Mental Health Information for Ministers and Lay Leaders

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Mental Health Information for Ministers and Lay Leaders

Agenda

- Opening and Introductions
- Mental health issues
- Disorders:
  - Anxiety / OCD / Trauma
  - Depression
  - Bipolar
  - Psychotic
  - Children’s
  - Personality
  - Substance-Related
- Recovery
- Suicide
- Families
- Spirituality
- What a congregation can do
Mental Health and Mental Disorders

Mental Health

The successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity

Mental Disorder

Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning.

Points on a Continuum

- People will move back and forth on the continuum

Everyone experiences emotional distress during difficult times; thus education helps all.

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‘Recovery’ means that a person has as much of an autonomous life as possible. It doesn’t necessarily mean the elimination of all symptoms, or the need for mental health care.

Success involves as many of these dimensions as possible.

Each person’s balance of these factors is unique.

When a person is troubled, visualize this diagram and ask “What’s missing?”

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# Myths and Stereotypes about those with Mental Disorders

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

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

The congregation, as adjunct to professional mental health care, can impart:

- A calm reassuring presence
- Knowledge that the person is loved and accepted
- Hope – which is necessary for the beginning of recovery
- Visits when in the psychiatric ward, just as you would visit any other hospitalized congregant
- Encouragement to continue on the road to recovery, especially when a person has had previous failures, maybe even harmful failures
- Use of spiritual practices consistent with the person’s beliefs that you think might be helpful and comforting. For example: prayer, meditation, communion and other rituals.
- Confrontation when needed – when the person is in denial or is disruptive to church life
- A safe place in a church that does not tolerate cruelty, exclusion or jokes at their expense.
- Sermons, classes or literature to educate the congregation and/or lay pastoral care workers about mental illness
- Referrals to appropriate professional treatment, including handling of psychiatric emergencies. A rule of thumb: if a person needs more than 3 counseling sessions, a referral should be given.
## Categories of Mental Disorders

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>CHARACTERISTICS</th>
<th>EXAMPLE DISORDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neuro-Developmental</strong></td>
<td>Onset is typically in a child’s developmental period.</td>
<td>Intellectual Disability, Autism Spectrum, Attention-deficit/Hyperactivity, Disruptive behavior</td>
</tr>
<tr>
<td><strong>Schizophrenia &amp; Other Psychotic</strong></td>
<td>Characterized by delusions, hallucinations, disorganized speech or behavior.</td>
<td>Schizophrenia, Schizoaffective, Delusional disorder, Schizotypal Personality</td>
</tr>
<tr>
<td><strong>Bipolar</strong></td>
<td>Characterized by episodes of depression and episodes of mania.</td>
<td>Bipolar I, Bipolar II, Cyclothymic</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td>Persistence of sad, empty mood with somatic and cognitive changes.</td>
<td>Major Depression, Dysthymia</td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td>Characterized by apprehension usually accompanied by palpitations, and shortness of breath.</td>
<td>Separation Anxiety, Panic attack, Agoraphobia.</td>
</tr>
<tr>
<td><strong>Obsessive-Compulsive</strong></td>
<td>Presence of obsessions (persistent unwanted thoughts) and/or compulsions (repetitive behaviors the person feels must be followed)</td>
<td>Obsessive compulsive, Body dysmorphic, Hoarding</td>
</tr>
<tr>
<td><strong>Trauma- and Stressor-Related</strong></td>
<td>Disorders in which exposure to a traumatic event causes psychological distress</td>
<td>Post-traumatic stress disorder (PTSD), Adjustment disorder</td>
</tr>
<tr>
<td><strong>Feeding &amp; Eating</strong></td>
<td>Severe disturbances in eating behavior.</td>
<td>Anorexia Nervosa, Bulimia Nervosa</td>
</tr>
<tr>
<td><strong>Personality</strong></td>
<td>An enduring pattern of inner experience and behavior that is pervasive since adolescence is inflexible and leads to distress or impairment.</td>
<td>Paranoid, Antisocial, Borderline, Histrionic, Narcissistic, Schizotypal, Dependent personality disorders</td>
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### Table 1. Categories of Mental Disorders

While the following mental disorders not often thought of as “mental illness,” they are also diagnosed using the Diagnostic and Statistical Manual of Mental Disorders (DSM).

<table>
<thead>
<tr>
<th>Substance-Related</th>
<th>Neurocognitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>These disorders result from taking a substance: i.e. a drug of abuse, the side effects of a medication, and toxin exposure.</td>
<td>Dysfunctions of the brain caused by neurological problem and/or drug abuse.</td>
</tr>
<tr>
<td>Substance-related disorders</td>
<td>Major and Mild disorders caused by: Alzheimer’s disease, Traumatic Brain injury, Parkinson’s disease</td>
</tr>
<tr>
<td>Hallucinogen-related disorders</td>
<td>Inhalant-related disorders</td>
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<tr>
<td>Inhalant-related disorders</td>
<td>Opioid-related disorders</td>
</tr>
</tbody>
</table>

### Table 2. Categories of Mental Disorders not often thought of as “mental Illness”

- Diagnosis of more than one mental disorder is possible.
- In general, a general medical condition is ruled out before making a diagnosis of a mental disorder.
- Categories of DSM mental disorders not included in this chart: Dissociative, Somatic, Elimination, Sleep-Wake, Sexual Dysfunctions, Gender Dysphoria, Disruptive, Impulse-Control and Conduct, and Paraphilic.

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Anxiety, OCD and Trauma

These disorders together are the most commonly diagnosed.

- **Generalized Anxiety Disorder:** Prolonged excessive anxiety and worry
- **Panic Attack:** A sudden onset of intense apprehension or terror.
- **Obsessive-Compulsive Disorder:** Recurrent obsessions and compulsions
  - **Obsessions:** Recurrent distressful and persistent thoughts and/or impulses
  - **Compulsions:** Repetitive behaviors that the person feels driven to perform
- **Post Traumatic Stress Disorder (PTSD)** Development of symptoms after exposure to a traumatic event that involved actual or threatened death or serious injury.
  - The event is persistently re-experienced in recollections or feelings that it is recurring.
  - The person makes efforts to avoid all stimuli, or activities associated with the trauma.
  - The person develops symptoms of increased arousal

Case Study

Suggestions for the Congregation:

- Be a calm presence, listen to them in a quiet place.
- Remind the person that there is effective treatment for anxiety disorders
- Cognitive behavioral therapy can be particularly useful for lessening the impact of excessive fears.
- Many veteran’s hospitals have special units for treating PTSD.
- If the person is in therapy, encourage that he or she continues in the program
- Share the General Coping Strategies for Mental Health Consumers handout in the appendix
**Depression**

Between 10-25% of women and 5-12% of men develop depression sometime in their lifetime. The following symptoms are associated with depression:

1. depressed mood most of the day
2. diminished interest or pleasure in almost all activities
3. significant weight loss when not dieting, or significant weight gain
4. insomnia or hypersomnia
5. fatigue or loss of energy
6. feelings of worthlessness or excessive guilt
7. diminished capacity to think or concentrate
8. recurrent thoughts of death

**Case Study**

**Suggestions for the congregation:**

- Reassure the person that he/she is loved and accepted.
- Sit quietly with the person in a peaceful, secluded place.
- Encourage professional therapy.
- Support the person in efforts to find a medication that works
- Suggest that the person join a peer support group.
- If there are no support groups in your area, consider starting one. To do this, see: [www.mpuuc.org/mentalhealth/depressionsupportgroup.html](http://www.mpuuc.org/mentalhealth/depressionsupportgroup.html)
- Share the General Coping Strategies for Mental Health Consumers handout in the appendix
- If the person has a supportive family, try and get the family involved.
- If he or she is suicidal, get immediate attention. If there is a suicide plan, hospitalization is necessary to keep the person safe.
**Bipolar Disorder**

Bipolar Disorder: involves alternating episodes of depression and mania. Symptoms of mania:

1. inflated self-esteem or grandiosity
2. decreased need for sleep
3. more talkative
4. flight of ideas, thoughts are racing
5. distractibility
6. excessive involvement in high-risk pleasurable activities (ex: spending sprees, sexual indiscretions, foolish business investments)

**Suggestions for the Congregation:**

- Reassure the person that he/she is loved and accepted.
- Sit quietly with the person in a peaceful, secluded place.
- Encourage professional therapy.
- Support efforts to find a medication that works.
- Suggest that the person keep a time line of mood swings. The [Depressive and Bipolar Support Alliance](https://www.depressionbipolar.org) has charts to do this.
- If the person has a supportive family, try and get the family involved.
- If the person is suicidal, get immediate attention. If there is a suicide plan, hospitalization is necessary to keep him or her safe.
- Share the [General Coping Strategies for Mental Health Consumers](https://www.depressionbipolar.org) handout in the appendix
- If behavior is destructive to congregational life, set boundaries for what is acceptable and what is not acceptable behavior at church and enforce them.
**Psychotic Disorders**

The most common psychotic disorders are schizophrenia and schizoaffective disorder. Schizoaffective disorder is schizophrenia plus a mood disorder. Psychotic symptoms:

1. delusions – erroneous beliefs held despite clear contradictory evidence
2. hallucinations in any of the senses – hearing voices is the most common
3. disorganized speech – derailment or incoherence
4. grossly disorganized or catatonic behavior – unable to perform activities of daily living

**Case Study**

**Suggestions for the Congregation**
- See the section on Communication Guidelines in the appendix of this document
- Call or talk to the schizophrenic congregant regularly because he or she may become isolated if you do not.
- Encourage the person’s efforts at autonomy.
- Don’t encourage meditating because meditation can be disturbing for people who are psychotic. Voices can come back in full force.
- Find an “angel” in the congregation willing to sit with the person on Sunday mornings, leaving to sit quietly with him or her outside if the person can’t remain in the service.
- Realize that delusions and hallucinations are real to the one experiencing them. You can let the person know that you don’t buy into this view, but that you understand that the experience is something as real to him or her.
- If voices are tormenting the person, suggest using earplugs and a music CD.
- If behavior is destructive to congregational life, set boundaries for what is acceptable and what is not acceptable behavior at church and enforce them.
Neuro-Developmental Disorders Usually Diagnosed in Children

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

Attention Deficit and Disruptive Behavior Disorders
- **Attention-Deficit / Hyperactivity Disorder (ADHD)** – a persistent pattern of inattention and/or hyperactivity-impulsivity.

- **Conduct Disorder** – a repetitive and persistent pattern of behavior in which the rights of others or major societal rules are violated.

- **Oppositional Defiant Disorder** – A pattern of negativistic, hostile and defiant behavior

Autistic Disorder and other Pervasive Developmental Disorders
- **Autistic disorder**: impairment in social interaction, in communication and in restricted repetitive and stereotyped patterns of behavior.

- **Asperger’s disorder** is a mild form of Autistic disorder in which the child is impaired in social interaction and has restricted behaviors, but not delayed in cognitive development.


Case Study

Suggestions for the Minister
- Make a commitment to welcome all children
- Give training to the congregation and religious educators.
  - Welcoming Children with Special Needs by Sally Patton has excellent suggestions for teaching children with specific needs.
  - Sally can be reached at [www.embracechildspirit.org/](http://www.embracechildspirit.org/)
  - Learn what has worked well for other congregations
- Support the family. They may be experiencing helplessness, denial, anger, guilt, resentment, grief or shame.
- Encourage getting an accurate diagnosis, informed decision making, and effective treatment
Personality Disorders

Personality disorders can be among the most frustrating for ministers to work with. In many cases, the person is highly intelligent and functional, but has a maladaptive pattern of behavior that has been part of his or her personality since adolescence. Some people with these disorders can cause havoc in a congregation, particularly if they have positions of responsibility, because of problems they create in interactions with other congregants and with the minister.

A central conflict of many of these people is that they have failed to develop a solid sense of themselves and their significance and worth. Unconsciously they feel empty, inadequate, or unlovable. Consequently, they are constantly turning to others for affirmation, attention, and rewards. When they can see their behavior as a problem in their lives, they will be motivated to change it. For most personality disorders, psychotherapy is the treatment of choice, with drugs being prescribed for another mental disorder which may be present.

General criteria for Personality Disorders: 4
An enduring pattern of inner experience and behavior that:

- deviates markedly from the expectations of the person’s culture in two or more of:
  1. cognition (ways of perceiving self and others)
  2. affectivity (range of emotional response)
  3. interpersonal functioning
  4. impulse control

- is inflexible and pervasive across a broad range of social situations
- has an onset in adolescence or early adulthood
- is stable over time
- leads to distress or impairment

Borderline Personality Disorder:
This disorder involves a pattern of instability in interpersonal relationships, self-image and affects, and marked impulsivity. The lifetime prevalence is 2%.

1. unbearable feeling of abandonment and frantic attempts to avoid it
2. unstable interpersonal relationships, unstable self-image, altering between extremes of idealization and devaluation
3. impulsivity in self-damaging ways (ex: substance abuse, recurrent suicidal behavior)
4. inappropriate or intense anger or difficulty controlling anger

As a result of these symptoms, some people with Borderline Personality Disorder may:
- stress the importance of something one day only to deny the significance of it the next
- consider people to be all bad or all good
- split groups by taking sides and alienating one side against the other
- be impulsive and have unpredictable mood shifts
- have angry outbursts out of proportion to the situation

Histrionic Personality Disorder
Histrionic personality disorder is characterized by a person who:

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- Must be the center of attention.
- Displays inappropriate sexually provocative behavior.
- Great emphasis on physical appearance to attract attention.
- Theatrical, exaggerates, and uses speech that is vague and lacking in detail.
- Considers friendships and relationships to be far more intimate than they are.

They can be excessively sensitive to criticism or disapproval, self-centered and rarely show concern for others.

**Narcissistic Personality Disorder**

Narcissistic personality disorder is a condition characterized by an inflated sense of self-importance, need for admiration, extreme self-involvement, and lack of empathy for others. Individuals with this disorder differ from those with Histrionic personality disorder by needing to be superior. They:

- Expect to be noticed as superior and have domineering behavior. Need to be admired.
- Are selfishly greedy, feeling they are entitled to receive more than they need or deserve.
- Are very sensitive to criticism or defeat. They may react with disdain, rage, or defiant counterattack.
- Are inter-personally exploitative, taking advantage of others
- Are usually arrogantly self-assured and confident.

They often have their social life impaired due to problems derived from entitlement, the need for admiration, and the relative disregard for the sensitivities of others.

**Paranoid Personality Disorder**

Paranoid personality disorder is characterized by excessive distrust and suspiciousness of others, so that their motives are interpreted as malevolent. People with this disorder are generally:

- Mistrustful of others, doubting without sufficient basis their loyalty or trustworthiness.
- Bearers of grudges, seldom forgiving others’ mistakes
- Feel exploited or victimized; seldom expressing gratitude

People with this disorder tend to need to have a high degree of control over those around them. Often rigid, critical of others, they are unable to collaborate, and can’t readily accept criticism themselves. They can be difficult to get along with and often have problems with close relationships because of their excessive suspiciousness and hostility. They can become involved in legal disputes.

**Suggestions for the Minister**

- Realize that the person’s behavior is not your fault. You cannot change the personality of your congregant, but you can try and work with him or her in ways that are consistent with the particular personality traits being expressed.
- Realize that because the behavior pattern has been present since adolescence, it is going to be very difficult to change, even if the person is working hard to do so. If the person is making a good faith effort to change, try to have patience with the person in his or her struggle.
- Realize that the person may not share the same view of reality that you have, and thus may not interpret events in the same way, or share sets of limits and boundaries you experience with others.
- Realize that as much as you are suffering in trying to deal with the behavior, the individual and his or her family are suffering as much or more. Try to have compassion. Many of these people behave as they do because they were emotionally if not physically abandoned and/or abused as children, and are still frantically seeking love in any way they can. Try to understand how it must feel to be so insecure that one puts up such disturbing defenses.
• Try to ensure that the person is not in a position of responsibility where the maladaptive behavior could affect the congregation.
• Support the individual’s family
• Don’t take everything that is said as being meant seriously
• If the person is not getting adequate therapy, encourage him or her to do so. This may be difficult because many people with personality disorders have poor insight into their problems.
• Be on your guard if the congregant sees you as “the best clergyperson ever.” Tomorrow he or she may discover all your faults and bring them to the attention of other congregants.
• Learn how to set boundaries for what is acceptable and what is not acceptable behavior at church and enforce them. This might even mean getting the board, or good offices people involved, and may result in asking the person to leave the church, if the behavior is destructive. If the person is destructive to the congregation, and won't change, there is no easy way out; the person needs to go.
• Talk to minister colleagues who have handled similar situations for emotional support and for advice.

Resources for Personality Disorders

Books
• Haugk, Kenneth C. Antagonists in the Church – How to Identify and Deal with Destructive Conflict, Minneapolis: Augsburg, 1988. Not about personality disorders per se, but good practical hard-nosed advice for dealing with people who might destroy a church.
• Horowitz, Mardi, ed. Hysterical Personality Style and Histrionic Personality Disorder, Jason Aronson, 1991. Updated version of classic work on histrionic personality disorder.

Websites

<table>
<thead>
<tr>
<th>Borderline Personality Disorder Resources</th>
<th>Geared for friends/family/loved ones of those with Borderline personality disorder.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Truth Behind Borderline Personality Disorder</td>
<td>An article with a good overview with resources that is actually in line with current research about BPD.</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>Mayo Clinic information about personality disorders, their symptoms, treatments, coping, and prevention.</td>
</tr>
<tr>
<td>TARA</td>
<td>Treatment and Research Advancements Association for Personality Disorders. Supports research, education, and advocacy for personality disorders.</td>
</tr>
</tbody>
</table>
**Co-occurring Disorders**

A diagnosis of a substance abuse disorder in addition to a mental disorder. As many as half of people with mental disorders also have some form of substance related disorder.

**Substance Related Disorder**

These disorders related to taking a *substance*: i.e. a drug of abuse including alcohol

**Substance Dependence**

The person continues use of the substance despite significant substance-related problems.

1. **Tolerance**: need for increasing amounts of the substance to achieve same effect
2. **Withdrawal**: withdrawal symptoms when using substance is stopped.
3. **Compulsive pattern of use**: taking in larger and larger amounts; spending more and more time in getting the substance

**Substance Abuse**: A maladaptive pattern of substance use that causes harmful consequences, but doesn't involve tolerance, withdrawal and compulsive patterns of substance dependence.

**Case Study**

**Suggestions for the Congregation**

- If a person has a substance related disorder, suggest that he or she also be screened for mental disorder, and vice versa.

- If the person has a co-occurring disorder strongly suggest a therapy program that treats both in an integrated way

- Don’t be an enabler for substance abuse through your forgiving and helpful behavior. Clearly confront the person until he or she gets over denial. Confront family members as necessary if they are enablers.

- Direct the person and his or her family to appropriate sources of help, such as 12-step programs or other effective addiction resources

- Understand that relapses happen before the person becomes stable.

- If the person’s behavior is destructive to congregational life, set boundaries for what is acceptable and what is not acceptable behavior at church and enforce them.

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## Therapies for Treating Mental Disorders

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Purpose</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Biological</td>
<td>Alleviate symptoms</td>
<td>Medications</td>
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<td></td>
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<td>• Antipsychotics for psychotic disorders</td>
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<td>• Antidepressants for depression</td>
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<td>• Anticycling agents for bipolar disorder</td>
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<td>• Hypnoanxiolytics for anxiety disorders</td>
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<td></td>
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<td>• Stimulants</td>
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<td></td>
<td></td>
<td>• Electroconvulsive Therapy (ECT) Chiefly used when other therapies are not successful.</td>
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<tr>
<td>Psychosocial</td>
<td>Address underlying issues, which will lead to changes in behavior.</td>
<td>Individual Therapy</td>
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<td></td>
<td></td>
<td>• Psychotherapy or counseling with a psychiatrist, psychologist or therapist</td>
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<td>• Pastoral counseling with a minister</td>
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<td>Group Therapy</td>
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<td>• Professionally run groups</td>
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<td></td>
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<td>• Peer support groups ex: Alcoholics Anonymous</td>
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<td></td>
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<td>Couples and Family Therapy</td>
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<tr>
<td></td>
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<td>• Marriage counseling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Family Therapy</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Address behavior, which will lead to change in feelings and attitudes</td>
<td>Biofeedback:</td>
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<tr>
<td></td>
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<td>Electronic instrument gives feedback to patient.</td>
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<td>Relaxation</td>
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<td>Systematic relaxation of parts of the body</td>
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<td>Operant Conditioning</td>
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<td></td>
<td></td>
<td>Reward and reinforce positive behaviors</td>
</tr>
</tbody>
</table>

Sources:
- *The Soul in Distress* by Richard W. Roukema, M.D., pp 42-47, 59
Some mental health client views on limitations of the “medical model” of mental health care

- The concept of “mental illness” is a form of social control for people who are “different”
- The medical model defines the problem in the individual instead of an oppressive society
- Some emotional crises are a reaction to difficult, oppressive circumstances and are not permanent “chemical imbalances” of the brain that will require medication for life
- Over-reliance on medication and ECT which sometimes has serious, irreversible side effects
- Use of forced treatment for mental illnesses is counterproductive
- DSM diagnosis based on symptoms is supposed to be unique, but in practice, different diagnoses are often given for the same symptoms in the same person
- Significant differences between Europe and US in how schizophrenia and bipolar disorder are diagnosed suggesting subjectivity of mental illness definition and treatment

Consumer Movement Stresses:

- Mental health client rights (see Personal Bill of Rights below)
- Self Determination and Self Advocacy
- Self Help and Peer Support, Peer-run Drop in Centers
- Networking with other mental health clients
- Lobbying and advocacy for rights of mental health clients
- Some mental health clients reject some or all medical intervention for mental disorders:
  - Psychiatric Medication
    - Against forced medication: Contentious issue between families and mental health clients
  - Psychiatric Hospitalization
  - Electroconvulsive Therapy (ECT)
Suicide

Suicide – The Warning Signs

- A preoccupation with and/or writing about death or suicide
- Making final arrangements and giving away special possessions
- Sudden loss of interest in something that was once quite important
- Dependence on alcohol and/or drugs
- Deep depression
- A recently experienced loss
- A sudden upturn in energy following a depression.

Case Study

Suggestions for the Congregation

- If a person says that he or she is contemplating suicide, professional mental health care should be consulted. Ask the person if he or she is getting professional care and if so, whether suicidal ideation has been discussed in that context. If not, they need a referral.

- Questions for judging suicide intent: Is intervention possible? Has a suicide plan been made, have treasured possessions been given away?

- If a person has actually made a plan for committing suicide, he or she needs to be in a hospital. Having an amateur trying to deal with a person in this much despair is not a good idea. Call 911 or take the person to the hospital emergency room for immediate treatment. Upon release from the hospital, there needs to be in an intensive after-care program in place.

- While it is true that a person who really wants to die by suicide can do it, it is also true that many times suicides are impulsive, and can be triggered by anniversaries of traumatic events, or by places with special association with suicide.

- After a suicide, suggest the family get involved in a suicide survivor’s support group, and determine if anyone in the congregation is troubled so much that he or she needs special attention. Special attention should be paid to other youth after a young person dies by suicide.

6 Information from Pathways to Promise website
Case Study
Suggestions for the Congregation

- In the catastrophic stage, provide comfort and empathy to the family members for what they are going through. Suggest that the family contact NAMI, especially the Family to Family Program.

- In the coping stage, help the family members to deal with any grief, guilt or strong feelings they have.

- In the advocacy stage, cheer them on, connecting them with any advocacy resources you may have.

- Give them a copy of the General Strategies for Coping with a Loved One’s Mental Disorder in the appendix.

- Review the Communication Guidelines in the appendix and share them with family members.

---

7 Picture illustrates Stages of Emotional Reactions among Family Members NAMI Family-to-Family Education Course
Spirituality and Mental Illness

The symptoms of some mental disorders can resemble experiences involved in spiritual awakening.

- These experiences have shaped the religious landscape throughout human history.
- The prophets and patriarchs of most religious traditions saw visions and heard voices, and shaman in native cultures have these experiences as a central role in initiation and practice.
- When helpful to the person and the church, they are experiences of the holy and need to be respected and honored.

Case Study

Suggestions for the Congregation

- Try to distinguish between mental health issues and spiritual awakening, ask:
  - Does the person describe the experience as mystical, as near death, as a revelation of a universal religious truth, as finding who he or she really is?
  - Does the person have a curiosity about the experience?
- Consider making a referral to a therapist or spiritual director who will respect the healing nature of the spiritual transformation process.
Religion and Mental Health

The following are findings from *Religion and Mental Health*, edited by John F. Schumaker, a book of articles reviewing recent research into the relationship between religiosity and mental health.

**Relationship of Religion and Mental Health – Two Sets of Views**

There have been different views of the way that religion and mental health relate to one another. Reasons given by those making the argument that religion is generally beneficial to mental health are that religion:

1. reduces existential anxiety by offering a structure in a chaotic world
2. offers a sense of hope, meaning, and purpose, and thus emotional well-being
3. provides reassuring fatalism enabling one to deal better with pain
4. affords solutions to many kinds of emotional and situational conflicts
5. offers afterlife beliefs, helping one to deal with one’s own mortality
6. gives a sense of power through association with an omnipotent force
7. establishes moral guidelines to serve self and others
8. promotes social cohesion
9. offers a social identity and a place to belong
10. provides a foundation for cathartic collectively enacted ritual

Reasons given by those who feel that religion doesn’t help, and may harm mental health are that religion has the potential to:

1. generate unhealthy levels of guilt
2. promote self-denigration and low self-esteem by devaluing human nature
3. establish a foundation for unhealthy repression of anger
4. create anxiety and fear by beliefs in punishment in hell for ‘evil’ ways
5. impede self-direction and a sense of internal control
6. foster dependency and conformity with an over-reliance on external forces
7. inhibit expression of sexual feelings
8. encourage black and white views of the world: all are ‘saints’ or ‘sinners’
9. instill ill-founded paranoia concerning evil forces threatening one’s integrity
10. interfere with rational and critical thought

How does your church measure up in this categorization?

---

What a Congregation Can Do – Making Plans

Dr. Gunnar Christiansen identifies the following steps (to be followed in order) in building a ministry that serves those with mental illness. You may want to consider these and adapt it for your congregation.

1. Gain approval from the senior clergy person and lay leadership
2. Establish a task force at your congregation
3. Education. Learn how you can respond to the need effectively. Get your pastoral care team involved. One curriculum for education is the *Caring Congregation Program* by Rev. Barbara Meyers.
4. Provide a support group for family members and a group for mental health clients.
5. Provide the full range ministry to those who have a mental disorder as you do to others, including pastoral care
   - Guidelines for all adults (not just those with mental disorders)
   - Guidelines for children, for example, how to handle hyperactive children
7. Outreach to those with mental disorders in the community surrounding a congregation. Examples are providing low-cost housing and/or a drop-in center.
8. Provide a model as an employer by offering jobs to those with mental disorders
9. Advocacy on behalf of those with mental disorders to local, state and national government.

Congregational Needs

- Covenant of Right Relations – how we treat each other in our congregation
- Disruptive Behavior Policy
- Training of church staff and lay leaders
- Referral list of therapists, support groups, and community programs
- Possibly a standing Grievance Committee
  - Small team gifted in discernment, wisdom and compassion
  - Helps minister / lay leaders in working with difficult people
Covenant of Right Relations

Definition of covenant

- *(Bible)* an agreement between God and his people in which God makes certain promises and requires certain behavior from them in return:

- Formal, solemn and binding agreement

- A signed written agreement between two or more parties (nations) to perform some action

Developing a formal covenant of right relations

Congregational Exercise Using a District Facilitator

An opportunity to determine how the members of a congregation wish to be in right relationship with one another.

- Working together in large and small groups

- We will develop guidelines for ourselves around how we interact as members of this congregation, with ourselves, with one another, with our minister, our staff, our board and the larger community.

- The workshop will be facilitated by PCD facilitator

- The result will be a good and as powerful as the people who are part of it. It is vital that as many members as possible attend

This lesson was adapted from a workshop initially created by the Pacific Northwest District CONTACT Team and the Unitarian Church of Victoria, British Columbia. Its structure was inspired by Code of Professional Practice in the Unitarian Universalist Ministers Association Guidelines.
Appendix

The following pages are handouts which may be useful to you and also which can be copied and given to congregants as you feel they would be helpful.

- General Coping Strategies for Mental Health Consumers is a list of suggestions that have worked for other people.

- General Strategies for Coping with a Loved One’s Mental Disorder has a list of suggestions for the families of a person living with a mental disorder.

- Communication Guidelines gives ways for communicating with a person who is in the depths of a mental disorder

- NAMI is the National Alliance on Mental Illness – the preeminent advocacy organization for mental health.

- The Consumer Movement tells about the civil rights movement by and for mental health consumers.

- Resources
  - General Mental Health and Religion Resources
  - Depression
  - Bipolar Disorder
  - Anxiety
  - Psychotic Disorders
  - Suicide
  - Families
  - Religion and Mental Health
  - Example Covenant of Right Relations
  - Example Disruptive Behavior Policy
General Coping Strategies for Mental Health Consumers

Here are some suggestions for coping with their mental illnesses collected from people who are living with them. As with any list, not every suggestion will work with every person.

Professional / Peer Help
- Psychotherapy with a therapist trained to know how to discover and deal with psychological problem areas.
- Effective medication in an effective dosage prescribed by a psychiatrist. If a medication isn’t working for you, work with your doctor to find another medication or therapy that works.
- Join a peer support group.
- Consider adding alternative therapies to your treatment plan. Ex: Acupuncture, Acupressure, Dance therapy, Art therapy, Music therapy, Tai Chi, Yoga...
- Help someone else, especially someone with problems similar to yours.
- Work with a counselor to identify and make progress toward career goals
- Attend a Wellness Recovery Action Plan (WRAP) group if there is one in your area.

Personal Care
- Eat a good solid balanced diet.
- Little or no caffeine
- No alcohol. Alcohol is a depressant and often interferes with medication.
- Get plenty of rest. If you can’t sleep, ask your doctor for something to help you sleep.

Stress Management
- Exercise. Elevate the heart rate for 15-30 minutes a day, with your doctor’s permission. Examples: walking, jogging, aerobics, swimming …
- Avoid getting over-committed in time to any activities, so that you feel overwhelmed.

Emotional Self Awareness
- Learn how to recognize warning signs of a coming episode of mental illness and take immediate action to head it off or minimize it. Involve your family so they can help you.
- Do something to make you laugh, cry, or get angry in a safe place. Ex: watch a sad movie and cry.

Life Enrichment
- Indulge in some creative activity. Ex: music, drawing, painting, crafts, creative writing, weaving
- Take an adult school class: swimming, art, history …
- Engage in volunteer work
- Continue to be active with friends and make efforts to develop friendships
- Seek out helpful relatives

Spirituality
- Learn how to love yourself as an individual, spiritually and creatively. There is no one else on Earth quite like you.
- Meditation. 15-60 minutes of quiet listening to your heartbeat and breathing. Caveat: This can be disturbing for people who are psychotic. If so, don’t use meditation, guided or silent.
General Strategies for Coping with a Loved One’s Mental Disorder

Here are some suggestions collected from people who have loved ones with a mental disorder:

**Professional / Peer Help**
- If someone is suicidal, get immediate attention for him or her. Call 911 if there’s an immediate danger.
- Make sure that the person gets the help needed, for example, a therapist or a hospital stay. You may have to help make the appointment and go with him or her.
- Get professional help for yourself to learn what your own responsibilities and capabilities are.
- Join your own support group, formal or informal.

**Learn about Mental Health and Mental Illness**
- Read and learn all you can about the mental disorder that your loved one has.
- Be flexible and patient. Cures are rarely instantaneous.
- Learn to recognize the signs of the mental disorder.

**Communicate with your loved one**
- Tell the person that you love and care about him or her.
- Visit him or her, especially if hospitalized. A smile, a flower, a picture or a short hug can make all the difference.
- Avoid doing things that trigger the person’s disorder, ex: if the person become anxious or depressed when he or she is pressured to hurry, don’t try and rush things.

**Help your loved one live with the illness**
- Help the person to keep his or her days structured.
- Support efforts to find the medicines and therapies that work best.
- Monitor medicine intake.
- Encourage physical exercise, good diet, plenty of sleep, creative activities, and sunlight.
- Learn to recognize the warning signs that an episode is going to happen, and help your loved one to take action to head it off or minimize it.
- Plan future activities for both of you to look forward to.
- Maintain some kind of social activity with your loved one, such as going to the movies.
- Make the best of the person’s good days. Drop the housework to enjoy time with your loved one.
- Keep guns out of the house.

**Have a life of your own.**
- If the depressed person needs monitoring or assistance, get help.
- Plan future activities for yourself alone.
- Live one day at a time.
**Communication Guidelines**

**Expression of Empathy and Compassion**
People with mental disorders can get discouraged with their illness and its stigma. It is important to have compassion for their experience. Examples of things that you can say are:

- “I know it must be difficult for you right now.”
- “It must be terrible to feel that way.”

Not all people with mental disorders will have these problems, but when they do, here are some guidelines to communicate effectively.

<table>
<thead>
<tr>
<th>When a mentally ill person …</th>
<th>You need to …</th>
</tr>
</thead>
<tbody>
<tr>
<td>has trouble with ‘reality’</td>
<td>be simple, truthful</td>
</tr>
<tr>
<td>is fearful</td>
<td>stay calm</td>
</tr>
<tr>
<td>is insecure</td>
<td>be accepting</td>
</tr>
<tr>
<td>has trouble concentrating</td>
<td>be brief, repeat</td>
</tr>
<tr>
<td>is over stimulated</td>
<td>limit input, not force discussion</td>
</tr>
<tr>
<td>is easily agitated</td>
<td>recognize agitation, allow escape</td>
</tr>
<tr>
<td>has poor judgment</td>
<td>not expect rational discussion</td>
</tr>
<tr>
<td>is preoccupied</td>
<td>get attention first</td>
</tr>
<tr>
<td>is withdrawn</td>
<td>initiate relevant conversation</td>
</tr>
<tr>
<td>has little empathy for you</td>
<td>recognize this as a symptom</td>
</tr>
<tr>
<td>believes delusions</td>
<td>empathize, don’t argue</td>
</tr>
<tr>
<td>has low self-esteem and motivation</td>
<td>stay positive</td>
</tr>
</tbody>
</table>

**How to make positive requests:** in a direct, pleasant and honest way:
1. Look at the person
2. Say exactly what you would like them to do
3. Tell them how it would make you feel

Example: “I would like you to …”

**How to express negative feelings:** in an effective, non-threatening way
1. Look at the person. Speak firmly.
2. Say exactly what they did to upset you.
3. Tell them how it made you feel.
4. Suggest how the person might prevent this from happening in the future

Example: “I feel angry that you shouted at me. I’d like it if you spoke quieter next time.”

**Giving praise:**
Use praise to encourage any progress, no matter how small, ignoring flaws. Be specific. Praise can be attention, physical affection, expression of interest, and/or commendation.

**What to avoid:** Research shows these can lead to relapses.

<table>
<thead>
<tr>
<th>Blaming</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly emotional responses</td>
<td>Ignoring them or their expressions of distress</td>
</tr>
<tr>
<td>Perpetuating stigma</td>
<td>Telling them to “buck up”</td>
</tr>
<tr>
<td>Character assassination</td>
<td>Setting too many demanding limits</td>
</tr>
</tbody>
</table>

---

9 Summarized from [Family Guidelines](#) by Dr. Christopher Amenson and “Tips for Crisis Prevention” from [Crisis Prevention Institute, Inc.](#), adapted.
General Mental Health Resources

Books


- Bramson, Robert M. *Coping with Difficult People,* Dell, 1988. Although not specific to mental illness, many of the suggestions in this book can be helpful.

- Hayes, Larry, *Mental Illness and Your Town – 37 Ways for Communities to Help and Heal,* Ann Arbor: Loving Healing Press, 2009. This is written by a Unitarian Universalist and mental health activist who himself has been hospitalized for depression. This is an excellent resource for how to get involved in advocacy work.

- Oates, Wayne. *The Care of Troublesome People,* The Alban Institute, 1994. Oates, the grand-daddy of pastoral counseling, on caring for various kinds of troublesome people, mentally ill or not.

- Roukema, Richard W., M.D. *Counseling for The Soul in Distress – What Every Pastoral Counselor Should Know About Emotional and Mental Illness, 2nd Edition,* New York: The Haworth Pastoral Press, 2003. This is an excellent book about mental illness written specifically for ministers. I recommend it highly as a supplement to this guide. Many of his suggestions have been incorporated here.

Religious Mental Health Curricula and Resources


Websites
<table>
<thead>
<tr>
<th>Website/Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health Information for Clergy</strong></td>
<td>Interfaith technical assistance and resource center which offers liturgical and educational materials, program models, and networking information to promote a caring ministry with people with mental illness and their families. I recommend this site highly.</td>
</tr>
<tr>
<td><strong>NAMI is a self-help, support and advocacy organization</strong></td>
<td>of consumers, families, and friends of people with severe mental illnesses. Local affiliates and state organizations identify and work on issues most important to their community.</td>
</tr>
<tr>
<td><strong>NAMI’s information for faith communities</strong></td>
<td>Facilitates the development within the faith community of a supportive environment for those with mental illness and their families; educates clergy; encourages faith community advocacy to bring about hope and help for all affected by mental illness.</td>
</tr>
<tr>
<td><strong>Unitarian Universalist Mental Health Ministry</strong></td>
<td>This website contains:  - Fairly comprehensive list of Mental Health Websites  - Public access TV shows on various mental health problems produced by Rev. Barbara F. Meyers. Each show has a case study of someone living with the disorder. They can be watched from the web at Mental Health Matters TV Show</td>
</tr>
<tr>
<td><strong>Interfaith outreach to enable faith communities</strong></td>
<td>to provide compassionate care to those affected by mental illness. Run by Methodist minister Rev. Susan Gregg-Schroeder, who runs a mental health ministry. Many of her resources can be downloaded for free. Her books and videos are reasonably priced and very well done. The spiritual messages may need “translation” for non-Christian audiences.</td>
</tr>
<tr>
<td><strong>The consumer technical assistance center</strong></td>
<td>has played a major role in the development of the consumer movement, which strives for dignity, respect, and opportunity for those with mental illnesses.</td>
</tr>
<tr>
<td><strong>The VA’s goal is to provide excellence in patient care and benefits for veterans of the US armed services.</strong></td>
<td>This site has VA Mental Health Consumer Council Newsletters.</td>
</tr>
<tr>
<td><strong>Wellness Recovery Action Plan (WRAP)</strong></td>
<td>A system that a person can use for monitoring and responding to symptoms of his or her mental disorder to achieve the highest possible levels of wellness. It focuses on empowering the client take control of health and wellness, by making decisions when he or she is well for what to do when ill. There are WRAP groups in many localities. Very highly recommended.</td>
</tr>
</tbody>
</table>
Resources for Depression

Books


- Thorne, Julia and Rothstein, Larry. *You are Not Alone – Words of experience and hope for the journey through depression*, New York: Harper Perennial, 1993. I have purchased multiple copies of this book and loan them out to people living with depression when I think they would be helpful.

Websites

<table>
<thead>
<tr>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive and Bipolar Support Alliance</td>
<td>Organization with many self-help group chapters to improve the lives of people with mood disorders.</td>
</tr>
<tr>
<td>National Alliance for Research on Schizophrenia and Depression</td>
<td>Raises funds and gives grants for psychiatric brain disorder research, in an effort to find the causes, better treatments, and eventual cures for these disorders.</td>
</tr>
<tr>
<td>Postpartum Support International</td>
<td>The purpose of this website is to increase awareness among public and professional communities about the emotional changes that women experience during pregnancy and postpartum.</td>
</tr>
<tr>
<td>Postpartum Education for Parents</td>
<td>PEP offers programs to help parents and families thrive with their new children.</td>
</tr>
</tbody>
</table>
Resources for Bipolar Disorder

Books


- Wootton, Tom, *The Bipolar Advantage*, Bipolar Advantage Publishers, 2005. Wootton has Bipolar Disorder and has recently started a holistic therapy program for it. See his website below for details.

Websites

<table>
<thead>
<tr>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar World</td>
<td>Information - books, medical information, treatments, personal stories, web sites - about bipolar disorder.</td>
</tr>
<tr>
<td>Bipolar Advantage</td>
<td>Tom Wootton's website and program to holistically help people with mental conditions shift their thinking and behavior to change the paradigm of mental conditions from an illness to an advantage.</td>
</tr>
<tr>
<td>Bipolar Disorder Magazine</td>
<td>On-line website for <em>bp Magazine</em>, a magazine to create community among and empower people living with bipolar disorder.</td>
</tr>
<tr>
<td>Depressive and Bipolar Support Alliance</td>
<td>This organization has many excellent self-help group chapters to improve the lives of people with mood disorders.</td>
</tr>
<tr>
<td>Lucid Interval</td>
<td>A Self-Management Guide for Bipolar Disorder written by a patient who has &quot;survived numerous manic episodes and consequent hospitalizations.&quot; Best bipolar website of 2006.</td>
</tr>
</tbody>
</table>
Resources on Anxiety Disorders

Books


Websites

<table>
<thead>
<tr>
<th>Website</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders Association of America</td>
<td>Promotes the prevention, treatment and cure of anxiety disorders and to improve the lives of all people who suffer from them.</td>
</tr>
<tr>
<td>Obsessive-Compulsive Foundation</td>
<td>Information and resources, for people with obsessive compulsive disorder, their families, friends, professionals and other concerned individuals.</td>
</tr>
<tr>
<td>National Center for PTSD in US Dept of Veterans Affairs</td>
<td>This website from the Veteran's Administration has much information about Post Traumatic Stress Disorder (PTSD), and a Guide for families</td>
</tr>
<tr>
<td>National Alliance on Mental Illness (NAMI) Veterans Resource Center</td>
<td>Access to a wide range of resources on veterans and mental illness. Designed for veterans and active duty military members, as well as their families, friends, and advocates.</td>
</tr>
<tr>
<td>Treatments for post-traumatic stress disorder</td>
<td>This website gives a lot of practical information about PTSD and the many kinds of treatments which are used.</td>
</tr>
</tbody>
</table>
Resources for Schizophrenia

Books


Websites where you will find the most current information on schizophrenia and its treatment:

<table>
<thead>
<tr>
<th>Website</th>
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<tbody>
<tr>
<td>National Alliance for Research on Schizophrenia and Depression</td>
<td>Raises funds and gives grants for psychiatric brain disorder research, in an effort to find the causes, better treatments, and eventual cures for these disorders.</td>
</tr>
<tr>
<td>Prevention and Recovery of Early Psychosis</td>
<td>A program at UCSF whose goal is to provide comprehensive, conscientious and evidence-based services to people suffering from signs and symptoms of serious mental illness. It aims at early intervention.</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>Non-profit web community dedicated to providing high quality information, support and education to the family members, caregivers and individuals whose lives have been impacted by schizophrenia.</td>
</tr>
</tbody>
</table>
Resources for Co-occurring disorders

Books


Websites for Substance Abuse and Co-occurring Disorders

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Double Trouble</td>
<td>A 12-step group specifically designed for co-occurring disorders.</td>
</tr>
<tr>
<td>Al-Anon / Alateen</td>
<td>12-Step Addiction Programs</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>For families and teen-age children of alcoholics</td>
</tr>
<tr>
<td>Cocaine Anonymous</td>
<td>For addicts</td>
</tr>
<tr>
<td>Emotions Anonymous</td>
<td></td>
</tr>
<tr>
<td>Narcotics Anonymous</td>
<td></td>
</tr>
<tr>
<td>Unitarian Universalist Addiction Ministry</td>
<td>Article from <em>UU World</em> with resources. Unitarian Universalist Addiction Ministry website is coming.</td>
</tr>
</tbody>
</table>
Resources for Suicide

Books – for heading off suicide, or dealing with the situation in its aftermath

- 1-800 SUICIDE is the national suicide hot line, which is automatically routed to a local provider.


- Litts, David, ed. *After a Suicide – Recommendations for Religious Services & Other Public Memorial Observances*, Suicide Prevention Resource Center, 2004. I am grateful for this excellent on-line guide that I have used for helping prepare memorial services after a suicide.

Websites

<table>
<thead>
<tr>
<th>Link</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Association of Suicidology</td>
<td>Dedicated to the understanding and prevention of suicide. Links to suicide support groups nation-wide.</td>
</tr>
<tr>
<td>Compassionate Friends</td>
<td>Grief support after the death of a child</td>
</tr>
<tr>
<td>International Association for Suicide Prevention</td>
<td>Dedicated to preventing suicidal behavior, to alleviate its effects, and to provide a forum for academicians, mental health professionals, crisis workers, volunteers and suicide survivors.</td>
</tr>
<tr>
<td>National Council for Suicide Prevention</td>
<td>An organization with a mission to further effective suicide prevention through collaborative activities and information sharing in order to save lives. It is a collaboration of many suicide prevention groups.</td>
</tr>
</tbody>
</table>
Resources for Families

Books – Including a number of guides for families written by people who’ve been there


Website

| NAMI Family-to-Family Education Program | A 12-week course for family caregivers of individuals with severe brain disorders. |
Resources for Religion and Mental Health

Books


Website

| Spiritual Competency Resource Center | Psychologist David Lukoff’s website with on line resources that enhance the cultural sensitivity of mental health professionals regarding spiritual matters. Spirituality is now accepted as an important component of cultural competence for mental health professionals. |
EXAMPLE COVENANT OF RIGHT RELATIONSHIP

Mount Diablo Unitarian Universalist Church

Covenant of Right Relationship

In my relationship with the MDUUC community, and in keeping with our UU values, I will:

* Speak and write openly, honestly and respectfully, with clarity, tact and compassion.

* Listen carefully, with an open mind and an open heart, to what others say.

* Take responsibility for my speech and actions as they affect both individuals and the congregation as a whole.

* Be sensitive to possible conflicts, and be willing to work toward solutions using available resources, accepting that some differences may not be resolvable.

* Respect my own boundaries and the boundaries of others (sexual or other), and protect and support vulnerable individuals.

* Respect and support the diversity within our congregation, and work to create a more welcoming environment.

* Support our congregation as a safe environment for healthy relationships.

Adopted by the Congregation, June 2, 2002
EXAMPLE DISRUPTIVE BEHAVIOR POLICY

Policy Regarding Disruptive Behavior

Adopted by the Executive Committee of the Board of Trustees
West Shore Unitarian Universalist Church, Cleveland, Ohio

While openness to a wide variety of individuals is one of the prime values held by our congregation and expressed in our denomination's purposes and principles, we affirm the belief that our congregation must maintain a secure atmosphere where such openness can exist. When any person's physical and/or emotional well-being or freedom to safely express his or her beliefs or opinions is threatened, the source of this threat must be addressed firmly and promptly, even if this ultimately requires the expulsion of the offending person or persons. There have been times when the disruptive behavior of an individual within the church building has led members to voice their concerns about one or more of the following:

1. Perceived threats to the safety of any adult or child;
2. The disruption of church activities;
3. Diminishment of the appeal of the church to its potential and existing membership.

The following shall be the policy of West Shore Unitarian Universalist Church in dealing with these issues:

1. If an immediate response is required, this will be undertaken by the Minister(s), if available, and/or the leader of the group involved. This may include asking the offending person or persons to leave, or suspending the meeting or activity until such a time as it can safely be resumed. If further assistance is required the Police Department may be called. Anytime any of these actions are undertaken without the Minister(s) being present, the Minister(s) must be notified. A follow-up letter detailing what steps must be taken before returning to the activities involved will be sent by the Minister(s) to the offending party or parties.

2. Situations not requiring immediate response will be referred to an ad hoc committee appointed by the Board of Trustees. The committee will respond in terms of their own judgment observing the following:
   a. The committee will respond to problems as they arise. There will be no attempt to define "acceptable" behavior in advance.
   b. Persons identified as disruptive will be dealt with as individuals; stereotypes will be avoided.
   c. The committee will collect all necessary information.
   d. To aid in evaluating the problem, the following points will be considered:
      DANGEROUSNESS - Is the individual the source of a threat or perceived threat to persons or property?
      DISRUPTIVENESS - How much interference with church functions is going on?
      OFFENSIVENESS - How likely is it that prospective or existing members will be driven away?

   e. To determine the necessary response, the following points will be considered:
      CAUSES - Why is the disruption occurring? Is it a conflict between the individual and
others in the church? Is it due to a professionally diagnosed condition of mental illness?
HISTORY - What is the frequency and degree of disruption caused in the past?
PROBABILITY OF CHANGE - How likely is it that the problem behavior will diminish in the future?

f. The committee will decide on the necessary response on a case by case basis. However, the following three levels of response are recommended:
LEVEL ONE - The committee shall inform the Minister(s) of the problem and either the Minister(s) or a member of the committee shall meet with the offending individual to communicate the concern.
LEVEL TWO - The offending individual is excluded from the church and/or specific church activities for a limited period of time, with reasons and the conditions of return made clear.

LEVEL THREE - The offending individual is permanently excluded from the church premises and all church activities. Before this is carried out, the committee will consult with the Board of Trustees and the Minister(s). If it is decided that expulsion will take place, a letter will be sent by the Minister(s) explaining the expulsion and the individual's rights and possible recourse.

g. Any action taken under item f. (above) may be appealed to the Executive Committee of the Board of Trustees and/or the Minister(s).

West Shore Unitarian Universalist Church strives to be an inclusive community, affirming our differences in beliefs, opinions and life experiences. However, concern for the safety and well-being of the congregation as a whole must be given priority over the privileges and inclusion of the individual. To the degree the disruptive behavior compromises the health of this congregation, our actions as people of faith must reflect this emphasis on security.
Biographical Information for Barbara Meyers

Rev. Barbara Meyers is a Unitarian Universalist Community Minister endorsed by the Mission Peak Unitarian Universalist Congregation in Fremont. Her ministry is focused on mental health issues and includes educational, healing, social justice and priestly functions. Barbara’s work is largely motivated by her own experience as a mental health client. Her ministry has encompassed several activities:

- She has written the curriculum *The Caring Congregation Handbook* that is a program for educating a congregation about how to be more intentionally supportive of people with mental disorders and their families.

- She works part time at a peer-run mental health center in Fremont.

- She produced a public access TV show called *Mental Health Matters* which for 6 years taped a half-hour show each month focusing on some aspect of mental health. She also taped a number of personal stories of recovery from mental health difficulties. The goal of each show is to give consumers and families hope. All shows are on YouTube and can be watched from her website. [www.mpuuc.org/mentalhealth](http://www.mpuuc.org/mentalhealth)

- She leads worship services at her church and other pulpits.

Barbara graduated from Starr King School for the Ministry in 2004 and was ordained in 2005. She earned a certificate in Spiritual Direction from the Chaplaincy Institute in 2010. Her entry into ministry marked a career change after working as a computer software engineer at IBM for 25 years.