

MENTAL ILLNESS AND FAMILIES OF FAITH

How Congregations Can Respond

Mental Illness and Families of Faith: How Congregations Can Respond is a two DVD set to help educate faith communities about various mental health issues. One in four families sitting in our pews has a family member dealing with a mental illness. Yet many are suffering in silence. Through education, we can erase the stigma associated with these “no fault” illnesses and provide congregations with examples of how they can become supportive and caring communities for individuals and families affected by mental illness.

These eight shows cover a variety of mental health issues. Professionals provide important information about each illness. But mostly you will hear from real people who live with these brain disorders. Each segment presents an issue related to the experience of mental illness, puts a face to the issue and offers a message of hope. The shows are short enough to be used in a variety of settings including classes and small groups. Each segment has a discussion guide with background information, questions for discussion and where to find additional resources.

LIST OF SHOWS

Disk 1

Coming Out of the Dark—Interfaith Introduction (Length: 53 seconds)

Mental Illness in Different Age Groups (Length: 17:39 minutes)

Mental Illness and Families of Faith (Length: 20:50 minutes)

Understanding Depression (Length: 16:31 minutes)

Overcoming Stigma: Finding Hope (Length: 13:13 minutes)

Disk 2

Addiction and Depression (Length: 16:42 minutes)

Anxiety: Overcoming the Fear (Length: 18:49 minutes)

Teenage Depression and Suicide (Length: 14:39 minutes)

Eating Disorders: Wasting Away (Length: 12:58 minutes)

Creating Caring Congregations (Length: 10:39 minutes)

Coming Out of the Dark

(Length: .53 seconds)

This interfaith opening is the signature piece for Mental Health Ministries. It can be used alone or before viewing the other segments.

Mental Illness in Different Age Groups

(Length: 17:39 minutes)

Background

The magnitude of mental illness in this country is staggering. According to the Surgeon General, one in every five Americans experiences a mental disorder in any given year and half of all Americans have such disorders at some time in their lives. These illnesses of the brain affect all of us, regardless of age, gender, economic status or ethnicity. Nearly every person sitting in our pews has been touched in some way by mental illness. And yet individuals and families continue to suffer in silence or stop coming to their place of worship because they are not receiving the support they so desperately need. They become detached from their faith community and their spirituality, which is an important source of healing, wholeness and hope in times of personal darkness.

The sharing of personal stories and experiences provides a way to give voice to those who have suffered in silence, and allows our faith communities to begin the process of reaching out and providing compassionate care to those affected by disorders of the brain.

Three individuals from different age groups share their personal experience with various mental illnesses. Shawn's Story tells of an adolescent's experience with bi-polar depression, addiction and suicidal ideations. Carol's Story is about the most common illness of the brain, clinical depression, with accompanying anxiety issues. Jan's Story highlights how the normal life changes associated with the aging process can lead to depression in older adults.

INTRODUCTION

(Length: 2:36 minutes)

Rev. Art Cribbs gives some background information and commentary as an introduction to this resource.

MENTAL ILLNESS IN ADOLESCENTS AND YOUNG ADULTS: SHAWN'S STORY

(Length: 5:16 minutes)

Background

Just like adults, children and adolescents can have mental health problems that interfere with the way they think, feel and act. Studies show that one in every five young people is affected by mental health issues at any given time and one in ten has a serious emotional disorder. In this segment, Shawn shares some of the ways his bipolar disorder severely disrupted his daily functioning at home, school and with his community of friends.

Because these years can be a confusing and difficult time for many young people, parents, teachers and even health care professionals often do not recognize the life-threatening consequences of untreated mental illness. The stigma of mental health problems keeps many young people from asking for help, resulting in an alarming increase in the rate of suicide and suicide attempts in this age group. Fortunately, there is increased public awareness of mental health issues affecting adolescents and young adults that can help persons get the treatment they need before the symptoms become severe.

QUESTIONS FOR DISCUSSION

1. Shawn has bipolar disorder, which used to be called manic depression. This brain disorder causes a person to cycle over time. There are cycles of elevated or heightened energy (mania), periods of depression, and times when a person's mood is normal. What are the symptoms Shawn talks about? Can you name other symptoms of bipolar depression?
2. Emotional ups and downs are normal among adolescents and young adults. What will help you decide that your emotional issues are within the normal range and when you should reach out for help? Who would you go to with these concerns?
3. Serious brain illnesses often lead to self-medication through alcohol or drugs to ease the very real emotional pain. How could you reach out to a friend or classmate to help them get the treatment they need?
4. Have you ever had thoughts of suicide? What did you do? What would you do if you knew that someone was talking about taking his or her life?

DEPRESSION AND ANXIETY IN ADULTS: CAROL'S STORY

(Length: 6:27 minutes)

Background

Symptoms of depression include a sad, anxious, or empty mood; feelings of hopelessness, guilt, worthlessness, helplessness, and pessimism; loss of interest or pleasure in activities once enjoyed, including sex; insomnia, early morning awakenings, or oversleeping; weight loss or gain; decreased energy; fatigue; difficulty concentrating, remembering, or making decisions; restlessness or irritability; persistent physical symptoms that do not respond to treatment; and thoughts of death or suicide. Women are almost twice as likely to experience depression as men and depression can be associated with the hormonal changes that accompany childbirth or menopause. Sometimes an event can trigger a major depressive episode when a person is already under a lot of stress. Depression and anxiety disorders are very treatable illnesses.

QUESTIONS FOR DISCUSSION

1. Carol experienced a depressive episode with accompanying anxiety when things in her life seemed to be going well. A common reaction to the symptoms of depression is denial. Have there been times in your life when you were suddenly overcome by intense feelings that seemed out of proportion to the actual event? How did you react?

2. If you had many of the symptoms of depression that persisted over time, how likely would you be to reach out for support? Who would you turn to?
3. Stress is a reality of life in today's world. What do you do to take care of yourself?
4. What kinds of support are available in your faith community for persons struggling with a mental illness and their family? What additional sources of care and support would you like to see your congregation offer? How can you help make that happen?

MENTAL ILLNESS AND OLDER ADULTS: JAN'S STORY

(Length: 4:18 minutes)

Background

Depression is the most common emotional disorder in older adults, occurring in about one in seven people over 65. Depression is not an inevitable consequence of aging, but is a common symptom of Parkinson's disease, stroke, arthritis thyroid disorders and cancer. It is often difficult to sort out whether a person is depressed because of illness or because the illness has triggered a chemical change in the brain. Loneliness, isolation and physical limitations can also contribute to depression. Medical intervention is often very effective and appropriate. But being a part of a caring community where each individual is valued as a child of God can help older adults address the spiritual issues of the meaning and purpose of life.

QUESTIONS FOR DISCUSSION

1. Competent and well-intentioned physicians sometimes overlook the signs of late-life depression. Symptoms of dementia, complaints of bodily aches and pains, and feelings of agitation and anxiety can be associated with depression in older adults. What are your feelings about discussing these issues with a health care professional?
2. In our current health care system, it is often necessary to become an advocate for yourself or for others. What would hold you back from seeking the care and support needed? How do you feel about taking medication for depression?
3. What can your faith community do to better serve the homebound or chronically ill members of your congregation?
4. How has your faith helped you deal with issues of meaning and purpose as you have experienced the normal losses that come with the aging process? Are you comfortable with "being" or do you feel your worth depends on your "doing"?

Mental Illness and Families of Faith

(Length: 20:50 minutes)

Background

Surveys show that forty to sixty percent of Americans seeking help with mental health issues turn first to ministers, priests, rabbis, imams and other faith leaders. Unfortunately, the response of clergy and congregations falls significantly short of what parishioners expect of their faith leaders. Mental illness has been called the “no casserole disease.” Individuals struggling with mental illness are less likely to receive the same level of pastoral care as those in the hospital with physical illnesses, those who are dying or those who have long-term illnesses.

There are a number of reasons that the needs of the persons with a mental illness and their families are not being met by many faith communities. Clergy do not receive adequate education about mental illnesses in seminaries. Some faith groups have theologies that associate sin or weakness with mental illnesses instead of seeing them as biochemical illnesses of the brain. Congregations are made up of individuals who mirror the stigma and fear we find in society as a whole. Even if people are aware of the problem, they may not know what to do or say.

Too often families, especially parents, have been wrongfully blamed for mental illness causing them to be burdened by the social stigma that surrounds these brain disorders. The shame and stigma associated with mental illnesses can be as damaging as the illness itself.

Emotional support for the family is essential to deal with the natural feelings of guilt, anger, fear and confusion. Clergy can help by referring the family to a mental health professional or to support groups offered in the community to help make a plan that is best for everyone. The faith community can be a source of spiritual and inner strength for the family. Families need to know that someone understands their pain and that they will have on-going support and care.

QUESTIONS FOR DISCUSSION

The Levens Family

Persons working with youth programs in faith communities are generally no better informed about mental health issues than the clergy. This is unfortunate given the fact that the onset of many mental illnesses is often when someone is an older teen or in their twenties. The response of the faith community around the initial episode will influence the family’s ability to turn to that community in the future.

1. Kelly’s illness triggers questions of faith such as why God would allow her to have this illness and how can she relate to God when she has had thoughts of suicide and self mutilation. How would you help Kelly work through these faith issues?

2. How can a congregation provide support over the long run when a family is coping with the unpredictable nature of a chronic mental illness? How can support groups outside the faith community be of help?
3. What are some ways that the rabbi could have been more helpful to the Levens family when Rachael told him of Kelly's initial hospitalization?
4. Kelly found comfort in the familiar prayers and worship services at her synagogue. What role can one's faith play in the healing and recovery process? How did Kelly find strength and hope in the traditions and beliefs of her faith?

Bob and Donna's Story

1. Bob struggles with bipolar or manic depression that can result in erratic mood swings and behaviors. What additional stresses can living with a chronic illness have on a marriage and other family relations?
2. Bob and Donna felt support from clergy and lay members of their church because persons in their faith community were open to sharing their stories and struggles with mental illness. How did this openness help them feel supported?
3. Bob and Donna have been active in the ministries of their faith community. How can faith communities be intentional in including those with a mental illness into the life of the congregation?
4. How does a sense of belonging and a perspective of hope affect the physical, mental, emotional, social and spiritual health of the entire family?

Understanding Depression

(Length: 16.31 minutes)

Background

A depressive illness is a “whole-body” illness, involving the body, mood, thoughts, and behavior. It is not just a passing blue mood. It is also not a sign of personal weakness or a condition that can be wished away. Depressive illnesses may be associated with an imbalance of chemicals in the brain, negative life experiences, other medical illnesses, medications, certain personality traits and genetic factors. With the effective medications and therapies available today, most people, including those with the most severe forms, can improve significantly.

The economic and social costs of untreated depression are staggering. Mental health conditions are the second leading cause of workplace absenteeism. Untreated and mistreated mental illness costs the United States \$150 billion in lost productivity each year.

Yet early diagnosis and appropriate treatment reduces overall costs by reducing hospitalizations, medical expenses, and disability. There are several different types of depressive illnesses including major depression, dysthymia (a milder, chronic form of depression) and bipolar disorder. Depression can often co-occur with other illnesses. Symptoms of depression can include:

- Persistent sad, anxious, or “empty” mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities once enjoyed, including sex
- Insomnia, early-morning awakenings, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Decreased energy, fatigue
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Difficulty concentrating, remembering, making decisions
- Persistent physical symptoms that do not respond to treatments, such as headaches, digestive disorders, and chronic pain

Bipolar Disorder

Bipolar disorder is a treatable illness marked by extreme changes in mood, thoughts, energy and behavior. It is also known as manic depression because a person’s mood can alternate between mania (highs) and depression (lows). Bipolar affects more than two million adult Americans and often begins in late adolescence.

There are different types of bipolar disorder determined by the patterns and severity of the symptoms. Bipolar I is the most severe form of this illness and is marked by extreme manic episodes. Bipolar II disorder is characterized as one or more depressive episodes accompanied by at least one hypomanic episode. The hypomanic episodes are less severe. Cyclothymic disorder is characterized by chronic fluctuating moods with periods of hypomania and depression. With cyclothymic disorder, the symptoms of both depressive and hypomanic symptoms are shorter and less severe. Symptoms of bipolar disorder can include.

- Excessively “high” mood
- Irritability
- Decreased need for sleep
- Increased energy and activity
- Increased talking, moving, and sexual activity
- Racing thoughts
- Disturbed ability to make decisions
- Grandiose notions
- Being easily distracted

QUESTIONS FOR DISCUSSION

1. What are some of the symptoms of major depression? How long do these symptoms need to last in order to qualify as a medical illness?
2. Name the three types of depression?
3. How did Luis’ depression affect his ability to work? What are some things you can do to overcome stigma in the workplace?
4. What are some of the stressors that led to Luis’s depression? How do you handle the major stressors in your life?
5. Why do you think a person with a depressive illness would consider suicide?
6. What are some of the hurtful things said to persons who are experiencing depression?
7. What are some of the new treatments available today that bring hope to persons struggling with these illnesses?
8. How can a person’s spirituality be a source of hope and strength when going through a difficult time?
9. How open, informed and caring is your faith community towards persons with a mental illness and their families? What steps could your congregation take to be a more welcoming and supportive community?

Overcoming Stigma: Finding Hope

(Length: 13.13 minutes)

Background

Mental illnesses are very common but they are also widely misunderstood. People with a mental illness are often stigmatized because of fear and ignorance. In American society, ex-prisoners stand higher on the ladder of acceptance than people with mental illness. When asked to rank twenty-one categories of disabilities from the least offensive to the most, mental illness was placed at the bottom of the list.

Many people believe that mental illnesses are a sign of personal weakness or a moral or spiritual weakness. These attitudes prevent persons from reaching out to get the care, treatment and support that can help them live a full life.

The U.S. Surgeon General's Report on Mental Health (1999) states; Stigma assumes many forms, both subtle and overt. It appears as prejudice and discrimination, fear, distrust, and stereotyping. It prompts many people to avoid working, socializing, and living with people who have a mental disorder. Stigma impedes people from seeking help for fear of confidentiality of their diagnosis or treatment will be breached. For our nation to reduce the burden of mental illness, to improve access to care, and to achieve urgently needed knowledge about the brain, mind and behavior, stigma must no longer be tolerated.

People of faith have the opportunity, and responsibility, to model appropriate language when speaking about persons with a mental illness. The language we use can compound the stigma and misconceptions about mental illness or it can educate persons and help reduce the stigma and shame associated with these illnesses of the brain. We can challenge stigmatizing images found in TV, film, print or other media. Words like "crazy", "psycho", "looney", "nuts" or other demeaning terms are not only hurtful, they are not accurate.

The language we use should reflect our belief in the dignity of each individual and that we are all created in the image and likeness of a loving God. It is important to use "people first language." We need to refer to people as the persons they are and not the illness they have. Instead of referring to people as "the mentally ill," we need to say, "A person who has a mental illness." Just as we don't refer to someone as "the cancer person," appropriate language helps to dispel misinformation about various forms of mental illness. There will be less stigma and discrimination when we achieve health parity and mental illness is treated the same as any physical illness.

QUESTIONS FOR DISCUSSION

1. How comfortable would you be to discuss a mental health issue at work? How would such a disclosure be received by persons in authority and by your co-workers?
2. Many persons keep their mental illness a secret because of the stigma and the fear of reactions from family, friends and co-workers. How does keeping silent about one's mental illness affect a person's ability to get help? Do you think this adds additional stress?

3. Our country is facing a crisis in access to health care. Do you believe that mental health care should be treated the same as any physical illness? What are some of the reasons given in opposition to providing mental health care parity?
4. What are some of the major issues in funding mental health care in your community, your city or your state? How can you or your faith community get involved in advocating for access to mental health treatment programs?
5. Richard Danford states that stigma first comes from fear because we fear what we do not understand. What fears do you have about persons with a mental illness?
6. Danford goes on to say that our society perpetuates the myth that persons with a mental illness are inherently dangerous. What can you share that would support or refute this idea?
7. The other assumption held by many people is that people with mental illnesses are inherently incompetent. Do you know of persons with a mental illness who are leading near normal lives? Share those stories.
8. Just as faith communities need to be educated about mental illness, so medical providers need to recognize the importance of incorporating a person's spirituality into the healing and recovery process. In your own experience with the medical profession, has your spirituality or faith perspective been part of your treatment plan?
9. Dr. Ewing tells how our culture has developed the idea that there is something wrong with pain, especially emotional pain. A different perspective is that the pain we experience may be one path to making important changes in our lives that can lead to a deeper connection to God. Do you believe that acknowledging our brokenness helps or hinders our spiritual journey?

Addiction and Depression

(Length: 16.42 minutes)

Background

Adults and adolescents are often first referred to treatment for alcohol and drug abuse. Studies show that more than half of the persons with a substance abuse diagnosis also have a diagnosable mental illness. But they are often not referred to a qualified mental health professional for appropriate diagnosis and treatment of the underlying cause of their addictive behaviors. Many persons use addictive behaviors as a way of self-medicating themselves for the pain associated with mental illnesses such as depression.

When a person suffers from both a mental illness and an addiction, they have a “dual diagnosis.” Unfortunately, the programs that treat people with brain disorders often do not treat individuals with active substance abuse. And programs for substance abusers are not geared for people with a mental illness. Consequently, many persons get caught in this treatment or services gap. Mental health and addiction counselors increasingly believe that brain disorders and substance abuse disorders are biologically and physiologically based. But the spiritual component is also a key to recovery and healing.

Susan, Jose and David share their stories of struggling with addiction and depression.

QUESTIONS FOR DISCUSSION

1. Dr. Clark Smith describes the “vicious cycle” of addiction and depression that often leads to denial and even thoughts of suicide. What are some of the underlying reasons of how addiction is linked to depression?
2. David discovered that he had the symptoms of depression while he was sober. What are some of the signs and symptoms of depression? Why do so many addicted persons contemplate suicide?
3. Susan, Jose and David share how early childhood trauma relates to their symptoms of depression in adulthood. How do our childhood experiences affect our feelings of worth, acceptance and trust?
4. Dr. Smith lists three characteristics of what it takes to recover from addiction. The first is the courage and willingness to make change. How do fear, shame and denial prevent us from taking the risk to make changes in our life?
5. How does rigorous honesty and speaking the truth about ourselves and our situation affect recovery?
6. The third key to recovery listed by Dr. Smith is a “spiritual awakening.” Letting go of the illusion that we are in control is the basis of self-help groups like Alcoholics Anonymous. What function does the community play in this type of support group? What can faith communities learn from this model?

Alcoholics Anonymous

www.alcoholics-anonymous.org (for meetings in your area)

Nar-Anon

www.nar-anon.org (for meetings in your area)

Anxiety: Overcoming the Fear

(Length: 18.49 minutes)

Background

More than 19 million Americans suffer from anxiety disorders. These disorders are much more than the stress that results from the fast pace of life today. Often the feeling of panic, fear or physical discomfort arises without warning. People with an anxiety disorder may understand that their reactions aren't logical, but they cannot control them. There is a high success rate by treating the symptoms of anxiety with medication and therapy.

Anxiety disorders fall into five main categories: Panic Disorder, Phobias, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, and Generalized Anxiety Disorder. Each of these disorders interferes with a person's life and work.

A Panic Disorder is primarily defined as a panic attack when the body sends out various warning signals such as pounding heart, chest pains, sweating, shortness of breath, sensations of choking, fear of losing control and even a fear of dying. Because these attacks occur suddenly with no logical cause, people think they are having a heart attack or other medical emergency.

A Phobia is a deep-seated fear that is irrational, distressing and disruptive to a person's life. The person may have a specific phobia such as a fear of confined spaces or a fear of heights. A social phobia is the fear of being watched, embarrassed or humiliated while doing something in public. A common form of social phobia is the fear of public speaking. Agoraphobia is the fear of places or situations from which escape might be difficult, such as being in a crowd or standing in line. In severe cases, untreated agoraphobia can keep a person from leaving his or her home.

A person with Obsessive-Compulsive Disorder (OCD) finds that his or her life is consumed by obsessions that cannot be controlled. To combat these obsessions, the person with OCD engages in repetitive rituals such as constant hand washing, checking and rechecking or following rigid procedural rules that have no realistic connection to whether the unwanted event happens.

Some people, who survive a disaster such as a fire, earthquake or war or a very traumatic experience such as a rape, death of a loved one or sexual abuse, will experience the same physical symptoms that they felt at the time of the incident. Often there is a triggering event for Post-Traumatic Stress Disorder (PTSD) that causes the event to replay over and over in their minds. Nightmares, flashbacks and physical discomfort are common.

Generalized Anxiety Disorder (GAD) occurs when individuals experience persistent feelings of exaggerated worry and tension that are unfounded or unrelenting. They may worry constantly about their health, loved ones, finances or jobs, even when there appears to be no reason to do so. Often people with GAD have additional mental health problems such as depression, another anxiety disorder, or a substance abuse disorder.

QUESTIONS FOR DISCUSSION

1. What are some of the causes of anxiety disorders?
2. How did anxiety affect Steven's life? Have you ever had anxiety or phobias that interfered with your life? Explain, as you are comfortable.
3. What is the difference between normal anxiety in social situations and social anxiety?
4. What are some of the physical symptoms associated with anxiety disorders? What are the emotional feelings connected with the physical symptoms?
5. Why do people with anxiety disorders pull back from social situations? How does this affect the person with the disorder and his or her relationships with others? How can your faith community offer care and support to such persons?
6. How are anxiety disorders and depression related?
7. What are some treatment options available for anxiety disorders?
8. How are trust and fear related? How can a person's faith be a source of hope?

RESOURCES ON ANXIETY DISORDERS

Anxiety Disorders Association of America
www.adaa.org

Freedom From Fear
www.freedomfromfear.com

Obsessive-Compulsive Foundation
www.ocfoundation.org

Teenage Depression and Suicide

(Length: 14.39 minutes)

Background

Adolescent depression is increasing at an alarming rate. Recent surveys indicate that as many as one in five teens suffers from clinical depression. But many teens are not diagnosed or treated for their underlying depression. This is partly due to the fact that depression can be difficult to diagnose in teens because many of the behaviors are seen as “normal” for the age. Also, adolescents do not always understand or express their feelings very well. The adolescent and his or her parents may not be aware of the symptoms of depression and may not seek help.

Depression can take several forms, including bipolar disorder (formally called manic-depression), which is a condition that alternates between periods of euphoria and depression. Teens may experiment with drugs or alcohol or become sexually promiscuous to avoid feelings of depression. They may also express their feelings through hostile, aggressive, or risk-taking behavior. But such behaviors only lead to new problems, deeper levels of depression and destroyed relationships with family, friends, law enforcement or school officials.

Symptoms of Depression

- Poor performance in school
- Withdrawal from friends and activities
- Sadness and hopelessness
- Lack of enthusiasm, energy or motivation
- Anger and rage
- Overreaction to criticism of being unable to satisfy ideals
- Poor self-esteem or guilt
- Indecision, lack of concentration or forgetfulness
- Restlessness and agitation
- Suicidal thoughts or actions
- Changes in eating or sleeping patterns
- Substance abuse
- Problems with authority

Sometimes teens feel so depressed that they consider ending their lives. Studies show that suicide attempts among young people may be based on long-standing problems triggered by a specific event. Often suicidal adolescents view a temporary situation as a permanent condition. Feelings of anger and resentment combined with exaggerated guilt can lead to impulsive, self-destructive acts. Four out of five teens who attempt suicide have given clear warnings.

Warning Signs of Suicidal Feelings

- Suicide threats, direct and indirect
- Obsession with death
- Poems, essays and drawings that refer to death
- Dramatic change in personality or appearance
- Irrational, bizarre behavior
- Overwhelming sense of guilt, shame or rejection
- Changed eating or sleeping patterns
- Severe drop in school performance
- Giving away belongings

QUESTIONS FOR DISCUSSION

1. Debbie shares about her self-mutilation, her family history of mental illness, and her own suicide attempts. What are some of the reasons Debbie gives for her actions?
2. What are some of the symptoms of depression that Debbie describes? Name some of her distorted thought patterns.
3. Dr. Chenvin stresses the importance of parents receiving education on how to deal with their teenager's depression and sometimes getting help in dealing with their own depression. What are some of the warning signs that Kathy describes before the suicide of her son?
4. What can you do if someone you know has the warning signs for suicide? Would you be comfortable telling someone? If so, whom?
5. How does your faith community view suicide? What can be done to provide support and understanding for attempters and survivors of suicide in your congregation?
6. How do your faith traditions and practices speak to finding hope even in the midst of our darkest times?

Eating Disorders: Wasting Away

(Length: 12:58 minutes)

Background

We are bombarded with media images of the ideal body image and diet products are a huge business in this country. While it is healthy to watch what we eat and to get enough exercise, people with eating disorders do harm to their bodies because of their obsession about their weight. Approximately ten million people in the United States have an eating disorder.

Research shows that more than 90 percent of those who have eating disorders are women between the ages of 12 and 25 (National Alliance for the Mentally Ill, 2003). However, increasing numbers of older women and men have these disorders. In addition, hundreds of thousands of boys are affected by these disorders (U.S. DHHS Office on Women's Health, 2000). More people die of eating disorders than any other mental illness.

There are three main types of eating disorders: anorexia nervosa, bulimia nervosa and binge eating.

Symptoms of Eating Disorders

- Anorexia nervosa—People who have anorexia develop unusual eating habits such as avoiding food and meals, picking out a few foods and eating them in small amounts, weighing their food, and counting the calories of everything they eat. Also, they may exercise excessively.
- Bulimia nervosa—People who have bulimia eat an excessive amount of food in a single episode and almost immediately make themselves vomit or use laxatives or diuretics (water pills) to get rid of the food in their bodies. This behavior often is referred to as the “binge/purge” cycle. Like people with anorexia, people with bulimia have an intense fear of gaining weight.
- Binge-eating disorder—People with this recently recognized disorder have frequent episodes of compulsive overeating, but unlike those with bulimia, they do not purge their bodies of food (NIMH, 2002). During these food binges, they often eat alone and very quickly, regardless of whether they feel hungry or full. They often feel shame or guilt over their actions. Unlike anorexia and bulimia, binge-eating disorder occurs almost as often in men as in women (National Eating Disorders Association, 2002).

Possible Warning Signs of Anorexia and Bulimia

- Unnatural concern about body weight
- Obsession with calories, fat grams and food
- Use of any medicines to keep from gaining weight (diet pills, laxatives, water pills)

More Serious Warning Signs (often kept secret)

- Throwing up after meals
- Refusing to eat or lying about amount eaten
- Fainting
- Over-exercising

- Not having periods
- Increased anxiety about weight
- Calluses or scars on knuckle (from throwing up)
- Denying that there is anything wrong

QUESTIONS FOR DISCUSSION

1. Serious side effects of eating disorders include osteoporosis, long-term infertility, low potassium levels that lead to heart problems, and suicide. Eating disorders are often linked to depression. Why do you think there is a strong link between depression and eating disorders?
2. What are some of the feelings and behaviors that led up to Neely's serious eating disorder?
3. Christine shares how a casual remark made by her father about her legs triggered a distorted body image. What are some of the social pressures that would cause her to say, "I was willing to die for my eating disorder?"
4. What are some ways that parents can model love, acceptance and support? What are some behaviors that are not helpful?
5. Parents often avoid seeking professional help because of guilt or the fear that they will be blamed for the behavior. Why is this a wrong assumption?
6. We need to learn to live in the paradox of trying to control behaviors and the need to let go. How do you live out these two opposites in your own life?
7. The Scriptures tell us that we are made in the image of God. Michelangelo in "The Creation of Adam" from the Sistine chapel portrays this so beautifully. And yet, advertising, the media, destructive websites and our country's obsession with dieting tell us that we are not good enough. How do we learn to accept a healthier body image for ourselves?
8. Neely's mother says that when people have addictive behaviors, "usually there is a hole inside them they're trying to fill." How can we use our spirituality to fill that hole?

RESOURCES ON EATING DISORDERS

American Anorexia/Bulimia Association, Inc.
www.aabainc.org

Anorexia Nervosa and Related Eating Disorders, Inc.
www.anred.com

National Assoc. of Anorexia and Associated Disorders
www.anad.org

National Eating Disorders Association (NEDA)
www.nationaleatingdisorders.org

Creating Caring Congregations

(Length 10:39 minutes)

Background

Creating Caring Congregations - Five Step Program

There are many ways that congregations can begin or expand a ministry to and with persons with a mental illness and their families. The Caring Congregations model uses a five step approach. These five steps include education, covenant or commitment, welcome, support and advocacy.

These steps are not linear. Rather the process of becoming a caring congregation is dynamic and unique to each community. Some congregations have developed models of ministry unique to the needs of their community. Hopefully our faith communities will become involved in an ongoing process of education, commitment, welcome, and support. We all need to be advocates for a just mental health delivery system.

1. Education

The first step in creating caring congregations is education. This begins with the leadership of the church. If the ministers, priests, amams and rabbis do not educate themselves, they will not be able to recognize the symptoms and make appropriate referrals to counselors and psychiatrists. This is often made more difficult because many religious leaders are hiding their own struggle with mental illness from the hierarchy of their religious organization. As clergy leave the ministry in record numbers, we can no longer ignore the mental health needs of our clergy and their families.

There are many ways to begin an education program with a congregation. Here are a few examples:

- Invite a speaker or offer a workshop to teach people that mental illnesses are brain disorders.
- Get educational material and referral information from groups like the National Alliance on Mental Illness (NAMI), the Depression Bipolar Support Alliance (DBSA), Mental Health America (MHA) and SAMHSA.
- Use bulletin inserts and newsletters to educate about serious mental illness especially during Mental Health Month in May and Mental Illness Awareness Week in October.
- Offer a health fair and include education about different mental illnesses.

2. Commitment (Covenant)

The second step in becoming a caring congregation is covenant or commitment. This means that the church leadership commits to be intentional in seeking ways to become a caring congregation. It is often a concerned lay person who initiates this process because pastors are so overwhelmed with other responsibilities.

Most successful programs have come from “the bottom up.” Because of the many demands on our clergy, few initiate such a ministry. But lay persons can collaborate with the church leadership to form a task force to look at ways their community can provide education about mental illness.

When mental health provider groups establish programs for persons with mental illness, the church is often left out. Part of covenant involves networking, collaborating and partnering with community based groups to educate them about what the faith communities have to offer in support of persons and families living with mental illness.

- Involve the clergy and other leadership groups in developing a task force to assess the needs of your congregation.
- Adopt a statement stating our congregation's commitment to this ministry.

3. Welcome

The third step of welcome involves seeking ways to integrate persons with a mental illness into the faith community. Often we distance ourselves from those persons most in need of a welcoming community. We send money to help survivors of natural disasters and other global concerns...which is very much needed. But welcoming and hospitality require us to reach out to persons in a way that allows for the mutual exchange of joys and concerns. When we take the time to really get to know another person, the barriers between "us" and "them" break down.

Welcoming persons with a mental illness involves seeking ways to integrate them into the faith community. When we practice hospitality, God can use our faithfulness in surprising ways.

- Provide training for ushers and greeters to be welcoming and supportive of all persons. Some communities have trained persons to act as "companions" to accompany a person to worship, to talk or simply to help them find a quiet place to rest.
- Invite persons with a mental illness to participate as they are willing and able...acting as a liturgist, being part of a group.
- Include persons with a mental illness in prayers, liturgies and sermon illustrations
- Partner with organizations in your area like the Ecumenical or Interfaith Council to identify persons who would need a ride to a faith community of their choice. This often results in congregations helping the person with housing, employment, transportation to medical appointments and practicing important social skills.

4. Support

We are brought up to be strong, self-sufficient and independent people. It is hard to ask for help and so often keep our struggles hidden. But God wants us to care for one another – and allow others to care for us in our time of need. We are called to "bear one another's burdens." (Galatians 6:2)

There are many ways to provide support to persons with a mental illness and their families.

- Train mentors through programs like Stephen Ministry, parish nurses and other volunteers.
- Have a referral list of mental health services in your community.
- Offer a support group or invite outside groups like your local NAMI affiliates "Family to Family" program to use your facilities.
- Provide counseling services through a sliding scale or voucher program.
- Involve members in programs to provide meals or housing.

- Make prayer quilts, comfort pillows or care baskets to take to persons who are in the hospital, residential facility or who do not come to worship due to their illness, to let them know they are not forgotten.
- Find ways to reach out and support family members.

5. Advocacy

The spirit of the Lord God is upon me, because the Lord has anointed me to bring good tidings to the afflicted; He has sent me to bind up the brokenhearted, to proclaim liberty to the captives, and the opening of the prison to those who are bound. —Isaiah 61:1

The mental health delivery system in this country is broken. There is a lack of resources and a lack of continuity in treating mental illness. People with a mental illness too often get caught in a “revolving door” health care system. This is especially true for persons who use the public health system for treatment. Mental illness is a justice issue involving such basic human rights as access to medical care, stable and supportive housing, and job training. Once a congregation has developed a mental health ministry, a natural next step is to be involved in advocacy.

Here are some ways which you can make a difference:

- Keep informed on pending legislation about mental illness.
- Attend workshops and conferences
- Contact your elected representatives or visit them as a group
- Support candidates working on mental health issues
- Keep in contact with advocacy groups like NAMI (National Alliance on Mental Illness, DBSA (Depression and Bipolar Support Alliance, and MHA (Mental Health America).
- Participate in community events such as NAMI Walks.
- Partner with other organizations for community events about mental illness. The community needs to be educated about the important role a person’s faith can play in the treatment and recovery process.

QUESTIONS FOR DISCUSSION

1. What are some of your perceptions and fears about persons with mental illness?
2. One in four families in your own congregations deal with mental illness. How has your faith community been affected by mental illness issues?
3. Given the unique gifts and graces of your congregation, how would you suggest beginning or expanding a ministry to and with persons with a mental illness and their families?
4. What are some of your church’s strengths that will assist you in developing and implementing a mental health ministry?
5. How would your congregation and community benefit from an outreach to, or inclusion of, persons with mental illness and their families into your faith community?
6. What are the major obstacles and challenges that would keep you from achieving this goal?

CLOSING PRAYER

Spirit God, you know our needs
 our wounds
 our hurts
 our fears
Even before we can form them
 into words of prayer.

You are patient with us.
You are protective of us.
You are present with us
 until such time that we are able
 to ask for what we need.

Thank you, Spirit God,
 for your healing taking place within
 before we are even aware
 of how broken we have become.

Susan Gregg-Schroeder

For More Information

American Association of Pastoral Counselors
www.aapc.org

Congregational Resource Guide
www.congregationalresources.org/mentalhealth.asp

Depression and Bipolar Support Alliance (DBSA)
www.dbsalliance.org

Families USA - Faith Based Resource Center
www.familiesusa.org

Mental Health America
www.mentalhealthamerica.net

Mental Health Ministries
www.MentalHealthMinistries.net

National Alliance on Mental Illness (NAMI)
www.nami.org

NAMI FaithNet
www.nami.org/faithnet

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

Pathways to Promise
www.pathways2promise.org

SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center)
www.promoteacceptance.samhsa.gov

Credits

MAJOR FUNDING FOR THIS RESOURCE PROVIDED BY:

General Board of Church and Society of the United Methodist Church

ADDITIONAL FUNDING PROVIDED BY:

The Bonnie R. and William H. Kinschner Foundation
California-Pacific Conference of the United Methodist Church
The James Irvine Foundation
San Diego Georgia Lynch Foundation
Juanita Gordon
Jean Wright-Elson
John and Sue Hays
Gisele Foundation
Friends of Pacific Media Ministry

PRODUCED AND DIRECTED BY

Rev. Susan Gregg-Schroeder

Production services and authoring provided by Dan Wagner and Mario Barnabe

Graphic design by Jennifer Smith

Study guide formatting by John Imel

“Coming Out of the Dark” from the CD “Into the Light.” Written and performed by Gloria Estafan, Estefan Music Publishing, Copyright 1990, All rights reserved.

“Let This Be Our Prayer” from the CD “Modim—We Give Thanks” performed by Cantor Alisa Pomerantz-Boro, Copyright 2002, Modim Music, All rights reserved.

Closed Captioning provided by CaptionMax

Copyright 2008 Mental Health Ministries
All rights reserved