THE Christian Citizen

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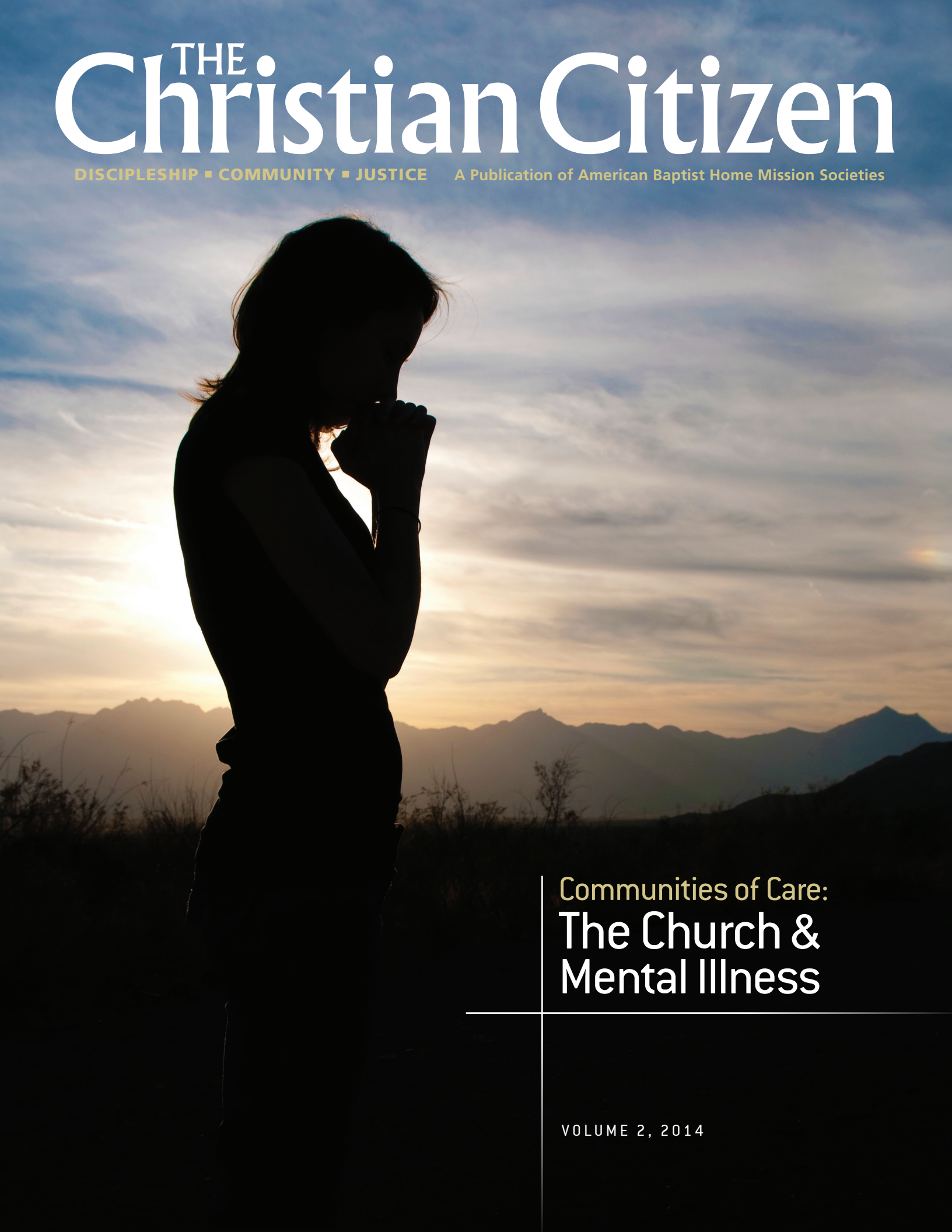

Communities of Care:
The Church & Mental Illness

VOLUME 2, 2014

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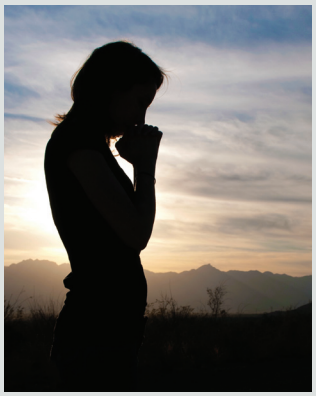

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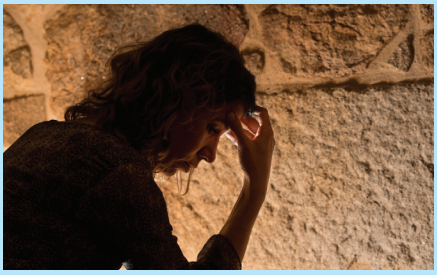
Editorial

Curtis Ramsey-Lucas

Mental Health and Faith Community Partnership to Reduce Stigma and Provide Help and Healing

One in four U.S. Americans annually experience mental health issues ranging in severity from temporary psychological distress to serious depression, schizophrenia and bipolar disorder, yet less than one-third of these persons receives appropriate care, often because of the stigma associated with these illnesses and their treatments.



American Baptist Home Mission Societies (ABHMS) wants to help change these statistics for the better. That is why we're providing leadership through the Interfaith Disability Advocacy Coalition (IDAC), a program of the American Association of People with Disabilities, in its partnership with the American Psychiatric Association (APA). This effort brings together religious leaders and psychiatrists to determine how we can better collaborate to reduce stigma and provide help and healing for those with mental health conditions.

This partnership grew out of a conversation with Dr. Paul Summergrad, head of the Department of Psychiatry at Tufts University and president of the APA. We met over lunch at the White House Conference on Mental Health on June 3, 2013. As we talked about the respective aims and interests of our organizations, we recognized each had something to offer the other. So we decided to meet again the next time Dr. Summergrad was in Washington.

Subsequently, we brought together the leadership of IDAC and APA for a series of meetings to further the work we will do together, beginning with a gathering of religious leaders and psychiatrists at APA's headquarters in July 2014. At this Mental Health and Faith Community Partnership Meeting, participants sought to bring the best of their respective traditions and practices together to create resources and opportunities for mutual understanding and action among members of the faith and psychiatric communities. Our discussion centered on the following goals:

- establishing an ongoing dialogue between psychiatrists and clergy;
- surveying organizations and resources that are already active at the intersection of mental health and faith;
- acknowledging and addressing the stress and mental health needs of clergy and other religious leaders;
- creating new resources to train religious leaders about mental health issues;
- improving mental health education offered in seminaries and pastoral and continuing education programs;
- exploring ways for medical schools and psychiatric residency training programs to address the importance of faith communities as a component of mental health recovery; and
- creating new resources that are useful to psychiatrists about faith and faith communities in mental health recovery.

Among those who attended the meeting are contributors to this issue of The Christian Citizen, including Susan Gregg-Schroeder, Craig Rennebohm and Doug Ronsheim. Their words, and those of others in this volume, speak with a wisdom borne of personal or familial experience as well as years of ministry with those with mental health conditions. They are witnesses to the inadequacies of current community-based services and supports for individuals and families but also to what is possible when we step out in love and service in ministry with those with mental illness.

It is our hope that this issue will spark an interest in your congregation and community and that you'll find resources for your own work and ministry. Moreover, we continue to hope and anticipate the good that God will do in and through the Mental Health and Faith Community Partnership to reduce stigma and improve the quality and accessibility of care for individuals and families living with mental illness.

Curtis Ramsey-Lucas serves ABHMS as managing director, Resource Development, and represents ABHMS on the IDAC.

Susan Gregg-Schroeder

Mental Illness and Families of Faith

How Congregations Can Respond

One in four families sitting in the pews has a member dealing with mental illness. Yet our religious communities are often silent when it comes to understanding mental disorders as treatable illnesses. Persons struggling with mental illness and their family members often become detached from their faith communities and their spirituality, which could be important sources of healing, wholeness and hope in times of personal darkness.

My depression began in 1991. I was in my third year of ministry at a large urban church. Despite my experience in pastoral counseling, I did not recognize or understand what was happening to me. Few people at church knew about my depression and hospitalization. For two years I suffered in silence, hiding my condition

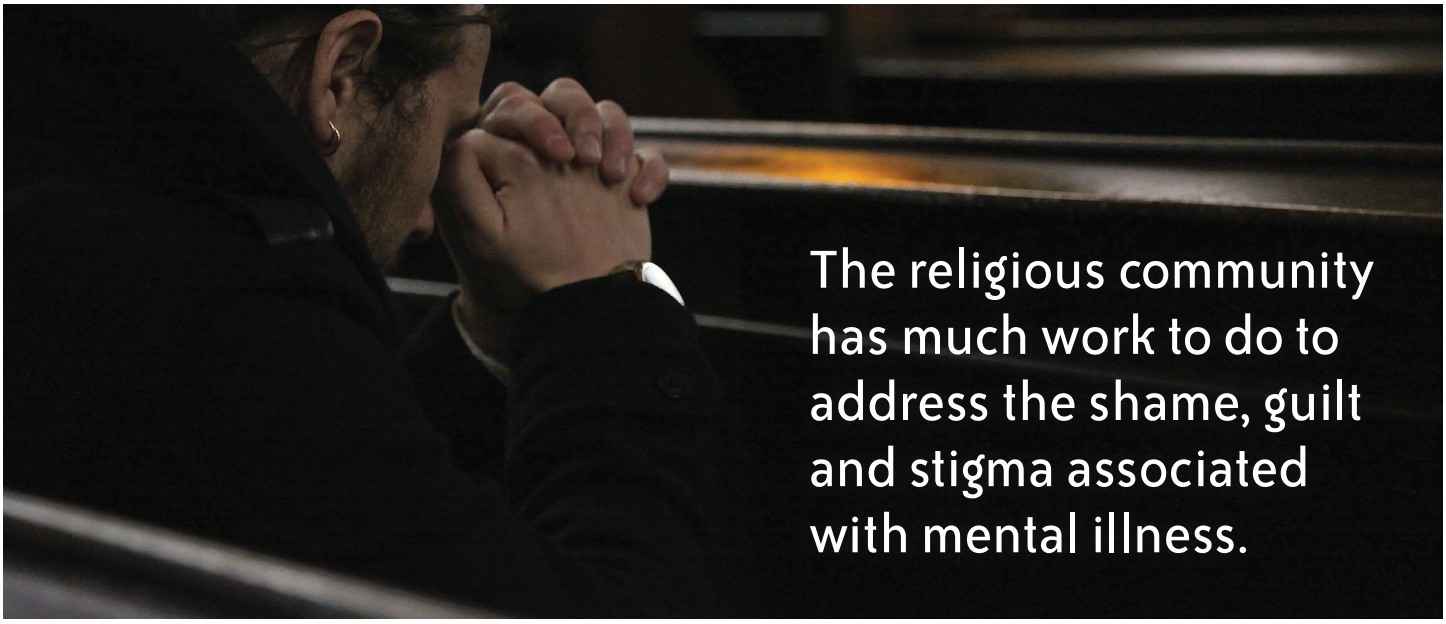
from the church community for fear of losing my job. With the support of my senior pastor, who had stood by me, believing in grace and believing in me, I finally decided to openly acknowledge my depression. I wrote an article for our church newsletter titled "The Burden of Silence." My senior pastor wrote an accompanying article about the ignorance that is common regarding mental illness. Our parish nurse set up an informational meeting on depression, and we had a turn-away crowd of more than 130 people.

A colleague asked me to speak at our Bishop's Convocation. The stories that my colleagues shared with me behind those closed doors made me realize that I was being called to speak out on mental illness in the church. I was especially concerned about my colleagues from certain groups, who feared disclosure could bring shame to the family or negatively impact a person's future in ministry. The sad truth is that hundreds of our clergy have been forced to leave the ministry because of the stigma and ignorance associated with mental illness.

I am one of the "wounded healers" described by Henri Nouwen in his book "The Wounded Healer: Ministry in Contemporary Society." I have had subsequent hospitalizations and a variety of diagnoses from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), that have changed over the years. But you cannot put a label on the human spirit. I know that I need to continue to have my medication monitored, maintain a good support system, and practice good self-care as well as preventive care at those times when I feel most vulnerable. I've learned coping skills and have developed inner resources. I relate to the words of Louisa May Alcott, who wrote in "Little Women": "I am not afraid of storms, for I am learning how to sail my ship."

The religious community has much work to do to address the shame, guilt and stigma associated with mental illness. Unfortunately, few seminaries incorporate adequate information about mental illness into their core curriculum. Studies show that a majority of individuals with a mental health issue go first to a spiritual leader for help. Yet clergy are often the least effective in providing appropriate support and referral information.

After 13 years in the local church, I took a sabbatical leave and Mental Health Ministries was birthed in 2001. Mental Health Ministries is an interfaith web-based ministry that provides educational resources to help erase the stigma of mental illness in our faith communities. Our mission is to help faith communities become caring congregations for both people living with a mental illness and those who love and care for them based on the "Caring Congregations" five-step model first approved by the General Conference of The United Methodist Church in 1996 and amended and readopted



in 2004 and 2012 ("The Book of Resolutions of The United Methodist Church" © 2004 by The United Methodist Publishing House). These steps, summarized below, are not linear. Rather, the process of becoming a caring congregation is dynamic and unique to each community.

- Education is the first step and includes involving faith leaders, providing educational resources and offering classes to reduce the stigma.
- Commitment means that the community pledges to be intentional in seeking ways to become a caring congregation.
- Welcome is offering hospitality by seeking ways to integrate persons with a mental illness into the life of the community.
- Support can be offered to individuals and family members by training persons to be a caring presence, providing support groups and referral information, and offering mutual respect along with prayer.
- Advocacy means helping to better access care, funding and support for mental health treatment as well as speaking out on mental health concerns.

The Mental Health Ministries website (www.MentalHealthMinistries.net) offers a wide variety of downloadable print and DVD resources with many print resources available in Spanish. The website also has training materials and other resources developed by denominations and national groups working in the area of spirituality/faith and mental illness, along with an inspiration section with devotions, prayers and quotations. Congregations can choose from the menu of resources and adapt them to their unique needs.

When I started Mental Health Ministries, not much attention was given to addressing the stigma of mental illness in our faith communities. Since then, we have seen increasing awareness of the important role of faith and spirituality in the treatment and recovery process; and we recognize the unique position of congregations to serve as caring communities for persons living with mental illness and those who care for them. When faith leaders and faith communities are well-informed about mental illness, they can be an important part of a support network, forming collaborative relationships with local mental health providers, advocacy groups and other community partners.

We can all be seed planters. Most mental health outreach ministries begin small. We plant seeds in faith that others will help nurture and water. A seed is a promise. Some seeds take root and grow in surprising ways resulting in a harvest we could have never imagined. When I began sharing my story and connecting with faith communities, I never expected that my work would evolve the way it has, which brings to mind the quotation often attributed to Robert Louis Stevenson: "Don't judge each day by the harvest you reap, but by the seeds you plant."

For me, the most painful part of my illness was the feeling of disconnection. A supportive faith community would have helped me feel that I was connected to something bigger than my own feelings of worthlessness and hopelessness. A supportive faith community would have embraced my family. We would not have had to suffer in silence. I pray that the time will come when families living with a loved one with mental illness will be silent no more.

The Rev. Susan Gregg-Schroeder, founder of Mental Health Ministries, serves on the National Alliance on Mental Illness' FaithNet Advisory Group. Print and media resources are available at the Mental Health Ministries website (www.MentalHealthMinistries.net).

Craig Rennebohm

A Call to Healing

For 25 years I worked as a chaplain on the streets of Seattle with individuals who were homeless and struggling with mental illness. My particular concern was persons like Terry, who slept hidden on the doorstep of the church, silently going through the meal line, fearful and disconnected from care.

Symptoms of mental illness can greatly reduce an individual's capacity to communicate and connect. Stigma can diminish our capacity as family, friends and neighbors to reach out. Yet we have this calling to welcome the stranger, to engage the outcast, and to help each other heal and become whole. As congregations, we are called to be home, to bind up our brokenness and find new life together.

As a young man, I experienced a prolonged episode of major depression. I felt utterly lost, greatly ashamed and deeply hopeless to the point of suicide. Over the years of recovery, I have learned that our brains are the most complex organs in our bodies. Billions upon billions of cells are intricately connected through incredibly subtle networks of energy and biochemical communication. Overwhelming experiences or just minute shifts in brain chemistry can profoundly impact and alter our feelings, thoughts, behavior and relationships. In biblical times, persons who suffered symptoms of mental disorder were often shunned, and the most ill were banished in chains and nakedness to the graveyard. Even today, the lack of adequate mental health services and housing leaves our streets and jails filled with individuals whose brains and being require great tenderness, not neglect or punishment.

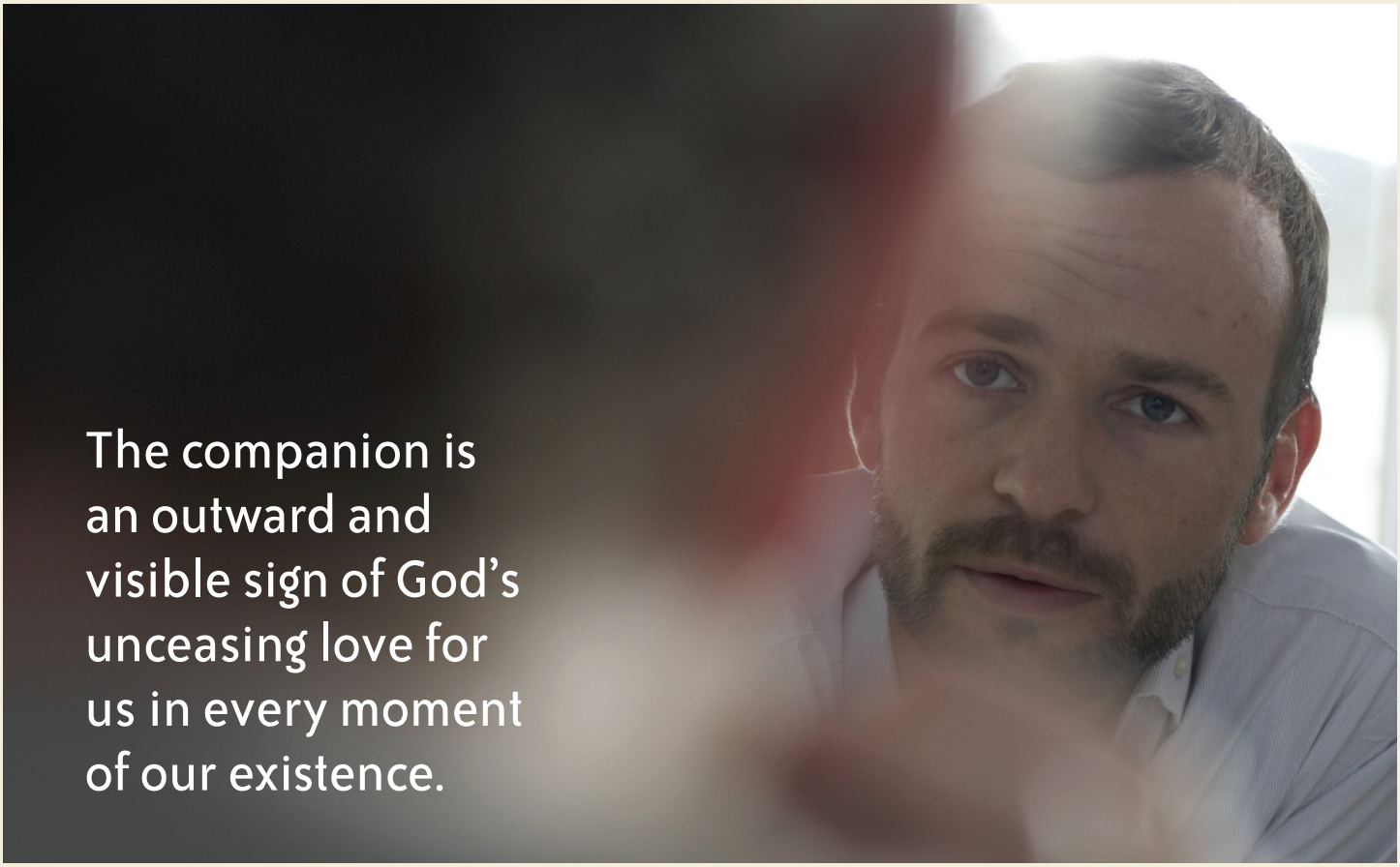
I was first helped by our pastor, Dick, who simply sat with me, making no attempts to "fix me" or offer advice. He came to the house, invited me for coffee, and we occasionally had lunch together. Dick looked for what we had in common, including an interest in books and theater. He listened, especially through pauses and silence, and without judgment, to my story. He went with me to see a doctor. He spoke honestly of his limits and related to me as one human being to another. He helped me build a sense of self and soul larger than my illness. I still am vulnerable to symptoms of depression. I take medication, and I have benefitted from several good counselors and the love of my family and friends, but Dick's early companionship laid a basic foundation for recovery and emerging well-being.

We are created for connection. Nothing, ultimately, separates us from one another or from God. Developmental challenges, trauma, mental disorder, drugs and alcohol, and dementia can all deeply disturb our souls, selfhood and social supports. Then is the gracious presence of another human being so helpful, so crucial. The companion is an outward and visible sign of God's unceasing love for us in every moment of our existence. The companion reminds us, despite our illness, that we are never lost.

Three gifts in human beings ready us for companionship. First, we are naturally sensitive. Our eyes see the sadness of another; we hear a person's muttered groan, their almost inaudible cry. We can smell the odor of an unwashed body, a wound left festering. We can taste in our own mouths the half-eaten sandwich fished from a garbage can or dumpster. We can feel on our own skin the heat and cold of living on the street, or days, weeks, and months without a hug or a handshake.

Our second gift is that we are naturally "feelingful." Each of us has a capacity for sympathy, empathy and compassion. We know what it is like to be lonely, to be humiliated, afraid or helpless. We can feel in our own being what another is experiencing. We can share with another person his or her condition and be near and at hand in the place of suffering.

Our sensitivity and feelingfulness give rise to our third gift—concern. We register the difficulty, the trouble, the need. We think about what kind of help we can offer. We wonder who else might be able to assist. Our concern is the working of the Spirit within us, awakening the possibility of response and service. On the street, I found myself concerned about more people than I could ever care for. I learned how to be a companion to four or five people at a time, perhaps 40 or 50 each year as a full-time chaplain. I did what I could, coming alongside one person at a time.



Companionship is a way of acting on our concern for a person who is suffering, struggling or alone. The way of companionship includes five basic spiritual practices that help build a relationship of trust and mutuality.

- **Hospitality:** creating a safe space with another, offering respect and refreshment
- **Neighboring:** beginning with what we have in common, meeting as equals
- **Side by side:** looking out at the world together, honoring our unique experiences
- **Listening:** hearing a person's story, their language of faith, hope and love
- **Accompaniment:** holding the person in thought and prayer, going with a person to a meeting or appointment

In every congregation, as clergy and laity, we can act on our concern for another, responding to companionship opportunities. Our hospitality may be as simple as a nod or a smile, our neighboring the willingness to linger a moment nearby rather than pass by on the other side. We may choose to share the pew, or to share the table at a meal program instead of remaining behind the serving line. We may follow up a "hello" with a "how is it going?" and a willingness to hear a person's story however they may be able to tell it. We may remember the stranger in our prayers, or help an individual add to their circle of care and support.

In every congregation, a small group of companions can meet regularly and share with one another this basic ministry of presence. Companions can be present at worship and coffee hour, available to members of the congregation as needed, or serve as community companions at shelters, meal programs and other points of human need. Companions gradually plant themselves in the life of the congregation, growing in knowledge and understanding, and providing an incarnate alternative to the stigma surrounding mental illness.

Companionship training resources for clergy and congregations are available from Pathways to Promise (www.pathways2promise.org), a national interfaith mental health ministry. Companionship is not an "add-on" to congregational life. It is at the heart of becoming a caring community.

Terry came in from her isolation. She became a minister of communion, sharing the gift of bread and cup, as well as companionship with others. Her church grew, and God rejoiced.

Craig Rennebohm is senior consultant with Pathways to Promise, an interfaith cooperative that offers liturgical and educational materials, program models and caring ministry with people and their families experiencing mental illness.

Craig Rennebohm

Un llamado a la sanidad

Durante 25 años trabajé como capellán en las calles de Seattle, con personas desamparadas, que vivían en la calle y luchaban con alguna enfermedad mental. Mi preocupación particular era por personas como Terry, que dormía escondida en la puerta de la iglesia, pasando por la línea de repartición de comida silenciosamente, temerosa y desconectada de recursos para ser atendida.

Los síntomas de una enfermedad mental pueden reducir en gran medida la capacidad de una persona para comunicarse y conectarse. El estigma puede disminuir nuestra capacidad como familia, amigos y vecinos para alcanzar a estas personas. Sin embargo, tenemos el llamado a acoger al extranjero y al marginado, y para ayudarnos unos a otros a tener una vida sana y completa. Como congregaciones estamos llamadas a ser refugios, a vendar nuestras heridas y a juntos y juntas encontrar nueva vida.

Cuando joven, experimenté un episodio prolongado de depresión. Me sentía completamente perdido, avergonzado en extremo y profundamente desesperanzado, al punto de suicidio. Durante los años de recuperación, he aprendido que nuestro cerebro es el órgano más complejo de nuestro cuerpo. Miles de millones de células están conectadas íntimamente a través de redes increíblemente sutiles de energía y comunicación bioquímica. Experiencias abrumadoras o sólo cambios mínimos en la química cerebral pueden impactar profundamente y alterar nuestros sentimientos, pensamientos, comportamientos y relaciones.

En tiempos bíblicos las personas que sufrían síntomas de trastorno mental a menudo eran rechazadas y las más enfermas eran proscritas al cementerio en cadenas y desnudez. Incluso hoy en día, la falta de servicios de salud mental y vivienda adecuadas tiene nuestras calles y cárceles llenas de personas cuyos cerebros y seres requieren un cuidado especial, no negligencia o castigo.

Quien me ayudó por primera vez fue nuestro pastor, Dick, quien simplemente se sentó a mi lado, sin intentar solucionar nada ni dar consejos. Él llegaba a la casa, me invitaba a tomar un café y de vez en cuando a almorzar. Dick buscó lo que teníamos en común, incluyendo el interés por los libros y el teatro. Escuchó, especialmente a través de los silencios y las pausas, y sin juzgarme. Él me acompañó a ver a un médico. Habló honestamente de sus limitaciones, y su relación conmigo fue la de un ser humano a otro. Él me ayudó a construir un sentido de mí mismo y de mi alma más grande que mi enfermedad. Yo todavía soy vulnerable a los síntomas de la depresión. Todavía tomo medicinas, me he beneficiado de varios buenos consejeros y tengo el amor de mi familia y amigos; pero el compañerismo de Dick al inicio ha sentado una base fundamental para mi recuperación y subsecuente bienestar.

Hemos sido creados para estar conectados y conectadas. Nada, en última instancia, nos separa el uno del otro o de Dios. Problemas de desarrollo, traumas, demencia, trastornos mentales, drogas y alcohol, pueden perturbar profundamente nuestra alma, individualidad y el apoyo social. Es ahí cuando la grata presencia de otro ser humano resulta tan útil, tan crucial. El acompañamiento es un signo externo y visible del amor incesante de Dios para nosotros y nosotras en cada momento de nuestra existencia. El acompañante nos recuerda, a pesar de nuestra enfermedad, que no estamos perdidos.

Los seres humanos tenemos tres dones que nos preparan para el acompañamiento. Somos naturalmente sensibles. Nuestros ojos ven la tristeza de otros; escuchamos el gemido que sale de alguien, ese grito casi inaudible. Podemos sentir el olor de un cuerpo sin lavar, o de una herida supurante. Podemos degustar en nuestra propia boca el sándwich a medio comer sacado de un cubo de basura. Podemos sentir en nuestra propia piel, el calor y el frío de la calle, o la sensación de pasar días, semanas y meses sin contacto humano, sin un abrazo o apretón de manos.

Somos naturalmente “emocionales”. Cada uno de nosotros y nosotras tiene la capacidad de la compasión, empatía y conmiseración. Sabemos lo que es estar solo, ser humillado, sentir miedo o desamparo. Podemos sentir en nuestro propio ser lo que otro está

experimentando. Podemos compartir con otra persona su condición, estar cerca y disponibles en el lugar de sufrimiento.

Nuestra sensibilidad y "emocionalidad" da lugar que nos preocupemos. Registramos la dificultad, la angustia, la necesidad. Pensamos en el tipo de ayuda que podemos ofrecer. Nos preguntamos: ¿quién más podría ser capaz de ayudar? Nuestra preocupación es la acción del Espíritu en nosotros, despertando la posibilidad de respuesta y servicio. En las calles me encontré preocupado por más gente de la que podía ayudar. Como capellán a tiempo completo, aprendí a ofrecer compañía a cuatro o cinco personas a la vez, quizá cuarenta o cincuenta cada año. Hice lo que pude, estar al lado de una persona a la vez.

El acompañamiento es una manera de hacer algo con nuestra preocupación por una persona que sufre o que lucha a solas. El camino del acompañamiento incluye cinco prácticas espirituales básicas que ayudan a construir una relación de confianza y reciprocidad:

- **Hospitalidad:** Creación de un espacio seguro con la otra persona, ofreciendo respeto y refrigerio
- **Establecer puentes:** Comenzando con lo que tenemos en común, reuniéndonos como iguales
- **Estar lado a lado:** Mirar hacia el mundo juntos, honrando nuestras experiencias únicas
- **Escuchar:** Poner atención a la historia de una persona, su lenguaje de fe, esperanza y amor
- **Acompañamiento:** Llevar a la persona en pensamiento y oración, ir con ella una reunión o una cita

En cada congregación, como pastores, pastoras y laicos, podemos actuar en relación a nuestra preocupación por los demás, respondiendo a oportunidades de acompañamiento. Nuestra hospitalidad puede ser tan simple como una sonrisa o un gesto amable; o la decisión de quedarnos un momento en lugar de pasarse al otro lado para evitar a alguien. Podemos optar por compartir la banca o compartir la mesa en un programa de comida en lugar de permanecer detrás de la línea de servicio. Podemos agregarle al saludo un "¿cómo te va?" y estar dispuestos a escuchar la historia de esa persona de la manera que sea capaz de contarla. Podemos recordar al forastero en nuestras oraciones, o ayudar a una persona a extender su círculo de atención y apoyo.

En cada congregación un pequeño grupo de acompañantes puede reunirse periódicamente y compartir mutuamente este ministerio básico de presencia. Las y los acompañantes pueden estar presentes en el culto y la hora del café, a disposición de miembros de la congregación, según sea necesario, o pueden servir como acompañantes en la comunidad, en refugios, en programas de alimentos y otros puntos en los que se provee ayuda humanitaria. Las y los acompañantes van sembrando poco a poco en la vida de la congregación el conocimiento y la comprensión que van creciendo, proporcionando así la encarnación de una alternativa al estigma que rodea las enfermedades mentales.

El acompañamiento es un signo externo y visible del amor incesante de Dios para nosotros y nosotras en cada momento de nuestra existencia.

Hay recursos de entrenamiento para el ministerio de acompañamiento, tanto para pastores y pastoras como para congregaciones, en la pág. de Pathways to Promise (www.pathways2promise.org), un ministerio ecuménico nacional dedicado a la salud mental. El acompañamiento no es un ministerio para "añadir" a la vida congregacional, es la clave para convertirse en una comunidad solidaria.

Terry salió de su aislamiento. Se convirtió en ministra de comunión, compartiendo el regalo del pan, la copa y el acompañamiento con los demás. Su iglesia creció y Dios se regocijó.

Craig Rennebohm es asesor principal de Pathways to Promise, una organización ecuménica que ofrece materiales litúrgicos y educativos, modelos de programas, y ministerio de atención a personas que sufren una enfermedad mental y a sus familias.

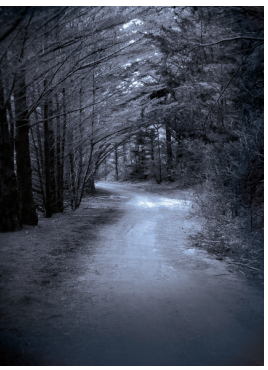
William Gaventa

Depression
Idols, Demons and Grace

As I wrestled with "Why?" during my first hospitalization for a major depression, I pored over Isaiah 57:7-13, where I found the reasons for what had happened to me. For "upon a high and lofty mountain" of work and accomplishment, I had set my bed and "went up to offer sacrifice," but when I "grew weary" from my "many wanderings," when I had "lied and did not remember" or think of God, so God had decided to close his eyes and keep silent. In my desire for security, I had gotten "off call," accepting a job that seemed to promise security, although it meant responsibilities for which I did not feel qualified and in which I had little interest. But I was sure, at some level, that my capacity for hard work would help me work it all out.

I had been wrong. I could not complete, fix or overcome the heavy workload and unexpected conflict; what's more, hard work and accommodating and appeasing others did me not one whit of good. All I could see was failure. All that was left was incredible shame for my own pretense that the gods of accomplishment could heal my feelings of worthlessness.

When the new medication did not help, I spent three weeks in an outpatient program and then tried to go back to work, but the anger at myself and at others was still churning, with no place to go except down the traditional path of my being responsible. My second hospitalization, some six weeks after the first, found me wondering in my journal—as I awaited my first experience of electroconvulsive therapy (ECT)—whether this was "the tin man or lion, looking for a magical wizard who would restore either the heart or courage that were no longer there." All of the issues were still going to be there—the sense of failure at work, the feeling of disconnection from family and friends, the guilt of failure, the fear it would never change, the painful memory of a good night's sleep, and the fatigue of just trying to keep going—but in the early morning hours before the first ECT, I heard birds singing and wrote in my journal:



I sure hope this goes well, and I can think somewhat clearly on return. It is clear during the night that the state of my depression and sleeplessness makes this necessary. One thing else is clear: My pattern of giving myself away—fitting in—is so much broader and longer than anything simply related to one part of my life. And the struggle, during the night, to maintain hope and faith, woke to the birds—or rather, the first birds reminded me of "his eye is on the sparrow," and the care is there, no matter what. Help me, O Lord, hold on to that this day and remember the prayers of those for me.

My treatment plans and journaling helped identify the building blocks of a more solid foundation—the need to cut back, take care of myself, focus on one day at a time, deal with primary relationships, learn to affirm myself, be open with my feelings, ask for help, trust that others care for me, and, most of all, stop pretending to be something I was not. My energy seemed to be back, the first real joy and excitement in six months. I made plans for a support network and committed myself, again, to the guidelines I would follow out of this pit, summed up in this revision of an Irish blessing, which I wrote and slid under the door of another patient:

One day at a time
Fight the demon (of suicidal ideation)
Hear the angels (the messages in all this)
Remember the ups and downs
One piece at a time.

So there it was: another accomplishment; a minister and chaplain who had battled depression with God and won. And was I ever wrong. Twenty-four hours later, I was feeling deeper in the pit than I had ever been. Thirty-six hours later, I refused a second ECT out of

despair over the hope that had proved to be an illusion. Four months later, I was back in the hospital.

As I look back, I know the real illusion was not hope, but control. There were people and times of faith that were crucial in keeping any kind of light alive—visits by pastors and colleagues, the bedrock support of wife and son, the readings of others' journeys, the psalmist, and particularly one prayer that I still recite from memory:

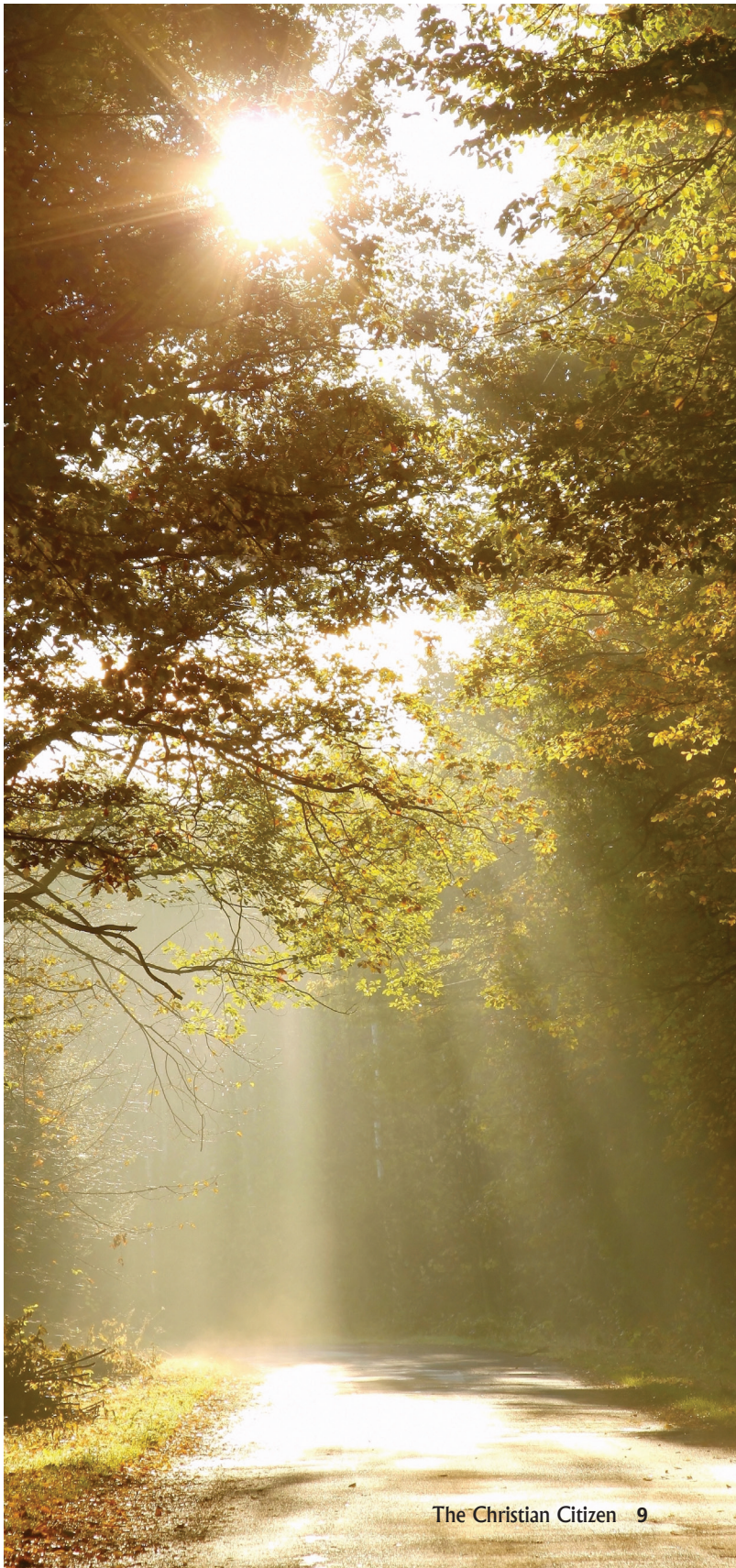
God bless this tiny little boat and me who travels in it.
It stays afloat for years and years
And sinks within a minute.
And the soul in which we sail
Unknown by years of thinking
Is deeply felt and understood
The minute that it's sinking.

(Michael Letting, "The Prayer Tree")

But as I began to sink once again, I was outwardly trying while inwardly dying. Nothing I could do was going to get me better (a failure here as well). It was too painful to stay where I was, yet I could not bear to go back to the hospital *because of what it would do to others*. Yet a third hospitalization did come with another round of ECTs followed by release just before Thanksgiving with new medication. Against internal and external voices that said I was crazy to do so, I cautiously returned to work. Each day got a little better. Then Advent came, and with it a feeling of "Oh, that's what light looks like." Was it the new medication, the ECT, the efforts made in therapy, the support and prayers of others, decisions about what to do in my job, or beginning to deal with complex issues and relationships? I have no idea what caused the change. I do know that each day has felt like a gift, and that a good night's rest is never taken for granted. My gut feeling is simply one of mystery, awe and gratitude. I can even begin to talk about the "gifts of depression," and the lessons of ignoring a sense of call and direction.

The lyrics to "Tin Man" by America—"Oz didn't give nothing to the tin man that he didn't already have, so please believe in me"—reverberate in my head. I shared them with one of the unit staff during my third hospitalization. He noted that the tin man had a heart all along, and the lion had courage, and even Dorothy was already home. They just didn't know it. A big part of me still wishes there were easier ways to learn. My favorite story from this journey comes from the wit of my son. During my third hospitalization, when my wife commented about how "a demon seemed to be hold of Dad" he added, "It's just too bad there's not a herd of pigs around when you need one."

William Gaventa serves as director of the Summer Institute on Theology and Disability at Wisconsin's Bethesda Institute and as consultant, trainer and writer for a variety of projects related to community supports and spiritual supports, training of seminarians and clergy, aging and end-of-life/grief issues, cultural competence and inclusive ministries. He can be contacted at bill.gaventa@gmail.com.



Doug Ronsheim

It Takes a Community

People with mental illness often wonder, "Can I love myself? Can someone love me? Am I worthy of God's love and redemption?" After a series of sessions with a pastoral counselor, one woman struggling with depression finally was able to declare, "When God finished the job of creating the world, our Creator said, 'It is good!' Now I believe this includes me." Unfortunately, the stigma associated with mental illness keeps many others from feeling included in the community of God. Often the stigma is caused by fear and lack of knowledge. Even in Scripture, we find stories in which people with mental and physical illnesses were feared, mistrusted and isolated from the larger community, because their conditions were believed to be the result of sin or demon possession (e.g., the Gerasene demoniac, Luke 8:26-34).

Mental health problems affect some 450 million people around the world, according to the World Council of Churches. Statistics from the National Institute of Mental Health indicate that approximately 26 percent of U.S. American adults suffer from a diagnosable mental illness in any given year. The escalation of mental health issues among military veterans and returning service men and women has also drawn attention to the burgeoning mental health needs of the general population. The term "mental illness" is used for a wide variety of conditions, with symptoms that range from mild and manageable to severe and debilitating. These include conditions such as major depression, postpartum depression, bipolar disorder, anxiety disorder, panic attacks and schizophrenia.

Just as a person with a family history of heart disease is predisposed to heart problems, a genetic predisposition also puts one at risk for mental illness. But emotional and physical well-being are also affected by environment. Just as environmental factors such as poor diet and lack of exercise may exacerbate a heart condition, living conditions are significant in determining whether a person develops mental illness. Since the early 1990s, researchers have been exploring the connection between Adverse Childhood Experiences (ACEs) and adult health. The findings confirm that traumatic childhood experiences, such as recurrent physical and emotional abuse, affect health and are influential throughout one's lifespan. The more ACEs a person experiences, the more severe the health outcomes are. This research suggests that understanding our past can be a pathway to improving our physical, emotional and spiritual well-being.

Although churches have been slow to welcome people with mental illness, partnerships among churches, health-related providers and community service groups offer the best hope for helping people affected by mental illness, who need the combined resources of a whole community. Results of a national survey published in 2005 by the Harvard School of Medicine showed that fewer than half of those who said they had a mental health concern actually sought treatment. Many people are reluctant to discuss their mental health, even with their own families. The reluctance to ask for help can

Although churches have been slow to welcome people with mental illness, partnerships among churches, health-related providers and community service groups offer the best hope for helping people affected by mental illness, who need the combined resources of a whole community.

isolate those with mental illness and keep them from receiving the support and understanding they need for healing.

In most congregations, members are much more likely to hear prayer requests and praises from people who are physically ill or in remission from a life-threatening physical illness than from someone undergoing treatment for a mental health issue or celebrating three years of sobriety from addiction. A close friend of mine, the father of six young children, has been hospitalized with severe depression seven times in the last 10 years. Although active in his church, he has not been offered any overt support from the congregation. I suspect that the response would be quite different for someone with a chronic physical illness.

Yet people with mental illness continue to turn to the church for help. The 2005 Harvard study found that 25 percent of those who sought treatment for a mental health concern turned first to a pastor or other church leader, while 17 percent contacted a psychiatrist or general medical doctor. Unfortunately, pastors and congregations often lack the knowledge and training to assist with the complex issues related to mental health. In a 2001 report by the National Center on Addiction and Substance Abuse at Columbia University, more than 90 percent of faith leaders said they considered abuse of alcohol and drugs—a significant influence on both mental and physical health—to be an important problem in their congregations. But only 12.5 percent of faith leaders reported having completed coursework pertaining to substance abuse during their theological studies.

A look at the community beyond the church reveals an equally troubling shortage of resources for people with mental illness. Organizations that monitor the healthcare industry say current numbers of trained mental health professionals and psychiatric services are woefully inadequate to meet the growing need.

The weaknesses in the system are poignantly portrayed in a June 2012 cover story in The New York Times Magazine. In "Love and Commitment: When My Crazy Father Actually Lost His Mind," Jeneen Interlandi describes the "revolving door of emergency rooms, short-term psych wards and jail" her father encountered in his struggle to find help with bipolar disorder. "In reporting this article," she writes, "I found scores of families trapped in the same fractured system. . . . They described programs that were underfinanced and overcrowded, not to mention involuntary commitment laws that were only haphazardly enforced." There's a growing consensus that responding adequately to the needs of people with mental health issues and their families will require the formation of partnerships among people in all of the "caring professions," including pastors and other religious leaders.

Strengthening relationships among faith communities, secular service providers and recovery programs will enable better coordination of care for people and families coping with mental health conditions. A good place for a congregation to begin is to find out what initiatives already exist for responding to mental illness, substance abuse and related issues. For example, the American Association of Pastoral Counselors helped develop a training initiative on mental health and substance abuse for clusters of congregations and partner organizations in neighborhoods across the nation. Pilot partnerships are underway in several states. The result is reduced stigma and increased knowledge and skills, and congregations are developing relationships with service providers, which enables them to assist in coordinating appropriate care and services. Involvement of the church is important because so many people with mental illness long for spiritual care. It takes an informed and caring faith community to help meet that spiritual hunger. As part of a holistic support system, the church can provide much-needed companionship and hope to people living with mental illness and to their families.

Doug Ronsheim, a Presbyterian minister, certified pastoral counselor and licensed marriage and family therapist, serves as executive director of the American Association of Pastoral Counselors (Fairfax, Va.) and on the board of Pathways to Promise.

Annelle Primm

Psychiatry and the Faith Community in Partnership

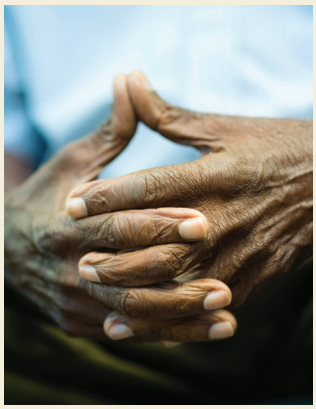
Spirituality, mental health and recovery are often inextricably connected and intertwined. For many people, faith is a key part of recovery, and many turn to clergy first when they experience mental distress. The American Psychiatric Association (APA) has long worked to increase members' understanding of connections with religion and spirituality and has worked collaboratively with the faith community in a number of ways.

At the APA's inaugural meeting in 1844, the founders established 16 committees, including the Committee on Chapels and Chaplains in Insane Hospitals. Over a century and a half later, APA members can join the Caucus on Religion, Spirituality and Psychiatry, which encourages communication and networking among psychiatrists who share an interest in religion and spirituality and provides a means of focusing attention on emerging issues. Each year, religion and spirituality are addressed at APA's Annual Conference, including the Oskar Pfister Award Lecture named in honor of a chaplain and psychologist who advocated for the compatibility of theology and psychology. This award, established in 1983 in collaboration with the Association of Professional Chaplains (formerly the Association of Mental Health Clergy), honors an outstanding contributor in the field of psychiatry and religion.

The APA has developed educational resources that incorporate religion and spirituality, including a manual specifically for clergy, "Mental Illnesses Awareness Guide for Clergy and Other Spiritual Leaders," developed in 1997. APA's new "Recovery-oriented Care in Psychiatry" curriculum acknowledges faith as part of a person-centered, holistic approach to psychiatric services. APA's "Resource Document on Religious/Spiritual Commitment and Psychiatric Practice" reflects the organization's interest in informing its members about religious and spiritual issues.

American Psychiatric Publishing, APA's publishing division, has numerous books and journal articles that address religion and spirituality. For example, The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), provides questions relating to religion and spirituality in its "Cultural Formulation Interview." Other titles focused in this area include: "Psychiatry and Religion: The Convergence of Mind and Spirit"; "Religious and Spiritual Issues in Psychiatric Diagnosis: A Research Agenda for DSM-V"; and the "Handbook of Spirituality and Worldview in Clinical Practice."

APA's traveling program on mental health disparities, known as "OMNA on Tour," has often involved collaboration with faith community leaders in culturally diverse communities around the nation to raise awareness about mental illness and the benefits of mental health care. In partnership with the African Methodist Episcopal Church, APA also developed an educational DVD and booklet called "Mental Health: A Guide for African Americans and Their Families." Most recently, APA, the American Psychiatric Foundation (APF), and the Interfaith Disability Advocacy Coalition (IDAC)—a program of the American Association of People with Disabilities (AAPD)—formed a partnership to reduce stigma associated with mental health conditions and foster dialogue between psychiatrists and leaders in the faith community. The partnership plans to create new resources for psychiatrists about faith and for members of faith communities about mental health recovery. The hope is to foster ongoing dialogue and networks of support and understanding between psychiatrists and clergy. One of the goals of the partnership is exploring ways for medical schools and psychiatric residency programs to address the importance of faith and spirituality as components of mental health recovery. This new collaboration is creating a pathway through which the connections between the field of psychiatry and the faith community will continue to grow into the future.



Dr. Annelle Primm is a psychiatrist and deputy medical director of the APA in Arlington, Va.

Carole Wills

NAMI FaithNet
A Lifeline, a Cairn and a Network

No one in our church, not even our pastor, knew how to help us ride the torrential waves of schizophrenia with our son. After years of searching, we found hope through the National Alliance on Mental Illness (NAMI). It truly became our lifeline. NAMI members at a local support group began setting out markers or cairns for a path to hope. We learned we were not alone. One in four families experiences some type of mental illness. So, why the silence in most churches, where many individuals in crisis first turn for help?

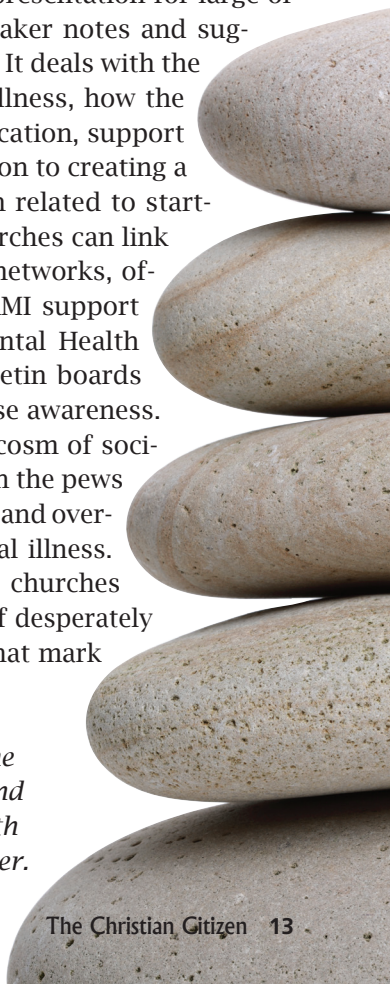
Our new NAMI friends set out another cairn: the "Family to Family" 12-week education course, a lifeline for any family dealing with serious mental illness. In time, we became part of the nationwide NAMI network, the largest grassroots education, support and advocacy organization in the United States. Besides "Family to Family" and support groups for family members, we discovered that NAMI offers other courses for those diagnosed with a mental illness ("Peer to Peer") and those who live and work with them: parents of children with mental illness ("Basics"); teachers ("Parents & Teachers as Allies"); police officers ("Crisis Intervention Team"); mental health providers ("Provider Education"); and clergy and religious groups ("NAMI FaithNet").

When I heard about NAMI FaithNet and its integration of faith and mental health education, I immediately resonated with its mission to educate clergy and congregations of all faith traditions to support people living with mental illness. I soon discovered the many online service planning ideas, prayers, Scripture readings, poems and articles. I began using these and other resources for May, the month designated as Mental Health Month, and for Mental Illness Awareness Week, which is the first full week of October.

Congregations can create a network of care for those facing mental health challenges by using NAMI FaithNet ideas and resources found at www.nami.org/namifaithnet. Two NAMI FaithNet PowerPoint presentations are particularly helpful for those seeking to begin a mental health ministry. "Reaching out to Faith Communities" is a four-unit, six-hour training tool that answers frequently asked questions about mental illness and the church, promotes interfaith dialogue, addresses the role of spirituality in recovery, and explains how to raise awareness, address hurtful views, and tell your story. "Bridges of Hope" is a one-hour presentation for large or small groups, complete with speaker notes and suggestions for audience interaction. It deals with the impact and red flags of mental illness, how the church can help, and NAMI's education, support and advocacy programs. In addition to creating a network and providing education related to starting a mental health ministry, churches can link to other mental health ministry networks, offer meeting space for a local NAMI support group or host a speaker for Mental Health Month. Members can design bulletin boards or write newsletter articles to raise awareness.

It is likely that someone sits in the pews in your congregation feeling alone and overwhelmed by the turmoil of mental illness.

Each congregation is a microcosm of society. It is likely that someone sits in the pews in your congregation feeling alone and overwhelmed by the turmoil of mental illness. With NAMI and NAMI FaithNet, churches can offer a lifeline and network of desperately needed support, building cairns that mark a path to help and hope.



Carole J. Wills is chairperson of the NAMI FaithNet Advisory Group and editor of "Wellspring Mental Health Ministries," a quarterly e-newsletter.

Joanne T. Kelly

WISE and Caring Congregations

Creating a Safe Haven for People in Your Church Who Have a Mental Illness

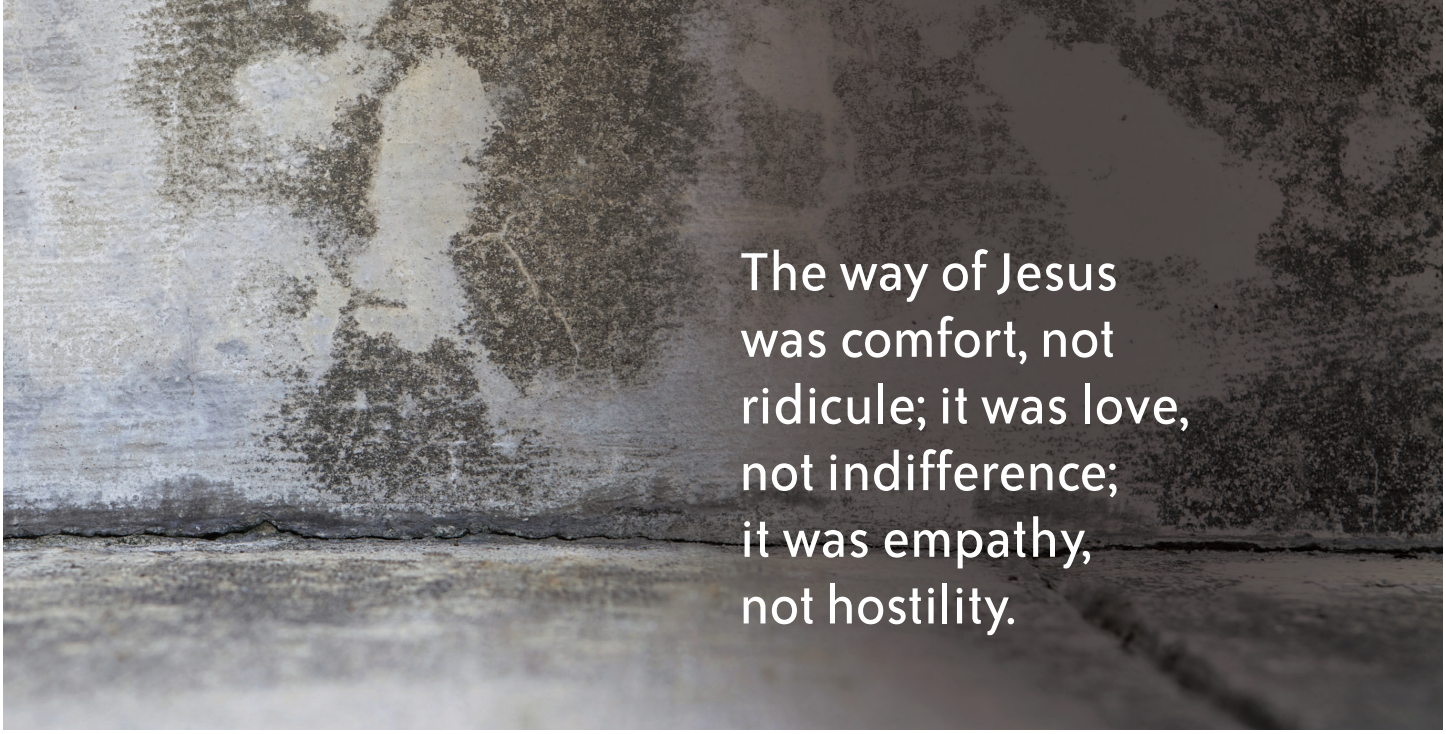
According to the National Institute of Mental Health, 26.2 percent of the population experiences mental illness. That means that in any given year, one of every four people who walk through the doors of your church are dealing with a mental illness. Yet, chances are, you don't hear anything about their diagnoses, their struggles or their journeys to recovery.

Mental illness affects people from all races, social classes, religions and denominations. Profound and pervasive stigma prevents many people with mental illness from sharing their stories with others in their churches, workplaces and neighborhoods. As a result, they don't get the support we typically offer people who are ill—no prayers for healing, no get-well cards, no casseroles when they return home after a hospitalization. They struggle alone or with the help of a few close family members who are trusted to keep their illnesses secret. Millions of people are affected by brain disorders; yet, because stigma is so ingrained, fewer than half get help. These disorders—most of which are treatable—have a huge impact on individuals and families, as well as on society as a whole.

In a perfect world, we'd identify the false stereotypes we harbor, examine our internal prejudices, recognize the ways we discriminate against people with mental illnesses, vow to make different choices and change how we behave toward them. Unfortunately, erasing stigma is not that easy. Affecting attitudinal change takes sustained effort, both on an individual level and on a church-community level. While some say we don't need mental health ministries in our churches—that including people with mental illnesses in the life and work of our congregations is sufficient—the matter is not that simple. We need mental health ministries to lay the groundwork for attitudinal change and carry out the ongoing work of ensuring our congregations are welcoming, inclusive and supportive. In addition, mental health ministries can work to eradicate stigma and nurture compassionate attitudes in the wider society.

Why should your church take this on? Jesus reached out to people who were marginalized, to those who were ostracized, and to those who were outcasts of the society. Jesus exemplified what we, his followers, ought to do: reach out with compassion and embrace those who are ill, lost and lonely. The way of Jesus was comfort, not ridicule; it was love, not indifference; it was empathy, not hostility.

According to "What Are the Effects of Stigma?", a report from the Scattergood Foundation (www.scattergoodfoundation.org), "Stigma is an issue of inequity and reducing it is a matter of social justice." Our churches can be instrumental in addressing this



social justice issue, and we can start right in our own vestibules and sanctuaries, making them safe havens for people suffering in silence.

The WISE (welcoming, inclusive, supportive and engaged) model offers a blueprint for combatting stigma and becoming more welcoming, inclusive and supportive of people with mental illness and their loved ones.

■ **Welcoming:** Form a mental health ministry to lay the groundwork for becoming welcoming. In a welcoming church, mental illness is normalized. In other words, it is treated like other illness. Prayers of petition include people with mental illness. Congregants and ministers are educated about mental illnesses. They understand that, while prayer is helpful for people in recovery from mental illness, effective treatment includes therapy and/or medication, just as it does for ailments such as heart disease or diabetes. The following suggestions and tools can help your church become more welcoming:

- "10 Steps for Developing a Mental Health Ministry in Your Congregation," Interfaith Network on Mental Illness (INMI) (www.inmi.us > "Resources for Faith Leaders"),
- "10 Things Faith Community Leaders Can Do to Make the World a Better Place for People with Mental Illnesses," INMI (www.inmi.us > "Resources for Faith Leaders") and
- Sponsor a Mental Health First Aid class at your church with various resources from www.mentalhealthfirstaid.org, Mental Health Ministries (www.mentalhealthministries.org) and INMI (www.inmi.us).

■ **Inclusive:** Include people with mental illness in the life, work and leadership of your congregation, inviting them to be part of a service project, serve as greeters or speak as part of a program about mental illness. "The Resource Guide for Mental Health Sunday," created by the United Church of Christ Mental Health Network (mhn-ucc.blogspot.com), provides a litany, sermon starters, prayers, bulletin inserts and other resources you can use as is or adapt for a "Mental Health Sunday" service.

■ **Supportive:** Offer a regular spiritual support group for people with mental illness and/or their families as well as practical support, such as meals, temporary housing, assistance with finding employment and respite care. The "Starting a Spiritual Support Group for Mental Health and Wellness in Your Faith Community" booklet from INMI (www.inmi.us > "Resources") provides sample guidelines.

■ **Engaged:** Work with other churches in your community to sponsor and promote programs that reduce the stigma of mental illness. Actively support organizations, such as INMI, the Caring Clergy Project (CCP), NAMI FaithNet, Pathways to Promise and Mental Health Ministries. Once your church has an active mental health ministry, register in INMI's Online Directory for Organizations Working at the Intersection of Faith/Spirituality and Mental Health (www.inmi.us). The Interfaith Directory aims to make it easier for faith communities and organizations to find each other, collaborate and share best practices. It is also useful for people who are looking for a faith community that welcomes, supports and values people with mental illness and their families.

Joanne T. Kelly is a cofounder of INMI.

John Swinton

Doing Small Things with Extraordinary Love

The mental health industry is a big and hugely complex beast. In the midst of the high-tech, neurological, genetic and pharmaceutical landscape, it is easy for religious communities to feel disempowered, wondering "What could we possibly offer that might bring healing?" In the book "Community and Growth," Jean Vanier offers an answer:

> We are not *all* called to do extraordinary things, but very ordinary things, with an extraordinary love that flows from the heart of God.

The church's vocation is not to become a community of psychiatrists but to become a community that reveals extraordinary love. Such a sentiment may sound foolish, but doing ordinary things with extraordinary love—things that look foolish to the world—is the heart of the gospel, the heart of discipleship and central to the reframing power of Jesus. As the apostle Paul puts it: "For God's foolishness is wiser than human wisdom, and God's weakness is stronger than human strength" (1 Cor. 1:25). There is power in small things. Faithful response to people with mental health concerns emerges naturally from such a beginning point.

Before mental health issues become diagnoses, they are deep and meaningful human experiences and continue to remain such after being labeled. Mental health problems are first and foremost unwanted intrusions into the personal narratives of individuals with unique stories, histories, dreams and desires—persons who are deeply loved by God. While these experiences may have biological, neurological or genetic bases, they cannot be fully explained on those bases alone. Recognizing that something has a biological root, for example, tells us nothing about how it impacts individuals. While their stories may be changed by their biology, they are not defined by it. The stories of such people can, however, be deeply affected by the meanings that we ascribe to their experiences.

Mental health issues are highly stigmatized in societies that prize intellect, reason and clear thinking as essential to being fully human. Stigma occurs when one aspect of a person is highlighted as the most important aspect of a person's life, thereby creating a narrative that hides the humanness of that person. When people's identities become entirely subsumed within a diagnosis (e.g., schizophrenic, depressive, neurotic, bipolar), they find themselves forced to live within—and out of—a story that is no longer their own. Stigma forces them to accept a false identity, a story of self that says they *are* their illness and unworthy of care, except from paid caregivers and perhaps family members. Unlike with other forms of mental or physical distress, living with a mental health problem in our culture challenges personal stories and, ultimately, erodes our sense of humanness. The relatively straightforward task of the church, therefore, is to love people experiencing mental health issues, to respect their stories and to call them by name.

Many of those with whom Jesus spent time were highly stigmatized—outcasts and the "unclean," whose status was similar to many with mental health problems in our culture. Some suggest that because Jesus sat with the marginalized, the task of the church is to reach out to those on the margins and bring them inside. That perspective misses the significance of what Jesus did. When Jesus offered friendship, acceptance and a place in his Kingdom to the marginalized, he *shifted the margins!* Those who were on the inside, who were comfortable within the established religious and cultural practices, found themselves on the margins. The actions and words of Jesus demonstrated that God was present and active in unexpected places—revealing the Kingdom in and through friendship offered to the outcast. Jesus offered relational space and time to people for whom the world had no time. Through these friendships, people ceased to be labels ("tax collector," "sinner" or "leper"). Jesus gave them back their identities as full human beings—he gave them back their names.

Perhaps the reason some in the church consider ministries with people experiencing mental health problems to be peripheral to the gospel is that, by neglecting the

marginalized, they have, themselves, become marginalized. While friendships cannot be manufactured, the church can and must *create space* in its life and in its communities for people experiencing mental health problems. Our call is to engage in the ordinary act of friendship with extraordinary love.

The world can be a pretty inhospitable place for those who are considered different. One of the extraordinary things about Jesus' ministry is the way in which he practiced hospitality. Sometimes he was a guest in people's houses; sometimes he was a host. The movement from guesting to hosting is a primary mark of the hospitable work of the incarnation. To be truly hospitable, we need to learn how to be a guest in the house of the "stranger." Rather than assuming that the churches' task is to *host* people with mental health issues and to find ways of "looking after them" because they "can't look after themselves," what if our congregations began to think of themselves as both guests and hosts—*guests* in the stories of the lives of those who have different experiences? What might it look like if we took the time to listen to and take seriously the meanings of such experiences—not just as products of illness but as important aspects of a person's life story? What kind of impact could it have if we invited people with mental health issues to speak to our congregations about what it feels like to go through such experiences? Moving from host to guest might open us up to beautiful and important learning.

I spoke to a woman not so long ago who was diagnosed with bipolar disorder. She told me about an experience she had on a mountaintop where she thought, just for a while, that she was in heaven. It was a quite beautiful experience, although, technically, it didn't happen. It is easy to dismiss such an experience, but, for her, it was a deeply meaningful experience—the memory of which, even now—two years later—brings her comfort, joy and hope. Another friend who bears the diagnosis of schizophrenia tells me how important some of her voices can be. While some of her voices are deeply unpleasant and she welcomes the relief medication provides, others are a source of comfort.

None of what I propose should be interpreted in any way as antipsychiatry. Quite the contrary. Medication and therapy can be helpful, and taking medication does not define a person by his or her condition. Mental health services have an important role, and churches need constructive relationships with them. But the gifts offered by professional services are only one part of the story. It is in the small stories of friendship, hospitality, love, listening and acceptance—all of which reflect the model of Jesus—that we find the context and the seedbed for extraordinary love. Here we encounter healing, even if cure is not an option. The task of the church is signaling the kingdom through small gestures. Look after the small things, and the big things will fall into place.

John Swinton is a professor of Practical Theology and Pastoral Care in the School of Divinity, Religious Studies and Philosophy at the University of Aberdeen, Scotland. He has a background in mental health nursing and healthcare chaplaincy and has published extensively.

Kathleen Bolduc

Admitting Our Powerlessness

Have you ever sat on the beach, on that part of the sand where the waves have just receded, where the sand is damp and packed down tight? You take a plastic shovel, or perhaps your hand, and begin to dig. You dig and dig until water begins to burble up from within the sand, finally filling the hole you've so carefully carved out.

In *The Prophet*, Kahlil Gibran writes of sorrow carving deep into our beings, leaving more room for joy.

I know what it is to grieve—parents of children with disabilities grieve the death of a dream—the dreamed-of child for whom they waited so long. My third son, Joel, has autism and moderate intellectual disabilities, along with an anxiety disorder and severe kyphosis of the spine. Everything I valued in my life before Joel's birth had to be re-thought and re-valued—intelligence, efficiency, logic, self-control. The old rules no longer applied, and my spirit, which craves peace, order, comfort, and security, withered as I struggled to make sense of the seemingly senseless—a beautiful boy with a damaged brain.

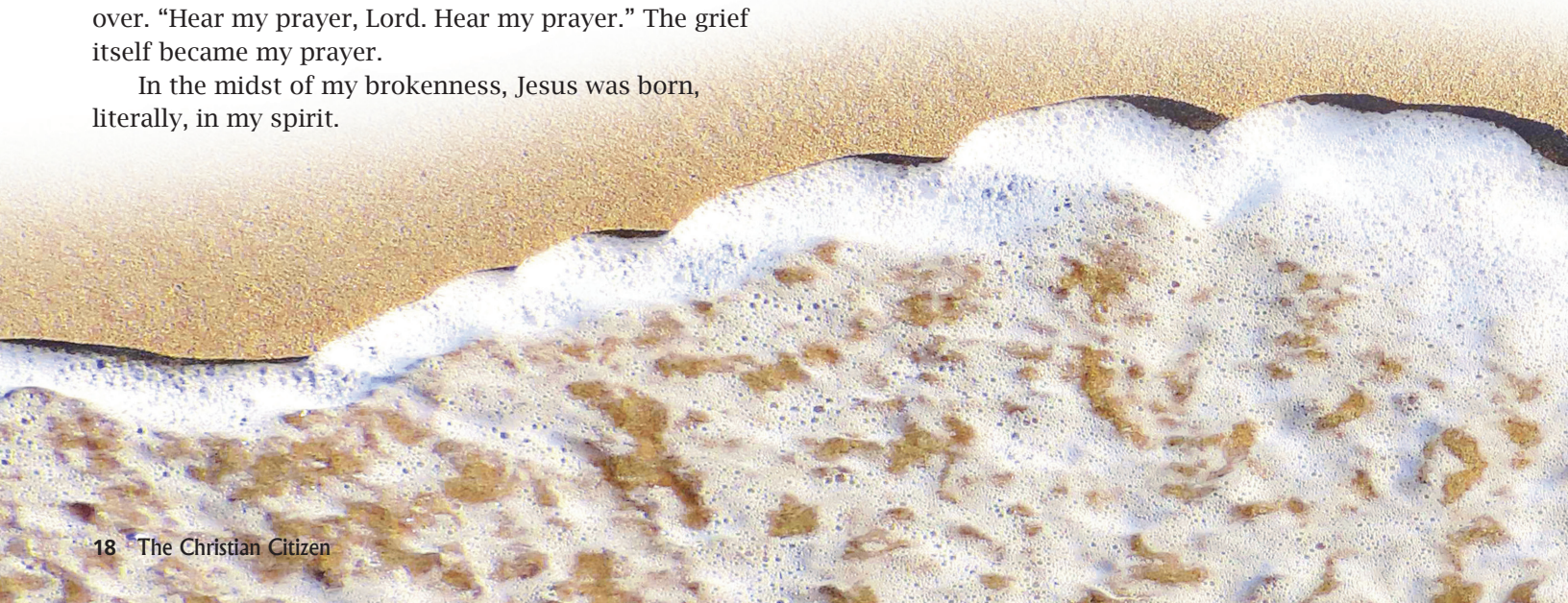
I was stuck in denial for a very long time, and when I finally broke free, I raced head-long into anger, self-blame, and depression. Through this grieving process, which lasted several years, I never stopped calling out to God. Even on my darkest days, when my mind was too numb to form a prayer, I repeated four words over and over. "Hear my prayer, Lord. Hear my prayer." The grief itself became my prayer.

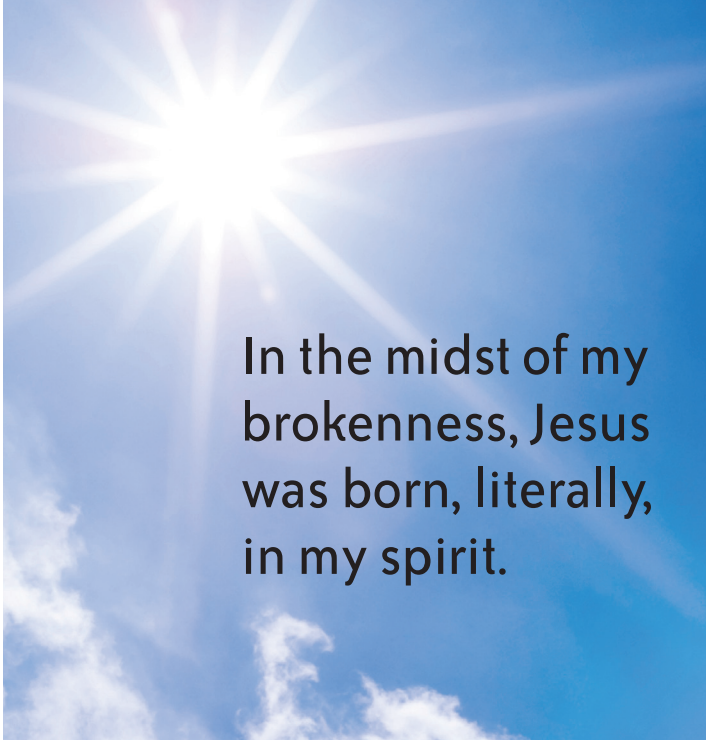
In the midst of my brokenness, Jesus was born, literally, in my spirit.

The pain I experienced as I grieved Joel's disability broke open the Scriptures for me. I came to understand that Jesus turns the cultural belief—that brokenness is to be avoided at all costs—upside down. Christ challenged me to face and embrace my brokenness, as well as Joel's brokenness, so that God's power might be released within both of us. I came to a gut-level understanding of 2 Corinthians 12:9: "My grace is sufficient for you, for my power is made perfect in weakness."

Those years of grieving—those years of calling out, again and again to God—those years of lament—carved a space in my parched spirit for God's living waters. The details of life with Joel did not change. The result of his neurological impairments caused behaviors that were very difficult to deal with—hair pulling, tantrums, an inability to be in large groups of people or to tolerate certain noises. His cognitive disability made learning the easiest of tasks difficult. But life-giving waters began to flow as I caught fleeting glimpses of reasons to rejoice in the midst of it all—Joel's infectious grin, his silly jokes, his compassion for people who were hurting, his spontaneity and unconditional love.

I had long struggled to fit prayer and meditation into my busy daily routine. Suddenly, it was no longer a struggle. I simply *made* the time because the waters that welled up in the silence filled all my empty places to over-flowing. I couldn't do without it! The dry soil of





my life became hydrated and fertile. In the words of the poet Wendell Berry, "it gets darker and darker, and then Jesus is born."

In her book *Plan B: Further Thoughts on Faith*, Ann Lamott recounts an old Hassidic story of a rabbi who taught his congregation to put Scripture on their hearts by studying the Torah diligently. One day, someone in the congregation asked, 'Why put Scripture *on* our hearts instead of *in* them?' The rabbi answered, "Only God can put Scripture inside. But reading sacred text can put it on your hearts, and then when your hearts break, the holy words will fall inside." These prove to be prophetic words in my life.

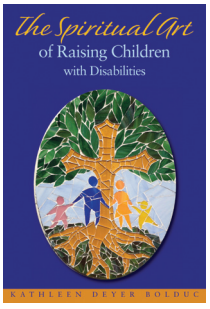
I write them in my journal as we barrel down I-65 at 70 mph; my husband, Wally, driving; me in the passenger seat; Joel in the backseat as we head to a beach vacation in the Florida panhandle. Little do I know that, as I copy these words from Lamott's book, Joel is headed toward one of the worst manic episodes of his life. And believe me, he has had many. Twenty-four hour bouts of absolutely no sleep. Extreme agitation. Aggression. A need to be on the move, every minute, around the clock, even in the middle of the night.

It is *not* a fun vacation!

Nothing breaks a person's heart like watching a family member disintegrate into mania. But then again, nothing breaks a person's heart like holding a stillborn baby. Like getting a call in the middle of the night with the news that a father, mother, sister, brother, or child has died. Like struggling to overcome an addiction. Like losing a job and being unable to support your family. Like being diagnosed with a chronic illness.

No one makes it through this life without experiencing a broken heart. Fragile hearts are a condition of our humanity. And yet, Scripture tells us that God's power moves in and through our brokenness: "When the righteous cry for help, the Lord hears and delivers them out of all their troubles. The Lord is near to the brokenhearted and saves the crushed in spirit." (Ps. 34:17-18); "My flesh and my heart may fail, but God is the strength of my heart and my portion forever." (Ps. 73:26); "Fear not, for I am with you; be not dismayed, for I am your God; I will strengthen you, I will help you, I will uphold you with my righteous right hand." (Is. 41:10); and "My grace is sufficient for you, for my power is made perfect in weakness. Therefore I will boast all the more gladly of my weaknesses, so that the power of Christ may rest upon me." (2 Cor. 12:9).

The question is, will we patch up our hearts with great globs of concrete, walling them in, protecting them from further damage? Or will we embrace our broken hearts, hold them tenderly in our hands, allow the love of Jesus to flow through our tears? Will we let words of Scripture fall into our hearts, releasing the power of the Holy Spirit?

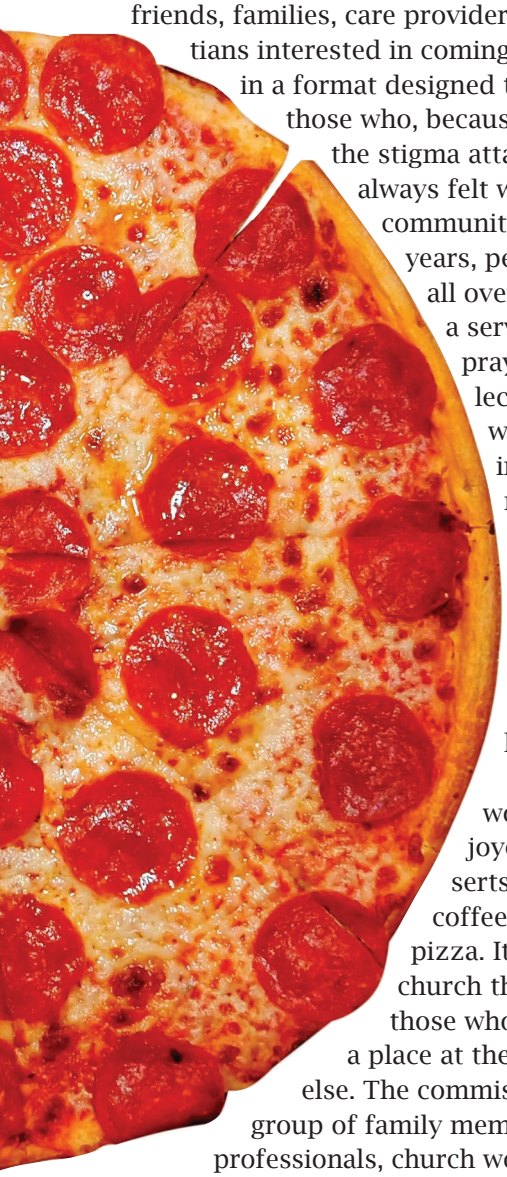


Excerpted from "The Spiritual Art of Raising Children with Disabilities," Kathleen Bolduc (Judson Press, 2014). Used by permission of the publisher. To order, call 800-4-JUDSON or visit www.judsonpress.com. Kathleen Deyer Bolduc (www.kathleenbolduc.com) is a spiritual director and a nationally recognized author and speaker in the field of disability and spirituality. Her other books include "Autism and Alleluias" (Judson Press, 2010) and *"His Name is Joel: Searching for God in a Son's Disability"* (Bridge *Resources, Louisville, 1999).*

Connie Rakitan

The Pizza Mass

Jackie asked, "When's the next Pizza Mass?" No, she was not referring to some avant-garde communion ritual. What she meant was the event sponsored annually by the Chicago Archdiocesan Commission on Mental Illness. It's a Mass with and for people with mental illness, their friends, families, care providers and all other Christians interested in coming together for worship in a format designed to be welcoming to those who, because of their illness and the stigma attached to it, have not always felt welcome by their faith communities. For more than 20 years, people have come from all over Chicagoland to enjoy a service in which readings, prayer and music are selected and led by people whose lives have been impacted by mental illness; where inclusion is a reality instead of merely a goal; where Jackie is free to be herself—a woman who has battled schizophrenia for most of her life.



And the pizza? The wonderful fellowship enjoyed afterward with desserts, fruit, soft drinks and coffee includes, of course, pizza. It's an expression of a church that loves and embraces those who so are so often denied a place at the table, or anywhere else. The commission, founded by a group of family members, mental health professionals, church workers and consumers, acts under the leadership of Deacon Tom Lambert to make sure that such a place is provided. The commission also offers educational programs, networking, referrals to social services, a listening ear and spiritual support.

One ministry that works with the commission is Faith and Fellowship, where adults struggling with mental illness come together several times a month at a neighborhood church for small-group reflection and prayer. Members of the congregation also attend, choosing to be together in sharing the spiritual journey. These "mini-churches" of 10–15 participants are a place of comfort and security. Friendships and trust develop slowly, blossoming over time and creating what one member, who had long been estranged from his kin, deems a "spiritual family." Gentle conversation, relaxing opportunities for creative expression, shared recreation and a homey atmosphere lead to an awareness of God in our midst, experienced then through Scripture, prayer, music and blessing. Table fellowship is elegant and festive. The refreshments may be as simple as cheese and crackers, or Oreos and tea, but served always on real dishes with real flatware, on a table with placemats, candles and a real centerpiece of a live plant or fresh flowers. The dignity and mutual respect that the members have for one another is also *real*.

When Jesus was at a table, it was with everyone and anyone. All were welcome. Our churches are where that type of gathering can, should and even sometimes does take place. And, as we know from Matthew 18:20—"If two of you agree on earth about anything you ask, it will be done for you by my Father in heaven"—Jesus can be found where the Spirit is present (Acts 2:1). Jesus is there when those gathered are yearning for understanding, acceptance, inclusion . . . and finding it. Jesus is there whether that place is a church, a fast food restaurant, a street corner or our own homes.

Or, a Pizza Mass.

Connie Rakitan serves as program director with The Faith and Fellowship Ministry, a congregation-based outreach in the Archdiocese of Chicago, which provides faith experiences suited to the needs of persons with mental illness within the context of a small community of believers.

Lissette Mira-Amaya

A Welcoming and Supportive Environment for Latinos

The Latino* population in the United States of America in 2009 was 50.5 million (16.3 percent of the total population), according to the U.S. Census Bureau, making it the largest ethnic minority in the country. The following information may increase understanding and, with it, the ability to reach Latinos in a more effective and respectful manner. The term *Hispanic* refers to ethnicity and emphasizes Spanish as the common ancestral language; therefore, Hispanics could be of any race, while sharing many cultural traditions and values. The term *Latino* relates to people whose family descended from Latin America, including those who are born in the United States. There are Latinos whose primary language is English, Miskitu, Portuguese, Quechua and Quitche, rather than Spanish.

Latinos value interdependence in relationships, which guides how families and communities function. Nuclear and extended family are important, and, therefore, individuals with mental illness or developmental disabilities as well as the elderly are cared for within the family—at times with extremely limited resources and support. As a rule, when Latinos first meet others outside the family, communication tends to be formal, becoming less formal as trust builds. As with many cultures, spirituality is an important value, with church serving as a source of connection, belonging, support and strength.

Many Latinos have serious challenges to overcome, especially those who do not speak English or may have entered the United States without proper documentation. Finding employment and providing for the family may be more difficult than expected, and many live in fear of deportation and separation from their families. Those undocumented are ineligible for most governmental services and have extremely limited access to health care. Women and children are often abused and may experience trauma while getting to the United States. As any other group, Latinos may confront mental health problems. Some may need therapy, which may be an unfamiliar concept. Frequently, children serve as translators for parents and organizations—a role reversal that decreases parental authority and may mean children have access to information that is inappropriate or even traumatizing to them. These individuals and families need trustworthy individuals to help them, along with community resources and places of worship.

Bilingual services and bicultural activities, culturally sensitive worship and supportive services create welcoming environments in churches. Both English- and Spanish-speaking churches could reach out to families and, when appropriate, provide information on community mental health services, assisting them in navigating the system when needed. Church staff and members would benefit from presentations by mental health workers. Identifying Spanish language organizations, professionals, information and resources would also be helpful for families dealing with issues related to mental illness. Resources in Spanish are available from the following entities:

- National Catholic Partnership on Disability (www.ncpd.org),
- National Institute of Mental Health (www.nimh.nih.gov),
- Substance Abuse and Mental Health Services Administration (www.samhsa.gov),
- National Alliance on Mental Illness en Espanol (http://www.nami.org/template.cfm?section=NAMI_en_espa%F1ol) and
- WomensHealth.gov en Espanol (http://womenshealth.gov/espanol/salud-mental/).

* Editor's note:
There is a diversity of opinion on use of the terms "Hispanic" and "Latino." While we respect diverse preferences, we are using language in this article that is consistent with the overall mission and ministry of ABHMS.

Lissette Mira-Amaya is a licensed master social worker in Michigan with experience in program development and ministration, clinical supervision, therapy and case management in outpatient and residential settings.

Christine J. Guth

A Deep Well of Meaning

"One of these days, you're going to come home and find me at the bottom of the well." A mother's ominous words struck terror into the heart of her 10-year-old daughter every time she heard them on her way out the door to school. The daughter grew up, married and had five children. She became a creative musician, writer and teacher. Like her mother before her, the young woman struggled with suicidal impulses, which she courageously determined never to share with her children. Even so, the dark periods when she would spend hours or days crying in her darkened bedroom were impossible to hide from her family. After they passed, no one spoke of them. These episodes made it hard for me, her daughter, to fully trust her love. Abundant care could unpredictably turn into anger or absence in a flash.

When waves of depression and traumatic flashbacks washed over me as an adolescent and young adult, perhaps I would have been better prepared to cope had I recognized that what I was experiencing was a mental illness that runs in families. I absorbed the family pattern of shame about the symptoms I would later learn to call "depression" and "post-traumatic stress disorder." With that shame, I adopted the prevailing belief that needing help was a sign of failure.

As a young adult, I joined a Christian intentional community, which provided the support I needed to renew and deepen my childhood faith in Christ and to weather the most serious depression I had yet encountered. One January, as I stared at the ice-bound waves of Lake Michigan, I felt God's presence holding me back from the urge to jump in and end my life.

Years later, my son, at age 10, sank into a depression that disrupted our family with rage outbursts and lasted years. Only a few months earlier, the low-grade depression that had been my constant companion for decades had vanished, thanks to my reluctant decision to see a psychiatrist and start a new medication regimen. My mood was brighter than it had been since childhood, but now my faith was in crisis. How could a loving God inflict a child with this terrible disease? Why did God choose generation after generation in our family to suffer? Why did cancer take my mother's life the very year Prozac hit the market? How could the world be in God's hands when such senseless misery exists?

The seminary community provided me with tools to escape the oppressive belief that my family's suffering was God's deliberate choice.

I was attending seminary part-time, where I felt like an imposter pretending to be a Christian. Yet the seminary community provided me with tools to escape the oppressive belief that my family's suffering was God's deliberate choice. A small group of faithful friends in my congregation stood with me through years of turbulence, raising an adolescent with a mental illness and another with autism. The body of Christ carried me through trauma to healing.

My call to ministry led me to work with Anabaptist Disabilities Network, where I invite others to create communities of healing that see people with disabilities as indispensable partners in ministry. As I support and encourage congregations in their hospitality to people with mental illnesses and other disabilities, God creates meaning from the pain of our family's past.

Christine J. Guth lives in Goshen, Ind., and serves in ministry as program director for Anabaptist Disabilities Network (www.adnetonline.org).

Be Still

Kirk Byron Jones

Remember the story of Jesus calming the storm? Instead of aspiring to be Jesus, imagine yourself as the storm itself. Feel the strong gusts of busyness and haste that are inside of you—that have become you.

For a moment, envision the countless tasks you have scheduled today as a great wave of overload. Can you hear the sound of the crashing waves of demand and expectation that others place on you, and that you place on yourself? As your rampage continues, imagine hearing a voice that breaks into your pandemonium, daring to demand, "Peace! Be still!"

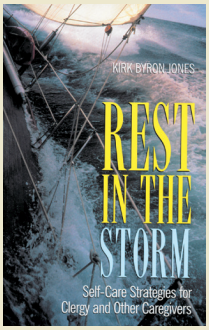
Most of us practice physical stillness in small ways throughout the day. We practice physical stillness in small matters, such as posing for a photograph, and in matters that may mean the difference between life and death, such as stopping at a busy intersection.

One of the greatest challenges of our time is to understand the value of stillness to our mental health. When I say *mental stillness,* I am referring to a resting of the mind. Our overloaded and overdriven lives are manifestations of our overloaded and overdriven minds. Most of the time, we are thinking about multiple matters, successively if not simultaneously. Yet our mental and emotional health depends on a rhythm of engagement and rest.

A legendary pianist was once asked, "How do you handle the notes as well as you do?" The artist is said to have responded, "I handle the notes no better than any others; but the pauses . . . Ah! That is where the art resides."

There is not only great art in the pauses, but great calm and strength as well.

Adapted from "Being Still," in Kirk Byron Jones' "Rest in the Storm: Self-Care Strategies for Clergy and Other Caregivers" (Judson Press, 2001), 75–81. Used by permission of the publisher. To order, call 800-4-JUDSON or visit www.judsonpress.com.



When the Caregiver Needs Care

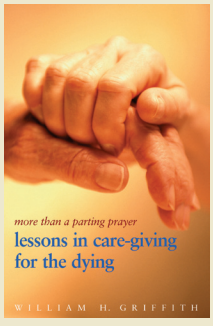
William H. Griffith

Caregivers are not exempt from experiencing the physical, emotional and spiritual pain that they are trained to care for in others. Admitting this is sometimes very difficult for caregivers, because they feel that it might in some way be unprofessional. But that is just the problem. I believe that compartmentalizing or separating the personal and the professional carries with it the risk of desensitizing a caregiver's feelings and seeing people as cases to be serviced rather than persons to be cared for. Many caregivers who do this do not know how to allow others to care for them.

Each caregiver has limited emotional strength and functions under the assumption that this limit is knowable and controllable. But when the unexpected happens at the most unlikely time, we hear those people referring to that moment as when "I lost it." What they are saying is that they lost control, and they apologize, as if doing so is a sign of weakness. What needs to be understood is that "losing it" is not so much a sign of weakness as a sign of humanness.

Such an experience provides a teachable moment. Out of such vulnerable experiences, caregivers discover their own humanness and become more genuine and honest with those for whom they care. Their experience does not give them the right to say, "I know how you feel," but it does help them to know the depth of others' feelings and to be more empathetic.

Excerpted from "Wounded Caregivers Need a Caregiver" in William H. Griffith's "More Than a Parting Prayer: Lessons in Care-giving for the Dying" (Judson Press, 2004), 111–12. Reprinted by permission of the publisher. To order, call 800-4-JUDSON or visit www.judsonpress.com.



Kathleen Bolduc

Sand Dollar

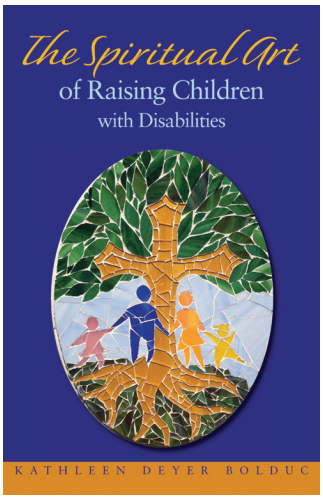
(2 Cor. 12:9-10)

Buffeted by ocean tumult
Crucified on timeless beach
Buried by storm and sand
Risen whole
Exposed by tide
Bleached by sun
Carried home as talisman
Lesson in adversity

Delicate
as baby's breath
Brittle
as old woman's bone
Weightless as Christ's presence
Powerful
as confessed weakness

Flawless flower
etched on orb
Hollow center
cradles dove
Strength in weakness
Christ in me
His grace
Sufficient

Spiritual insights for parents, clergy, and churches ministering to special needs families.



The Spiritual Art of Raising Children with Disabilities

By Kathleen Deyer Bolduc; Foreword by Ginny Thornburgh; Afterword by William Gaventa

"If you are the parent of a child with disabilities and you don't know where to go with your faith or wonder whether you even have faith in God anymore, I highly recommend *The Spiritual Art of Raising Children with Disabilities*."

—Rev. Mark Stephenson, Director, Disability Concerns, Christian Reformed Church

"*The Spiritual Art of Raising Children with Disabilities* offers life-giving suggestions for connecting with God amid the everyday, moment-to-moment challenges and joys of living with disabilities. The stories shared within are real, honest, life-affirming, and spirit-nurturing. It feels good to connect with others who have similar thoughts and concerns and to feel peace that God is with us every step of the journey. Kathleen Bolduc offers us many ways to connect with and rest in our loving God, who will fill our cups to overflowing if we but let him."

—Victoria McGoey, parent

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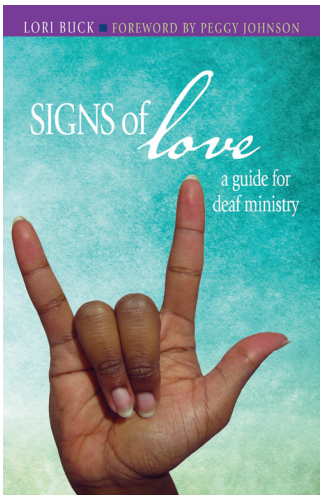

Signs of Love: A Guide for Deaf Ministry

By Lori Buck; Foreword by Peggy Johnson

"*Signs of Love: A Guide for Deaf Ministry* comes from years of experience in the field of deaf ministry. Dr. Buck teaches the reader the basics about Deaf culture and history and then quickly unveils a step-by step approach to starting a deaf ministry. This book gives numerous creative suggestions for ministry, not only in the context of the worship service but in the life of the church at large. I hope that everyone who reads this book finds a way to incorporate Deaf ministry into their local church in some way. The goal of such a lively and integrated ministry is clear: "so that they (the Deaf community) too can experience the joy of being an eternal member of the kingdom of God."

—Bishop Peggy A. Johnson
United Methodist Church, Philadelphia Episcopal Area

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For more on the partnership, see:
www.psychiatry.org/faith

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