI Book No.4. Arlington, VA: NAMI, 1990.

_____. _____ (Supplement), NAMI Book No. 5. Arlington, VA: NAMI, 1991.

_____. The Experiences of Patients and Families: First Person Accounts, NAMI Publication No. 2. Arlington, VA: NAMI, 1989.

Robins, Lee N. and Darrel A. Regier, eds. Psychiatric Disorders in America: The Epidemiological Catchment Area Study. New York: The Free Press, 1992.

Ronch, Judah L. Alzheimer's Disease: A Practical Guide for Families and Other Caregivers. New York: Continuum Publishing Co., 1991.

St. Louis Metro Alliance for the Mentally Ill. Referral Guide. St. Louis: Alliance for the Mentally Ill, n.d.

Scheifler-Roberts, Patricia and Robert W. Mullaly. Medication Maze. Keene, NH: Intuition Press, 1985.

Taylor, Cecelia Monat. Mereness' Essentials of Psychiatric Nursing, Twelfth Edition. St. Louis: The C. V. Mosby Company, 1986.

Van Buren, Abigail. A Family Affair: Helping Families Cope with Mental Illness. New York: Brunner/Mazel Publishers, 1986.

E. Schizophrenia:

Bisbee, Cynthia Carson and Patricia Scheifler-Roberts. The Nova Program: Hospital Treatment of Chronic Schizoprhenia. Tuscaloosa, AL: n.p., 1985.

Fair, Talitha Day. Lily. Denver: Accent Books, 1982.

Gottesman, Irving I. Schizophrenia Genesis: The Origins of Madness. New York: W. H. Freeman and Co. 1991.

Jeffries, J. J., E. Plummer, M. V. Seeman, and J. F. Thornton. Living and Working with Schizophrenia. Toronto: University of Toronto Press, 1990.

McGlashan, Thomas H. and Christopher J. Keats. Schizophrenia: Treatment Process & Outcome. Washington, D.C.: American Psychiatric Press, Inc., 1989.

Selzer, Michael A., Timothy B. Sullivan, Monica Carsky, and Kenneth G. Terkelsen. Working with the Person with Schizophrenia: The Treatment Alliance. New York: New York University Press, 1989.

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

Walsh, Maryellen. Schizophrenia: Straight Talk for Family and Friends. New York: Warner Books, 1985.

F. Bipolar/Unipolar Depression:

Copeland, Mary Ellen. The Depression Workbook: A Guide for Living with Depression and Manic Depression. Oakland, CA: New Harbinger Publications, Inc., 1992.

Fieve, Ronald R. Moodswing: The Third Revolution in Psychiatary. New York, Bantam Books, 1975,

Goodwin, Frederick K. and Kay Redfield Jamison. Manic Depressive Illness. New York: Oxford University Press, 1990.

Grinspoon, Lester, and James B. Balkalar. The Harvard Medical School Mental Health Review: Depression and Other Mood Disorders. New York: The Harvard Mental Health Letter, 1990.

Papolos, Demitri F. and Janice Papolos. Overcoming Depression. New York: Harper & Row, 1987.

Shimberg, Elaine Fantle. Depression: What Families Should Know. New York: Ballantine Books, 1991.

G. Children:

Hunsucker, Glenn. ADD: Attention Deficit Disorder. Ft. Worth: Forresst Publishing, 1988.

Jordan, Dixie, Paula Goldberg, and Marge Goldberg, eds. A Guidebook for Parents of Children with Emotional or Behavioral Disorders. Minneapolis: Pacer Center, Inc., 1991.

McElroy, Evelyn, ed. Children and Adolescents with Mental Illness: A Parents Guide. Kensington, MD: Woodbine House, 1987.

Peschel, Enid, Richard Peschel, Carol W. Howe, James W. Howe, eds. Neurobiological Disorders in Children and Adolescents, New Directions for Mental Health Services, no. 54. San Francisco: Jossey-Bass Publishers, 1992.

II. JOURNALS, MAGAZINES, PUBLICATIONS

A. General:

Decade of the Brain. NAMI's qtr. publication to highlight medical research and science.

Innovations & Research: In Clinical Services, Community Support, and Rehabilitation. (Published qtr. by NAMI and the Center for Psychiatric Rehabilitation, Sargent College of Allied Health Professions, Boston University.)

Life In Balance. Monthly newsletter of Manic-Depressive and Depressive Association of Metropolitan Detroit.

Lumen. NAMI's ecumencial Religious Outreach Network qtr. publication.

NAMI Advocate. NAMI's monthly national newspaper.

Oakland AMI Update. Monthly newsletter of the Alliance for the Mentally Ill of Michigan-Oakland County.

Pathways Newsletter. Pathways to Promise semiannual newsletter.

The Harvard Mental Health Letter. Published monthly by the Harvard Medical School Health Publications Group.

The Journal of the California Alliance for the Mentally Ill. qtr., (3:4 issue: Religious Outreach).

B. Specific Issues: (Mental Illness)

Church & Society. January/February 1991 (Published by the Social Justice and Peacemaking Unit of the General Assembly, Presbyterian Church (U.S.A.)

The Caregiver Journal. (The College of Chaplains). 8:2

C. Specific Articles:

Aist, Clark S. "Pastoral Care of the Mentally Ill: A Congregational Perspective." The Journal of Pastoral Care 41 (December 1981): 299-310.

Allanach, Robert C. "Schizophrenia Demythologized-The Complexes Personified." The Journal of Pastoral Care 42 (Spring 1988): 62-75.

Anderson, Herbert. "The Congregation: Health Center or Healing Community." Word & World 9 (Spring 1989): 123-131.

Anderson, Robert G. "The Role of the Church in Community Based Care of the Chronically Mentally Disabled: Reclaiming an Historic Ministry." Pastoral Psychology 28 (Fall 1979): 38-52.

_____. "The Assessment of Systems in Promoting Collaborative Aftercare: Religious and Mental Health Organizations in Partnership." The Journal of Pastoral Care 39 (September 1985): 67-83.

_____. and John L. Young. "The Religious Component of Acute Hospital Treatment." Hospital and Community Psychiatry 39 (May 1988): 528-533.

Barnette, Henlee. "The Psychiatric Patient as a Person." Pastoral Psychology 27 (Fall 1978): 39-48.

Beck, James R. and Gordon R. Lewis. "Counseling and the Demoniac: A Reaction to Page." Journal of Psychology and Theology 17 (Summer 1989): 132-134.

Cannon, John M. "Pastoral Care for the Families of the Mentally Ill." The Journal of Pastoral Care 44 (Fall 1990): 213-221.

Caplan, Gerald. "Loss, Stress, and Mental Health." Community Mental Health Journal 26 (February 1990): 27-48.

Carter, Rosalynn. "A Voice for the Voiceless: The Church and the Mentally Ill." Second Opinion 13 (March 1990): 213-221.

Cassell, Eric J. "Recognizing Suffering." Hastings Center Report 21 (May-June 1991): 24-31.

Clayton, Jean. "Let There Be Life: An Approach to Worship with Alzheimer's Patients and Their Friends." The Journal of Pastoral Care 45 (Summer 1991): 177-179.

Council, Raymond J. "Out of the Depths: Pastoral Care to the Severely Depressed." Pastoral Psychology 31 (Fall 1982): 58-64.

DeMarinis, Valerie. "Spiritual, Psychological, and Social Dimensions of Pastoral Care with Patients

and Families in the Home Health Care Context." Pastoral Psychology 37 (Summer 1989): 275-296.

Domino, George. "Clergy's Knowledge of Psychopathology." Journal of Psychology and Theology 18 (Spring 1990): 32-39.

Eimer, Kenneth W. "The Assessment and Treatment of the Religiously Concerned Psychiatric Patient." The Journal of Pastoral Care 43 (Fall 1989): 231-241.

Erickson, Richard C. "Compassion Without Illusion." Journal of Religion and Health 28 (Summer 1989): 109-118.

_____. "Pastoral Care and Counseling With the Chronically Ill." Pastoral Psychology 377 (Fall 1988): 15-24.

_____, David Cutler, Victor Brannon Cowell, and George Dobler. "Serving the Needs of Persons with Chronic Mental Illness: A Neglected Ministry." The Journal of Pastoral Care 44 (Summer 1990):153-162.

Eyer, Richard. "Psychiatry and Pastoral Care in Tandem." Bulletin - American Protestant Hospital Association 46 (Fall 1982): 80-85.

Farley, Wendy. "Natural Suffering, Tragedy, and the Compassion of God." Second Opinion 18 (October 1992): 23-29.

Favassa, Armando R. "Modern Christian Healing of Mental Illness." American Journal of Psychiatry 139 (June 1982): 728-735.

Gottlieb, John F. and Mark Olfson. "Current Referral Practices of Mental Health Care Providers." Hospital and Community Psychiatry 38 (November 1987): 1171-1181.

Govig, Stewart D. "Wilderness Journal: Parental Engagement with Young Adult Mental Illness." Word & World 9 (Spring 1989): 147-153.

Graham, Larry Kent. "Care of Persons, Care of World: Discovering the Prophetic in Ministry to Suffering Persons." Pastoral Psychology 40 (Fall 1991): 15-29.

Holinger, Paul C. "The Severely Emotionally Distressed: A Conceptual Framework and Potential Roles for

Clergy and Church." Pastoral Psychology 27 (Summer 1979): 236-250.

Hunt-Meeks, Swanee. "Pastoral Care and the Psychomaintenance of Chronic Illness." Pastoral Psychology 29 (Summer 1981): 231-243.

Isaacs, T. Craig. "The Possessive States Disroder: The Diagnosis of Demonic Possession." Pastoral Psychology 35 (Summer 1987): 263-273.

Johnson, Eric L. "Sin, Weakness and Psychopathology." Journal of Psychology and Theology 15 (Spring 1987): 218-226.

Koenig, Harold G., Havey Cohen, Dan G. Blazer, Carl Pieper, Keith G. Meador, Frank Shelp, Veeraindar Goli, and Bob DiPasquale. "Religious Coping and Depression Among Elderly, Hospitalized Medically Ill Men." American Journal of Psychiatry 149 (December 1992): 1693-1700.

Linse, Eugene. "Mental Illness: Knocking at the Church Door." Lutheran Witness 108 (September 1989): 10-12.

Lowe, C. Marshall. "The Healing Community: Church and Mental Hospital." Pastoral Psychology 20 (October 1969): 55-59.

Meigs, Thomas J. "Pastoral Care Methods and Demonology in Selected Writings." Journal of Psychology and Theology 5 (Summer 1977): 234-246.

Miller, Judith S. "Mental Illnes and Spiritual Crisis: Implications for Psychiatric Rehabilitation." Psychosocial Rehabilitation Journal 14 (October 1990): 29-47.

Oie, Thomas. "Searching Scripture: Dealing With Mental Illness." Lutheran Witness 108 (September 1989): 17.

Ostow, Mortimer and Betty Cholst. "Unhappiness and Mental Health." New York State Journal of Medicine 74 (June 1974): 984-992.

Page, Sydney H. T. "The Role of Exorcism in Clinical Practice and Pastoral Care." Journal of Psychology and Theology 17 (Summer 1989): 121-131.

_____. "Excorism Revisited: A Response to Beck and Lewis and to Wilson." Journal of Psychology and Theology 17 (Summer 1989): 140-143.

Schmidt, Stephen A. "The Sufferer's Experience: A Journey through Illness." Second Opinion 13 (March 1990): 90-108.

Simundson, Daniel J. "Mental Health in the Bible." Word & World 9 (Spring 1989): 140-146.

Southard, Samuel and Donna Southard. "Demonizing and Mental Illness: The Problem of Identification, Hong Kong." Pastoral Psychology 33(Spring 1985): 173-188.

_____. "Demonizing and Mental Illness (2)The Problem of Assessment: Los Angeles." Pastoral Psychology 34 (Summer 1986): 264-287.

_____ and _____. "Demonizing and Mental Illness (III): Explanations and Treatment, Seoul." Pastoral Psychology 35 (Winter 1986) 132-151.

Swindall, Alan J. "The Impact on the Family of a Chronically Ill Child: A Systems Perspective." The Caregiver Journal 8 (n.d.): 9-17.

Talley, Brenda S. "The Chronically Mentally Ill: Issues of Individual Freedom Versus Societal Neglect." Journal of Community Health Nursing 9 (Spring): 33-41.

Tjeltveit, Alan C. "Psychotherapeutic Triumphalism and Freedom from Mental Illness: Diverse Concepts of Mental Health." Word & World 9 (Spring 1989): 132-139.

Trew, Alberta. "The Religious Factor in Mental Illness." Pastoral Psychology 22 (May 1971): 21-28.

Weiss, Frederic S. "Pastoral Care Planning: A Process-Oriented Approach for Mental Health Ministry." The Journal of Pastoral Care 45 (Fall 1991): 268-278.

Wikstrom, Owe. "Possession as Role-Taking." Journal of Religion and Health 28 (Spring 1989): 26-35.

Wilson, William P. "Demon Possession and Exorcism: A Reaction to Page." Journal of Psychology and Theology 17 (Summer 1989): 135-139.

Woodruff, Roy C. "Pastoral Care of the Discharged Psychiatric Patient." Pastoral Psychology 21 (March 1970): 21-29.

Wright, Scott D., Clara C. Pratt, and Vicki L. Schmall. "Spiritual Support for Caregivers of Dementia Patients." Journal of Religion and Health 24 (Spring 1985): 31-38.

III. PAMPHLETS:

American Psychiatric Association: "Let's Talk Facts About:"
"Anxiety Disorders"
"Childhood Disorders"
"Choosing a Psychiatrist"
"Depression"
"Manic Depresive Disorder"
"Mental Health of the Elderly"
"Mental Illness: There Are a Lot of Troubled People"
"Obsessive-compulsive Disorder"
"Panic Disorder"
"Phobias"
"Post-traumatic Stress Disorder"
"Schizophrenia"
"Substance Abuse"
"Teen Suicide"

Care Notes (Abbey Press):
Bennett, Gary D. "When Someone You Love Has a Mental Illness."
Czillinger, Ken. "When Someone You Love Is Suffering."
Jaffe, Hirshel. "Hanging on to Hope Through a Serious Illness."
Jaffe, Hirshel. "Praying in Times of Depression."
Lord, Janice Harris. "Being a Friend to Someone Who Hurts."
Muto, Susan A. "Journeying Through Loneliness."
Sing, Susan Saint. "Finding God in Pain or Illness."
Weber, Herbert. "Climbing Up From Depression."
Wheeler, Eugenie G. "Finding Strength to Survive a Crisis or Tragedy."

NAMI Medical Information Series:
"Attention Deficit Hyperactivity Disorder in Children"
"Depressive Disorders In Children And Adolescents"
"Mood Disorders: Depression and Manic Depression"
"Panic Disorder"
"Sleep Disorders"
"Tardive Dyskinesia"

IV. VIDEORECORDINGS:

A Place to Come Back To. Produced by Ephphatha Service of The American Lutheran Church. 30 min. Pathways to Promise, 1986. Videocassette.

When The Music Stops: The Reality of Serious Mental Illness. Produced by DuPont Company. 20 min. National Alliance for the Mentally Ill, 1987. Videocassette.