

FAITH IN RECOVERY
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A Mental Health Ministry in Faith Communities

VISION

The VISION in Faith in Recovery is the belief that spirituality plays an important role in faith communities to support individuals and family members dealing with mental illness. This provides the courage, persistence, optimism and role models that enable a person to participate as fully as they desire in community life.

MISSION

The MISSION in Faith in Recovery is to assist individuals and families to develop mental health ministries in faith communities of all religious traditions. These ministries provide education and support in ways that emphasize a mind-body-spirit understanding of mental illness and decrease stigma.

SCOPE

Mental illness afflicts people and families of every faith tradition. To date, Faith in Recovery has dealt with Christian traditions but we believe that the methods for developing a mental health ministry can be uniquely shaped to conform to each faith's own culture, tradition, music, images, liturgy and spiritual role models. When this occurs we will welcome any additions or modifications to the tool kit or web site that reflect these experiences.

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FAITH IN RECOVERY

A Mental Health Ministry for Faith Communities

HISTORICAL OVERVIEW

This is a story told on behalf of others who have collaborated over the past five or more years to develop and implement a model for initiating mental health ministries in faith communities. While our experience has been in several Catholic, United Methodist and Presbyterian churches, our intent and hope has been, and is, ecumenical.

When it comes to religion, mental illness is an equal opportunity event that afflicts one in four or five families in every faith denomination. Over half of these people either do not seek or cannot obtain treatment. Sometimes this is due to stigma or fear of discrimination but it is also the result of a national health policy that under funds or fails to provide health insurance that covers mental illness in the same way as medical conditions. This is despite the fact that major psychiatric disorders are now known to have genetically determined biochemical causes similar to medical conditions like hypertension and diabetes.

As State and Federal funding sources continue to discriminate against people with mental illness, health care facilities are restricting or eliminating their treatment programs for people with mental illness. A program that fails to generate profit is seldom considered viable. The administrators of our not for profit corporations are proud to affirm the slogan, "No margin, no mission."

The potential role of faith communities in supporting people and families dealing with mental illness is obvious and increasing. The tool kit we have developed describes how this can be accomplished and is available to anyone wishing to start a ministry.

Spirituality, Faith and Mental Illness: An Overview

The role of spirituality, in whatever faith tradition, has a long and variable history similar to Jesus' ministry of miracles that included the "casting out of demons." During the nineteenth century, the Quakers in England began "moral" treatment as the organizing principle of institutional care. Dorothea Dix promoted the model in America where hospitals for people with mental illness were often co-administered by clergy and physicians. This led to humane and considerate conditions, certainly an improvement on earlier asylums and prisons where those with mental illness had previously been hidden from the world and often subjected to barbaric and ineffective treatments. But as time progressed, conditions in these institutions began to deteriorate once more. During World War II, Quaker and Mennonite conscientious objectors that shunned military service were assigned to work in state mental institutions. They began to discover and expose the "snake pit" conditions they encountered and their efforts led to the founding of the National Institute of Mental health.

The discovery of the first effective medications, beginning with Thorazine in the mid-nineteen fifties, provided the tools to change all this. Soon, people benefited sufficiently to be discharged from institutions back into the community where they all too often discontinued their medication, relapsed and were readmitted—the so called revolving door syndrome. Unfortunately, the financial savings from closing hospitals were often diverted elsewhere and seldom ploughed back into community support programs.

For most of the remainder of the twentieth century, the spiritual dimension took a back seat to scientific hopes of a complete cure. Mental health professionals developed a reputation for religious skepticism that often shaded into agnosticism or even atheism. Whatever spiritual support had existed in the earlier institutional settings did not follow people into the community where stigma and discrimination flourished even, sadly enough, in faith communities.

This mid-twentieth century parting of the ways between medicine and spirituality in the treatment of mental illness was similar in many ways to the Enlightenment of the eighteenth and nineteenth centuries. During that historical period discoveries and developments in science and philosophy promoted reason over faith, challenging core religious beliefs. But just as a more mature spirituality eventually reunited science with faith, so has there been a recent recognition that medical and spiritual factors are both vital to well being in mental illness.

Two developments contributed to this shift in emphasis, one medical the other spiritual, coinciding in time over the last ten to fifteen years. A whole new generation of medications began to appear with broader therapeutic properties and fewer side effects. These enabled people to live much fuller and more productive lives. Almost simultaneously the *Procovery* concept developed, pioneered by Katherine Crowley. This describes an individual's unique adaptation to illness that allows the person to live a satisfying, hopeful and contributory life despite any limitations of their disorder. *Procovery* encourages people to view themselves as valuable members of a community rather than being disabled or handicapped. This invites them to be more open about their illness and to share their talents with the community, both of which have powerful effects in reducing stigma and discrimination.

Central to the *Procovery* process is a person's hopeful, optimistic attitude and a courageous commitment that focuses on strengths. This is fueled by grace. Pat Deegan, a consumer herself has described it as:

The birth of hope called forth by the possibility of being loved. All of the polemic and technology of psychiatry, social work and science cannot account for this phenomenon of hope. But those of us who have recovered know this grace is real. We lived it. It is our shared secret.
(Quoted in *A Conceptual Model of Recovery* by Nora Jacobsen, July, 2000).

For those individuals with spiritual beliefs this grace is found in their relationship with the Divine and is nurtured by their faith community.

Unlike much of traditional ministry based on the "charity" model, *Procovery*-based programs seek to avoid "doing to" people with mental illness. Instead they embrace "doing with." Essential to the Procovery concept and the role of faith is empowerment of the individual dealing with mental illness. Full partnership in the community and its liturgical life is the goal. When those with and without mental illness regard one another as equals, stigma and discrimination are eliminated.

The tool kit includes a spirituality for mental illness (p. 7) as well as an integrated spiritual and medical approach (p. 10). The British author Susan Howatch has written nine novels that describe the interplay of spiritual and psychological forces including three that deal with the role of healing ministries in the Church. She recently made the following statement during an interview that discusses this aspect of her work. It summarizes the core philosophy of Faith in Recovery.

...you know how some doctors just think of people as bodies, and some ministers just think of people as spirits. But when you get the two together, you have a much better chance of healing. You can be healed but not cured; it's not necessarily about being cured. You can have a healing of the spirit, even if the illness is not curable; a better quality of life and a better, sort of restful emotional attitude. (A Conversation with Susan Howatch in "TheHeartbraker", p.502)

The National Scene

Attention to the spiritual aspects of mental illness began to appear in the last decade of the twentieth century in the form of books, organizations and individuals. In 1995, a Mennonite psychiatrist and an adult education specialist published *No Longer Alone* exploring the boundaries between spirituality and mental illness with a scriptural basis for community action. At about this time, an interfaith group of fourteen agencies in St. Louis combined to form *Pathways to Promise*, an organization that publishes training manuals, videotapes and other scriptural materials for faith communities interested in developing programs for people and families dealing with mental illness. In 1997, they conducted a national survey that found 142 faith communities throughout America with mental health ministries. There were programs in 33 states and Wisconsin had four.

In 1997, the National Alliance for the Mentally Ill published a scripture-based curriculum for adult study, *Creating a Circle of Caring: The Church and the Mentally Ill*. In 1999, a professor of religion at a Lutheran University published *In the Shadow of our Steeples* for families dealing with mental illness in the parish. In the same year, Russell Shorto charted the course of interest in spirituality within the mental health field in his book *Saints and Madmen; Psychiatry Opens its Doors to Religion*. He mentions the Milwaukee Behavioral Health Division as leaders in that movement.

The Milwaukee Scene

Around 1995, the Milwaukee County Behavioral Health Division began to pay attention to the spiritual dimension of the *Procovery* process. People on the inpatient units were offered the opportunity to participate in non-denominational spirituality groups co-led by a mental health professional and a hospital chaplain.

The success of the groups led to a regional conference in 2002 cosponsored by the Behavioral Health Division and the Mental Health Association of Milwaukee (MHA). By this time it was clear that the success of the hospital-based groups had affirmed the significance of people's faith lives in the *Procovery* process. The obvious challenge was how to extend the concept into our faith communities to support people and family members dealing with mental illness after they left the hospital.

From Hospital to Faith Community

The challenge of translating the role of spirituality in recovery from hospital to faith community is influenced and complicated by several factors.

People in hospital are clearly identified as having a mental illness. Back in the faith community, individuals often prefer to remain anonymous to protect themselves from stigma and discrimination. People discharged home from a mental hospital are less likely to contact their minister than those recently admitted to hospital with a physical disability. As a family member said at the *Building Bridges* national conference, "*Mental illness is a 'no casserole' disease. When you have other illnesses, congregations reach out—not always with mental illness.*"

Secondly, in hospital, everyone is fully informed about mental illness, its treatment and the *Procovery* concept. Most people in the faith community know very little about these topics.

Finally, in a government funded public institution, spiritual groups must be non-denominational and uniform. In the faith community each ministry is free to pursue its own unique culture and faith tradition.

SPIRITUALITY AND MENTAL ILLNESS

Faith represents our personal experience of the Divine. It is mediated by the gift of spirituality or, as the Hebrew Bible says, our "knowledge of things not seen."

Spirituality is that part of each person that is beyond body and mind and which defines our relationship with the Divine, a higher power or whatever is transcendent in human existence. It is a common thread that unites monotheism (Islam, Judaism, Christianity), polytheism (Hinduism) and non-deistic philosophies (Buddhism). Spirituality reaches beyond the self and the solid world in search of meaning and purpose.

There is no easy definition of how individuals tap into a personal awareness of transcendence. There are many different ways so that it is like blind people groping various parts of an elephant. Because there is so little shared experience, accepted wisdom or agreement, the topic is seldom spoken about in lay circles. It feels private, personal and too confusing to share.

It may be easier to state what spirituality is *not*. It is not organized religion nor is it confined to a particular faith or theistic tradition although rituals and liturgy sometimes facilitate access to the Divine. But there are diverse pathways of human experience through which to cross the threshold to the transcendent.

In this poem, *Seek and Find*, each stanza portrays a potential opening available to some but not all. The last stanza makes clear that however hard we try, and often this is too hard, access to the Divine is a gift and not a goal.

SEEK AND FIND

Man may find God
In anxious prayer
Or maybe not.

Man may find God
In gracious faces
Or maybe not.

Man may find God
In glorious nature
Or maybe not.

Man may find God
In pious churches
Or maybe not.

Man may find God
In tedious work
Or maybe not.

Man may find God
In obvious places
Or maybe not.

*God will find man
Somewhere he searches
And never not.*

Spirituality is often equated with meditation or contemplative prayer. For some gifted individuals this path can lead to ecstatic peak experiences of union with the Divine. But it requires special gifts – an ability to totally silence the inner mind and the capacity for unconditional attachment in a loving union. These are qualities some people lack or find difficult.

This poem *Late Harvest* illustrates some of the difficulties that can impede communion with the Divine.

LATE HARVEST

Prayer is a want
God plants at birth,
But unmet needs,
A drought of love
Force weeds to grow.

Our haste to speak,
Our introspection,
Our must control,
Our self perfection,
Our lack of trust:

These faults that nip
The buds of faith
Yield no crops: just
Silence between
God and us.

Despite these doubts,
We will keep vigil.
Divine seeds sprout
What God has sown
God means to reap.

The tranquility necessary for a contemplative spiritual life may ask too much of a mind distracted by inner voices, obsessional thoughts or attention deficits. Intimacy may be incompatible with the unearned bruises of childhood due to emotional, physical or

sexual abuse or the flashbacks of adult post-traumatic stress. Unconditional love may be unattainable for those whose depression has temporarily deprived them of that capacity.

But the poem ends on an optimistic note. God's promise will be fulfilled—there are many ways to access the Divine that may be better suited to a ministry of mental illness. In third world countries individualism takes a back seat to community. "*I am because we are,*" expresses a vital shift in focus from the personal to the communal. In this framework the primary fruit of spiritual growth is compassion, expressed in a community context.

Faith in Recovery places its emphasis on support groups made up of people with mental illness, family members and advocates, with or without experience of mental illness. The spiritual focus and source of faith is the *Golden Rule*, loving one's neighbor as oneself. This ethic is shared by all the major religions.

So the name, Faith in Recovery reflects both our mission and our source of spiritual renewal. Faith fuels the recovery of those battling mental illness by providing the hope, courage, persistence and optimism that helps people achieve their personal goals despite any challenges imposed by the illness. Simultaneously, all those who participate in the ministry are nourished spiritually and find their faith refreshed when they see God in others, sharing the tribulations and triumphs of their brethren.

Our spirituality evolves and our faith deepens as sharing and trust develop over time in each support group. It manifests itself in many different ways:

- It permits sharing experiences that decrease stigma.
- It facilitates support that alleviates suffering.
- It unveils the whole person, distinct from their mental illness.
- It normalizes the experience of illness, stifling shame.
- It encourages affirmation and acceptance that breed courage and confidence.
- It allows mentors to model healthy choices.
- It provides friends in times of crisis.
- It is a forum for information exchange.
- It enables members to observe each other's progress and well-being.
- It offers an atmosphere in which prayer and bible study deepen understanding.
- And much, much more!

AN INTEGRATED MEDICAL AND SPIRITUAL APPROACH TO MENTAL ILLNESS

If we believe that spiritual factors can enhance recovery from serious mental illness and we aspire to offer a ministry of faith to those dealing with such disorders then it should be consistent with the best medical and spiritual practices.

Serious mental illness is an equal opportunity disorder that affects one in five families of every faith. This essay is written in the context of the Christian tradition but its intent is inclusive and its content may be freely adapted to other faith traditions.

When we assume responsibility for coping with our illnesses we come to rely not only on our personal gifts and religious role models but also on the medical and spiritual models of the culture in which we live.

These models are intellectual frameworks on which contemporary ideas are draped to yield portraits of reality. Like fashion, models change over time and people often differ about how attractive or accurate they are.

Medical Models

Before medicine became a science Hippocrates advised, "first do no harm." Despite this axiom physicians in the Middle Ages treated medical and mental illness with cupping, bleeding, purging and an assortment of violent remedies intended to counter the presumed causes of sickness and madness such as wandering wombs, unbalanced humors and sexual excess. In the nineteenth century well-intentioned "moral treatments" confined the insane in rural asylums often co-administered by ministers and doctors. But kindness was not a cure and these institutions evolved into early twentieth century "snake pits."

During the first two thirds of the twentieth century, science began to assert itself with fruitful new discoveries. Anesthesia, x-rays, antibiotics and effective medicines ushered in an era when causes of disease became clearer and cure more common. Brain research revealed that severe mental disorders were based on chemical imbalances, often genetically determined and similar to medical conditions like diabetes and high blood pressure. In psychiatry, the earliest treatments including electroshock, insulin coma, amphetamines and barbiturates offered hope to some but harm to others.

These powerful new treatments spawned a different medical model which valued cure over comfort. Impressed by its interventions the medical profession came to expect that technology would triumph over every illness. In mental health more effective drugs appeared and asylums began to empty out. But cruel side effects, inhospitable communities and lack of funding conspired to create revolving doors to institutions and homelessness on the streets.

In the last quarter of a century a new medical model evolved, as the limitations of technology became clearer. In contrast to the idea that physical causes and cures were the end all and be all of treating disorders, this model suggested that social and psychological factors often contributed an important role in response to illness and recovery.

People with identical disease can be sick in very different ways. Some people with a common cold stay home for comfort while others with the same virus and runny nose go to work and give it to their colleagues. Sudden chest pain causes some people to call an ambulance while others exercise to see if the pain is real. Once admitted to a cardiac care unit some people demand to go home and others are paralyzed with fear in spite of having the same physical findings.

In the last fifteen years this new bio-psycho-social model has expanded to include spiritual factors. A relationship with the Divine, prayer, contemplation and spiritual support have all become accepted as making contributions to the equation of how a person deals with their afflictions.

Spiritual Models

Because medical models reflect the science of their time they differ in accuracy, popularity and durability. By contrast spiritual models derive largely from faith and are less influenced by reason and science. They are more stable and slower to evolve.

For most of the last two millennia, mental and physical illnesses were often attributed to sin and were to be redeemed by faith and repentance. Even after the Enlightenment of the nineteenth century, Christian Scientists and many Protestant fundamentalists shunned medical explanations and interventions. It is true that some disorders are aggravated by unwise lifestyles but most serious medical and mental disorders are due mainly to genetic and environmental factors. Both spiritual and physical factors need attention.

In historical terms it is only relatively recently that medical and spiritual models have united in a common understanding of how physical and spiritual influences often interact in understanding and dealing with illness.

In serious mental illness, medicines with broader efficacy and fewer side effects now provide tools to control disorders of brain chemistry and restore thinking, feeling and behavior to normal. *Procovery* stresses how important spiritual factors are in a person's adaptation to their mental illness. It is faith that provides the courage, optimism and endurance to overcome limitations in order to be an active participant in the full life of the community. This in turn is a powerful force in reducing stigma and discrimination as people with and without mental illness mingle as equals.

Synthesis

We need not wait for miracles to face the challenge of mental illness. Contemporary medical and spiritual models encourage us to combine all our spiritual, psychological, social and physical resources to embrace and overcome our illnesses. In doing so faith offers role models to follow and resources to cope. When we choose to face the world with optimism and courage, embrace or challenge our disability and are able to speak of it in public, stigma and discrimination often fade away.

ENGAGING A FAITH COMMUNITY

Not every faith community is equally interested in or prepared to make a commitment to a mental health ministry. There are a number of steps that may help obtain support and ensure viability. We have developed a brochure about Faith in Recovery that is included in the front pocket of the cover of this tool kit and describes our mission and vision. Some of the steps to setting up a ministry are as follows:

- Seek the endorsement of the clergy. Although the primary energy and effort must come from the members of the community, support of the clergy is important. The interest/sophistication of the minister varies. Some have degrees in counseling or social work and others have personal experience with mental illness themselves or through family members. This may affect willingness to preach from the pulpit on the topic or to stand behind the ministry. Others have different ministerial or social priorities with realistic demands on their time—especially in faith traditions with a priest shortage. Look for aspects of a ministry that might appeal to the minister. Will the project satisfy unmet needs in the congregation? The presence of a support group often relieves the parish staff of a responsibility. Will the program build bridges to neighboring faith communities? Some Faith in Recovery programs operate as a collaboration between neighboring parishes. While support of the clergy is valuable, the success of a ministry is not a "top down" matter. Rather it springs from the grass roots upward and outward through the faith community.
- Identify a few people with mental illness or family members who can be champions for the ministry and who will own it. It helps if these individuals endorse the *Procovery* outlook or are members of NAMI.
- Obtain the endorsement of key leadership and committees in the community such as Social Concerns, Justice and Peace, the Parish Council or Health Committee including the Parish Nurse if there is one.

- Sponsor an initial educational program designed to attract as large an audience as possible. The most frequent topic requested is about depression and suicide prevention—almost every faith community has had to deal with the suicide of one of its members in recent memory—often, tragically, an adolescent. It is important and very valuable that the presentation includes at least one person with personal experience of mental illness either as a speaker or to answer questions about the role of faith in their own recovery. A person telling their story is a powerful encouragement for others to come forward.
- At the initial educational program explain what a ministry might look like and be sure to seek feedback about people's perceived needs and interest in participating. A written feedback form allows individuals to declare an interest in private (p. 30).
- Another way to begin a ministry and identify interested people is to hold a healing service in which someone with mental illness can participate in the liturgy and testify about faith in their own recovery.
- Based on the response to this initial program and feedback create a team of five or more people to meet regularly including as many people as possible with personal experience of mental illness. A critical mass is important to avoid burnout. This often develops into a support group and can also plan future educational programs.
- If desired Faith in Recovery will assign someone to be a guardian angel in the early stages of development. This person will ensure that the community is linked to the resources of the parent Faith in Recovery program and provide assistance from other existing ministries.
- Explore if the parish or any of its committees can provide modest resources to support expenses such as copying for bulletin inserts, handouts, announcements or small stipends for speakers.
- While there are some common features of a mental health ministry and we provide a tool kit to help develop one, this apparent “*how to*” emphasis does not do justice to one prominent aspect of our shared experience. That is the diverse and unique way in which each individual ministry evolves, reflecting the charisms of its members and the work of the spirit.

SUPPORT GROUPS

Purpose

As mentioned in *The Spirituality of Mental Illness* (p. 7), support groups provide the main forum for a ministry to explore and develop the faith lives of its members so that each person can fully experience the way in which spirituality provides the courage, optimism and strength to lead a fulfilling life and encourage others to do likewise. How this process can be facilitated is described below in Guidelines for Sharing.

Development and Composition of Groups

The initial educational programs, bulletin inserts and word of mouth serve to identify those who seek and may benefit from a support group. The speed with which this happens varies and membership is diverse. It can take many months for a group to coalesce.

Group members can include people with mental illness, family members, parish nurses, ministers, mental health professionals and interested parishioners. This mix has a normalizing influence when those with and without mental illness mingle around a common purpose. It promotes mutual respect and stifles stigma. As a group evolves members explore ways to provide mutual support in times of crisis and how to share information about community resources.

Setting the Ground Rules for the Group

At the first meeting people should discuss and agree on the ground rules. These can include:

- What is the purpose of the group? Review and discuss the Guidelines for Sharing.
- Define what you share in common and what you hope to achieve.
- How often will you meet, where and for how long?
- Discuss the importance of confidentiality, what this means and how you will respect it.
- Do people understand and agree with the *Procovery* concept—the importance of discovering, developing and supporting each other's strengths and coping capabilities. How will this lead toward fuller participation in parish and community life? If you have questions or concerns consider reading Kathleen Crowley's book (see reading list, p. 33)

- Select someone who agrees to serve as the group's facilitator. A facilitator acts out of caring, not superior knowledge. This may be someone with a mental illness, a family member, a religious person, an advocate or a mental health professional. The only credential is that the person be secure in their own spirituality and the role that faith can play in mental illness.

The Role of Facilitator

- Make sure regular meetings are scheduled and someone is designated to remind members by phone before each meeting. Keep a list of everyone who wishes to attend with his or her phone number.
- Review the Guidelines for Sharing initially and remind people of them whenever necessary.
- Bring the meeting to an end in a timely way. Inquire if people have any brief concluding comment about what has taken place. End with communal prayer. This might be the Our Father, a favorite prayer of a group member or petitions for individuals.
- While there is no formal training to be a facilitator it may help to attend one or more of the existing Faith in Recovery groups to get a feel for the ways in which they are run. Call the contact person listed under Resources (p. 38) or visit our web site.

Guidelines for Sharing in Support Groups

- Listen carefully to one another. Try not to interrupt.
- The main purpose is not to resolve difficulties or even to offer advice but to listen, support and comfort each other, guided by the spirit. This includes facilitators, professionals or "experts" who sometimes feel coaxed to "problem solve". Any wisdom that emerges comes from the group.
- Participants either speak in turn at random or may pass the baton to someone who has not yet spoken. Allow each person time and opportunity to express himself or herself before anyone speaks twice.
- It is all right to stay silent or request a pass. Silence can be as much a gift as speech.
- Share feelings as well as thoughts, including personal insights or prayer experiences. Try to use "I" statements when possible.
- Confidentiality is maintained

Variations in Format

In addition to sharing and support some groups make use of other formats particularly in the early stages of forming a group. This can include inviting speakers on topics of interest, holding a healing service, showing videotapes or reading a selected book, perhaps one chapter at a time (for example about *Procovery*). If members wish to pursue a more faith sharing method based on scripture or spiritual reflections they may consider the *Lectio Divina* or African Method described under Resources (p. 32) Groups may decide to hold an occasional social event, for example a picnic, tailgate party, sporting event or visit to a restaurant for a shared meal.

Logistics

- *Refreshments*: Some groups encourage members to bring light snacks, cookies or sodas, for example.
- *Location*: Groups usually meet in rooms on church property, which is a symbolic reminder of attachment to the larger faith community, but there is no reason why meetings cannot be held in a member's home.
- *Frequency/Duration*: Each group sets its own timetables with regard to duration of each meeting (usually about 90 minutes) and the frequency (anywhere from weekly to monthly). The timing may vary to suit people's differing needs. For example, a group may choose to alternate between an evening meeting one week and a meeting between, before or after a church service on another week. There is no limit to the number of sessions—they continue as long as members are interested. Not everyone attends every meeting. Some groups choose to take a break at holiday or vacation times but some holidays, Christmas for example, can be especially stressful and members may choose to continue meeting.
- *Educational Programs*: All Faith in Recovery ministries try to put on twice-yearly educational programs (May and October) for the whole church community. These can be planned either by the entire group or by a smaller subcommittee with input from everybody.
- *Boundary Issues*: Support groups are not *therapy*, there is no *expert* and the purpose is not to *cure* those who participate. People are often concerned about liability issues and fear of being sued, particularly if it involves medical treatment. For this reason, it is important to define the boundary between support and medical intervention. Because major mental illnesses are biochemical brain disorders, we recognize that both spiritual support and medicine are powerful complimentary forces that enable people with mental illness to lead a productive life. Group members support and encourage each other to obtain and make appropriate use of mental health services but do not provide medical advice, treatment or therapy. Support and encouragement can include helping someone who is having suicidal thoughts or neglecting their treatment obtain immediate help.

RESOURCES

Educational Programs

Discrimination and stigma are based on attitudes that derive in part from lack of knowledge about mental illness, its causes, effects and treatment. Simply presenting the facts in a calm, neutral setting provides a forum in which people dealing with mental illness can begin to get to know one another and feel more comfortable talking about themselves and their illnesses. This is facilitated if there is also a person who can talk about their own mental illness and the role played by faith in their own recovery. Often it is not just the formal presentations but the opportunity to mingle, ask questions and share experiences afterwards that creates a stronger sense of community that ignites a ministry. Providing hospitality and seeking feedback facilitate this process.

This section includes examples of announcements (p. 27), potential topics and programs (p. 18) as well as examples of two talks, Mental Illness 101 (p.19) and Depression and Suicide Prevention (p. 24).

While each parish has gone about this in its own way, there are two times in the year when educational programs are especially appropriate. May is Mental Health Awareness Month and October has Mental Illness Awareness Week. This is coupled with National Depression Screening Day. Using these occasions to present programs emphasizes the scope and commonality of mental health issues. Find out who the mental health professionals are in your parish and if they are willing to speak—nurses, social workers, psychologists and psychiatrists. Sr. Ann Catherine's email address (see Resources, (p. 38) has people's own stories of mental illness, several of whom may be willing to take part in a program. You can also contact the Faith in Recovery office for assistance.

While education is an important starting point and serves to spread the word through the faith community, education alone does not defeat stigma. Mark Twain had a wonderful aphorism, "You can't throw an attitude out the window; you have to coast it down the steps one stair at a time."

This is why we need to start and sustain mental health ministries in as many faith communities as possible in order to defeat stigma and discrimination.

Potential Topics For Twice Yearly Informational Programs

To be provided in Mental Health Awareness Month (May) And Mental Illness Awareness Week (October)

- Depression and Suicide: Dark nights of the Soul
- Mental Illness 101: Basics for a Faith Community
- Childhood Emotional Disorders
- Schizophrenia and Psychotic Disorders
- Mood Disorders: anxiety, depression, bipolar
- Creating a Caring Community (videotape)
- Suicide Prevention
- Alzheimer's Disease
- Dealing with Loss (Death, Divorce, Unemployment)
- Caring for the Elderly
- Coping with Everyday Stress
- Abuse and Post Traumatic Stress
- Alcohol and Drug Dependence

Finding Speakers

Not every speaker has to be an expert—having consumers tell their stories is very powerful. (See Sr. Ann Catherine's email address under Resources for suggestions p. 38). Find out who the mental health professionals are in your own parish and if they are willing to speak—nurses, social workers, psychologists and psychiatrists. Ask for help from NAMI or the MHA -see Resources (p. 38).

Sample Talks

Mental Illness 101

Overview

Until the turn of the twentieth century only two types of mental illness were recognized; dementia affecting the elderly (what we now call Alzheimer's Disease) and all other disorders affecting younger people which were lumped together. There were no effective treatments; people were incarcerated, often for life, in prisons or insane asylums and theories of causation were primitive. They often blamed either the person suffering from the disorder or their parents for faulty upbringing. Many considered that mental illness was due to a character defect or to some sin such as excessive masturbation.

As a result, several faith communities began to express their concern and to advocate for moral treatment. Begun by the Quakers in England in the nineteenth century, this idea was advanced in America by a Unitarian, Dorothea Dix. Noting that many people with mental illness were in prisons, she campaigned to build large asylums in rural areas throughout the United States. When the Federal government declined to provide land the responsibility fell to the states and local government where it mostly remains today. These large institutions became self-sufficient communities, often with farms of their own, co-administered by clergy and physicians. The goal was to socialize and morally perfect people back to normality. One Protestant chaplain, Anton Boisen, who suffered psychotic episodes himself, realized the link between his recovery and his spiritual life and went on to become a founder of Clinical Pastoral education programs.

Despite some successes, moral treatment in huge asylums was largely a failure. People segregated from a real life began to lose their skills and social contacts, developing what was called institutional neurosis. Asylums degenerated into "snake pits" of the kind portrayed in *One Flew over the Cuckoo's Nest*.

The modern history of mental illness and its successful treatment is the story of the twentieth century. It exists within memory beginning about 1900 and evolving alongside the plane, car and television. A new profession of psychiatry began to make distinctions among different disorders describing schizophrenia and manic-depressive disorder.

In the mid nineteen fifties, the first effective drug treatments began to be discovered by chance or serendipity. A French anesthetist noticed that the drug he was using to sedate people before surgery had an unusually long calming effect. It was Thorazine, the first medicine used to treat psychosis. A few years later a physician treating patients for tuberculosis noticed that the drug he was using made them less depressed. It was then found to alter enzymes in the brain that influence mood.

The idea that serious mental illness might be brain disorders began to take firm hold, supported by scientific discoveries in brain imaging and neurochemistry that revealed abnormalities in areas of the brain that control thinking and mood. Some of these

disorders were also found to have a hereditary component. Anybody who has used caffeine, nicotine or alcohol knows that chemical substances can profoundly alter how we think, feel or behave over the short term. In fact many young people in the early stages of their mental illness self-medicate their symptoms in this way and develop co-occurring substance abuse disorders. Fortunately the newer psychotropic medications produce longer lasting changes in brain chemistry without causing addiction.

Discoveries in brain chemistry coincided with the increasing awareness of the inadequacy of institutional care. During World War II, over 3,000 Methodists, Quakers and Mennonites who refused to bear arms were assigned to mental hospitals and began to advocate for more humane conditions. The reform movement they started led to the foundation of the National Institute of Mental Health in Washington, DC. The availability of effective medications and concern for the civil rights of individuals to live in community began a rapid process known as de-institutionalization. Between 1970 and 1990, the number of people with mental illness in hospitals and the number of hospital beds fell by over fifty percent. Today almost everybody with a serious mental illness is able to live at home or in the community.

This picture remains far from perfect for several reasons. When hospitals closed, saving states considerable dollars, the funds were often diverted to other causes and did not follow people into the community to provide the services necessary to keep them out of hospitals. There were inadequate case management services and insufficient housing options. This resulted in three phenomena: homelessness (one-third of that population have a mental illness), repeated readmissions to hospitals (called the revolving door), and incarceration in prison, often for minor offenses. (Currently over 275,000 people with severe mental illness are in prison or jail—more than are in hospital beds.)

These problems were contributed to by the fact that many of the earlier medications were less than ideal. People often experienced serious side effects of a kind that interfered with their quality of life, encouraging them to stop taking the drugs. These included Parkinsonism, excessive sedation, seizures, interference with sexual function and weight gain. Not surprisingly many people decide that it is better to risk a recurrence of their illness than have their quality of life seriously infringed. Unfortunately, the symptoms of serious mental disorder can include loss of ability to self-monitor one's own illness. This lack of self awareness can lead to a recurrence.

A final reason that things are still less than ideal relates to health insurance which often still covers only physical illnesses despite evidence that mental illnesses are biological disorders, just like hypertension and diabetes.

The next chapter in this story is still being written. Now that scientists have unraveled the human genome, the pharmaceutical industry is designing newer medications, which are far more specific and have fewer side effects than those discovered by chance. Insurance parity for mental illness is now becoming available in many States. Successful lawsuits are being brought against insurance companies that deny coverage for brain disorders. Finally, we have moved from building segregated asylums in far-away places to welcoming people back into their community.

Facts About Major Mental Illness

It is important to distinguish between what are often called serious and persistent mental illnesses and the more common less severe conditions that afflict the worried well. The latter include the grief, worry, anxiety or sadness, which almost everybody experiences from time to time, especially as a result of changes in life circumstance or stress.

Severe and persistent mental disorders are different. Like hypertension and diabetes there is often a family history, they may begin early in life and although they can fluctuate in severity and even go into remission they have a strong tendency to recur over a lifetime. Also, like other physical disorders, they can be made worse by stress but they often occur without any obvious provocation. A major difficulty created by these disorders is that they frequently disrupt the normal development of a person's life producing all kinds of secondary social and economic consequences.

Because the illnesses often begin in adolescence or early adult life they can interfere with emancipation from parents, education, work and social life including marriage and child rearing. Mental illnesses lack health insurance and are expensive to treat; creating added financial burdens on families and reducing access to the private medical sector.

The burden of coping with a member who has a mental illness is considerable and can easily overwhelm a family especially if stigma and discrimination lead to fear of reaching out to others for support.

Altogether, about 25 million individuals suffer from severe and persistent mental illness in the United States. This means that one in every four or five families is affected. The three major categories of disorder in the population are Schizophrenia (3%), Mood Disorders (9%) and Anxiety Disorder (13%).

A second term that it is important to understand is *psychosis*. This means a loss of contact with reality and it can occur in both severe forms of schizophrenia and mood disorders. Psychosis results in two kinds of symptoms, *hallucinations* (seeing or hearing things that do not exist) and *delusions* (false beliefs). Those who saw *A Beautiful Mind* will remember how John Nash had a roommate nobody else saw and believed he was a government spy.

Schizophrenia

Schizophrenia is not a split personality. Instead the term refers to a loss of integration between the three functions of the mind: thinking, feeling and behavior. It often results in a person experiencing bizarre or unpredictable thoughts, moods or actions. Most symptoms begin between the ages of 17 and 30. Medication is the major treatment method and benefits over two thirds of people with the diagnosis. Because there are many forms of the condition, probably based on different abnormal genes, some people may benefit from one medication and not another. Susceptibility to particular side effects may also differ, so trial and error to find the best medication is often necessary. Just over a third of people may experience a relapse while taking the medicine, perhaps

due to stress. The relapse rate can be reduced to below ten percent by involving families in treatment and by skills training for the individual. The earlier treatment starts the more helpful it is.

Mood Disorder

This category includes people who only have episodes of severe depression (Major Depression), and much less often those who have both abnormal highs (mania) and depression. (Manic Depression or Bipolar Disorder.)

About 1 in 10 people experience a significant mood disorder in their lifetime and as many as 15% commit suicide. They are one of the most common, most fatal disorders in the population. Mood disorders occur for the first time most often between the ages of 25 and 35 although even young children and the elderly may suffer. Each episode usually lasts up to six months if untreated, but repeat episodes during a lifetime are quite common. A serious loss or disappointment often triggers them.

Symptoms of mania include excessive laughter, spending, sexuality, talkativeness and loss of sleep. Symptoms of depression include profound sadness, persistent loss of appetite, sleep, sex drive, energy and concentration with feelings of guilt or worthlessness. Over 80% of people recover completely with treatment which can include both medication and several different kinds of therapy designed to change depressive thought patterns or behaviors.

Anxiety Disorders

About 1 in 12 adults suffer from these disorders which include panic, post-traumatic stress and obsessive compulsive disorder. These disorders are common in the early to middle adult years and many go unrecognized because they mimic physical conditions. Anxiety affects the body in many different ways causing palpitations, diarrhea, dizziness, muscle tension (including headaches) or fatigue. People often worry about seemingly minor issues and live in a state of constant apprehension or fear which can lead them to avoid social activities and become housebound (Agoraphobia). Episodes are often triggered by environmental events, particularly in post-traumatic stress, by reminders or flashbacks of previous threat, harm or abuse. In obsessive compulsive disorder the fears are often associated with elaborate rituals designed to protect the person from contamination.

Treatment is often very successful and includes several different forms of therapy, which encourage people to confront and overcome their irrational fears by challenging their assumptions, behaviors or thought patterns. Medications can help in this process but have in the past been overused leading to dependency or addiction to drugs like Valium.

Faith in Recovery

Throughout history people of faith have been involved in ways to help persons dealing with mental illness. This included *moral treatment*, initially segregating people, followed

later by de-institutionalization, which returned them to their larger communities. The time is now ripe for a third phase, which includes reintegration with a person's faith community to facilitate recovery.

The *Procovery* Process

For most people *recovery* implies complete relief from a disorder and a return to complete normality. But disorders like schizophrenia, severe depression, bipolar disorder and post-traumatic stress are often recurrent and lifelong causing severe disruption of educational, occupational and social development. For people with these disorders *Procovery* has come to have a very special meaning. It describes an individual's unique adaptation to illness that allows the person to lead a satisfying, hopeful and contributory life despite any limitations due to the disorder. *Procovery* encourages people to view themselves as valuable members of a community rather than being disabled or handicapped. It allows them to be more open about their illness and to share their talents with the community. The recent advances in treatment and public understanding of mental illness have opened the door wider to these possibilities.

Central to the *Procovery* process is a person's adoption of a hopeful, optimistic attitude and a commitment to personal change that focuses on strengths. This is fueled by grace. Pat Deegan, a consumer herself has described it as,

The birth of hope called forth by the possibility of being loved. All the polemic and technology of psychiatry, social work and science cannot account for this phenomenon of hope. But those of us who have recovered know this grace is real. We lived it. It is our shared secret.
(Quoted in *A Conceptual Model of Recovery*, by Nora Jacobsen, July 2000).

For those individuals with religious beliefs this grace is found within their faith and nurtured within their faith community. Prayer, support and medication become powerful adjuncts, not alternatives. Neither prayer alone or medication alone can cure severe mental illness.

Faith and its Impact on Illness

There have been several research studies about the spiritual lives of people coping with mental illness. At least 80% report they are spiritual and half consider themselves deeply religious. Over nine out of ten people use some form of religious coping strategy to help deal with their illness including prayer, scripture, worship, meditation, religious music or meeting with a spiritual leader. Three quarters or more report that religion helped relieve the burden of illness and brought relief as a source of support, love or confidence. Work, medication, friends and spiritual practices were all-important and contribute to successful adjustment. Religion and spirituality also help to prevent suicide, depression, and drug and alcohol abuse.

Faith in Recovery and the Faith Community

Unlike much of traditional healing and pastoral ministry the community response seeks to avoid “doing to ” people with mental illness and embraces “doing with.” Essential to the *Procovery* concept and the role of faith is empowerment of the individual dealing with mental illness. Full partnership in the community and its liturgical life is the goal. To eliminate stigma and discrimination requires that those with and without mental illness regard one another as equals.

A Faith Based Response To Depression And Suicide

What is our Goal?

To recognize the medical illness or brain disorder called depression and learn how to avoid its consequences, including suicide.

Why should we know this?

- Depression is the world's leading cause of disability from the age of five on and claims more life-years lost than war, cancer and AIDS combined. Depression affects 5- 10% of the population and is increasing in all age groups. Up to 15% of people with severe depression commit suicide and many more attempt it.
- Depression affects 1 in 10 adolescents. Most do not get help and are at risk for school failure, social isolation, sexual promiscuity and drug or alcohol abuse. Seven out of 100 kill themselves and suicide is the third most common cause of death from ages 10 to 24.
- Depression and suicide risk often go unrecognized. In adults people often complain of physical symptoms and in adolescence symptoms are mistaken for normal moodiness or falsely viewed as personal weakness. Stigma in society towards mental illness encourages a conspiracy of silence.
- Depression is a treatable illness. Modern research shows that almost everyone recovers completely from the underlying chemical imbalance with medication and counseling. Medications are not perfect. Some have side effects and all can take several weeks for gradual improvement to occur. During this time energy may improve before mood, slightly increasing the risk of suicide and the need for close supervision, especially in children.
- Catholics are concerned with everyone's right to life. We campaign for the lives of the unborn and for murderers condemned to death yet often ignore the senseless and preventable loss of life due to suicide. Almost every Catholic parish has lost at least one person (often a teenager) to suicide in recent memory. Suicide is a very permanent solution to a treatable illness and it casts a lifelong shadow over surviving friends and family.

- Depression should be a topic of profound concern to Christians. Jesus' first two commandments (Mk.12, 29-31) are to love God and one another. A depressed person feels an absence of love: love of self, others and God. They feel empty, insignificant and abandoned. In the Medieval church, depression was called the Noonday Demon. It was viewed as a sin, a turning away from God. During the Inquisition those who suffered were affirmed or imprisoned and until relatively recently those who committed suicide were denied a Christian burial. Today we know better; it is our Christian duty to provide the love that is lacking, to affirm the value of those who feel worthless and to ensure that they stay safe and find help.

What Can I Do?

Recognizing Depression and Suicide Risk.

Listed below are the ten symptoms used to screen for depression.

1. I am unable to do the things I used to do.
2. I feel hopeless about the future.
3. I can't make decisions.
4. I feel sluggish or restless.
5. I am gaining or losing weight.
6. I get tired for no reason.
7. I am sleeping too much or too little.
8. I feel unhappy.
9. I become irritable or anxious.
10. I think about dying or killing myself.

If a person answers yes to five or more of these questions and has felt that way for several weeks there is a good chance they are suffering from depression and should seek help. If anyone answers yes to question 10 they should seek help immediately. Because children are less able to talk about feelings depression is more likely to express itself by changes in behavior and physical symptoms.

Seeking Help

- Contact your family doctor or your insurance company for advice and, if necessary, a referral.
- Visit www.mhamilw.org the web site of the Milwaukee Mental Health Association for listings of all mental health agencies and providers in our area. They also have free brochures and pamphlets on all aspects of mental illness.
- Anyone seeking help at anytime can call the National Hopeline at 1-800- SUICIDE.

Helping a Friend who is Suicidal

CPR (Cardio-Pulmonary Resuscitation) is the way to save life in a heart attack.

QPR (Question, Persuade, Refer) is the way to save a life in a depression.

- Question the person about suicide—this does NOT increase the risk. Begin with, "How do you feel about the future?" Then, "Are you feeling life isn't worth living?" If so, ask if there are specific plans to end life and if so, how.
- Persuade the person to seek help—make sure they are firmly committed.
- Refer: assist or accompany the person to a family doctor or a mental health professional. This is especially urgent if the person has a plan to end life. Don't worry about being disloyal or breaking a trust—ACT!

Examples of Program Announcements/Bulletin Inserts

FAITH AND SPIRITUALITY IN MENTAL ILLNESS
HOW DOES A CARING CONGREGATION WELCOME AND SUPPORT PEOPLE AND
FAMILIES DEALING WITH MENTAL ILLNESS?

Please come to an educational evening for our Four North Shore Parishes

Sponsored by the Faith in Recovery Program at Holy Family

VIEW THE NATIONALLY ACCLAIMED VIDEOTAPE *CREATING CARING
CONGREGATIONS*

Discussants: Father Laurin (Holy Family)
Father John (St. Roberts)
Deacon Gene (St. Monica's)
Florence Mahoney (St. Eugene's)

WEDNESDAY, OCTOBER 29, 2004

7:00-8:30 p.m.

In McCormick Hall

Holy Family Parish

A light supper will be provided by Pfizer Pharmaceutical Company

MAY IS MENTAL HEALTH AWARENESS MONTH

MAY 15TH IS THE FEAST DAY OF SAINT DYMPHNA, PATRON SAINT OF PEOPLE WITH MENTAL ILLNESS

FAITH IN RECOVERY* IS SPONSORING A PROGRAM FOR THE FOUR NORTH SHORE PARISHES

"DARK NIGHTS OF THE SOUL "

Mental Illness, Suicide and Prevention

On May 15th, 7:00-8:30 p.m.

In

McCormick Hall

Snacks, dessert, beverages provided

Ask questions, share concerns, and listen to a brief talk by Barry Blackwell M.D., retired Professor of Psychiatry and member of the Wisconsin Governor's Council on Mental Health.

WHAT DO YOU KNOW? TRUE OR FALSE? FIND THE ANSWERS!

The suicide rate in Wisconsin is 3 times greater than the homicide rate.

People who talk about suicide rarely kill themselves.

Suicide is the second most common cause of death in young people.

1 in 5 high school students seriously consider suicide.

The economic cost of suicide exceeds \$100 billion annually.

Women are more likely to kill themselves than men.

*Faith in Recovery is committed to creating a caring community for people and families dealing with mental illness. Its goals are to provide faith-based support, improve access to services and increase information about mental illness and its treatment. Call Barry at 414-228-9684 for more information.

DEPRESSION AND SUICIDE PREVENTION



How do we know when it's not just the blues?

When do we need to seek some expert help for our depression, our children's?

What does every parent need to know about depression and suicide prevention?

What can we, as parents, neighbors and a faith community do to support individuals and families that are dealing with depression?

Join us Wednesday, February 5, 2003, 7:00-8:30 p.m. in Johnson Hall

Come to hear a Catholic Panel. Refreshments will be served

Barry Blackwell M.D., a retired psychiatrist and Chair of the Wisconsin Council on Mental Health will talk about Depression and Suicide Prevention.

John Quaal, President of Waukesha National Alliance of the Mentally Ill (NAMI) and seven-year member of the state legislative committee for the mentally ill. He will talk about what a parent needs to know about mental illness.

Mary Hartinger, Holy Apostles Parishioner will talk about the role of faith in the journey of recovery.

Please come, listen, learn, discuss and help plan.

Questions or concerns? Contact Mary Hartinger at 262- 786-5862

*Johnson Hall, adjacent to Lofy Hall, can be entered from the Gathering Place. Use the elevator or stairs.

Guidelines for Sharing in Faith in Recovery Support Groups

Try to listen carefully to one another.

Allow each person time and opportunity to express himself or herself before anyone speaks twice.

Participants either speak at random or may pass the baton to someone who has not yet spoken. It is OK to stay silent; silence can be as much a gift as speech.

Share feelings as well as thoughts, including personal insights or prayer experiences.

Our main purpose is not to resolve difficulties or even to offer advice but to listen, support and comfort each other, guided by the spirit. This includes facilitators, professionals or experts who sometimes feel coaxed to problem solve. Any wisdom that emerges belongs to the group.

Confidentiality is maintained in the group.

Method of Faith Sharing – Lectio Divina or African Method

This method challenges you to listen and respond with your heart, not your head.

It can be used with scripture, Sunday's Gospel, the Hebrew bible or Koran, or with a prayer or a brief reading from a book. Large groups should divide into about four to eight people each.

- If necessary, each person introduces themselves to the others at the table.
- One person reads the Scripture selection for the whole group. Everyone else quietly listens.
- After a moment of silence, each member shares a word or phrase from the reading, which struck him or her and speaks to the person. No one will be asked to explain why.
- Another person in the group reads the scripture selection for a second time. Everyone listens in meditative silence.
- After a moment of silence each person is asked to briefly describe how the scripture reading speaks to you, this day in your present life, circumstances, joys and struggles. Comments are to be kept in the first person, I rather than we. Speak from your heart/soul/spirit, not your head. What is God saying to you at this moment?
- A third person reads the Scripture again. After a moment of silence each member then shares a prayer need that you have for yourself, based on the Gospel reflection.
- The group closes by forming a circle, holding hands and praying for the person on the right of them. The session closes by everyone praying the Our Father together.

A Reading List For Mental Health Ministry

This bibliography is organized by topic and within each topic by author in alphabetical order. It will be updated on a regular basis. Readers are encouraged to suggest the addition of new books or topics by contacting Faith in Recovery at 414-329-9100 or writing to us at: Faith in Recovery, 4415 West Forest Home Avenue, Milwaukee, WI, 53219. The reading list is also posted on our web site at www.faithinrecovery.com. This list is limited to books that deal directly with both mental illness, religion and spiritual aspects. We plan to develop a second list of resources that may be helpful and of interest to this ministry but do not deal directly with mental illness.

RELIGION AND MENTAL HEALTH

Handbook of Religion and Mental Health; Edited by Harold G. Koenig. Academic Press. 1998.

No Longer Alone: Mental Health and the Church; John Toews with Eleanor Loewen. Herald Press. 1995.

Healing the Split; Integrating Spirit with our Understanding of the Mentally Ill; John E. Nelson. Suny. 1994.

Saints and Madmen: Psychiatry Opens its Doors to Religion; Russell Shorto. Henry Holt and Co. 1999.

SPRITUALITY AND MEDICINE

Medicine in Search of Meaning: A Spiritual Journey for Physicians; Bill Bazan. Caritas Communications. 1999.

The Healing Power of Faith: Science Explores Medicine's Last Great Frontier; Harold G. Koenig. Simon and Schuster. 1999.

Spiritual Care: The Nurse's Role; Judith Ann Shelly and Judith Fish. InterVarsity Press. 1983. (2nd Edition).

Why God Won't Go Away; Brain Science and the Biology of Belief; Andrew Newberg, Eugene D' Aquili and Vince Rause. Ballantine Books. 2001.

PROCOVERY

The Power of Procovery in Healing Mental Illness; Kathleen Crowley. Kennedy Carlisle Publishing Co. 2000.

WORSHIP AND PRAYER IN MENTAL ILLNESS

Pray as you Can: Discovering your own Prayer Ways; Jean Gill. Ave Maria Press. 1989.

Worship with the Mentally Challenged; Lo-Ann and David Trembley. Eden Publishing 1996.

FAMILY MEMBERS AND CAREGIVERS

I am Not Sick: I Don't Need Help; Helping the Seriously Mentally Ill Accept Treatment; Xavier Amador. VidaPress. 2000.

In the Shadow of our Steeples: Pastoral Presence for Families Coping with Mental Illness; Stewart D.Govig. Hayworth Pastoral Press. 1999.

When Someone You Love Has a Mental Illness: A Handbook for Family, Friends and Caregivers. Rebecca Woolis. Tarcher/Putnam. 1992.

BIOGRAPICAL STORIES OF MENTAL ILLNESS

Room for J; A Family Struggles with Schizophrenia; Daniel S. Hanson. Beaver's Pond Press. 2005.

The Day the Voices Stopped: A Memoir of Madness and Hope; Ken Steele and Claire Berman. Basic Books. 2001.

Lincoln's Melancholy; How Depression Challenged a President and Fueled His Greatness; Joshua Wolf Shenk. Houghton Mifflin. 2005.

NOVELS ABOUT PERSONS WITH MENTAL ILLNESS

I Know this Much is True; Wally Lamb. Harper Collins. 1998.

DEPRESSION

God is Close to the Brokenhearted: Good News for those who are Depressed; Rachel Callahan and Rea McDonnell. St. Anthony Messenger Press. 1996.

Adolescent Depression: A Guide for Parents; Francis Mark Mondimore. Johns Hopkins Press. 2002.

In the Shadow of God's Wings: Grace in the Midst of Depression; Susan Gregg Schroeder. Upper Room Books. 1997.

The Noonday Demon: An Atlas of Depression; Andrew Solomon. Simon and Schuster. 2001.

BIPOLAR DISORDER

An Unquiet Mind: a Memoir of Moods and Madness; Kay Redfield Jamison. Vintage Books. 1995.

Touched with Fire: Manic Depressive Illness and the Artistic Temperament; Kay Redfield Jamison. Free Press Paperbacks. 1993.

SUICIDE

Step Back from the Exit: 45 Reasons to say No to Suicide; Jillayne Arena. Zebulon Press. 1995.

Night Falls Fast: Understanding Suicide; Kay Redfield Jamison. Vintage Books. 1999.

Videotapes on Aspects of Mental Illness and Faith

The videotapes listed below are available at our Faith in Recovery Resource Center and may be taken out on loan. Those produced by Mental Health Ministries may be ordered from their web site at www.Mentalhealthministries.net . Please contact Faith in Recovery if you are aware of additional videotapes you would like added to our list by calling 414-329-9100 or writing us at: Faith in Recovery, 4415 West Forest Home Avenue, Milwaukee, WI, 53219. This list is also posted on our web site at www.faithinrecovery.com .

ALZHEIMER'S

Alzheimer's Care and Support: Mental Health Ministries

DEPRESSION

Teenage Depression and Suicide: Mental Health Ministries

Addiction and Depression: Mental Health Ministries

Rhythms: Overview of Depression: University of Pittsburgh (sponsored by Pfizer Pharmaceuticals)

Understanding Depression: Mental Health Ministries

Gifts of the Shadow: Faith and Depression: Mental Health Ministries

A Guide to a Healthy Mind: Understanding Depression for African Americans: National Medical Association (sponsored by Pfizer Pharmaceuticals)

ANXIETY DISORDERS

Anxiety Disorders; Overcoming the Fear: Mental Health Ministries

EATING DISORDERS

Eating Disorders: Wasting Away: Mental Health Ministries

SCHIZOPHRENIA

A Guide for People Living with Schizophrenia: Bristol Myers Squibb Pharmaceuticals

A Guide for Family and Friends of People Living with Schizophrenia: Bristol Myers Squibb Pharmaceutical Company

PROCOVERY

Movin' On: Stories from the Recovery Road: Wisconsin Coalition for Advocacy

FAITH COMMUNITIES

Creating Caring Congregations: Mental Health Ministries

FAMILIES

Mental Illness and Families of Faith: Mental Health Ministries

STIGMA

Overcoming Stigma. Finding Hope: Mental Health Ministries

FAITH AND MENTAL ILLNESS

Mental Health Mission Moments: Mental Health Ministries (DVD)

FaithNet NAMI Special Interest Workshop: 2004 NAMI Convention

MENTAL ILLNESS EDUCATION PROJECT

A series of 30 minute videotapes that include family and consumer discussion on a variety of topics including, families dealing with mental illness, consumers talking about recovery, problems raising their children or obtaining employment and dealing with co-occurring substance abuse. Contact www.miepvideos.org .

MINISTRY AND MENTAL HEALTH

A one-hour videotape developed by the multi-faith organization, Pathways to Promise. Contact www.pathways2promise.org .

Related Organizations

There are a number of organizations, which provide resources, and information that can help in the development of a mental health ministry including written materials and videotapes. You are encouraged to visit the web sites or email addresses listed below:

Pathways to Promise: www.pathways2promise.org

Mental Health Ministries: www.mentalhealthministries.net

Mental Illness Education Project: www.miepvideos.org

National Alliance for the Mentally Ill (NAMI): www.nami.org

Hope to Healing: www.hopetohealing.com

Sr. Ann Catherine's email: srann@hopetohealing.com

Mental Health Association: www.mhamilw.org

Faith In Recovery Resource Center

The books and videotapes listed above are available on loan through our Resource Center located at the United Seniors Center, 4415 West Forest Home Avenue, Milwaukee, WI, 53219.

These must be picked up in person, signed for and returned within 21 days. For additional information call: (414) 329-9100

Chapter and Contact Resources

Faith in Recovery Chapters

Blessed Trinity Parish

4702 N. 39th Street
Milwaukee, WI 53209-5949
2nd Wednesday 11:15 AM
Bob Graf (414) 379-4162

Christ United Methodist Church

5200 S. 48th Street
Greenfield, WI 53220
4th Thursday 7:00 - 8:00 PM
Marlene Bruno (414) 529-3849
Jerome Trewyn (414) 281-4434

Crossroads Presbyterian Church

6031 W. Chapel Hill Road
Mequon, WI 53097
Thursday 7:00 - 8:30 PM
Call for day each month
Judi Barnes (262) 243-9400

Faith United Methodist Church

400 S. 91st Street
Milwaukee, WI 53214
Last Sunday of Month 10:15 - 1:00 PM
Worship Service, Lunch, Healing Service
Pastor Andy Oren (414) 453-1710

Gesu Parish

1210 W. Michigan Street
Milwaukee, WI 53233
Beginning Monday, September 18th
1st Monday 6:30 - 8:00 PM
3rd Monday 1:00 - 2:30 PM
Marcia Isherwood (414) 288-5288

Holy Apostles Parish

16000 W. National Avenue
New Berlin, WI 53151
3rd Tuesday 7:00 - 9:00 PM
Seb and Mary Hartinger (262) 786-5862

Holy Family Parish

4825 N. Wildwood Avenue
Whitefish Bay, WI 53151
1st and 3rd Tuesday 7:00 - 8:30 PM
Carmello Gaudioso (414) 962-5298

Our Lady of Good Hope Parish

7152 N. 41st Street
Milwaukee, WI 53209
3rd Wednesday 7:00 PM St. Bernadette
Call to confirm date and additional information
Betty Lovinus (414) 358-4600

Our Lady of Lourdes Parish

3722 S. 58th Street
Milwaukee, WI 53220
3rd Wednesday 6:30 - 9:00 PM
1st Saturday 5:00 PM Mass followed by dinner
Sr. Ann Catherine (414) 384-6535

St. Bernadette Parish

8200 W. Denver Avenue
Milwaukee, WI 53223
3rd Wednesday 7:00 PM
Call to confirm date and additional information
Betty Lovinus (414) 358-4600

Faith in Recovery Chapters

St. Gabriel Parish

3727 Hubertus Road
Hubertus, WI 53033
2nd Wednesday 7:00 PM
Kelly Lemens (262) 993-4273
klemens@sgabrielp.org

St. Mary of the Hill Parish

1525 Carmel Road
Hubertus, WI 53033-9770
4th Wednesday 7:00 PM
Arlene Barron, RN (262) 673-7505 Ext. 7
Monica Bartley (262) 673-6025

St. Matthias Parish

9306 W. Beloit Road
Milwaukee, WI 53227
1st Tuesday 6:30 - 8:00 PM
3rd Sunday 10:15 AM -12:00 Noon
Har Vanderport (414) 425-3720

Solomon Community Temple UMC

3295 N. Dr. Martin Luther King Jr. Drive
Milwaukee, WI 53212
Every Monday 1:00 - 2:30 PM
Rev. Marvin G. Spence, Pastor
(414) 372-2101
Julia Means, RN Parish Nurse (414) 840-8893

Southminster Presbyterian

200 Richard St.
Waukesha, WI 53189
Sunday 6:00 – 8:00 PM
(See calendar for dates)
Joan Hoefakker, Parish Nurse (262) 547-5100

United Methodist Church of Whitefish Bay

819 E. Silver Spring Drive
Whitefish Bay, WI 53217
Every Wednesday 6:30 - 7:30 PM
Deb Love (414) 220-9416