

Faith Based Mental Health Academy

**A Training Guide for
Faith Leaders and Mental Health Professionals**



Faith Based Academy for Mental Health

A Training Guide for Faith Leaders and Mental Health Professionals

Interfaith Community Services

Interfaith Community Services empowers people in need to stabilize and improve their lives through comprehensive programs in partnership with diverse faith communities and people of compassion.



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Table of Contents

Acknowledgements	4
Introduction	8
Chapter 1. Recognizing & Responding to Mental Health Conditions ..	12
Chapter 2. Common Mental Health Disorders & Behavioral Health....	34
Chapter 3. Substance Abuse & Other Addictions	70
Chapter 4. Depression & Faith Communities	105
Chapter 5. Suicide & Prevention.....	120
Chapter 6. Mental Illness Stigma Reduction	138
Chapter 7. Cultural Considerations.....	162
Chapter 8. Dealing with Resistance to Mental Health Treatment	196
Chapter 9. Wellness, Spirituality & Mental Health.....	208
Chapter 10. Trauma and Spirituality.....	222
Chapter 11. Faith and Spirituality.....	254
Chapter 12. Using Faith and Spirituality as Part of Recovery	270
Chapter 13. Assisting Families in Finding Strength and Hope	284

Introduction

Purpose of this Training

This training will help to:

- Reduce the stigma of mental illness.
- Educate about the signs and symptoms of mental illness.
- Inform you under what conditions to access professional services.
- Give you the tools to handle a mental health crisis.
- Explain how faith families can provide support and help to those suffering and their families.
- Provide resources for children, youth, adults, older adults and families who are experiencing mental health challenges.

What brings us here today? 19.1% of U.S. adults experienced mental illness in 2019 (51.5 million people). This represents 1 in 5 adults; 1 in 20 has a serious mental illness; and 1 in 12 has a substance abuse disorder. One half of all mental illness begins by age 14 and 75 percent begins by age 24. Mental illness in older adults lacks consistent data but in 2015 the World Psychiatric Association published numbers that collectively indicated more than 30 percent of seniors experience depression, personality disorder, substance abuse, or a psychotic disorder. Worldwide depression and anxiety disorders cost the global economy \$1 trillion in lost productivity each year. Depression is the leading cause on disability.

There were 465 suicides in San Diego County in 2018, more than one a day. Suicide is the 2nd leading cause of death among people aged 10-34.

40 percent of all persons suffering a mental illness will seek out clergy.

One-quarter of those who ever sought treatment for mental disorders did so from a clergy member. Clergy continue to be contacted by higher proportions than psychiatrists or medical doctors. Nearly one-quarter of those seeking help from clergy in a given year have the most seriously impairing mental disorders. The majority of these people are seen exclusively by the clergy, and not by a physician or mental health professional.

The clergy continue to play a crucial role in the U.S. mental health care delivery system. However, interventions appear to be needed to ensure that clergy members recognize the presence and severity of disorders, be able to recognize the symptoms and make appropriate referrals to mental health professionals and collaborate appropriately with health care professionals.

There are more reasons this is a subject that needs to be shared specifically with you. Recent deaths by suicide include the worship pastor of the Rock Church, Will Fejeran, the associate pastor of the Harvest Church in Riverside, Jarriid Wilson and the children of two high-profile pastors, Rick Warren's son Matthew and Joel Hunter's son Isaac. These losses have led to open discussions on mental illness in these faith communities. In 2010 a Pastor in La Costa, California voiced his distress over four suicidal congregants.

Pastor Perry Noble and Reverend Susan Gregg-Schroeder have publicly documented their struggles with mental illness. Pastor Noble wrote *Overwhelmed* (2014) about his struggles with mental illness. Rev. Gregg-Schroeder's best known book, *In the Shadow of God's Wings: Grace in the Midst of Depression* (1997), shares her very personal story as she has struggled with severe depression. Rev. Gregg-Schroeder founded Mental Health Ministries to provide educational resources to help erase the stigma of mental illness in our faith communities. There

are a number of biographical books that tell how people of faith suffered in silence or worse spoke up only to experience greater isolation and disdain.

Another serious problem for those with untreated mental illness is the numbers that are housed in jails and prisons. The United States has the highest rate of adult incarceration among the developed countries, with 2.2 million currently in jails and prisons. Those with mental disorders have been increasingly incarcerated during the past three decades, probably as a result of the deinstitutionalization of the state mental health system. Correctional institutions have become the *de facto* state hospitals, and there are more seriously and persistently mentally ill in prisons than in all state hospitals in the United States. A 2006 study by the U.S. Department of Justice's Bureau showed that 64 percent of local jail inmates, 56 percent of state prisoners, and 45 percent of federal prisoners have symptoms of serious mental illnesses. These numbers are nearly 20 percent higher for females than males. 70.4% of youth in the juvenile justice system have a diagnosed mental illness. For specific racial and ethnic groups, the circumstances are worse. Most all incarcerated African Americans and Latinos who are diagnosed with a mental illness report never having received any treatment prior to incarceration. The problem is enormous and clergy are central to shifting outcomes.

The County of San Diego Health and Human Services has sponsored and funded this training and will ask any of you who are willing to become ***Champions*** in the fight to shift this paradigm. To open discussions in your own faith homes. To build caring congregations that can support those who are suffering and their families. As ***Champions*** you can carry this message to others in your profession and congregations.

This training will provide information that can empower you to understand mental illness, be able to recognize symptoms in children, adults, including older adults. We will discuss diagnosis, treatment, and how the mind, body, and spirit are all connected.

Substance abuse and depression are the most common forms of mental illness and we will offer better understanding and appropriate response. We will give you the tools and a comprehensive resource guide that you can use to prevent a suicide, to handle a crisis event, and to connect those in need to the proper persons or services. You will hear a variety of speakers all of whom bring their own training, understanding and experience to share. You will be amazed how those who sought treatment function at exceptional levels despite or because of their experience.

Chapter 1. Recognizing & Responding to Mental Health Conditions

1.1 Here Are Some Facts You May Not Know

- While mental disorders are common in the U.S., their burden of illness is particularly concentrated among those who experience disability.
- Mental health challenges and disorders can be as disabling as cancer or heart disease in terms of premature death, lost productivity, and increased challenges to having a good quality life.
- One in five Americans is estimated to have a diagnosable mental disorder, such as depression, anxiety, or substance abuse, in any given year (including 13.7 million children).
- In the United States, almost half of adults (46.4 percent) will experience a mental illness during their lifetime.
- In 2019 there were 51.5 million Americans who experienced a mental health disorder; of those, there were an estimated 1 in 20 adults in the U.S. with a Serious Mental Illness (SMI).

- In 2018, 5 percent of adults (18 or older) experience a mental illness in any one year, equivalent to 43.8 million people.
- 1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year
- Of adults in the United States with any mental disorder in a one-year period, 14.4 percent have one disorder, 5.8 percent have two disorders and 6 percent have three or more.
- Half of all mental disorders begin by age 14 and 75% by age 24.
- Annual prevalence of mental illness among U.S. adults, by demographic group: Non-Hispanic white: 20.4%, black or African-American: 16.2%, Hispanic or Latino: 16.9%, Lesbian, Gay or Bisexual: 37.4%
- In the United States, only 41 percent of the people who had a mental disorder in the past year received professional health care or other services.
- Untreated mental illness can disrupt one's ability to be employed, to handle everyday situations, sustain relationships, make sound decisions, and even maintain daily hygiene.
- 20 (potentially underestimated) number of veterans die by suicide each day, according to a 2018 report by researchers at the Department of Veterans Affairs.

- 70–90 percent of individuals with mental illness saw improvements in their symptoms and quality of life after participating in some form of treatment.
- Understanding, offering support, intervention, and treatment can lead to recovery.

What Will You Take from This Class?

You will not be able to diagnose mental illness, but you will be able to:

- Recognize possible signs and symptoms of mental health challenges.
- Provide comfort and resources for someone experiencing a mental health challenge.
- Have a better understanding of basic mental health disorders.
- Have resources for local mental health providers.
- Have the confidence to support and encourage people to get professional help.

1.2 What Is the Difference Between Mental Health and Behavioral Health?

In recent years, professionals have combined what were previously separate classifications into Behavioral Health. The definition of a behavioral *disorder* or mental *illness* is a diagnosable illness that affects a

person's thinking, emotional state and behavior, as well as disrupts the person's ability to work or carry out other daily activities and engage in satisfying personal relationships. The key is that it affects a person's behavior.

NOTE

- Mental illness is not a result of personal weakness, a lack of belief, failure to pray enough, a character defect or poor upbringing.
- Recovery from mental illness is not simply a matter of will, of keeping with religious practices, or self-discipline.
- Mental illness responds to a variety of treatments which support a person in leading a fulfilling life.

What is Mental Illness? A clinical definition:

A mental disorder is a syndrome characterized by **clinically significant disturbance** in an individual's cognition, emotion regulation, or behavior that **reflects a dysfunction** in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with **significant distress** or **disability** in social, occupational, or other important activities.

An **expectable** or **culturally approved** response to a common stressor or loss, such as the death of a loved one, is **not** a mental disorder.

Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily **between the individual and**

society are **not** mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

What is Mental Illness? A definition for the rest of us **A condition that disrupts the ability to:**

Work: remain in gainful productive work or contribution

Relate: maintain healthy relationships with family, friends, others

Live: carry out typical daily activities, personal hygiene

The Four D's

The four D's make up a working definition of behaviors or feelings that are maladaptive. It is the interaction of the four D's that may indicate a person needs professional help.

- **Dysfunctional:** Behaviors, thoughts, and feelings that interfere with a person's ability to function in daily life.
- **Distressful:** Behaviors, thoughts, and feelings that cause distress to the individual or to others around them.
- **Deviant:** Behaviors, thoughts, and feelings that are so different it cannot be explained by culture or norms, a markedly different behavior from what is expected in society.
- **Dangerous:** Behaviors, thoughts, and feelings that are potentially harmful to an individual or the individuals around them.

1.3 What Are the Causes of Mental Illness?

Diagnosing mental illness isn't like diagnosing other chronic diseases. Heart disease is identified with the help of blood tests and electrocardiograms. Diabetes is diagnosed by measuring blood glucose levels. But classifying mental illness is a more subjective endeavor.

No blood test exists for depression; no X-ray can identify a child at risk of developing bipolar disorder. At least, not yet.

Thanks to new tools in genetics and neuroimaging, scientists are making progress toward deciphering details of the underlying biology of mental disorders. Yet experts disagree on how far we can push this biological model. Are mental illnesses simply physical diseases that happen to strike the brain? Or do these disorders belong to a class all their own?

Although the exact cause of most mental illnesses is not known, it is becoming clear through research that many of these conditions are caused by a combination of biological, psychological, and environmental factors.

What Biological Factors Are Involved in Mental Illness?

Some mental illnesses have been linked to an abnormal balance of special chemicals in the brain called neurotransmitters.

Neurotransmitters help nerve cells in the brain communicate with each other. If these chemicals are out of balance or are not working properly, messages may not make it through the brain correctly, leading to symptoms of mental illness. In addition, defects in or injury to certain areas of the brain have also been linked to some mental conditions.

Other biological factors that may be involved in the development of mental illness include:

- **Genetics (Heredity)**—Many mental illnesses run in families, suggesting that people who have a family member with a mental illness are more susceptible (have a greater likelihood of being

affected) to developing a mental illness. Susceptibility is passed on in families through genes. Experts believe many mental illnesses are linked to abnormalities in many genes, not just one. That is why a person inherits a susceptibility to a mental illness and doesn't necessarily develop the illness. Mental illness itself occurs from the interaction of multiple genes and other factors such as stress, abuse, or a traumatic event, which can influence, or trigger, an illness in a person who has an inherited susceptibility to it.

- **Infections**—Certain infections have been linked to brain damage and the development of mental illness or the worsening of its symptoms. For example, a condition known as pediatric autoimmune neuropsychiatric disorder (PANDA) associated with the Streptococcus bacteria has been linked to the development of obsessive-compulsive disorder and other mental illnesses in children.
- **Brain defects or injury**—Defects in or injury to certain areas of the brain have also been linked to some mental illnesses.
- **Prenatal damage**—Some evidence suggests that a disruption of early fetal brain development or trauma that occurs at the time of birth, for example, loss of oxygen to the brain, may be a factor in the development of certain conditions, such as autism.
- **Other factors**—Poor nutrition and exposure to toxins, such as lead, may play a role in the development of mental illnesses.

What Psychological Factors Contribute to Mental Illness?

Psychological factors that may contribute to mental illness include:

- Severe psychological trauma suffered as a child, such as emotional, physical, or sexual abuse.
- An important early loss, such as the loss of a parent.
- Neglect.
- Isolation, lack of human contact, failure to bond with parental figure.

What Environmental Factors Contribute to Mental Illness?

Certain stressors can trigger an illness in a person who is susceptible to mental illness. These stressors include:

- Death or divorce
- A dysfunctional family life
- Living in poverty
- Changing jobs or schools
- Social or cultural expectations (For example, a society that associates beauty with thinness can be a factor in the development of eating disorders.)
- Substance abuse by the person or the person's parents

1.4 Signs and Symptoms of Mental Illness

How can I see the signs and symptoms?

- Observations
- Conversations
- Applying your own lived experiences and knowledge

Over 200 classifications of Mental Disorders

- You do not need to know what it is, rather you need to know when to refer to a mental health clinician or health professional

Telling the difference between what expected behaviors are and what might be the signs of a mental illness isn't always easy.

There's no definitive test that can let someone know if there is mental illness or if actions and thoughts might be typical behaviors of a person, an extreme reaction to a situation, or the result of a physical illness.

Knowing warning signs can help let you know if someone needs to see to a professional.

Children and youth with mental illness are defined as:

Persons from birth to age 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Adults and older adults with mental illness are defined as:

Persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, resulting in functional impairment, which substantially interferes with or limits one or more major life activities.

Facts about Behavioral Health Disorders in Children and Adolescents

- 20 percent of youth live with a behavioral health condition.
- Anxiety disorders are among the most common mental health challenges that occur in children and adolescents.

- Attention deficit/hyperactivity disorder (ADHD) affects an estimated 4.3 percent of youth ages 9-17.
- Approximately 3 percent of adolescents in the U.S. have eating disorders, including anorexia nervosa and bulimia.
- 5 percent of children and 8 percent of adolescents suffer from depression in the U.S.

The Connection between Mental Health and Physical Conditions

Mind and body are connected in many important ways. Problems that first affect the mind can later increase a person's risk of physical problems, such as diabetes, high blood pressure, or malnutrition.

Conversely, problems that first affect the body, such as a disease or an accident, can affect mental health (i.e., emotions, thinking, and mood).

- 68% of adults with mental disorders also have medical conditions.
- 29% of adults with medical conditions also have mental disorders.

Adults living with serious mental illness die on average many years earlier than other Americans, largely due to treatable medical conditions.

1.5 Diagnosis & Treatment of Mental Illness

Some mental illnesses can be related to or mimic a medical condition. Therefore, a mental health diagnosis typically involves a full evaluation including a physical exam. This may include blood work or neurological tests.

The diagnosis of a mental health condition helps clinicians to develop treatment plans with their patients. However, the diagnosis of a mental

disorder is not the same as a need for treatment. Need for treatment takes into consideration the severity of the symptoms, level of distress, and extent of disability associated with the symptom(s), risks and benefits of available treatments, and other factors (for example, psychiatric symptoms complicating other illness).

Each person is unique and may express or describe mental disorders in different ways. The level of distress, effect on daily living, culture, religion, and spiritual content are important considerations in diagnosis and treatment.

Mental health conditions are treatable, and improvement is possible.

Many people with mental health conditions return to full functioning. Mental health treatment is based upon an individualized treatment plan developed collaboratively with a mental health clinician and an individual (and family members if the individual desires). It may include psychotherapy (talk therapy), medication, or other treatments. Often a combination of therapy and medication is most effective. Complementary and alternative therapies are also increasingly being used. Self-help and support, including by a faith community and its leaders, can be very important to an individual's coping, recovery, and well-being. A comprehensive treatment plan may also include individual actions (for example, lifestyle changes, support groups, exercise, and so on) that enhance recovery and well-being.

Guidelines for recovery

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.

- Recovery has cultural dimensions.
- Recovery is holistic.
- Recovery exists on a continuum of improved health and wellness
- Recovery emerges with hope.
- Recovery involves a process of healing and self-redefinition.
- Recovery is supported by peers and allies.
- Recovery involves (re)joining and (re)building a life in the community.
- Recovery is reality.

1.6 Therapy

Psychiatrists and other mental health clinicians help individuals and families understand mental illnesses and what they can do to control or cope with symptoms in order to improve health, wellness, and function.

Talk Therapy — while medications can be an important part of treating many mental health conditions, medications alone may not be enough. They cannot heal damaged relationships or give insight into challenges. These are things that require reflection, thinking, talking, and, for some, praying. Therapists can be extremely helpful in this vital part of recovery; they are trained to help with these problems in a nonjudgmental way.

Psychotherapy — sometimes called “talk therapy” — involves a series of meetings with a trained therapist. Since mental health conditions often cause complicated problems affecting many parts of a person’s life, relationships may suffer and it may be difficult to work, think clearly, or make good decisions. Talking openly to a trusted person can be comforting and can help one see problems or situations more clearly.

There are many types of psychotherapies. Specific types work better for some types of mental health conditions.

Cognitive-behavioral therapy—(CBT) helps people identify and change negative or irrational thought patterns that lead to unhelpful behaviors.

Behavioral therapy—is based on principles of learning and aims to reinforce desired behaviors while eliminating undesired behaviors.

Family therapy—provides a safe place for family members to share feelings, learn better ways to interact with each other, and find solutions to problems.

Group therapy—typically involves a group of people dealing with the same or a similar mental health condition. Discussion is guided by a trained therapist. It can be very reassuring and helpful to hear from others who are facing the same challenges and share experiences.

Interpersonal therapy—is used to help patients understand underlying interpersonal issues that are troublesome, like unresolved grief and problems relating to others.

1.7 Medications for Mental Health Conditions

Just as many people take medications daily for diabetes or high blood pressure, many people take a medication daily for a mental health condition. Medication can help calm anxiety, lift depression, and improve attention. Age, individual needs, overall health, and personal preferences are important considerations in making decisions about medication in treatment. Some medications for mental health

conditions are taken every day, even when the person feels better, just as they are with diabetes or high blood pressure.

In some cases, medications for conditions such as ADHD, depression, anxiety, and schizophrenia may need to be taken on a long-term basis. Other medications are taken only when a person needs them. Some medications help prevent the symptoms of an illness such as depression from returning. Successful medication use requires close communication with the health care professional.

Before taking medication, people should ask about and understand the purpose and effects of the medication, how to take it, and possible side effects. People should talk with the health care professional when they are experiencing bothersome side effects or feel that something is not right.

Psychiatrists and other physicians (who have more than eight years clinical training) take into account each person's needs and symptoms when determining medications to prescribe. They will consider such factors as general medical health and history, allergies, lifestyle, age, family history, and benefits and risks of medication (potential to be habit forming, interaction with other medications, side effects).

Class of Medications¹

CLASS OF MEDICATIONS	CONDITIONS TREATED	ADDITIONAL INFORMATION
Antidepressants	Depression, panic disorder, PTSD, anxiety, obsessive-compulsive disorder, borderline personality disorder, bulimia nervosa	May take 3-4 weeks for full effect, longer if dose is gradually increased
Antipsychotic medications	Psychotic symptoms (delusions and hallucinations),	Some side effects can be extreme but can be treated

¹ Source: APA, *Understanding Mental Disorders: Your Guide to DSM*

	schizophrenia, bipolar disorder, dementia, autism spectrum disorder	
Mood stabilizers	Bipolar disorder	
Sedatives, Hypnotics, and Anxiolytics	Sedatives and Anxiolytics: anxiety, insomnia Hypnotics: to cause and maintain sleep, pain disorder	Benzodiazepines (one class of anxiolytics) can be habit forming; Hypnotics are prescribed for a brief time only
Stimulants	ADHD	Most commonly prescribed for children

1.8 Peer Support Services

Peer services can be an important part of recovery- oriented mental health and substance use treatment— helping people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services are delivered by individuals who have been successful in the process of recovery from mental health and/or substance use conditions. Peer specialists model recovery, teach skills, and offer supports to help people experiencing mental health / substance use challenges to lead meaningful lives in the community. Because peers who have been successful in the recovery process deliver these services, they carry a powerful message of hope. Peer support specialist's roles can include peer-wellness coaching, education and advocacy, support-group facilitation, and assistance navigating community services and supports. Peer specialists supplement existing treatment.

1.9 Alternative Therapies

Many people turn to alternative health therapies, such as herbal remedies. It is important to discuss with the health care professional any medication being used, including alternative therapies and over-

the-counter medications being used, since some herbal products and over-the-counter medications can change the way other medicines work in the body.

Support and Self-Help

People can boost chances of recovery from a mental health condition and help maintain wellness in many ways:

Exercise—is one of the best things a person can do to improve body, mind, and mood. This doesn't mean having to go to a gym or do anything elaborate or intense. Brisk walking can be a fine exercise. Even walking five or 10 minutes a day is a start; building up to at least 30 minutes a day might be a goal.

Yoga—the many forms of yoga combine poses that stretch and tone muscles and breathing exercises that can help relieve stress and tension. Some studies find that people who practice yoga feel more positive and more energetic.

Relaxation Techniques—Meditation can help give a sense of calm and balance and help improve emotional wellbeing and overall health. Many techniques are available to help relax muscles and calm the mind. A common technique is to focus on breathing while sitting comfortably, with muscles relaxed and eyes closed. If distracted by thoughts, the mind is gently redirected back to breathing. This is continued for 10 to 20 minutes.

Support Groups—many types of support groups are available, online or in person, to help with mental health and substance use concerns. Joining such groups can provide an opportunity to learn how other people are coping, hear their stories, ask questions, talk about personal

experiences, and help others. Groups can be facilitated by professionals or by members of the group.

A Role for Spirituality

Studies show that people involved in a religious or spiritual group of some kind have a lower risk of premature death or illness than those not involved. The reasons for this apparent benefit are not well understood. But the fellowship, goodwill, and emotional support offered by religious or spiritual groups may also promote healthy living and mental health.

Some faith communities offer pastoral counseling services, which can be an additional support to therapy and/or medication, and may help people, cope with mental health challenges.

1.10 BLESS—ACTION PLAN

- B** Be aware of risk of suicide or harm
- L** Listen without judgment
- E** Encourage and reassure
- S** Suggest appropriate professional help and resources
- S** Support with further spiritual counseling, self-help ideas, and other strategies

Be Aware of Risk of Suicide or Harm

Two main crises that may be associated with depression are when:

- The person has suicidal thoughts or behaviors
- The person is engaging in non-suicidal self-injury

Be aware of the way the person speaks about how they're feeling, for example saying they have no reason to live, they can't face life

anymore, they just want to die, etc. Don't be afraid to ask the question, *"Do you have thoughts of hurting yourself or taking your life?"*

Listen Without Judgment

You can be an effective nonjudgmental listener by paying special attention to two main areas:

- Your attitudes and how they are conveyed.
- Effective verbal communication skills—using caring and compassionate words.

Things to say to a person with a mental illness:

- *"I love you"*
- *"What can I do to help?"*
- *"This must be very hard for you."*
- *"I am there for you. I will always be there for you."*
- *"You are amazing, beautiful and strong and you can get through this."*
- *"Have you seen your doctor/therapist?"*
- *"You never have to apologize for your illness or for feeling this way."*
- *"Your faith family is here for you."*
- *"I'm not scared of you."*

Comforting nonverbal skills—if you are shocked or alarmed try not to show it on your face or with your body language.

Encourage and Reassure

- Treat the person with respect and dignity.
- Do not blame the person for the illness.
- Have realistic expectations for the person.
- Offer consistent emotional support and understanding.
- Give the person hope for recovery.
- Provide practical help.

- Provide information.

Verbal Skills

- Ask questions that show you genuinely care and want to understand.
- Check your understanding by restating what the person has said and summarizing facts and feelings.
- Listen not only to what the person says, but also how they say it; tone of voice and nonverbal cues will give extra clues about how the person is feeling.
- Respect the person's culture by asking about and exhibiting verbal behaviors that convey this respect.
- Use minimal prompts, such as "I see" and "Ah".
- Be patient if the person is struggling to communicate.
- Do not be critical or express frustration at the person or their symptoms.
- Avoid giving unhelpful advice such as "cheer up," or "get it together".
- Do not interrupt the person when they are speaking, especially to share your opinions or experiences.
- Avoid confrontation unless necessary to prevent harmful or dangerous acts.

Suggest Appropriate Professional Help and Resources

Professionals who can help:

- Primary care physicians
- Pediatricians
- Nurse practitioners
- Allied health professionals, youth workers, and mental health nurses
- Psychiatrists and child and adolescent psychiatrists

- Psychologists and child and adolescent psychologists
- Mental health care providers
- Social workers
- Peer specialists
- In home assessment professionals

Support with further spiritual counseling, self-help ideas, and other strategies

- Balance your body, mind, and spirit.
- Create a social support system
- Remember who you are and who you belong to
- Develop problem-solving skills
- Have a healthy diet and lifestyle
- Participate in self-help strategies
- Nurture your spiritual self

1.11 Accessing Mental Health Care and the People Who Can Help

- **Medical doctors, pediatricians and neurologists**—look for the possible physical causes of a mental or behavioral health challenge and can prescribe medication.
- **Psychiatrists**—are medical doctors who specialize in the evaluation, diagnoses, and treatment of mental disorders.
- **Psychologists**—may provide psychological evaluation, assessment, testing, and treatment but may not prescribe medications.

- **Licensed social workers**—are trained to help individuals deal with a variety of mental health and daily living problems to improve overall functioning.
- **Social workers**—may have a bachelor’s or master’s degree and are helping professionals who focus on both individuals and their environment.
- **Counselors and therapists**—provide advice, support, and specific mental health therapy to a person or group of individuals, such as a family. A licensed professional counselor is a counselor with a specific legal license.
- **Nurse Practitioners**—are registered nurses who have advanced education and clinical master’s level training in a health care specialty area. They recommend medications and areas of treatment, and, in many states, they are allowed to prescribe medications.
- **Peer Support providers or specialists**—are individuals who have “lived experience” and work to assist and mentor others with similar life experience. They may have specialized education or certification, but their biggest asset is their personal experience, knowledge, and success.

This image shows a single page of white paper with horizontal blue lines. The lines are evenly spaced and run across the width of the page, typical of notebook paper or a document template. There are no margins, text, or other markings on the page.

Chapter 2. Common Mental Health Disorders & Behavioral Health

Introduction

Children from ages 2-12 are at pivotal times of their development that will greatly influence them throughout their adult lives. Personalities emerge and a sense of identity become prominent as the child becomes older. Although each child is unique, there are similar behaviors that have been considered to be common and maladaptive for child's growth and development. The occasional tantrum and misbehavior are not out of the ordinary but there are patterns of behavior that can be indicators of a disorder that can result into more serious consequences in later life.

Psychosocial Disorders involve a child's maladaptive behavior in association with their social environment as well as communicative and cognitive processes with their environment. Culture, socioeconomic status, religious background and interpersonal relationships are one of the few factors that effect a child's psychological makeup and mental stability. It is important to understand that mental illness is caused by variety of factors ranging from biological make-up, hereditary influences, environment, and social factors. Each of these factors effect each child differently as an example a child that has been diagnosed as bipolar may be caused by genetic factors while the cause in another child may be due to a traumatic event. Children with such disorders may have trouble maintaining close interpersonal relationships as well as acting appropriately in social situations.

Bipolar disorders are considered a mental illness consisting of a radical change in mood and behavior. This ranges on many spectrums and the severity of each case is different. However, it is noted that the majority of children with this condition experience an alternating change of mood or behavior between mania (wild or insane) and depression. It is difficult to diagnose bipolar disorders in young children because symptoms are similar to Attention Deficit Hyperactivity Disorder (ADHD) or other conduct disorders, not to mention tantrums, which is normal in any child.

The most distinctive symptoms are:

- Children may be more likely to have psychotic symptoms such as seeing or hearing things that aren't real.
- They may be more likely to complain about aches and pains from depressive episodes.
- While in adults, fluctuations of manic and depressive episodes may be separated by weeks, months or years, they can all happen in a single day for children.

2.1 Behavior

Behavior is the way one acts in social situations or towards others. Childhood behavior varies among every individual that is also affected by psychosocial, biological and genetic factors. The behavior of each child can be molded accordingly to how a parent or caregiver teaches a child starting at toddler years. However, when a child develops maladaptive behaviors that effect daily aspects of life, there could be other factors involved that need special attention.

Attention Deficit Hyperactivity Disorder (ADHD)—Formally called ADD (Attention Deficit Disorder) is described as several inattentive or hyperactive symptoms prior to age 12 (DSMV). ADHD is prevalently

seen in males at a 2:1 ratio. According to American Academy of Pediatrics ADHD is normally screened between ages 4 -18. There are three types of ADHD: Hyperactive- Impulsive, Inattentive and a combination of both.

Severity of symptoms ranges from person to person and normally consists of having difficulty doing activities such as:

- Sharing
- Taking Turns
- Letting others talk
- Finishing homework or chores
- Keeping track of items such as books or homework

It is normal for any child to have such symptoms but children with ADHD have more trouble than the average child.

2.2 Developmental Disorders

Developmental disorders are seen in a wide range of impairments in a child usually that affect performance in school and mental performance that is necessary to achieve everyday tasks.

Learning Disabilities

A learning disability is not a physical handicap. It is a condition where an individual has difficulty acquiring knowledge and skills compared to the expected level to others of the same age or level. There are different types of disabilities that may be resolved with minor adjustments in the environment or with special attention. Learning disabilities can affect an individual beyond just academics, it can also affect relationships, and work environment.

There are different types of learning disabilities such as:

Auditory Processing Disorder (APD)—Sound that the brain processes travel through ear. Children with APD don't recognize subtle differences between sounds of words, regardless of how clear and loud. Children with APD, can usually describe the environment, such as sounds or music, but have difficulty distinguishing where sounds are coming from or making sense or order of where sounds are coming from. Children with APD have difficulty comprehending complex sentence structure and rapid speech. Diagnosing APD may be difficult especially with small children who are learning language. Common symptoms may be: saying "what" a lot, interprets words too literally, is often distracted by background noise, may process thoughts and ideas slowly and have difficulty explaining them, may misspell words and mispronounce words that sound similar (e.g. *celery/salary, belt/built*).

There are other language processing disorders that are diagnosed in children such as **dyscalculia**; understanding number and learning math facts and **dyslexia** (has problems with the order of letters and words).

Dysgraphia, a person struggles to think and write at the same time and may have cramped or unusual grip while writing despite practice.

Autism Spectrum Disorder

(ASD) is neuro-developmental disorder that impairs a child's ability to communicate and interact socially with others. Restricted and repetitive behaviors are common among the spectrum of autism and is formally diagnosed at 3-years of age. The prevalence of autism is on the rise and experts are not sure whether is due to better detection or an environmental effect. There are theories of the cause being an interaction between the biological environment and genetic factors.

Autism is a spectrum ranging from very mild to almost no symptoms displayed in the child's behavior to very prominent deficits in communication and repetitive behavior. The following graph is an overview of levels of autism.

299.00 Autistic Disorder		
Proposed Revision	Rationale	Severity
DSM-IV		
Revised January 26, 2011		
Severity Level for ASD	Social Communication	Restricted interests & repetitive behaviors
Level 3 'Requiring very substantial support'	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning; very limited initiation of social interactions and minimal response to social overtures from others.	Preoccupations, fixated rituals and/or repetitive behaviors markedly interfere with functioning in all spheres. Marked distress when rituals or routines are interrupted; very difficult to redirect from fixated interest or returns to it quickly.
Level 2 'Requiring substantial support'	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions and reduced or abnormal response to social overtures from others.	RRBs and/or preoccupations or fixated interests appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress or frustration is apparent when RRB's are interrupted; difficult to redirect from fixated interest.
Level 1 'Requiring support'	Without supports in place, deficits in social communication cause noticeable impairments. Has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.	Rituals and repetitive behaviors (RRB's) cause significant interference with functioning in one or more contexts. Resists attempts by others to interrupt RRB's or to be redirected from fixated interest.

Source: www.mayoclinic.org

Symptoms of autism for social skills can be:

- Constant fidgeting
- Lack of eye contact
- Rigid behavior (having to do something a certain way)
- Does not understand personal space
- Does not understand other people's feelings
- Prefers to play alone
- Does not share interests with others
- Does not understand jokes or sarcasm

- Repeats words and phrases
- Has few facial expressions and almost no gestures

These are only a few of the most common symptoms, a wide range of symptoms can be found at: <http://www.cdc.gov>.

2.3 Signs of Physical, Sexual Abuse and Trauma

Unfortunately, childhood abuse is all too common and victims are often too young to know or acknowledge the extent of what is happening and how to seek help. In order to get proper help and treatment, it is the responsibilities of an adult to be able recognize signs of distress that the child may be subtly expressing as a cry for help. Without proper treatment such abuse can result in a life-time of depression, anxiety, PTSD and in some cases suicide.

Sexual Abuse

It is more common for children to fall victims of sexual abuse at the hands of a well-known adult as opposed to a stranger. It has also been reported that children are three times more likely to be a victim of rape than adults.

Signs to look out for are:

- Hyper-sexual behavior and poor self-esteem at a young age (this is often a reaction to the sexual abuse)
- Withdrawal and mistrust of adults
- Sleep problems
- Nightmares and fears of going to bed
- Unusual aggressiveness
- Fear of being touched
- Refusing to go to school or doctor
- Unexplained fear of an adult or unusual liking to them

- Forcing sexual acts on other children and sexual behavior or sexual knowledge at an abnormally young age are other symptoms.

Victims of sexual abuse often feel embarrassed, or ashamed, or are threatened by the abuser. It is important to reassure the child that it is not his/her fault and telling an adult about what the abuser has done is important.

Child Abuse

There are different types of child abuse aside from sexual abuse, such as physical abuse, emotional abuse, and negligence. An abused child may be afraid to tell anyone for fear, confusion, shame or guilt, especially if abuser is a parent or relative.

Red flags to look out for:

- Social withdrawal
- Aggression
- Hyperactivity
- Depression or anxiety
- Sudden loss of self-confidence
- Obvious lack of supervision
- Attempts of suicide or running away
- Rebellious behavior
- Child will display fear of going home or desperately seeks affection
- Poor growth and lack of clothing
- Taking food or money without permission
- Poor school attendance and performance

PTSD (Post-Traumatic Stress Disorder)—PTSD usually manifests after abuse, violence or traumatic events. It is characterized by three types of symptoms: re-experiencing traumas through flashbacks, nightmares and recollecting events; avoiding places, people and activities that can remind individual of trauma; easily irritated, angered or easily started; and also having difficulty sleeping. Children may have unwanted thoughts or memories that can be shown as reenacting what happened in play or drawings, or may have avoidance by avoiding to think and talk about events and avoiding stimuli that may remind them of the event. They may also have negative thinking and moods since the event occurs such as feeling detached, always looking out for danger, problems paying attention or focusing and not being able to feel positive emotions. Symptoms will usually occur within the first month of trauma.

Bullying

Bullying and cyber bullying are frequent issues that many children and teens suffer from. It is most commonly seen in school or daycare. It has often led to depression, anxiety and in many cases suicide. It is important to be able read warning signs of a child that is bullied and a child who is doing the bullying.

Being Bullied

When child is being bullied some symptoms may include:

- Unexplainable injuries
- Lost or destroyed belongings
- Kids may come home hungry
- Sudden loss of friends
- Feeling helpless or low self-esteem
- Decline in school performance
- Harming themselves or talking about suicide

Signs of Doing the Bullying

Children who are bullies generally start physical and verbal fights, have friends who are bullies, are more aggressive, have money and new belongings that are unexplained, don't take responsibilities for their actions, blame others for their problems, and are concerned with their reputation and popularity.

Cyber bullying

Bullying through the Internet is a new phenomenon of this day and age that has only been more common with the increase of social media. Many lives have been destroyed through this new form of bullying and it is much easier for this new kind of bully to do the bullying. It is important for parents to talk to children about cyber bullying from an early age, especially since children are beginning to have access to technology at earlier ages. Cyber bullying can be more emotionally damaging as the humiliation is displayed to a larger audience through the internet, and whatever is posted or said cannot be taken back. The most distinct symptom for this type of bullying is that child will appear upset or anxious after being on the computer, or reading a text message on their cell-phone.

2.4 Child Depression

Children are most likely unable to directly express their depression or they may not even recognize that they are depressed. Therefore, adults are responsible for acknowledging signs of depression in young children.

There are four basic categories that establish signs of depression in children: emotional symptoms, cognitive signs, physical complaints and changes in behavior.

- *Emotional* signs are: Sadness, aloofness, anxiety, anger and loss of interest in pleasurable activities.
- *Cognitive* signs include: organizing thoughts or completing tasks in school, pessimism, thinking they are worthless or have guilt, hopelessness, and suicidal thoughts.
- *Physical* signs are more obvious signs and are seen as: changes in appetite and weight, problems with sleep (too much or too little sleep), lethargic, agitation.
- *Behavioral* signs are the most obvious signs and are detected as: avoidance from family and friends, exaggerated sense of insecurity (clinging or dependent), acting up or reckless behavior, self-injury.

Adults who are most familiar with a child's natural disposition are most likely to notice these symptoms and changes in behavior. If any of these symptoms are apparent it is important to address them to parent or caregiver.

2.5 Anxiety Disorders in Adolescence

Anxiety is a feeling or worry or fear of an event or outcome. Feeling anxiety becomes a disorder when it is constant frequent and for unnecessary reasons. Anxiety disorders often can affect everyday life or events that wouldn't normally cause any distress. Such disorders are common in adolescence as they are growing more understanding about, which can sometimes be impaired by insecurities that they feel from their environment.

Specific Phobias

Specific phobias are an unprecedented fear towards an object, place or activity that poses no actual danger. When presented with the phobia the individual may feel intense anxiety and may try to avoid the object or situation entirely. The distress from the phobia may effects the individuals' ability to function even if there is recognition that the fear is unreasonable depending on the individual's age and cognitive function. Most specific phobias are categorized in: Animal phobias, Blood-injection –injury phobias, natural environment phobias (fear of heights or storms), Situational Phobias (e.g. driving, going over bridges, being in an elevator), other phobias (e.g. fear of clowns or loud sounds). In children the anxiety may be expressed by clinging, freezing in place, crying or tantrums. Such phobias can be addressed and treated through cognitive-behavioral therapy, hypnotherapy, and desensitization therapy.

General Anxiety Disorder

GED is a chronic, unnecessary worry or fear with seemingly no real reason. Children and adolescents with anxiety often worry about various things. This can include future past, present or future events along with family problems, personal abilities and school performance. Symptoms can include worrying about: events before they happen, safety, sleeping away from home. Also, an inability to relax, irritability, being easily startled, extreme tiredness, feeling as though there is a lump in the throat, refusing to go to school, sleep disturbance and muscle aches and tension.

Physical Signs and Symptoms of Anxiety Disorder

- Pounding heart, chest pain, rapid heartbeat and blushing
- Rapid, shallow breathing, and shortness of breath
- Dizziness, headache, sweating, tingling, and numbness

- Choking, dry mouth, stomach pains, nausea, vomiting, and diarrhea
- Muscle aches and pains (especially neck, shoulders, and back), restlessness, tremors and shaking
- Unrealistic or excessive fear and worry about past and future events
- Racing thoughts or mind going blank
- Decreased concentration and memory
- Indecisiveness
- Irritability
- Impatience
- Anger
- Confusion
- Feeling on edge
- Nervousness
- Sleep disturbance
- Vivid dreams
- Avoidance of situations
- Obsessive or compulsive behavior
- Distress in social situations
- Phobic behavior
- Increased use of alcohol or other drugs

Signs that may be noticed at home

Young people may –

- Complain of headaches and other physical problems to avoid going to school.
- Be tearful in the morning, saying they don't want to go to school
- Spend excess time on homework or express concern about the quality of their work.
- Demand constant reassurance from parents.

Both adults and youth may —

- Be touchy and irritable with family members.
- Take too long getting ready for social occasions, worrying about their appearance, etc.
- Being withdrawn, edgy, or demanding at school or work.
- Not turn in work on time because of a fear it's not good enough.
- Complain or sudden, unexplained physical illness when projects, presentations, exams are due.

Types of Anxiety Disorders

- Generalized Anxiety Disorder
- Panic Disorders
- Phobic Disorders
 - Agoraphobia—fear of leaving home
 - Social phobia—fear of being in a social environment
 - Specific phobias—fear of specific creatures, environments, or situations
- Separation Anxiety Disorder
- Posttraumatic Stress Disorder—can occur after a traumatic event
- Obsessive-Compulsive Disorder—recurrent thoughts, impulses, and images
- Mixed Anxiety, Depression, and Substance Abuse

Social Anxiety Disorder

SAD is feeling of extreme fear in social performance situations. It is one of the most common mental health disorders that can often persist in teens throughout adulthood. Social anxiety disorder can often effect extracurricular activities, ability to make friends and school performance. There are many symptoms for social anxiety disorder that may be very difficult to distinguish from other disorders.

Some are avoiding social situations, sweating, heart pounding, shaking, diarrhea and confusion.

Panic Disorder

Panic disorder is a different from of an anxiety disorders in that it strikes with sudden fear and panic for no reason. Signs of a panic attack are seen as sweating, dizziness, nausea, and shortness of breath, pounding heart or chest pain for at least ten minutes. The causes of panic disorder are not entirely understood but it is noted to be due to a combination of factors such as family history, abnormalities in the brain, substance abuse or major life stressors. Panic disorder is more common in women than in men usually known to begin in late adolescence or early adult hood. Panic disorder is usually treated with psychotherapy, cognitive behavioral therapy, and medication or relaxation techniques.

Agoraphobia

Agoraphobia is a known fear of an intense or irrational fear of crowded spaces and/or enclosed public spaces. It is reported to be one of the most common phobias and is often involves fearing places that may be difficult or embarrassing to escape. Symptoms also include trembling, sweating, heart pounding, fatigue or tingling in hands and feet.

Obsessive Compulsive Disorder

OCD is an anxiety disorder in which a person irrationally fears, thinks or worries and obsesses over performing rituals to cope with recurrent fears, thoughts, and worries. While it is normal for children or adolescents to have rituals that can help them socialize and make sense of the world, individuals with OCD will have obsessive concerns or thoughts that are unwanted, leading to rituals that are frequent and interfere with daily activities. An example is: having fear of touching

dirty things and controlling fear by excessively washing hands. Symptoms can be: extreme preoccupation with dirt or germs, obsessing with symmetry or exactness, obtrusive thoughts about violence such as hurting or killing someone, or harming self, excessive worrying of something bad happening, attention to detail or need to remember things.

Mood Disorders consist of having a mood disorder means your emotional state is usually distorted or inconsistent with your circumstances. Common mood disorders are:

Major Depressive Disorder (Clinical Depression)

Major Depression is a form of depression lasts for long periods of time, and affects the ability to function for daily activities such as grooming and going to work or school. Symptoms in teens are similar to adult symptoms, which also include extreme sensitivity, using drugs or alcohol, self-harm, feeling negative and worthless along with irritability and poor performance in school.

If a child, adult, or older adult is clinically depressed, they would have five or more of these symptoms (including at least one of the first two) nearly every day for at least two weeks:

- An unusually sad mood.
- Loss of enjoyment and interest in activities that were previously enjoyable.
- Lack of energy and tiredness.
- Feeling worthless or guilty when they are not really at fault.
- Thinking about death or wishing to be dead.
- Difficulty concentrating or making decisions.
- Moving more slowly or sometimes becoming agitated and unable to settle.
- Having sleeping difficulties or sleeping too much.

- Loss of interest in food or sometimes eating too much.
- Changes in eating habits, which may lead to either weight loss or weight gain.

Signs and Symptoms of Depression at Home

- Complaining of tiredness, even if they are sleeping more than usual.
- Having difficulty doing household chores, either forgetting to do them or not doing them thoroughly.
- Withdrawing from family, spending a great amount of time in isolation.
- Snapping at family members, behaving irritably, or picking fights with family members.
- Avoiding the discussion of important future events, such as decisions about education, work opportunities, future health care options.

Signs and Symptoms of Depression at School or Work

- Showing a decline in school grades because they do not complete work.
- Not doing as good a job as they used to at school or work
- Increase in absence from work or school.
- Failing to engage in classroom or work discussions or struggling to understand and communicate.
- Snapping or starting fights with other students or coworkers.
- Struggle to work effectively in the morning, but do better in late afternoon.

Signs and Symptoms of Depression in Social or Family Relationships

- Avoiding spending time with family and friends.
- Spending more time with friends who appear to be depressed as well.
- Becoming ostracized from their usual social groups either because they continually refuse invitations or friends find the individual difficult to spend time with.
- Refusing to attend family events such as birthdays and holidays.
- Using alcohol or other drugs to deal with emotional symptoms.

Risk Factors for Depression

- Family history
- Being a more sensitive, emotional, and anxious person
- Adverse experiences in childhood, such as lack of care or abuse
- Raised in poverty and social disadvantage
- Learning and other school difficulties
- Caring full-time for a person with a long-term disability
- Changes in hormone levels
- Drug and alcohol abuse
- Adverse events, such as victim of crime, death or serious illness in the family, some kind of accident, being bullied or victimized
- Parental separation or divorce
- Lack of a close, confiding relationship with someone
- Long-term or serious physical illness
- Other mental illness, such as an anxiety disorder, psychotic disorder, or substance use disorder

Importance of Early Intervention

- Early intervention is particularly important for youth, because depression can have negative effects on a young person's development.
- Depression in youth is associated with delays in social, emotional, and cognitive development.
- Youth who have had depression are more likely to have a range of problems in adulthood, including low education attainment, difficulties at work, unemployment, problems in personal relationships, early pregnancy, and problems with the law.
- Untreated behavioral health issues can lead to self-medication with alcohol and/or drugs in harmful dosages.
- Increases the vulnerability of youth and older adults to predators.
- Leads to physical health that can be life threatening.
- The earlier the intervention for youth, adults, and older adults the sooner the person can start feeling better and resume healthy relationships and a healthy life.

Bipolar Disorder

Bipolar Disorder is also known as manic depression, which causes mood swings to shift from one direction of euphoria or a burst of energy to a drastic low of depression and hopelessness along with loss in interest of pleasurable activities. Bipolar is a long-term condition that can be treated with psychotherapy; medications as well as a treatment

plan to monitor emotions. There are multiple types of bipolar disorders each with distinct criteria to fit the category.

However, 3 or more of the following symptoms must be present:

- Inflated self-esteem
- Feelings of grandiosity
- Decreased need for sleep (sleeping two hours a night)
- Being unusually very talkative
- Racing thoughts
- Distractibility
- Increased goal directed behavior or agitation

Lastly symptoms also include doing things that are uncommon and can be highly painful and consequential, some examples are foolish business investments, sexual indiscretions, and destructive buying sprees, such symptoms are not due to drugs or external stimuli. The extents of symptoms are categorized into two types of episodes manic (lasts one week, at least) or hypomanic (last at least four consecutive days). Symptoms are difficult to distinguish in children and adolescence along with normal ups and downs of mood swings. Symptoms that indicate bipolar disorder in teens and children are having extreme mood swings that are different from usual mood swings.

Differences between Adolescents and Adults with Bipolar Disorder

- Research indicates that adolescents with bipolar disorder are less likely to experience sleep disturbances than adults with the disorder.
- Bipolar disorder has a high level of co-occurrence with ADHD, substance use disorders, and anxiety disorders.

Psychotic Disorders

Mental illnesses that cause irrational thinking and perception are often characterized as disorders in the psyche. Individuals with psychotic disorders often struggle to stay connected with reality, often seen with delusions or hallucinations that the individual may refuse to see as unreal.

Signs and Symptoms of Psychosis

The symptoms of psychosis differ from person to person; however, some of the common symptoms are listed below:

- Disorganized way of thinking
- Unclear speech pattern
- Paranoia
- Hostility
- Suspicion
- Unrealistic sense of superiority (grandiosity)
- Delusional behavior (false beliefs)
- Hallucinations (hearing, seeing/feeling things that are not there)

Early Symptoms of Psychosis

- Becomes increasingly secretive or avoid answering questions.
- Spends more time alone/isolated.
- Begin expressing strange ideas.
- Have sudden outbursts or explosive, highly emotional reactions.
- Appears changed in a way that you cannot quite describe.
- Experience auditory hallucinations and sometimes try to drown them out with loud music or TV and get angry if asked to remove headphones or turn down TV.
- Withdrawal from friends.
- Use of alcohol or drugs.
- Appear to not react or react inappropriately to friends or family.

Common Types of Psychosis

Schizophrenia— is a brain-based condition with symptoms of bizarre thinking, behaviors, emotions and perceptions of sights and sounds that are not real. The condition can develop gradually or suddenly usually has its onset in late adolescence and early adulthood, from ages 18-22. Early warning signs are laughing at sad events, poor eye-contact, have low body- language and facial expression. Clicking, tapping, knocking or name being called may be heard although there is no sound. Very common early signs are sudden change in behavior and withdrawal from others. **Disordered** thinking is generally onset is after age 18. It is uncommon in children; sometimes it looks like other mental illness such as depression or bipolar disorder.

- **Psychotic Depression**— Sometimes depression is so intense it causes psychotic symptoms such as delusions about guilt over something that is not their fault, believing they are severely physically ill or that they are being mistreated or observed. Sometimes includes hallucinations.
- **Schizoaffective Disorder**— Has symptoms of psychosis and elevated or depressed mood or both, but does not meet criteria for bipolar disorder.

Substance-Induced Psychosis—Symptoms brought on by intoxication or withdrawal from alcohol or drugs. The psychosis generally appears quickly and lasts a short time (a few hours or time or a few days) until the effects of the drugs wear off. The most common symptoms are visual hallucinations, disorientation, and memory problems.

Delusional Disorder—According to the DSM V delusions are false beliefs due to the false perception of reality despite contradictory evidence. Delusional Disorder is having persistent delusions with no other symptoms for at least a month. There are different characterizations of delusions which are: Persecutory (claiming that one will be harmed by individual, organization or group), referential (belief that environmental cues are always directed towards the individual, e.g. claims everyone in restaurant is talking about them), grandiose (belief that individual has special abilities, wealth or fame), erotomaniac (false belief that another person is in love with them), nihilistic (belief that major catastrophe will occur), and somatic (focus on bodily functions or sensations in a bizarre way).

Eating Disorders

Food can be used to gain a sense of control that is manifested from having lack of control in other areas of an individual's life that are stressful or overwhelming. Feelings of worthlessness, having low self-esteem, anxiety, depression and anger are factors in eating disorders. Also, individuals with such disorders often have a history of being teased, having toxic relationships or feeling pressures from society to be thin enough to fit an unrealistic physical appearance.

Anorexia Nervosa—Anorexia is an eating disorder that is diagnosed when an individual weigh less than 85% of normal body weight, such physical condition can lead to dangerous health problems and even death if treatment is not applied on time. Individuals with anorexia tend to be perfectionist including depressive and anxious disorders. Other than physical appearance other queues that can indicate anorexia can be seen as: compulsive exercising, social withdrawal, being self-critical and striving for perfection.

Body Dimorphic Disorder—BDD consists of being highly focused on minor physical details usually on the skin and nose. This can be seen with obsessing over acne, scarring, facial lines, marks thinning or excessive body hair and having a large or crooked nose. The individual with this condition usually has excessive anxiety or stress about physical perception. More symptoms are checking in the mirror excessively, excessive grooming, or hiding imperfection. Such individuals may also seek reassurance from others and in many cases gets cosmetic surgery and is not satisfied with the results.

Bulimia Nervosa—Bulimia is a common public health problem due to the effect of the physical and mental health of the individual that is notably characterized with BDD, depression, anxiety and drug abuse. This eating disorder is characterized by having episodes of purging or eating food along with evoking vomiting. Bulimia is most common among teenagers at ages 15 and under age 22. Signs to look out for are rapid weight loss, going to the bathroom after eating amounts of food that most people would not consume, excessive exercise, abusing laxatives, diet pills, fasting, typically link their self-esteem to their appearance and weight. Physical symptoms are often seen: sore throat, discolored or deterioration of teeth, abdominal pain, cramping and bloating, constipation, dehydration, thinning skin and swollen salivary glands that cause having bigger cheeks.

Binge Eating Disorder—BED is an eating disorder that has three key components: frequent episodes of uncontrollable eating to the point of feeling uncomfortably full. Feeling distressed during or after episode of binge eating, and having no attempts to make up for overeating by vomiting, fasting or over-exercising, unlike bulimia. Individuals with the disorder are often embarrassed of their eating habits and often hide their symptoms and distress.

Behavioral symptoms to search for are:

- Inability to stop or control eating
- Eating when full
- Rapidly eating large amounts of food
- Hiding or saving food for later
- Eating normally around other but gorging when alone
- Continuously eating throughout day with no planned meals

Binge-eating disorder is normally linked with depression, which can also be another factor to look for.

Drug Addiction

Drug addiction is one the most common issues that many teens face. Each drug has different effects on the body and mind and usually results in self- destructive behavior. This can also be seen with prescription drugs that are legal. Symptoms to notice: deterioration of appearance (less focus on appearance), social withdrawal (stop going to social activities or family functions, church), unexplained need for money and unknown spending habits, change in friends and spots that teen normally hangs out, increased legal problems or thinking and behaviors become unpredictable, neglecting responsibilities.

2.6 Many Millennials Suffer from Mental Illness²

Millennials aren't feeling well.

As a generation, Millennials are putting up startling figures for measures of mental health. Suicide rates after years of decline, have jumped back up by nearly 25 percent. The trend is worst among adolescent girls, but many millennial subgroups, like those in the military, are also at elevated risk.

² By Edgar Wilson, May 23, 2016.

Depression is also rampant among this age demographic, according to numerous studies—even though it is routinely under-diagnosed among adolescents, which helps exacerbate the suicide risk among teens as well as the risk of more severe mood disorders in adulthood.

Psychologists have observed that stress and anxiety disorders are the norm today, afflicting upwards of one in every five Millennials.

There is even emerging evidence that the crushing weight of student debt and financial insecurity in the wake of a succession of financial crises may be having a pointed psychological effect on this generation as well. More than one-third of Millennials exhibit the symptoms of PTSD, specifically in response to financial stressors. Rather than making decisions based on optimism, confidence, or a sense of strategic self-discipline, fear is governing the behavior of the new majority in America.

It might be tempting to use growing awareness, better diagnostics, or even a lack of resilience to explain away the whole spike in behavioral health problems among Millennials, but the continuing rise in suicide rates shows that the impact is all too real, and devastating. And although Millennials are the new face of the crisis, the effects of their struggle with behavioral health go far beyond a single generation. Healthcare in the United States has been extremely slow to embrace behavioral health. This is at least partly a result of the historic (and continuing) tendency in American society to treat emotional problems as a personal choice or individual failing, rather than a legitimate clinical concern. The lack of compassion and understanding helped create a stigma surrounding mental health that has persisted even in the face of awareness campaigns, improved counseling and psychological treatment, and of course, the recent rise in suicides among the nation's youth.

Given the real and perceived social risks of asking for help, it should come as no surprise that many victims of depression try to self-medicate. Depression has a strong correlation with substance abuse (this is often referred to as 'dual-diagnosis'), which carries its own cultural baggage. It is hard for those suffering from addiction or other behavioral health problems to seek help, because treatment can carry as much of a stigma as the original complaint.

To understand just how severe the issue still is one need only look at America's physical medicine establishment. Medical students learn early on to fear talking openly about depression, suicidal thoughts, or anything else that might wind up in their professional record and taint their reputation among colleagues, patients, or potential employers. This same fear—of being found out, of disappointing the many people counting on them or expecting great things—has made suicide the second leading cause of death among medical students, after accidents.

Those that survive medical school and go on to practice carry this magnified perception of the mental health stigma with them. More than 400 physicians commit suicide every year. It is no coincidence that physicians, unwilling to admit to their own depression or seek professional help, are also notoriously poor at screening their patients. So even though some 80 percent of Millennials are at least getting their annual physicals and have access to a primary care physician or similar provider, they are not being sufficiently diagnosed with behavioral health problems, much less referred to the appropriate specialists.

Although it hasn't been well publicized, this has been the scale of the situation for some time. Now, however, the demographics of the country are shifting. Millennials are, by most measures, officially the majority, and well on their way to dominating employment as they

enter their prime working years. At the same time, baby boomers (formerly the largest cohort) are both dying and retiring, which adds even greater momentum to the shift.

That all means that a generation of high anxiety, depression- and suicide-prone individuals are going to become the primary care providers to America, working in the field that, sadly, takes the worst care of itself.

Science has given us the ability to live longer than ever—baby boomers will be the first generation to fully experience the progress that was made in medicine throughout the 20th century. This, along with the expansion of health insurance through the Affordable Care Act, means there is more demand for medical care than ever before. Meeting this demand is now the responsibility of Millennials.

To take care of America, Millennials must learn to take better care of themselves, and that starts with a new approach to mental health. Fighting the stigma requires more than a change of policy; the culture of silence, tolerance, and personal blame needs to give way to one of compassion, understanding, and openness. No generation can afford to allow current trends to continue unchallenged.

2.7 Common Middle-aged Disorders (Ages 45-60)

Depression

An individual who is depressed will often be caught in a cycle of feeling helpless and having negative thoughts. Depression is often accompanied a midlife transition, which often occurs around age 37- 50, but this sort of depression usually leads to a period of tremendous personal growth. However, when the depression is a result from a life

transition or is a frequent condition in a person's life that is when it is time to recognize that help is necessary.

Symptoms to be aware of:

- Change in eating
- Sleep
- Feelings of fatigue
- Restlessness
- Anxiety and feelings of guilt and worthlessness
- Loss of interest in activities such as sex and hobbies
- Thoughts or attempts of suicide
- Headaches and bowels upset not due to treatment

Anxiety

Criteria for diagnosing anxiety in adults are very similar to those of children along with the symptoms.

Some key symptoms for adults include:

- Becoming tired easily
- Lack of concentration
- Lack of memory or attention
- Feels as if the mind has gone blank
- Irritable
- Muscle tension and headaches
- Sleep problems and panic attacks

Suicide

Suicide often occurs due to being chronically depressed and can be prevented if the symptoms are recognized and treatment is addressed.

Suicidal thoughts and warnings to pay attention to are:

- Talking about suicide
- Buying a gun or pills

- Withdrawing from human contact
- Mood swings
- Increased use of alcohol
- Changing normal routine
- Using drugs or driving reckless
- Giving away belongings
- Suddenly writing a will
- Feeling agitated

Many individuals who are feeling suicidal but aren't yet willing to immediately hurt themselves often reach out to a minister, friend or doctor and often struggle to express feelings. Therefore, by recognizing the above signs and taking action could possibly uplift the individual into recovery.

Insomnia

Someone with insomnia will often take longer than 30 minutes to fall asleep for three or more nights in a week for over a month. Symptoms include: waking up during the night, waking up too early, feeling tired during the day after having a full night's rest, irritability, depression or anxiety, increased errors or accidents, tension headaches, stomach pain, difficulty paying attention.

Insomnia is noted to become more common with age so it is important to pay attention to possible causes such as eating habits, stress, anxiety, depression, medication and other medical conditions.

Prescription Drug Addiction

Over the counter drugs are often abused recreationally by teenagers but all too often become an addiction for adults whom are prescribed such drugs. Certain drugs such opioids (pain killers), depressants also

known as benzodiazepines (e.g. Xanax, Valium and Klonopin) and stimulants known as amphetamines and dextroamphetamine are category names for drugs that treat ADHD and sleep disorders such as Ritalin, Concerta and Adderall.

Not everyone who uses prescription drugs become addicted environment and genetic factors play a role in how prone and individual becomes addicted. Self- monitoring is important when taking such medications and it is important to seek or address help when certain behaviors are noticed. When an individual is taking more than the dosage prescribed or taking the medication for reasons other than prescribed, then this is considered abuse. Some changes in appearance are bloodshot or glazed eyes, sudden changes in weight, pupil constriction or dilation. Some behavioral changes in adults are: lethargy, depression, financial problems, criminal activity, changes in habits and priorities attitude changes and aggression. Specific drugs can have specific symptoms of addiction and can be reviewed at: <http://drugabuse.com/library/symptoms-and-signs-of-drug-abuse/>

2.8 Older and Retired Seniors (60 and Older)

Alzheimer's

Alzheimer's is a progressive disease that is characterized by seven stages that each has criteria of displaying changes in memory and behavior. Each stage has symptoms and warning signs to look at, but not all cases of Alzheimer's fall perfectly into each category.

Stage 1—Displays Normal Behavior: no symptoms that you can spot unless there is a PET scan reveal how the brain is working.

Stage 2—Mild Changes: this can be as small as misplacing objects or forgetting words, but at this stage life has Alzheimer's has not affected Individual's ability to function.

Stage 3—Mild Decline: at this point it is changes are noticeable with symptoms such as: Forgetting something he just read, ask the same question repeatedly, has more trouble making and organizing plans, and cannot remember meeting new people he just met.

Stage 4—Moderate Decline: Signs and symptoms become more obvious with: forgetting detail about themselves, forgetting the date, forgetting month or season, having trouble cooking meals or ordering from menu.

Stage 5—Moderately Severe Decline: Individual starts to lose track of where they are and what time it is. They may also have trouble remembering address, phone number and details of their life, such as where they went to school. They may also have trouble dressing appropriately for the season.

Stage 6—Severe Decline: individual may recognize a familiar face but forget names or mistake someone for somebody else (e.g. thinking his wife is his mother), or thinking he still needs to go to work even if he is retired.

Stage 7—Very Severe Decline: Basic abilities such as walking, seating up or eating begins to fade at this stage. They can also fail to tell that they are thirsty. At this point constant care is necessary.

Dementia

Dementia is a decline in mental ability severe enough to affect daily life. It is not a specific disease and has a wide range of symptoms associated

with a decline in memory and other thinking skills. Two core mental functions must be present to be considered dementia such as: memory, communication and language, reasoning, judgment and visual perception.

Individuals may have problems with short-term memory such as keeping track of purse or wallet, paying bills, planning or preparing meals. It is also a progressive disease that gradually gets worse; therefore, early warning signs should not be ignored. Early diagnosis allows a person to get available treatment and plan for the future.

Depression in Elderly

Symptoms of depression for seniors are different than symptoms in younger adults. The symptoms of depression in the elderly are often mistaken for other illnesses and disabilities that normally accompany depression. Depression is known to increase the risk of cardiac disease, heart attack, diminished rehabilitation and suicide. Depression for individuals 65 or older is considered to be a major health concern and this can be due to the fact the individuals are expected to slow down and therefore the signs of depression may not be as noticeable. Also, aging often follows with the loss of family members, spouses, retirement and ultimately lowered social support. Not only are older adults at a higher risk but they are often misdiagnosed and not treated.

Some symptoms to notice in the elderly are: feelings of hopelessness, pessimism, guilt and worthlessness, fatigue, insomnia and excessive eating, changes in appetite, thoughts of suicide and attempts and constant aches and pains, cramps and digestive issues that do not improve with treatment. Most of the following symptoms are typical symptoms of younger adults however, prevalence of having other

illnesses can frequently get such symptoms confused with the presence of that illness and therefore, diagnosis is poor.

Addiction to Medication

Elderly are not commonly the first age group that are thought of for drug addiction. However, the elderly is known to be a large group of consumers for prescribed narcotics, and depressants. Such drug addiction is difficult to notice especially sense tolerance develops over time and reaching the same effects takes higher doses. Doctors are not normally suspicious of seniors having an addiction to medication, which has made prescriptions more accessible to elderly patients who are more likely to have chronic pain.

Symptoms of prescription addiction in the elderly:

- If prescription used to be 1 to 2 a day and individual is now taking 4 or 6, that's a warning sign.
- Having constant excuses for needing to take pills.
- They tend to have a change in mood or behavior, they become argumentative, withdrawn or anxious.
- They carry around a supply of medication in case of emergency.
- They have been treated for any type of addiction earlier in life.
- They have changed Doctors and drug stores.
- They are seeing multiple doctors and using multiple pharmacies.

- They become uncomfortable when the use of their medication is addressed.
- They sneak or hide pills.
- They have already been treated for excessive pill use.

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Chapter 3. Substance Abuse & Other Addictions

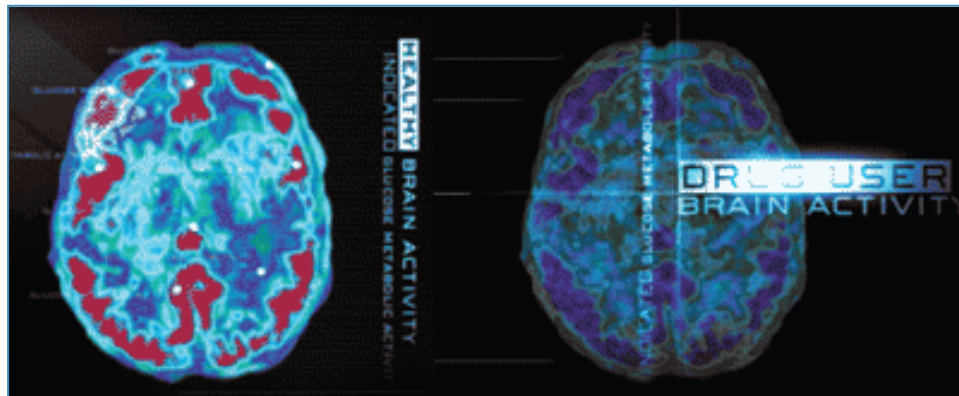
3.1 Drugs, Brains, and Behavior: How Science Has Revolutionized the Understanding of Drug Addiction³

For much of the past century, scientists studying drug abuse labored in the shadows of powerful myths and misconceptions about the nature of addiction. When scientists began to study addictive behavior in the 1930s, people addicted to drugs were thought to be morally flawed and lacking in willpower. Those views shaped society's responses to drug abuse, treating it as a moral failing rather than a health problem, which led to an emphasis on punishment rather than prevention and treatment. Today, thanks to science, our views and our responses to addiction and other substance use disorders have changed dramatically. Groundbreaking discoveries about the brain have revolutionized our understanding of compulsive drug use, enabling us to respond effectively to the problem.

As a result of scientific research, we know that addiction is a disease that affects both the brain and behavior. We have identified many of the biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease. Scientists use this knowledge to develop effective prevention and treatment approaches that reduce the toll drug abuse takes on individuals, families, and communities.

³ Nora D. Volkow, M.D., *Director of the National Institute on Drug Abuse*

Despite these advances, many people today do not understand why people become addicted to drugs or how drugs change the brain to



foster compulsive drug use. This booklet aims to fill that knowledge gap by providing scientific information about the disease of drug addiction, including the many harmful consequences of drug abuse and the basic approaches that have been developed to prevent and treat substance use disorders.

At the National Institute on Drug Abuse (NIDA), we believe that increased understanding of the basics of addiction will empower people to make informed choices in their own lives, adopt science-based policies and programs that reduce drug abuse and addiction in their communities, and support scientific research that improves the Nation's well-being.

3.2 What is Drug Addiction?⁴

Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful

⁴ Source: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Service.

consequences.⁵ It is considered a brain disease because drugs change the brain—they change its structure and how it works. These brain changes can be long-lasting, and can lead to the harmful behaviors seen in people who abuse drugs.

Addiction is a lot like other diseases, such as heart disease. Both disrupt the normal, healthy functioning of the underlying organ, have serious harmful consequences, and are preventable and treatable, but if left untreated, can last a lifetime.

3.3 Why Do People Take Drugs?

In general, people begin taking drugs for a variety of reasons: *To feel good*. Most abused drugs produce intense feelings of pleasure. This initial sensation of euphoria is followed by other effects, which differ with the type of drug used. For example, with stimulants such as cocaine, the “high” is followed by feelings of power, self-confidence, and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction.

- *To feel better*. Some people who suffer from social anxiety, stress-related disorders, and depression begin abusing drugs in an attempt to lessen feelings of distress. Stress can play a major role in beginning drug use, continuing drug abuse, or relapse in patients recovering from addiction.



Faith Based Acad

⁵ The term addiction as used in this booklet may be regarded as equivalent to a severe substance use disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5, 2013). Source: From the laboratories of Drs. N. Volkow and H. Schelbert.

- ***To do better.*** Some people feel pressure to chemically enhance or improve their cognitive or athletic performance, which can play a role in initial experimentation and continued abuse of drugs such as prescription stimulants or anabolic/androgenic steroids.
- ***Curiosity and "because others are doing it."*** In this respect adolescents are particularly vulnerable because of the strong influence of peer pressure. Teens are more likely than adults to engage in risky or daring behaviors to impress their friends and express their independence from parental and social rules.

If Taking Drugs Makes People Feel Good or better, what's the Problem?

When they first use a drug, people may perceive what seem to be positive effects; they also may believe that they can control their use. However, drugs can quickly take over a person's life. Over time, if drug use continues, other pleasurable activities become less pleasurable, and taking the drug becomes necessary for the user just to feel "normal."

They may then compulsively seek and take drugs even though it causes tremendous problems for themselves and their loved ones. Some people may start to feel the need to take higher or more frequent doses, even in the early stages of their drug use. These are the telltale signs of an addiction.

Even relatively moderate drug use poses dangers. Consider how a social drinker can become intoxicated, get behind the wheel of a car, and quickly turn a pleasurable activity into a tragedy that affects many lives.

3.4 Is Continued Drug Abuse a Voluntary Behavior?

The initial decision to take drugs is typically voluntary. However, with continued use, a person's ability to exert self-control can become seriously impaired; this impairment in self-control is the hallmark of addiction. Brain imaging studies of people with addiction show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.

Scientists believe that these changes alter the way the brain works and may help explain the compulsive and destructive behaviors of addiction.

No single factor determines whether a person will become addicted to drugs.

3.5 Why Do Some People Become Addicted to Drugs, While Others Do Not?

As with any other disease, vulnerability to addiction differs from person to person, and no single factor determines whether a person will become addicted to drugs. In general, the more *risk factors* a person has, the greater the chance that taking drugs will lead to abuse and addiction. *Protective factors*, on the other hand, reduce a person's risk of developing addiction. Risk and protective factors may be either environmental (such as conditions at home, at school, and in the neighborhood) or biological (for instance, a person's genes, their stage of development, and even their gender or ethnicity).

What Environmental Factors Increase the Risk of Addiction?

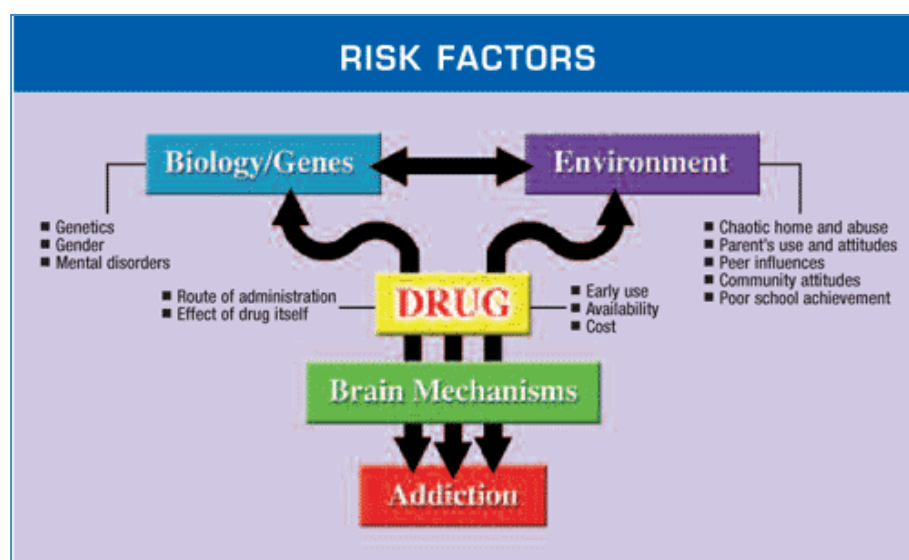
- **Home and Family**—The influence of the home environment, especially during childhood, is a very important factor. Parents

or older family members who abuse alcohol or drugs, or who engage in criminal behavior, can increase children's risks of developing their own drug problems.

- **Peer and School**—Friends and acquaintances can have an increasingly strong influence during adolescence. Drug-using peers can sway even those without risk factors to try drugs for the first time. Academic failure or poor social skills can put a child at further risk for using or becoming addicted to drugs.

What Biological Factors Increase Risk of Addiction?

Scientists estimate that genetic factors account for between 40 and 60 percent of a person's vulnerability to addiction; this includes the effects of environmental factors on the function and expression of a person's genes. A person's stage of development and other medical conditions they may have are also factors. Adolescents and people with mental disorders are at greater risk of drug abuse and addiction than the general population.



Children's earliest interactions within the family are crucial to their healthy development and risk for drug abuse.

Risk and Protective Factors for Drug Abuse and Addiction	
Risk Factors	Protective Factors
Aggressive behavior in childhood	Good self-control
Lack of parental supervision	Parental monitoring and support
Poor social skills	Positive relationships
Drug experimentation	Academic Competence
Availability of drugs at school	School anti-drug policies
Community poverty	Neighborhood pride

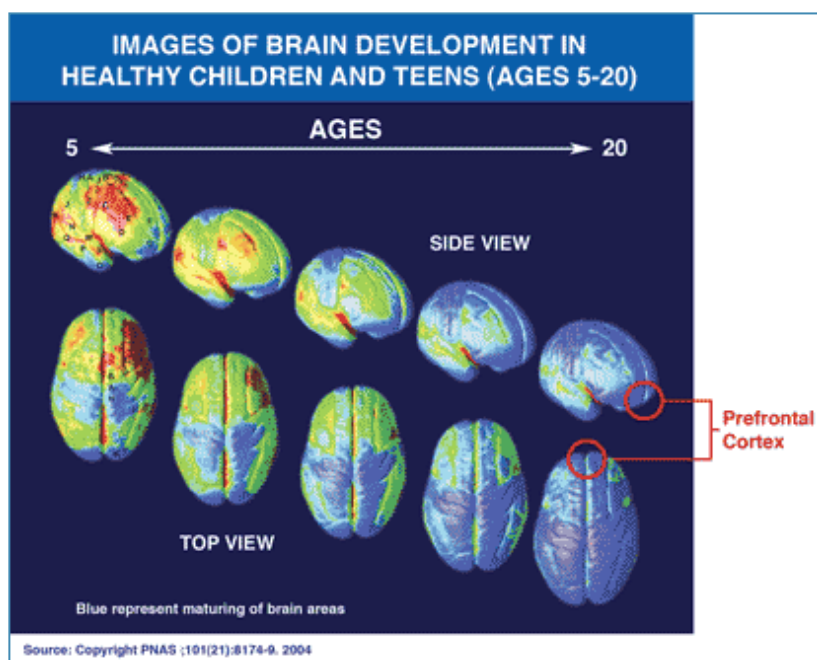
What Other Factors Increase the Risk of Addiction?

- **Early Use**—Although taking drugs at any age can lead to addiction, research shows that the earlier a person begins to use drugs, the more likely he or she is to develop serious problems. This may reflect the harmful effect that drugs can have on the developing brain; it also may result from a mix of early social and biological vulnerability factors, including unstable family relationships, exposure to physical or sexual abuse, genetic susceptibility, or mental illness. Still, the fact remains that early use is a strong indicator of problems ahead, including addiction.



- **Method of Administration**—Smoking a drug or injecting it into a vein increases its addictive potential. Both smoked and injected drugs enter the brain within seconds, producing a powerful rush of pleasure. However, this intense “high” can fade within a few minutes, taking the abuser down to lower, more normal levels. Scientists believe this starkly felt contrast drives some people to repeated drug taking in an attempt to recapture the fleeting pleasurable state.

Addiction is a developmental disease—it typically begins in childhood or adolescence.



The brain continues to develop into adulthood and undergoes dramatic changes during adolescence. One of the brain areas still maturing during adolescence is the prefrontal cortex—the part of the brain that enables us to assess situations, make sound decisions, and keep our emotions and desires under control. The fact that this critical part of an adolescent’s brain is still a work in progress puts them at increased risk

for making poor decisions (such as trying drugs or continuing to take them). Also, introducing drugs during this period of development may cause brain changes that have profound and long-lasting consequences.

3.6 Preventing Drug Abuse: The Best Strategy

Why is adolescence a critical time for preventing drug addiction?

As noted previously, early use of drugs increases a person's chances of developing addiction. Remember, drugs change brains—and this can lead to addiction and other serious problems. So, preventing early use of drugs or alcohol may go a long way in reducing these risks. If we can prevent young people from experimenting with drugs, we can prevent drug addiction.

Risk of drug abuse increases greatly during times of transition. For an adult, a divorce or loss of a job may lead to drug abuse; for a teenager, risky times include moving or changing schools.¹² In early adolescence, when children advance from elementary through middle school, they face new and challenging social and academic situations. Often during this period, children are exposed to *abusable* substances such as cigarettes and alcohol for the first time. When they enter high school, teens may encounter greater availability of drugs, drug use by older teens and social activities where drugs are used.

At the same time, many behaviors that are a normal aspect of their development, such as the desire to try new things or take greater risks, may increase teen tendencies to experiment with drugs. Some teens may give in to the urging of drug-using friends to share the experience with them. Others may think that taking drugs (such as steroids) will improve their appearance or their athletic performance or that abusing substances such as alcohol or MDMA (ecstasy or “Molly”) will ease their anxiety in social situations. A growing number of teens are

abusing prescription ADHD stimulants such as Adderall® to help them study or lose weight. Teens' still-developing judgment and decision-making skills may limit their ability to accurately assess the risks of all of these forms of drug use.

Using *abusable* substances at this age can disrupt brain function in areas critical to motivation, memory, learning, judgment, and behavior control.⁷ So, it is not surprising that teens who use alcohol and other drugs often have family and social problems, poor academic performance, health-related problems (including mental health), and involvement with the juvenile justice system.

National drug use surveys indicate some children are already abusing drugs by age 12 or 13.

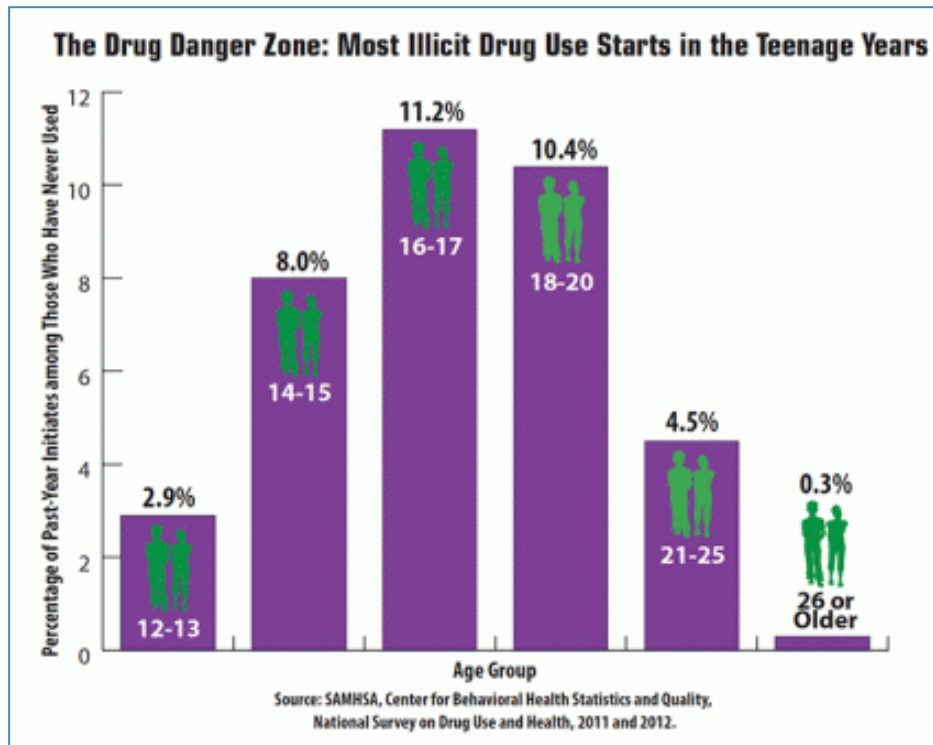
Can Research-based Programs Prevent Drug Addiction in Youth?

Yes. The term “research-based” means that these programs have been rationally designed based on current scientific evidence, rigorously tested, and shown to produce positive results. Scientists have developed a broad range of programs that positively alter the balance between risk and protective factors for drug abuse in families, schools, and communities. Studies have shown that research-based programs can significantly reduce early use of tobacco, alcohol, and illicit drugs.⁶

⁶ <https://www.drugabuse.gov/publications/science-addiction/citations>

How Do Research-based Prevention Programs Work?

These prevention programs work to boost protective factors and eliminate or reduce risk factors for drug use. The programs are designed for various ages and can be designed for individual or group settings, such as the school and home.



There are three types of programs:

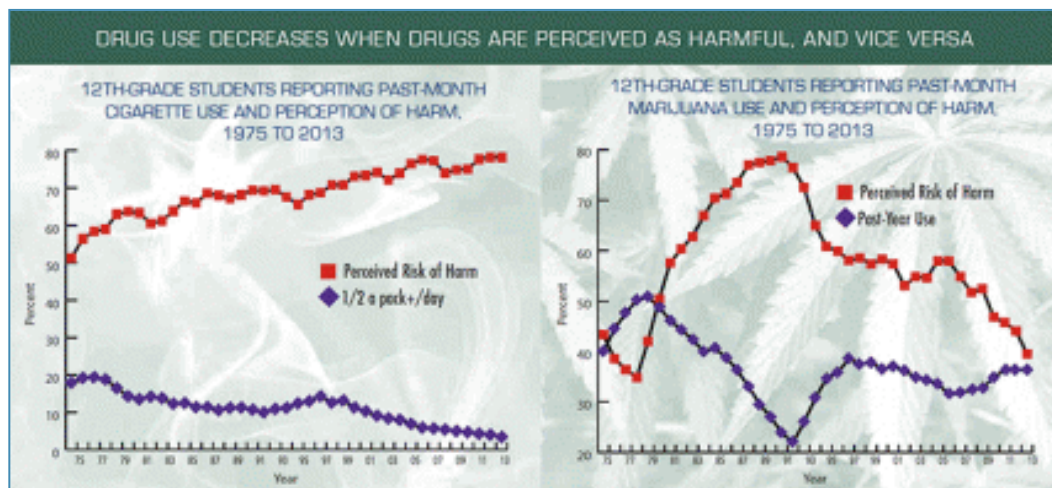
- 1) Universal programs address risk and protective factors common to all children in a given setting, such as a school or community.
- 2) Selective programs target groups of children and teens who have factors that put them at increased risk of drug use.
- 3) Indicated programs are designed for youth who have already begun using drugs.

Are All Prevention Programs Effective in Reducing Drug Abuse?

When research-based substance use prevention programs are properly implemented by schools and communities, use of alcohol, tobacco, and illegal drugs is reduced. Such programs help teachers, parents, and health care professionals shape youths' perceptions about the risks of substance use. While many social and cultural factors affect drug use trends, when young people perceive drug use as harmful, they reduce their level of use.⁷

Cigarette smoking among teens is at its lowest point since NIDA began tracking it in 1975. But marijuana use has increased over the past several years as perception of its risks has declined.⁸

Prevention is the best strategy.

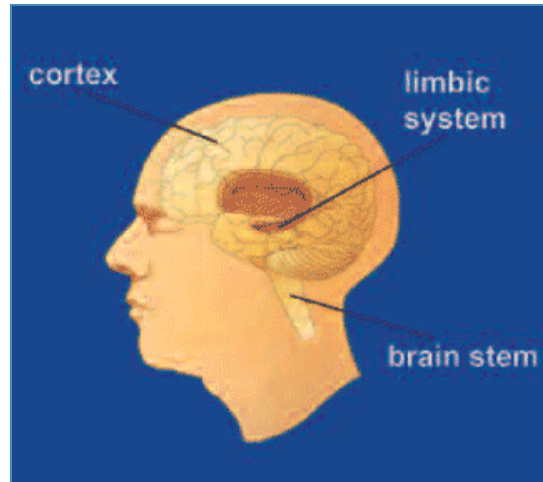


⁷ <https://www.drugabuse.gov/publications/science-addiction/citations>

⁸ Source: 2013 monitoring the Future survey. University of Michigan, with funding from the National Institute on Drug Abuse.

3.7 Drugs and the Brain: Introducing the Human Brain

The human brain is the most complex organ in the body. This three-pound mass of gray and white matter sits at the center of all human activity—you need it to drive a car, to enjoy a meal, to breathe, to create an artistic masterpiece, and to enjoy everyday activities. In brief, the brain regulates your body's basic functions; enables you to interpret and respond to everything you experience; and shapes your thoughts, emotions, and behavior.



The brain is made up of many parts that all work together as a team. Different parts of the brain are responsible for coordinating and performing specific functions. Drugs can alter important brain areas that are necessary for life-sustaining functions and can drive the compulsive drug abuse that marks addiction.

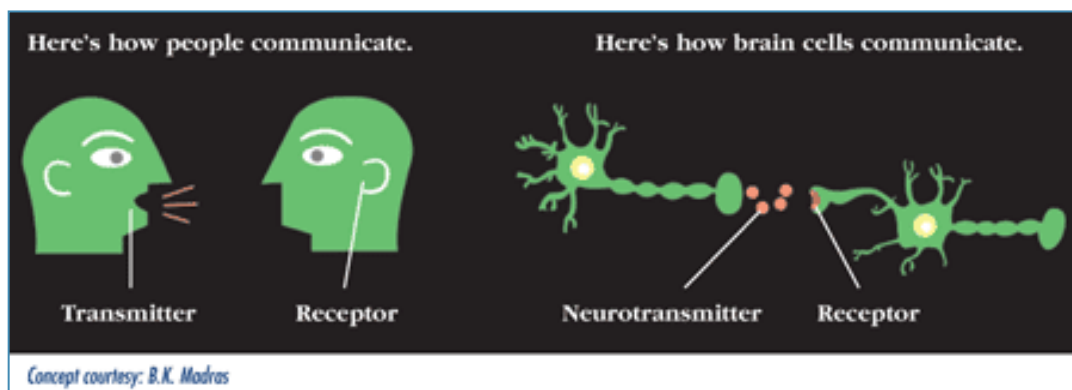
Brain areas affected by drug abuse include:

- **The brain stem**, which controls basic functions critical to life, such as heart rate, breathing, and sleeping.
- **The cerebral cortex**, which is divided into areas that control specific functions. Different areas process information from our senses, enabling us to see, feel, hear, and taste. The front part of the cortex, the frontal cortex or forebrain, is the thinking center of the brain; it powers our ability to think, plan, solve problems, and make decisions.

- **The limbic system**, which contains the brain's reward circuit. It links together a number of brain structures that control and regulate our ability to feel pleasure. Feeling pleasure motivates us to repeat behaviors that are critical to our existence. The limbic system is activated by healthy, life-sustaining activities such as eating and socializing—but it is also activated by drugs of abuse. In addition, the limbic system is responsible for our perception of other emotions, both positive and negative, which explains the mood-altering properties of many drugs.

How Do the Parts of the Brain Communicate? The brain is a communications center consisting of billions of neurons, or nerve cells. Networks of neurons pass messages back and forth among different structures within the brain, the spinal cord, and nerves in the rest of the body (the peripheral nervous system). These nerve networks coordinate and regulate everything we feel, think, and do.

- **Neuron to Neuron**—Each nerve cell in the brain sends and receives messages in the form of electrical and chemical signals. Once a cell receives and processes a message, it sends it on to other neurons.



- **Neurotransmitters—The Brain's Chemical Messengers**
The messages are typically carried between neurons by chemicals called neurotransmitters.
- **Receptors: The Brain's Chemical Receivers**—The neurotransmitter attaches to a specialized site on the receiving neuron called a receptor. A neurotransmitter and its receptor operate like a “key and lock,” an exquisitely specific mechanism that ensures that each receptor will forward the appropriate message only after interacting with the right kind of neurotransmitter.
- **Transporters: The Brain's Chemical Recyclers**—Located on the neuron that releases the neurotransmitter, transporters recycle these neurotransmitters (that is, bring them back into the neuron that released them), thereby shutting off the signal between neurons. To send a message, a brain cell (neuron) releases a chemical (neurotransmitter) into the space (synapse) between it and the next cell. The neurotransmitter crosses the synapse and attaches to proteins (receptors) on the receiving brain cell. This causes changes in the receiving cell—the message is delivered.

How Do Drugs Work in the Brain?

Drugs are chemicals that affect the brain by tapping into its communication system and interfering with the way neurons normally send, receive, and process information. Some drugs, such as marijuana and heroin, can activate neurons because their chemical structure mimics that of a natural neurotransmitter. This similarity in structure “fools” receptors and allows the drugs to attach onto and activate the neurons. Although these drugs mimic the brain's own chemicals, they don't activate neurons in the same way as a natural neurotransmitter,

and they lead to abnormal messages being transmitted through the network.

Other drugs, such as amphetamine or cocaine, can cause the neurons to release abnormally large amounts of natural neurotransmitters or prevent the normal recycling of these brain chemicals. This disruption produces a greatly amplified message, ultimately disrupting communication channels.

How Do Drugs Work in the Brain to Produce Pleasure?

Most drugs of abuse directly or indirectly target the brain's reward system by flooding the circuit with dopamine. Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, motivation, and feelings of pleasure. When activated at normal levels, this system rewards our natural behaviors. Overstimulating the system with drugs, however, produces euphoric effects, which strongly reinforce the behavior of drug use—teaching the user to repeat it.

Most drugs of abuse target the brain's reward system by flooding it with dopamine.

How Does Stimulation of the Brain's Pleasure Circuit Teach Us to Keep Taking Drugs?

Our brains are wired to ensure that we will repeat life-sustaining activities by associating those activities with pleasure or reward. Whenever this reward circuit is activated, the brain notes that something important is happening that needs to be remembered, and teaches us to do it again and again without thinking about it. Because drugs of abuse stimulate the same circuit, we learn to abuse drugs in the same way.

Why Are Drugs More Addictive Than Natural Rewards?

When some drugs of abuse are taken, they can release 2 to 10 times the amount of dopamine that natural rewards such as eating and sex do.⁹

In some cases, this occurs almost immediately (as when drugs are smoked or injected), and the effects can last much longer than those produced by natural rewards. The resulting effects on the brain's pleasure circuit dwarf those produced by naturally rewarding behaviors.¹⁰ The effect of such a powerful reward strongly motivates people to take drugs again and again. This is why scientists sometimes say that drug abuse is something we learn to do very, very well.

Long-term drug abuse impairs brain functioning.

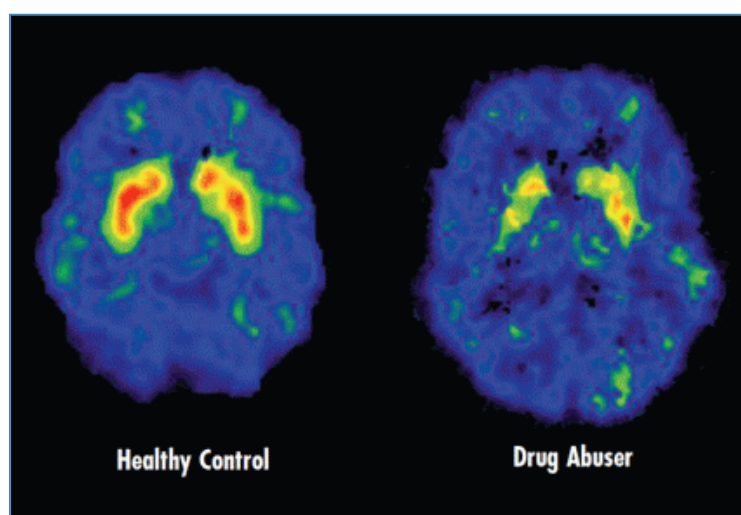
What Happens to Your Brain if You Keep Taking Drugs?

For the brain, the difference between normal rewards and drug rewards can be described as the difference between someone whispering into your ear and someone shouting into a microphone. Just as we turn down the volume on a radio that is too loud, the brain adjusts to the overwhelming surges in dopamine (and other neurotransmitters) by producing less dopamine or by reducing the number of receptors that can receive signals. As a result, dopamine's impact on the reward circuit of the brain of someone who abuses drugs can become abnormally low, and that person's ability to experience *any* pleasure is reduced.

This is why a person who abuses drugs eventually feels flat, lifeless, and depressed, and is unable to enjoy things that were previously pleasurable. Now, the person needs to keep taking drugs again and again just to try and bring his or her dopamine function back up to

⁹ <https://www.drugabuse.gov/publications/science-addiction/citations>

normal—which only makes the problem worse, like a vicious cycle. Also, the person will often need to take larger amounts of the drug to produce the familiar dopamine high—an effect known as tolerance.



Decreased Dopamine Transporters in a Methamphetamine Abuser

How Does Long-term Drug Taking Affect Brain Circuits?

We know that the same sort of mechanisms involved in the development of tolerance can eventually lead to profound changes in neurons and brain circuits, with the potential to severely compromise the long-term health of the brain. For example, glutamate is another neurotransmitter that influences the reward circuit and the ability to learn.

When the optimal concentration of glutamate is altered by drug abuse, the brain attempts to compensate for this change, which can cause impairment in cognitive function. Similarly, long-term drug abuse can trigger adaptations in habit or non-conscious memory systems. Conditioning is one example of this type of learning, in which cues in a person's daily routine or environment become associated with the drug experience and can trigger uncontrollable cravings whenever the

person is exposed to these cues, even if the drug itself is not available. This learned “reflex” is extremely durable and can affect a person who once used drugs even after many years of abstinence.

What Other Brain Changes Occur with Abuse?

Chronic exposure to drugs of abuse disrupts the way critical brain structures interact to control and inhibit behaviors related to drug use. Just as continued abuse may lead to tolerance or the need for higher drug dosages to produce an effect, it may also lead to addiction, which can drive a user to seek out and take drugs compulsively. Drug addiction erodes a person’s self-control and ability to make sound decisions, while producing intense impulses to take drugs.

3.8 Addiction and Health

What Are the Medical Consequences of Drug Addiction?

People who suffer from addiction often have one or more accompanying medical issues, which may include lung or cardiovascular disease, stroke, cancer, and mental disorders. Imaging scans, chest X-rays, and blood tests show the damaging effects of long-term drug abuse throughout the body.

For example, research has shown that tobacco smoke causes cancer of the mouth, throat, larynx, blood, lungs, stomach, pancreas, kidney, bladder, and cervix. In addition, some drugs of abuse, such as inhalants, are toxic to nerve cells



and may damage or destroy them either in the brain or the peripheral nervous system.

The impact of addiction can be far-reaching:

- Cardiovascular disease
- Stroke
- Cancer
- HIV/AIDS
- Hepatitis B and C
- Lung disease
- Mental disorders

Does Drug Abuse Cause Mental Disorders, or Vice Versa?

Drug abuse and mental illness often co-exist. In some cases, mental disorders such as anxiety, depression, or schizophrenia may precede addiction; in other cases, drug abuse may trigger or exacerbate those mental disorders, particularly in people with specific vulnerabilities.

Addiction and HIV/AIDS are intertwined epidemics.

How Can Addiction Harm Other People?

Beyond the harmful consequences for the person with the addiction, drug abuse can cause serious health problems for others. Three of the more devastating and troubling consequences of addiction are:

- *Negative effects of prenatal drug exposure on infants and children.*
A mother's abuse of heroin or prescription opioids during pregnancy can cause a withdrawal syndrome (called neonatal abstinence syndrome, or NAS) in her infant. It is also likely that some drug-exposed children will need educational support in the classroom to help them overcome what may be subtle deficits in

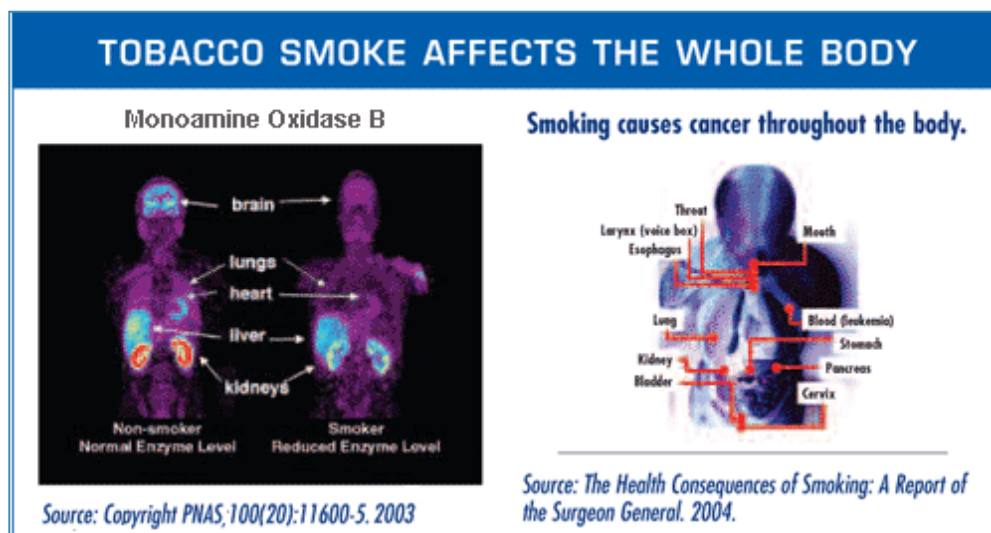
developmental areas such as behavior, attention, and thinking. Ongoing research is investigating whether the effects of prenatal drug exposure on the brain and behavior extend into adolescence to cause developmental problems during that time period.



- ***Negative effects of secondhand smoke.*** Secondhand tobacco smoke, also called environmental tobacco smoke (ETS), is a significant source of exposure to a large number of substances known to be hazardous to human health, particularly to children. According to the Surgeon General's 2006 Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke*, involuntary exposure to secondhand smoke increases the risks of heart disease and lung cancer in people who have never smoked by 25–30 percent and 20–30 percent, respectively.
- ***Increased spread of infectious diseases.*** Injection of drugs such as heroin, cocaine, and methamphetamine currently accounts for about 12 percent of new AIDS cases. Injection drug use is also a major factor in the spread of hepatitis C, a serious, potentially fatal liver disease. Injection drug use is not the only way that drug abuse contributes to the spread of infectious diseases. All drugs of abuse cause some form of intoxication, which interferes with judgment and increases the likelihood of risky sexual behaviors. This, in turn, contributes to the spread of HIV/AIDS, hepatitis B and C, and other sexually transmitted diseases.

What Are Some Effects of Specific Abused Substances?

- **Nicotine** is an addictive stimulant found in cigarettes and other forms of tobacco. Tobacco smoke increases a user's risk of cancer, emphysema, bronchial disorders, and cardiovascular disease. The mortality rate associated with tobacco addiction is staggering. Tobacco use killed approximately 100 million people during the 20th century, and, if current smoking trends continue, the cumulative death toll for this century has been projected to reach 1 billion.



Tobacco use is responsible for an estimated 5 million deaths worldwide each year.

- **Alcohol** consumption can damage the brain and most body organs. Areas of the brain that are especially vulnerable to alcohol-related damage are the cerebral cortex (largely responsible for our higher brain functions, including problem solving and decision making), the hippocampus (important for memory and learning), and the cerebellum (important for movement coordination).

- **Marijuana** is the most commonly abused illegal substance. This drug impairs short-term memory and learning, the ability to focus attention, and coordination. It also increases heart rate, can harm the lungs, and can increase the risk of psychosis in those with an underlying vulnerability.

Nearly half of high school seniors report having used marijuana, and 6.5 percent are daily marijuana users.

- **Prescription medications**, including opioid pain relievers (such as OxyContin® and Vicodin®), anti-anxiety sedatives (such as Valium® and Xanax®), and ADHD stimulants (such as Adderall® and Ritalin®), are commonly misused to self-treat for medical problems or abused for purposes of getting high or (especially with stimulants) improving performance. However, misuse or abuse of these drugs (that is, taking them other than exactly as instructed by a doctor and for the purposes prescribed) can lead to addiction and even, in some cases, death. Opioid pain relievers, for instance, are frequently abused by being crushed and injected or snorted, greatly raising the risk of addiction and overdose. Unfortunately, there is a common misperception that because medications are prescribed by physicians, they are safe even when used illegally or by another person than they were prescribed for.
- **Inhalants** are volatile substances found in many household products, such as oven cleaners, gasoline, spray paints, and other aerosols, that induce mind-altering effects; they are frequently the first drugs tried by children or young teens. Inhalants are extremely toxic and can damage the heart, kidneys, lungs, and brain. Even a healthy person can suffer heart failure and death within minutes of a single session of prolonged sniffing of an inhalant.

- **Cocaine** is a short-acting stimulant, which can lead users to take the drug many times in a single session (known as a “binge”). Cocaine use can lead to severe medical consequences related to the heart and the respiratory, nervous, and digestive systems.
- **Amphetamines**, including methamphetamine, are powerful stimulants that can produce feelings of euphoria and alertness. Methamphetamine’s effects are particularly long-lasting and harmful to the brain. Amphetamines can cause high body temperature and can lead to serious heart problems and seizures.
- **MDMA (Ecstasy or “Molly”)** produces both stimulant and mind-altering effects. It can increase body temperature, heart rate, blood pressure, and heart-wall stress. MDMA may also be toxic to nerve cells.
- **LSD** is one of the most potent hallucinogenic, or perception-altering, drugs. Its effects are unpredictable, and abusers may see vivid colors and images, hear sounds, and feel sensations that seem real but do not exist. Users also may have traumatic experiences and emotions that can last for many hours.
- **Heroin** is a powerful opioid drug that produces euphoria and feelings of relaxation. It slows respiration, and its use is linked to an increased risk of serious infectious diseases, especially when taken intravenously. People who become addicted to opioid pain relievers sometimes switch to heroin instead, because it produces similar effects and may be cheaper or easier to obtain.

- **Steroids**, which can also be prescribed for certain medical conditions, are abused to increase muscle mass and to improve athletic performance or physical appearance. Serious consequences of abuse can include severe acne, heart disease, liver problems, stroke, infectious diseases, depression, and suicide.



- **Drug combinations.** A particularly dangerous and common practice is the combining of two or more drugs. The practice ranges from the co-administration of legal drugs, like alcohol and nicotine, to the dangerous mixing of prescription drugs, to the deadly combination of heroin or cocaine with fentanyl (an opioid pain medication). Whatever the context, it is critical to realize that because of drug–drug interactions, such practices often pose significantly higher risks than the already harmful individual drugs.

3.9 Treatment and Recovery

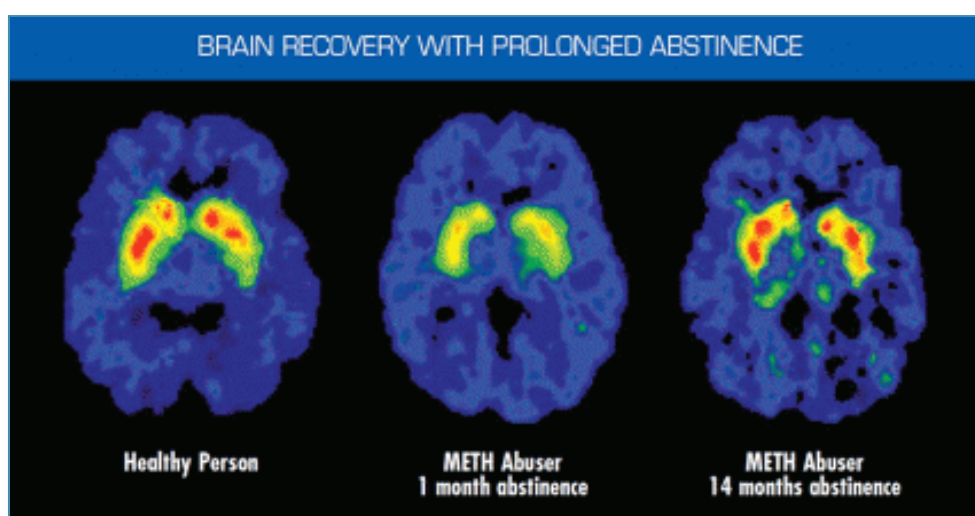
Can Addiction Be Treated Successfully?

YES. Addiction is a treatable disease. Research in the science of addiction and the treatment of substance use disorders has led to the development of evidence-based interventions that help people stop abusing drugs and resume productive lives.

Can addiction be cured? Not always—but like other chronic diseases, addiction can be managed successfully. Treatment enables people to

counteract addiction's powerful disruptive effects on their brain and behavior and regain control of their lives.

These images showing the density of dopamine transporters in a brain area called the striatum illustrate the brain's remarkable potential to recover, at least partially, after a long abstinence from drugs—in this case, methamphetamine.¹¹

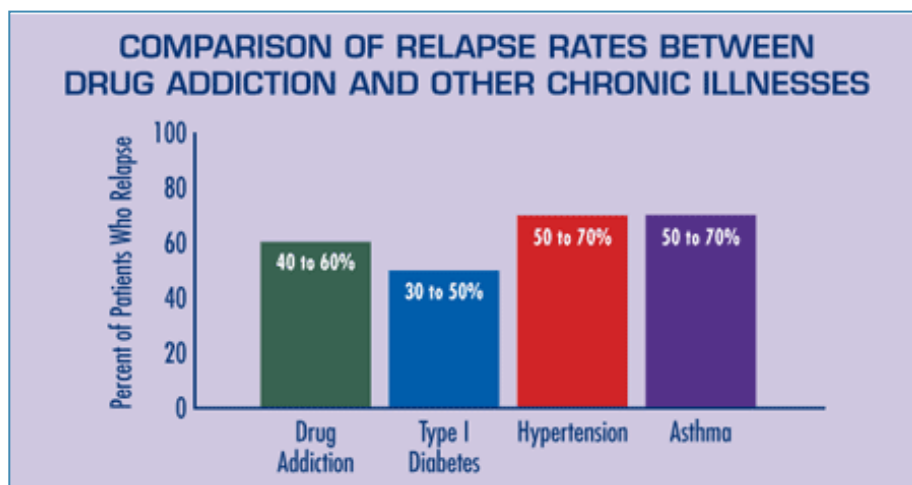


Does Relapse to Drug Abuse Mean Treatment Has Failed?

No. The chronic nature of the disease means that relapsing to drug abuse at some point is not only possible, but likely. Relapse rates (i.e., how often symptoms recur) for people with addiction and other substance use disorders are similar to relapse rates for other well-understood chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. Treatment of chronic diseases involves changing deeply imbedded behaviors, and relapse does not mean treatment has failed. For a person recovering from addiction, lapsing back to drug use

¹¹ Source: *The Journal of Neuroscience*, 21(23):9414-9418. 2001

indicates that treatment needs to be reinstated or adjusted or that another treatment should be tried.



Source: JAMA, 284:1689-1695, 2000

Relapse rates for people treated for substance use disorders are compared with those for people with diabetes, hypertension, or asthma. Relapse is common and similar across these illnesses (as is adherence/non-adherence to medication). Thus, drug addiction should be treated like any other chronic illness; relapse serves as a trigger for renewed intervention.

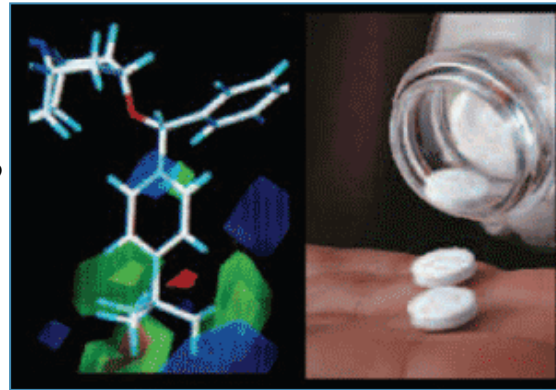
What Are the Principles of Effective Substance Use Disorder Treatment?

Research shows that combining treatment medications (where available) with behavioral therapy is the best way to ensure success for most patients. Treatment approaches must be tailored to address each patient's drug use patterns and drug-related medical, psychiatric, and social problems.

Addiction does not need to be a life sentence.

How Can Medications Help Treat Drug Addiction?

Different types of medications may be useful at different stages of treatment to help a patient stop abusing drugs, stay in treatment, and avoid relapse.



Discoveries in Science Lead to Advances in Drug Abuse Treatment

- ***Treating Withdrawal***—When patients first stop using drugs, they can experience a variety of physical and emotional symptoms, including depression, anxiety, and other mood disorders, as well as restlessness or sleeplessness. Certain treatment medications are designed to reduce these symptoms, which makes it easier to stop the drug use.
- ***Staying in Treatment***—Some treatment medications are used to help the brain adapt gradually to the absence of the abused drug. These medications act slowly to stave off drug cravings and have a calming effect on body systems. They can help patients focus on counseling and other psychotherapies related to their drug treatment.
- ***Preventing Relapse***—Science has taught us that stress, cues linked to the drug experience (such as people, places, things, and moods), and exposure to drugs are the most common triggers for relapse. Medications are being developed to interfere with these triggers to help patients sustain recovery.

Medications Used to Treat Drug Addiction

Tobacco Addiction

- Nicotine replacement therapies (available as a patch, inhaler, or gum)
- Bupropion
- Varenicline

Opioid Addiction

- Methadone
- Buprenorphine
- Naltrexone

Alcohol and Drug Addiction

- Naltrexone
- Disulfiram
- Acamprosate

How Do Behavioral Therapies Treat Drug Addiction?

Behavioral treatments help engage people in substance use disorder treatment, modifying their attitudes and behaviors related to drug use and increasing their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive use. Behavioral therapies can also enhance the effectiveness of medications and help people remain in treatment longer.

Treatment must address the whole person.

How Do the Best Treatment Programs Help Patients Recover from the Pervasive Effects of Addiction?

Gaining the ability to stop abusing drugs is just one part of a long and complex recovery process. When people enter treatment for a substance

use disorder, addiction has often taken over their lives. The compulsion to get drugs, take drugs, and experience the effects of drugs has dominated their every waking moment, and abusing drugs has taken the place of all the things they used to enjoy doing. It has disrupted how they function in their family lives, at work, and in the community, and has made them more likely to suffer from other serious illnesses. Because addiction can affect so many aspects of a person's life, treatment must address the needs of the whole person to be successful.



This is why the best programs incorporate a variety of rehabilitative services into their comprehensive treatment regimens. Treatment counselors may select from a menu of services for meeting the specific medical, psychological, social, vocational, and legal needs of their patients to foster their recovery from addiction.

- ***Cognitive Behavioral Therapy*** seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs.
- ***Contingency Management*** uses positive reinforcement such as providing rewards or privileges for remaining drug free, for

attending and participating in counseling sessions, or for taking treatment medications as prescribed.

- ***Motivational Enhancement Therapy*** uses strategies to evoke rapid and internally motivated behavior change to stop drug use and facilitate treatment entry.
- ***Family Therapy (especially for youth)*** approaches a person's drug problems in the context of family interactions and dynamics that may contribute to drug use and other risky behaviors.

How do 12-step or Similar Recovery Programs Fit into Drug Addiction Treatment?

Self-help groups can complement and extend the effects of professional treatment. The most well-known programs are Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA), all of which are based on the 12-step model. This group therapy model draws on the social support offered by peer discussion to help promote and sustain drug-free lifestyles.

Most drug addiction treatment programs encourage patients to participate in group therapy during and after formal treatment. These groups offer an added layer of community-level social support to help people in recovery with abstinence and other healthy lifestyle goals.

Additional Treatment Resources

- For science-based principles of treatment see NIDA's Principles of Drug Addiction Treatment: A Research Based Guide.
- Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locator or 1-800-662-HELP.

- The “Find a Physician” feature on the American Society of Addiction Medicine (ASAM) Web site.
- The Patient Referral Program on the American Academy of Addiction Psychiatry Web site.
- The Child and Adolescent Psychiatrist Finder on the American Academy of Child & Adolescent Psychiatry Web site.
- For clinical trials information, go to www.clinicaltrials.gov.

Other Useful Links

- National Suicide Prevention Lifeline: 1-800-273-TALK.
- National Institute on Drug Abuse (NIDA): www.drugabuse.gov
- NIDA for Teens: www.teens.drugabuse.gov.
- NIDA's Easy-to-Read Drug Facts: www.easyread.drugabuse.gov
- National Institute on Alcohol Abuse and Alcoholism: www.niaaa.nih.gov
- National Institute of Mental Health: www.nimh.nih.gov
- Faces and Voices of Recovery: www.facesandvoicesofrecovery.org
- The Partnership at Drug Free: www.drugfree.org
- To order NIDA materials, visit: <https://drugpubs.drugabuse.gov>

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Chapter 3 Notes

Chapter 4. Depression & Faith Communities

4.1 Depression and Faith Communities

Depression is somewhat of a charged issue among Christians. Some flatly declare it to be a sin. The thinking is that depression reveals a lack of faith in God's promises, God's judgment on sinful behavior, or just laziness. We know that God is good and loving and that we are secure in Him, so what is there to be depressed about?

Others flatly declare depression to be a medical issue. The thinking is that all depression is a result of chemical imbalances in the brain, so depression is no more wrong than having the flu.

And then there are those in the middle who aren't really sure what the ugly beast of depression is. Faith seems somewhat related, but so do brain chemicals.

Of course, there are also the depressed Christians, left to feel guilty, defensive, confused, lost, or simply too depressed to even care what the church thinks."

So, is it wrong for a Christian to be depressed?

4.2 Original Sin and Disease

In the beginning, what God created was good. After he created man, He said it was "very good". For some period of time, Adam and Eve walked in perfect harmony with God in the Garden of Eden. We can only speculate as to what that was really like - but we can know it was "perfect". At that time, everything was geared toward life and death did not yet exist.

However, when Adam and Eve exercised their free will to disobey God, not only were they expelled from the Garden, all of creation suffered as a result and death of every living thing entered our world. Scriptures tell us that the whole of physical creation was affected by our sin and longs for the day of redemption (Romans 8:19-22).

The church emphasizes the spiritual effects of sin while minimizing or disregarding altogether the mental and physical effects. It's important to recognize that mental illness fits within the Christian teaching of the effects of original sin, just as any other illness or disease does

4.3 How the Church Gets It Wrong about Depression

It is common practice in churches to treat mental illness differently than other illnesses such as cancer, heart disease, etc. Spiritual leaders have long assumed there is something else, some deeper spiritual struggle causing mental and emotional strain.

The fact is that mental illness and spiritual struggle can be (and usually are) interrelated. We are complex beings remarkably connected in mind, body and spirit. We know this is true from Matthew 22:37 when Jesus says, "Love the Lord your God with all your heart and with all your soul and with all your mind."

The church has long made the matter of depression among its congregants solely a spiritual issue. The most frequent responses to those with depression has been to "Pray it away!" "Have More Faith!" "Read your Bible more!" "You just need to think more positively!"

Myths about Depression in Faith Communities

- ***“True believers don’t suffer from depression.”***—If we claim to believe that the bible is the inerrant, Holy Spirit inspired word of God, then this statement cannot be true. No one questions if Elijah or King David were true believers, but both dealt with debilitating depression.
- ***“Depression is a faith issue.”***—More often, depression causes a crisis of faith for believers who become consumed with guilt for their depression. The church’s response of shame has only intensified that guilt.
- ***“Depression is a sin.”***—Being sick is not a sin. That said, depression can sometimes lead to sinful behaviors. If we view depression as a sin, we remove any reason for seeking professional treatment. This leaves the sufferer with the only option being "self-treatment" of their illness, often in unhealthy ways, numbing themselves and worsening their condition.
- ***“Depression can be prayed away.”***—Prayer is absolutely essential to the Christian life. One of God’s names is Jehovah Rapha - The LORD our Healer. Though he spoke the universe into being, in the Old Testament he tells King Hezekiah to use a poultice of figs for healing (2 Kings 20:1-7). Was that needed for the king’s healing? Of course not, but God told him to take an action in addition to prayer. Some believers are so debilitated by depression they lose their ability to pray and need to rely on the prayers of their church, family and friends.

- ***“Depression isn’t a physical illness.”***—Studies show that there is a chemical imbalance in the brain of those who suffer from clinical depression, an imbalance that cannot be restored on its own - much like the chemical imbalance in diabetes that needs to be treated with insulin. Additionally, there is strong evidence that shows mental illness has a genetic link.

Depression takes a physical toll on its sufferers as well, leaving them unable to function in their daily routines. Often they spend days, even weeks in bed. Consider a healthy person: It would be impossible for that person to spend day after day in bed—doing nothing! No computer, no TV, no cell phone, no books. Day after endless day with the covers pulled over their heads.

- ***“Depression shouldn’t be talked about.”***—Depression and all mental illnesses must be talked about, openly and without judgement or shame. The very silence of the church has locked people in dark caves of suffering with little hope of change. In a recent study by LifeWay Research, it was found that 1 out of 5 people with mental illness broke ties with the church because of the negative response to their illness.

Statistics show that approximately 80 percent of people suffering from depression show an improvement with the combination of medication and talk therapy. Talking about depression sets people free to seek the help they need and there is a greater chance for improvement in the quality of their lives. When their quality of life improves, the quality of life and the health of your congregation also improves.

4.4 Facts You Need to Know about Depression

Depression is a common mental health condition that has a variety of physical and mental symptoms. Although we all feel down and fed up every now and again, depression is more than just that. If you have the condition, you can be sad for weeks, or even months at a time. Clinical Depression is much more than being sad for a long period of time, it can paralyze all the otherwise vital forces that make us human.

Types of depression include:

- Mild Depression
- Clinical Depression
- Bipolar Disorder
- Postnatal Depression
- Seasonal Affective Disorder (SAD)

Symptoms of Depression

- Difficulty concentrating, remembering details, and making decisions
- Fatigue and decreased energy
- Feelings of guilt, worthlessness, and/or helplessness
- Feelings of hopelessness and/or pessimism
- Insomnia, early-morning wakefulness, or excessive sleeping
- Irritability, restlessness
- Loss of interest in activities or hobbies once pleasurable, including sex
- Overeating or appetite loss
- Persistent aches or pains, headaches, cramps, or digestive problems that do not ease even with treatment
- Persistent sad, anxious, or "empty" feelings
- Thoughts of suicide, suicide attempts

Gender Differences in Depression

Men and women tend to experience depression differently.

WOMEN TEND TO:	MEN TEND TO:
Blame themselves	Blame others
Feel sad, apathetic, and worthless	Feel angry, irritable and ego inflated
Feel anxious and scared	Feel suspicious and guarded
Avoid conflicts at all costs	Create conflicts
Have trouble setting boundaries	Need to feel in control at all costs
Easy to talk about self-doubt, despair	Find it 'weak' to admit self-doubt or despair
Use food, friends, and love to self-medicate	Use alcohol, TV, sports and sex to self-medicate

4.5 Can (True) Christians Suffer from Depression?

This question is as ridiculous as asking if a true Christian can suffer from a cold! Or from HEART DISEASE? DIABETES? LIVER DISEASE? CANCER? Or any host of illnesses.

John 9:2-3 (NIV) His disciples asked him, "Rabbi, who sinned, this man or his parents, that he was born blind?" "Neither this man nor his parents sinned," said Jesus, "but this happened so that the work of God might be displayed in his life."

For believers who suffer from depression, there is a great paradox in their faith. The very faith that brought them to an eternal life with Christ is what perplexes them and causes them to doubt their faith is real - after all, "If I'm really a Christian, I shouldn't be depressed." And the church is culpable for those thoughts and feelings.

4.6 Can Faith Leaders Suffer from Depression?

According to most statistics, 1 in 4 Americans will suffer with a mental illness in their lifetime, therefore it is reasonable to assume that at least 1 in 4 pastors will as well. If anything, due to the strain and expectations of their jobs, this number might be greater amongst faith leaders.

Statistics don't change because someone went to seminary. Statistics don't change when people walk through the door of a church. Sadly, faith communities are rife with tragic stories of faith leaders ending their lives:

Rev. Teddy Parker, 42, of Macon, Ga., died of a self-inflicted gunshot wound in the driveway of his home while his 800-member church and his family waited for him to show up to preach on Sunday morning.

An Illinois pastor who was grieving the death of his wife, whom he buried last December, reportedly shot himself inside his Matteson home in front of his pleading son, after lamenting that he was hearing her voice and footsteps. He later died from the gunshot wound.

Friends and church members took to social media Wednesday to remember former Summit Church pastor Isaac Hunter as a powerful speaker who inspired others with the power of his Christian faith, even as he struggled with his inner demons. Hunter, 36, shot himself to death Tuesday morning at his apartment off State Road 434 in Altamonte Springs.

Paul Tripp has written about the problem of pastoral depression as well. He notes that unrealistic expectations, tension at home, fearing

man more than God, and pursuing personal glory more than God are four reasons pastors typically burn out and become depressed.

“Churches forget that they've called a person who's a man in the midst of his own sanctification,” he writes. “This tends to drive the pastor into hiding, afraid to confess what’s true of him and everyone to whom he ministers. There's a direct connection between unrealistic expectations and deepening cycles of disappointment.”

If depression could be talked about openly, might these pastors have been able to seek help rather than die by their own hand? Has God allowed these tragedies so that the church will awaken to the dire need to acknowledge depression as a real illness that needs real treatment?

In the clinically depressed, there are things that go wrong in the brain and the neurotransmitters in the brain, causing the synapses to no longer properly connect. This dysfunction in the brain leads to a host of problems, including distorted thinking and the inability to reason well.

When you meet with someone who is suicidal, you may see them, their lives and circumstances, in a completely different way than they do. Perhaps you see the person sitting before you as bright, intelligent, having a good job, a nice home and a seemingly good marriage. Yet they themselves lament, how much better off everyone would be if they were dead. They see their life as without purpose or meaning and have no hope that this will ever change. That’s how depression distorts a person’s perceptions. Similar to a psychotic break, they are unable to grasp reality.

4.7 The Church's Response to Depression

True healing comes from a prayerful, loving community that seeks to honestly understand major depressive disorder and related conditions, and one that develops a positive response.

Prayer, scripture and faith are powerful tools of encouragement for struggling individuals, but the church fails when it presents them as the sole cure for mental disorders, including depression.

Scriptures / Expectations That Are Not Helpful

- Christians should just, "Rejoice in the Lord always...."? (Phil 4:6)
- Christians should just, "...eat food with gladness and drink wine with joy"? (Eccl 9:7)
- Christians should just, "...overflow with Hope..."? (Rom 15:13)

Scriptures / Expectations That Are Helpful

- Psalm 34:18, "God is close to the brokenhearted." God understands how you're feeling.
- 1 Peter 5:7, "Casting all your care on him because he cares for you." God cares that you are depressed. He wants to take your cares and carry them for you.
- Romans 8:38, "and I am convinced that nothing can ever separate us from God's love. Neither death nor life, neither angels nor demons, neither our fears for today nor our worries about tomorrow - not even the powers of hell can separate us from God's love." God loves us, no matter what.

Several Spiritual Giants in the Bible Suffered from Depression

David in Psalm 6:6 says he is weary with his groaning; that all night his bed is swimming in tears.

Paul in 2 Corinthians 1:8-10: "... we were so utterly burdened beyond our strength that we despaired of life itself. Indeed, we felt that we had received the sentence of death. But that was to make us rely not on ourselves but on God who raises the dead. He delivered us from such a deadly peril, and he will deliver us. On him we have set our hope that he will deliver us again."

Elijah in 1 Kings 19:4-5: "...he asked that he might die, saying, "It is enough; now, O LORD, take away my life, for I am no better than my fathers." And he lay down and slept under a broom tree. And behold, an angel touched him and said to him, "Arise and eat."

Pastors have the unique opportunity to open the pages of Scripture and speak to people about other people. Elijah, David, Paul and the defeated apostles immediately after Christ's crucifixion, all point to the experience of depression in the lives of real people. It has been said that Scripture addresses two main topics: the human condition and the character of God. Rather than minimizing depression, teaching directly about its existence allows listeners to experience the empathy of those "in that great cloud of witnesses."

Pastors and fellow church members must also admit their limitations and be willing to refer people struggling with depression to those gifted and trained to help. Just like a person experiencing a heart attack needs more than a family physician, those suffering from depression often benefit from the expertise of skilled professionals and possibly treatment through therapy.

Most churches probably have the very best intentions when dealing with issues of mental illness. However, the Church may confuse these clinical conditions and respond to them in ways that aggravate them and inadvertently demoralize those suffering. If churches begin responding to mental disorders as a community willing to offer encouragement and support, people suffering from those illnesses may just be able to accept the help that can lead to recovery.

4.8 Call to Action: What You Can Do

- Educate yourself, your congregations and communities.
- Promote awareness by educating the members of your congregation and communities about depression and other mental health issues through educational forums and other opportunities.
- Invite local mental health experts - including those who have experienced depression - to speak with your congregation.
- Share facts and common myths about depression and mental illness.
- Connect with local mental health resources and providers.
- Budget permitting, hire a mental health professional to be part of your staff.
- Invite NAMI (National Alliance on Mental Illness) to host their programs in your church.

- Train to be hosts for Mental Health Grace Groups through the Mental Health Grace Alliance or partner with a congregation who is already hosting the groups.
- Start a support group for Christians with Depression.
- Train in Mental Health First Aid.
- Train key members of your staff and church to identify the signs of depression and suicide.
- Talk about mental health from the pulpit.
- Be authentic about your own mental health and experience with depression.
- Create a resource library.

References

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5. Blame It on the Brain? Distinguishing Chemical Imbalances, Brain Disorders and Disobedience. by Edward T. Welch
6. "Depression: What You Need to Know"; Free PDF download from National Institute of Mental Health (NIMH)

<http://www.nimh.nih.gov/health/publications/depression-what-you-need-to-know-12-2015/index.shtml>

7. “Mental Health: A Guide for Faith Leaders”; Free PDF download from American Psychiatric Association.
<https://www.psychiatry.org/newsroom/news-releases/apa-releases-new-resources-on-mental-health-for-faith-leaders>
8. Or available for purchase: https://www.appi.org/Mental_Health

Chapter 4 Notes

Chapter 5. Suicide & Prevention

Introduction

Suicide is a serious and preventable public health problem.

The learning objectives for this course are:

- 1) The scope of the problem
- 2) The facts and myths about suicide
- 3) The warning signs of suicide
- 4) How to talk about it
- 5) Resources

5.1 The Scope of the Problem

Suicide occurs when a person ends his or her life. Suicide is not a conversation friendly topic. Like most provocative subjects, it makes people uncomfortable. There has never been a greater need for education on suicide and prevention than today, as suicide rates are increasing.

It is the 10th leading cause of death among Americans. But suicide deaths are only part of the problem. Suicide attempts impact a larger population—more individuals survive suicide attempts than die. It is estimated that for every documented death by suicide, 25 others have attempted to end their lives, often leaving them seriously injured and in need of medical care.

For every suicide, there are six to ten people that are directly affected. Surviving family members not only suffer the trauma of losing a loved one to suicide, but have a potentially higher risk of suicide and emotional problems. Suicide happens in every kind of family, every

hour of every day of every month of every year. It is no respecter of age, economic status, educational achievement, or social status nor ethnicity.

Suicide in the United States

- Over 41,000 people die by suicide every year.
- Suicide is the 2nd leading cause of death in the 15-24 age group.
- Suicide is the 3rd leading cause of death in the 25-34 age group.
- Suicide is the leading cause of death of men under age 45.
- Up to 90% of people who die by suicide have a diagnosable mental illness.
- Depression is the number one cause of suicide.
- Suicides outnumber homicides more than two-fold.
- Firearms are the leading suicide method.
- Men are 4 times more likely to die by suicide.
- Women are 3 times more likely to attempt suicide.
- Alcoholism plays a role in 1 out of 3 suicides.
- Suicide results in an estimated \$51 billion in combined medical and work loss costs.

Suicide in San Diego

Like other areas in America, suicide rates in San Diego continue to increase. In 2021, San Diego lost 378 people to suicide. Military suicides are not included in the San Diego statistics. The impact of suicide is much wider than those 378 losses. It is estimated that for every person who dies by suicide, at least 25 others have made an attempt to end their life - for 2021 that translates to 11,600 people. In addition, at least six to ten people are deeply impacted by losing someone to suicide; that population (approximately 2700 to 4500 San Diegans) carry higher rates of drug and alcohol, mental health issues and suicide themselves if they do not find effective support services after the suicide.

5.2 Myths and Facts about Suicide

Suicide is a very preventable kind of death, but because there is so much stigma surrounding the subject, much misinformation exists. Replacing these myths with the truth is imperative in order to save lives.

- **Myth 1** - People who talk about suicide do not kill themselves.
Fact - People who talk about wanting to die by suicide often kill themselves.
- **Myth 2** – Suicide always occurs without any warning signs.
Fact – Warning signs almost always precede the suicide.

- **Myth 3** – Never ask a person if they are thinking about taking their life. Talking about it gives them the idea, and they might become suicidal.
Fact – Talking about suicide can actually help diffuse some of the tension causing the disturbing feelings and lowers the risk of a compulsive act.
- **Myth 4** – People who take their life by suicide want to die.
Fact – Most suicidal people experience unrelenting emotional pain. They see suicide as the way to end the pain.
- **Myth 5** – Only experts can prevent suicide.
Fact – Everyone has a role to play in preventing suicide.
- **Myth 6** – There is nothing you can do to prevent suicide once someone has made that decision.
Fact – Help is available. Suicide is preventable.

The truth is that suicide is a complex human behavior. To prevent suicide, it is important to understand who is at increased risk of suicide, what the warning signs are, and what events can be catalysts for suicide.

Increased Risk

Suicide is not caused by any one factor alone, but research shows that certain populations have a higher risk for suicide or suicide attempts than the general population. Awareness of this increased risk is important in working with these populations to help prevent suicide.

This is valuable information when observing other warning signs or other risk factors in an individual.

- Native Americans
- Survivors of suicide loss – someone they love took their life
- Survivors of previous suicide attempts
- People with substance abuse disorders
- People with mental health diagnosis, such as bi polar or depression
- Members of the military and veterans
- People with a recent diagnosis of a serious or terminal illness

5.3 Warning Signs

Most people communicate their intent to take their life sometime during the week preceding their attempt. Almost always, there are warning signs before the suicide. All signs of potential suicide should be taken seriously.

The verbal clues are the easiest to detect. The suicidal person may clearly state they want to die or kill themselves. They also might be less direct by talking about feeling trapped, living with unbearable pain, or being a burden to others. When their conversation is punctuated with hopelessness, seeing no way out, or their desire to die, the risk for suicide is high.

Some examples of what a suicidal person might say are:

- *"I just want out."*
- *"Who cares if I am dead anyway?"*
- *"Everyone will be better off if I am gone."*
- *"If she breaks up with me, I don't want to live."*

Behavioral clues can be very obvious. One of the clearest indications are when someone starts formulating a plan and acquiring the means to carry it out, such as searching for a gun online. Other behaviors that

may stand out include becoming preoccupied with death, visiting or calling people to say goodbye, giving away prized possessions, exhibiting extreme mood swings, or becoming completely hopeless. Some clues might be less obvious such as having a loss of interest in things they previously cared about, putting their affairs in order, acting anxious or agitated, behaving recklessly, showing rage or isolating. When a person increases the use of drugs or alcohol or relapses after a period of sobriety, the danger is higher. Alcohol reduces the inhibition to act impulsively, and is directly related to higher incidences of suicide.

One of the hardest signs to perceive is when a suicidal person suddenly feels happier and calmer. Usually the family and friends are relieved and believe that the crisis has passed. In reality, many times it means that the suicidal person has made peace with their decision and knows that their pain will soon end. For others, they were previously too depressed to act on their suicidal tendencies, but when they regain a little strength, they finally have the energy to put their plan into action.

Events, Triggers, and Catalysts

After a suicide, there is a tremendous focus on the events that led up to the suicide. Isolated events are not the cause of the suicide, but may be the straw that broke the camel's back. Up to 90 percent of people who take their lives by suicide have a diagnosable mental health disorder and years of emotional distress. This underlying "condition" most likely was triggered by the catalyzing event that preceded the suicide. Some events that might be a "catalyst" include:

- Being fired or expelled from school
- Financial loss
- Loss of relationship
- Diagnosis of terminal illness

- Death of a spouse, child or best friend
- Suicide of loved one

Many survivors of suicide loss are guilt ridden by the event that became the trigger for the suicide. It is important to remember that the mentally healthy person is able to deal with these types of negative life events without choosing to end their life. Knowing the difference between the “catalyst” and the “condition” is key in being able to recover from the trauma of losing someone to suicide.

There are a variety of risk factors, conditions and events that lead to suicide, but hopelessness is the common denominator in suicide. Hope is the greatest tool in suicide prevention. Being able to instill hope is key in persuading the suicidal person to choose life.

5.4 Talk About It

When you see the signs, it is time to have the conversation. If in doubt, don't wait, have the talk! Many left behind after a suicide regret not having the conversation with their loved one. Talking about it might save a life.

This will be one of the most difficult conversations you will ever have, and it is important to be prepared. Identify a private place to talk and allow plenty of time. Gather suicide crisis resources in case you need to make calls or take action. Practice asking the questions beforehand. These words are very hard to say to a loved one. Practicing ahead of time, you will be able to maintain calm in an emotional situation. Be prepared to listen. Understanding the suicidal person is critical in being able to determine if they are a threat to themselves or others.

Start the conversation by expressing your concern about what you have noticed. Connecting with them because you care about them, will be more effective in getting them to share what they are thinking. You might start by simply saying, “I notice you have been very unhappy lately. I am concerned. Would you like to talk about it?”

Listen carefully to what they say, and don’t try to point out the error in their thinking. That will cause them to shut down. Rather, validate their feelings even when you don’t agree with them. The first step in the conversation is to make them feel safe so that they will be honest with you.

After listening, if you hear anything that indicates they are thinking about suicide, find the courage to ask the question, “I am concerned about what you are saying, and I wonder if you are thinking about suicide.” Or even more directly “Are you thinking about killing yourself?”

This is a serious matter and asking the question more directly will result in getting a clearer answer. If they say no, and your instinct is to trust in the answer, you can wind up the conversation by asking how you can help. But you can rest at ease, that they are safe. If they say no, and you are uncomfortable, this is the time to be persistent. Trust your instincts! Better to be a bit pushy than give in and get the wrong answer.

The questions that you will use to determine the level of risk are:

- *“Are you thinking about killing yourself?”*
- *“Do you have a plan?”*
- *“Do you have the means to put your plan into action?” For example, if they plan to use a gun, do they have one? Do they have ammunition?*

- *“Have you decided when you will do it?”*

When you get a “no”, that you trust to be true, to any of the above, you don’t need to ask any of the rest of these questions. Be present with them, listening to them and giving them your full attention. Resist any urge to judge them as it will not be useful in persuading them to get help.

Assessing the Level of Risk

None	They have no suicidal thoughts
Low	They have some suicidal thoughts, but no plan. They promise they will not take their life.
Moderate	They have suicidal thoughts and a vague plan that is not very lethal. They promise they will not take their life.
High	They have suicidal thoughts and a specific plan that is very lethal. They promise they will not take their life.
Severe	They have suicidal thoughts and a specific plan that is very lethal. They are stating that they will take their life.

After assessing the level of risk, the goal is to persuade them to get the level of help they need and to keep them safe if necessary. Ask them if they are willing to get help, and if they will let you help them. Ask them to articulate their promise not to kill themselves until you have found help. Be authentic, and do not make promises you cannot or do not intend to keep.

Next Steps

If your conversation reveals that they have no risk of taking their life, let them know you are available to help if they need you in the future. With someone who is low risk, you can help them identify the kind of support they need, but you know there is no urgent intervention needed.

Having suicidal thoughts, even without a plan, indicates that they are not mentally healthy. They might need medical intervention, counseling, or a support group. Talking it through with you, might help them determine their next steps. Moderate risk should be dealt with so that it does not escalate, and should be referred to professional care; medical and psychological. It might mean helping them make appropriate appointments and following up to ensure that they kept them.

More immediate action is needed when someone falls into the high risk level. Keeping them safe will be a priority! Connecting them to appropriate resources, medical and psychological, is crucial. If they are willing, it is best to take them to someone who can help. Together you can call the Suicide Access and Crisis line to determine the best course of action. At this point, they might not be capable of making and following through on appointments without support.

When someone is at severe risk for suicide in order to keep them safe, you might need to take them directly to the hospital, or call 911 if necessary. Do not ever put yourself in danger. If you are concerned about your own safety call 911.

If someone falls into the high to severe risk level, and they are not willing to get help, or there is a waiting period before they can get help,

do what you can to keep them safe. If you have determined that they have weapons or medications in their home, ask them if they will let you remove them from the premises. You might need the assistance of another friend, family member or even law enforcement to accomplish this. Studies have shown that reducing access to means reduces suicides and saves lives. The goal is to keep them safe for now.

One of the pioneers in suicidology, Edwin Shneidman, said, “The acute suicidal crisis (or period of high and dangerous lethality) is an interval of relatively short duration – to be counted, typically, in hours or days, not usually in months or years. An individual is at a peak of self-destructiveness for a brief time and is either helped, cools off, or is dead.” The hope is to keep them safe or to get them help, until the crisis has passed, which is a relatively short period of time.

Remember that hopelessness is the common path to suicide. Offering them hope in any way will help them choose life. Hope is the key to saving lives.

5.5 Suicide Postvention

The goal of suicide prevention programs is to reduce the number of suicides, but unfortunately, we continue to lose more people to suicide than ever before. Research shows that the mental health of survivors of suicide loss (six to ten people left behind after a suicide) is compromised. Because of the traumatic nature of the loss, they carry higher incidences of drug/alcohol problems, mental health issues and suicide risk if they do not receive effective postvention services.

The most effective suicide prevention programs include prevention (education and awareness), intervention (how to respond to a suicidal crisis) and postvention (services tailored to the needs of survivors of suicide loss).ⁱ Postvention services are activities which are implemented after a suicide which reduce risk and promote healing after a suicide. The trauma of losing someone to suicide must be addressed. Effective after care meets the needs of a clearly identified “at risk” population to improve their mental health and reduce further instances of suicide. Postvention is prevention!

The reason that Postvention programs and services are needed is that grief after a suicide is different. Some of the reasons are:

- A suicide death creates ambiguity about the volition of the deceased. The person who died played a role in their death leaving their loved ones to struggle with powerful, conflicting and confusing emotions.
- Suicide is characterized as preventable. Survivors of suicide loss wrestle with guilt that they should have been able to prevent the suicides. They hold themselves responsible for situations out of their control to change.
- Suicide is stigmatized. Stigma is powerful and keeps the topics of mental health and suicide shrouded in silence and mired in

darkness. Stigma leads to myths, misunderstanding, untruths, partial truths, and distorted facts.

- Suicide is traumatic. The healing process after a suicide includes addressing both grief and psychological trauma. The American Psychiatric Association ranks the trauma of losing a loved one to suicide as “catastrophic”. It is one of the most difficult and challenging life experiences to navigate.

Meeting the Needs of Survivors

Postvention programs must be planned for before the suicide occurs, in order that the services are readily and quickly available to this population. Some of the most urgent needs after a suicide include:

- Coordinated, comprehensive community response
- Useful information
- Compassionate assistance from first responders
- Practical assistance
- Support from social networks and communities
- Help from mental health professionals
- Peer support
- Additional support for children and adolescents
- Family support

Survivors of Suicide Loss Support Groups

Survivors of suicide loss support groups have proven to be some of the most effective postvention support services. The NY State Office of Mental Health gives four reasons that support groups are effective:

- Normalizing the reaction to suicide. In a group setting, it is reassuring to hear that others share their fears and their losses, and that it is not pathological to feel this way. In fact, it is perfectly normal. The intense emotions are validated, and survivors begin to understand that their experience is a normal reaction to an abnormal situation. This is often the first step in the healing process.
- Survivors can talk about the suicide as much as they need in a judgment free place. The opportunity to share their story and hear the stories of others helps survivors of suicide loss to organize their thoughts and feelings. This may be the first step in understanding the "whys", "what ifs", and "why didn't I?"
- The third benefit is monitoring suicide risk. Given the link between the suicide of a family member and the increased risk for other family members, this is a critical benefit. Peer support groups may simultaneously provide healthy role models for grieving survivors while increasing social support.
- Finally, making sense of the suicide of a loved one is an emotional journey. Support groups provide educational

resources to help educate survivors regarding the nature of suicide and suicide bereavement. They also hear from those further along in the bereavement process who have quit asking the question “why?” and started asking, “What I am going to do now that this has happened? How can I move forward into my life and community to bring good out of this tragedy?”

Survivors of Suicide Loss – San Diego

In San Diego County, SOSL (Survivors of Suicide Loss) is a non-profit providing postvention support services for those left behind after a suicide loss. SOSL holds survivors of suicide loss support groups throughout San Diego County at no cost to anyone impacted by suicide, including a bilingual group in the South Bay. Other services include: long-term post-traumatic growth groups, warm line, phone and email support, special events targeted for the survivor community, a website with valuable resources, social media outreach, and a quarterly newsletter. SOSL has been offering these life-saving series since 1981. Many survivors, who found SOSL after losing their loved one to suicide, say that being connected to these services and community has saved their life! Postvention is prevention!

5.6 Resources in San Diego

San Diego has a number of resources for those who are suicidal or concerned that someone they love is suicidal.

- Suicide & Crisis Lifeline dial: **988**
- The Diego County Access and Crisis Line: 888 724-7240. Trained and experienced counselors are available to speak to someone in crisis and who needs immediate help. They will also speak to those concerned about a loved one, and provide referrals to resources in the San Diego area. They are available 24 hours a day, 7 days a week. The call is FREE.
- **It's Up to Us** <http://www.up2sd.org/> The It's Up to Us campaign¹² is designed to empower San Diegans to talk openly about mental illness, recognize symptoms, utilize local resources and seek help. The KNOW the SIGNS – Suicide is preventable is available on the website.
- Suicide Prevention Council - SPC / Community Health Improvement Partners-CHIP. SPC is a collaborative, community-wide effort focused on realizing a vision of zero suicides in San Diego County. SPC offers free suicide prevention trainings-QPR – Question, Persuade, Refer-to businesses,

¹² <http://www.up2sd.org/>

community organizations, universities, faith-based organizations. These trainings help San Diegans to recognize the warning signs of suicide, offer hope, and get help to save a life.

- Survivors of Suicide Loss – San Diego¹³, WWW.SOSLsd.org
SOSL is a local non-profit that provides support services that offer hope, comfort, and healing to those in grief from suicide loss as well as promoting suicide awareness and prevention in San Diego. Free support groups are held 13 times each month throughout the county.

Resources used for statistics and information

- “Myths and Facts about Suicide”, Jeffrey Jackson, “SOS a Handbook for Survivors of Suicide”, 20013, Available in pdf format. <http://www.suicidology.org>
- “11 Facts about Suicide”, <https://www.dosomething.org/facts/11-facts-about-suicide>
- Populations at Risk for Suicide, Substance Abuse Mental Health Services Association, SAMHSA, www.samhsa.gov
- American Association of Suicidology, www.suicidology.org
- “Know the Signs of Suicidal Behavior”, www.suicideispreventable.org

¹³www.SOSLsd.org

- “Suicide Facts at a Glance 2015”, Centers for Disease Control and Prevention, <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf>
- “Report to the Community 2018”, San Diego Suicide Prevention Council

Chapter 5 Notes

Chapter 6. Mental Illness Stigma Reduction

Introduction

Mental illness is an illness like any other. We must break down the stigma surrounding the topics of mental illness in order for people to find help and recovery.

Learning objectives for this course are:

- 1) The stigma of mental illness
- 2) What the bible teaches about stigma
- 3) The truth about mental illness
- 4) Mental health issues in the Church
- 5) Practical ways for your congregation to be more inclusive of those with mental illness

6.1 What is Stigma?

Stigma can be defined as a set of negative and often unfair beliefs that people have about a subject or topic. Stigma is born out of fear and misinformation. There is a great deal of stigma surrounding mental health issues. Stop and think for a minute - What is your perception of people who suffer from mental illness?

We all bring our personal perspectives to our understanding of mental illness. Many of them are based on misinformation and the picture the media paints.

What do you think a person with mental illness looks like? Who fits your image of someone who is mentally ill? The bright young professional man in your office? The soccer mom next door? The homeless man you pass every day on your way to work? The head cheerleader with a 4.0 GPA? Do you instantly think of Jack Nicholson in "One Flew Over the Cuckoo's Nest?"

The truth is you cannot tell by looking at anyone if they have a mental illness. Not all people who look happy, are happy. Not all people who look sad, are sad.

You can't tell if someone has heart disease, lung disease or diabetes just by looking at them. Mental illness is an illness like any other, and you can't tell by looking if someone suffers with mental illness.

Who in Your Community Might Be Struggling with a Mental Health Issue?

Is it the mom who faithfully attends bible studies and works in Sunday school? You have no idea that her husband struggles with depression to the point of being suicidal. She is isolated and fearful.

Could it be the successful professional woman with a beautiful family and amazing husband? Do you realize that her world is falling apart, and she is looking for places on the road to have a single car crash? She is hopeless.

Perhaps it is the teenage student leader. You don't know she is cutting, purging and bingeing. She is insecure and in emotional pain.

What about the couple serving on the usher team who is struggling with their adult son? The diagnosis is schizophrenia, and he is unable

to live on his own. They have little hope he will ever marry, have children, or hold down a job. They are grieving and overwhelmed.

Is it your youth pastor who is worrying incessantly about measuring up and all the demands of his new job? His anxiety is starting to cause problems. He is sleep deprived and agitated.

Maybe you are struggling, but don't know where to turn. The Pastor isn't supposed to have these problems.

How is Stigma Causing Them to Suffer in Silence?

Studies show that the first place many go for help in a mental health crisis is not to a loved one, friend, co-worker or healthcare professional, but rather to their pastor or priest. Yet when they find the courage to approach their faith leader, they are often met with judgment rather than compassion.

Due to ignorance, almost half of the churches in America believe that mental illness is merely a faith issue. Because they don't know the truth, that mental illness is an illness like any other, the sufferer is often met with harsh judgmental statements such as:

- *"You just need to have more faith!"*
- *"You just need to pray more, read your bible more!"*
- *"You need to get the sin out of your life!"*

In the most extreme cases, they may be told that evil spirits possess them.

People who attend church are well aware of the stigma in the church. LifeWay Research completed a survey, and they found stigma is more prevalent in the church than outside the church. They asked the question: “If you had a mental health issue, do you believe most churches would welcome you?” Of those who never attend worship services, 55 percent thought they would be welcome. Of those who attend worship once a week or more, only 21 percent felt they would be welcome.

What's Faith Got to Do with It?

When faith leaders tell a person with mental illness to pray more, have more faith, read their bible more, and so forth, they are implying that doing those things alone will make the mental illness go away. In essence, they are saying that mental illness is *simply* a spiritual issue.

Very few faith leaders would tell a person newly diagnosed with cancer to do the same things. Rather they would encourage the person with cancer to seek medical help. They would be empathetic and show compassion, while the congregation would gather around in support and care.

For families living with mental health issues, there are no visitations, no prayer quilts, and no casseroles! They experience a vastly differently response to their loved one's mental illness.

A mother of two related her experience of both responses to her family's health issues. When her youngest daughter was diagnosed with diabetes, friends called, sent notes and flowers, brought food, and posted encouraging Facebook messages. When her eldest daughter was diagnosed with bipolar disorder a few years earlier, however, the

family got a different response: silence. That is why it has become known as the “no casserole” illness.

6.2 What Does the Bible Teach Us about Stigma?

Jesus dealt with stigma in his ministry here on earth. The story of the man born blind (John 9:1-3) is a perfect example of the fear and misunderstanding in society. The common belief of the day was that sin or unrighteousness was the cause of the man’s blindness.

The people questioned Jesus, “Why was this man born blind? Was it because of his own sins or his parent’s sins?” Jesus replied “It was not because of his sins or his parents’ sins. This happened so the power of God could be seen in him.”

The people were asking the wrong question. Instead of having compassion on the man’s condition and asking how they could help the man, they focused on why he was blind. Jesus’ response was to heal this stigmatized outcast, and he restored both his physical and spiritual sight.

On another occasion, Jesus healed a man with an advanced case of leprosy (Luke 5:12-14). The man broke all protocol at the time, came and bowed down to Jesus, begging him, “Lord, if you are willing, you can heal me and make me clean.”

Jesus did the unthinkable and met this man who was “unclean” and an “outcast” of society. He didn’t just heal him, but chose to do it by touching him. He not only healed the leper, but restored his dignity as a human being in the process.

The More Things Change the More They Stay the Same!

Today, just as in Jesus' day, stigma marginalizes, disgraces and dehumanizes people who are different and often suffering. Stigma allows people not to act or to withhold compassion. It keeps people disconnected and living in shame. Jesus' answer was to respond in love and with the truth.

Shame is a huge component of stigma. According to Dr. Brene Brown, "Shame needs three things to grow exponentially: secrecy, silence and judgment. When you start naming (the cause of your shame) and talking about it with people who have earned the right to hear these stories in your life, it dissipates, because shame only works when it keeps you in the false believe that you are alone."

There is tremendous stigma and misunderstanding surrounding the topic of mental illness. Stigma is born out of fear and misinformation, and the way to break it down is by teaching the truth and educating people.

6.3 The Truth about Mental Illness

Mental illness is a disease like any other. The brain is the organ that is affected and that sometimes creates unusual behavior. Mental illness is a disorder of the brain that disrupts a person's thoughts, moods, behaviors, and ability to relate to others severe enough to require treatment and/or intervention. If not treated or treated properly, it can be fatal.

Mental illness is no respecter of age, gender, socioeconomic status, education, or spiritual belief. The church is not immune, as it occurs at the same rate inside and outside of the church. It is important to understand the basic statistics about mental illness.

- 1 in 5 adults – approximately 52.9 million Americans – experiences mental illness in a given year.
- 1 in 20 – about 14.2 million– live with a serious mental illness such as schizophrenia, major depression, or bipolar disorder.
- 1 in 6 children – approximately 16.5% percent of youth ages 6-17 experience severe mental disorders in a given year.
- One-half of all chronic mental illness begins by the age of 14.
- Three-quarters of all mental illness begins by age 24.
- 90 percent of those who die from suicide had one or more mental illnesses.
- Suicide is the 10th leading cause of death in the United States.¹⁴

The U.S. Surgeon General identified stigma against mental illness as a major barrier to our public health, causing many to needlessly suffer in silence rather than seek care. Stigma in the Church does the same. The faith community needs to overcome stigma with the truth in order to alleviate the suffering and save lives.

Holistic Approach to Mental Illness

Mental illness affects the body, mind, spirit and relationships. It is a complex medical condition that presents with a variety of symptoms that keeps a person from functioning normally. Addressing and

¹⁴ Statistics from NAMI –www.nami.org

treating mental illness from this holistic understanding has proved to be most effective in helping people find recovery.

The Body

There is a physiological component to the illness, which affects the brain, an organ of the body. Much like diabetes, which stems from the pancreas not working correctly, mental illness is a function of the brain not working correctly. Because the brain is an organ, it needs to be treated physically, which includes:

- Medication
- Diet
- Exercise
- Proper sleep and rest
- Relaxation

The Mind

The mind is also affected when someone struggles with a mental health disorder, a fierce psychological battle is waged between reality and the negative thoughts that overwhelm the individual. Cognitive dysfunction and distorted thinking can lead to unusual behaviors.

Some of the dysfunctional behaviors can include:

- Isolation
- Extreme moods
- Overspending
- Hyper sexuality
- Lethargy

Although mental health disorders are not the result of a spiritual failing, a person's spirit is deeply impacted by the illness. A distorted concept of who they are and who God is can lead to a crisis of faith

while the constant struggle with negative thoughts can lead to spiritual exhaustion. To live in that constant state of turmoil creates spiritual chaos. The truth of God will counter the lies, and bring peace to the sufferer.

Lies of Mental Illness	God's Truth
<i>"Nobody loves me."</i>	"I am holy and dearly loved by God." Colossians 3:12
<i>"I will never amount to anything."</i>	"I am God's workmanship, His masterpiece." Ephesians 2:10
<i>"God will never forgive my sins."</i>	"I have been redeemed and forgiven." Ephesians 1:7

Relationships

The impact of the illness on a person's body, mind and spirit also takes a toll on their relationships. A mental health diagnosis is not just a diagnosis of the person with the illness. That diagnosis affects the family and friends of that person. Certainly, a number of those relationships take place in the church.

6.4 Mental Health, Faith Communities and Fear

What is the Church afraid of? Have they bought into the lies, believed the myths, and let fear take over? Many in the faith community believe that people with mental illness are violent, and they don't want them in their congregation. Others are simply afraid that "those people" will scare people away from church. Still others believe that mental illness is a spiritual affliction and that the mentally ill are possessed by demons.

What is the truth about these myths based in fear?

- **Myth #1: People with mental illness are violent.**

The fact is that the vast majority of people with mental health problems are no more likely to be violent than anyone else. Only 3-5% of violent acts can be attributed to individuals living with a serious mental health issue. The truth is that the mentally ill are actually 2 ½ times more likely to be victims of violence.

- **Myth #2: The mentally ill will scare people away from church.**
The truth is that some of the most extreme cases might scare people away. But it is also true that the grumpy, judgmental people in your congregation might scare people away. Some people are afraid of more expressive types of worship, including people holding their hands up when they sing. That sermon about tithing has already scared many people away from church.
- **Myth #3: Spiritual affliction or demon possession.** The belief is that demon possession does exist today, but it is very rare. The bible clearly makes a distinction between disease and possession. Mark 6:13 states that “They drove out many demons and anointed many sick people with oil and healed them.” “Mystique foster fear of the unknown and allows supernatural explanations to be linked to mental illness. Much like demon possession used to be linked to epilepsy.”¹⁵

Pastor Steven Waterhouse identified at least six factors that differentiate schizophrenia from demonic possession as described in the bible. These factors can be helpful when trying to determine if an individual is possessed or has a neurobiological disorder.¹⁶

¹⁵ Praveen R. Kambam MD *Why is Mental Illness Scary? Psychology Today* 2013

¹⁶ Steven Waterhouse, *Strength for his People: A Ministry for Families of the Mentally Ill* (Amarillo, Texas, Westcliff Press)

Mental Illness	Demonic Possession
Medicine alleviates the problem	Prayer alone solves the problem
Attraction to religion (hyper religiosity)	Demons want nothing to do with Christ
Might claim to be possessed	Demons wish to be secretive
Possess ordinary knowledge	Demonstrate supernatural knowledge
Irrational speech – nonsensical and jumping rapidly between unrelated topics	Speak in a rational manner
Normal atmosphere – the disorder afflicts only the schizophrenic sufferer	Occult Phenomena – Spooky aspect to activity that affects others in the room

What Are the Obstacles the Church Faces in Serving the Mentally Ill?

Many argue that the faith communities are ill equipped to help because pastors are trained for spiritual struggles. They are not trained for mental illness. The truth is that mental illness is an illness like any other, and the role of the pastor remains the same as it does for supporting congregants with other illnesses. Being educated about mental illness helps the faith leader to know how to provide the needed spiritual support and refer to the appropriate professional resources.

One of the other obstacles is the lack of resources, finances, and time.

When has the church ever had enough of any of those things?

Lack of resources or time is not an excuse to not relieve the suffering of those who live among us.

Scripture clearly teaches that we are to care for others.

- Galatians 6:2 “Bear one another’s burdens, and thereby fulfill the law of Christ.”
- Mark 10:45 “For even the Son of Man came not to be served, but to serve, and to give his life as a ransom for many.”

Stigma has a ripple effect that:

- Disconnects people from the help and support they need.
- Distorts their relationship with God and affects their spiritual growth.
- Reinforces and perpetuates negative stereotypes of people with mental illness as dangerous and unstable.
- Can cause real life harm.
- At its worst, has fatal outcomes.

Why Is It Important for Churches to Overcome Stigma and Become More Inclusive?

The Church is God’s representative in the world to show the true love and grace of Jesus Christ. Creating a grace filled congregation will relieve suffering, reveal the grace of God, and restore hope. Jesus clearly stated that, “By this everyone will know that you are my disciples, if you love one another.” (John 13:35)

The benefits of becoming a stigma-free congregation include:

- Connecting the suffering to the help they need
- Allow people to live in authentic relationships with God and others
- Getting others involved reduces the stress on the pastor/s

The role of the pastor is complicated and stressful, and they should not be expected to carry the burdens of the entire congregation. The pressures of pastoral ministry take a toll on pastors and their families. “Pastors are burning out every day. Many are leaving the ministry as a

result. It is a real and immediate problem with many pastors and many churches.”¹⁷

6.5 What Can Your Church Do to Reduce Stigma and Support People in Your Congregation?

Every church, no matter the size, can break down stigma and make everyone feel welcome.

Here are some basic things every faith community can do.

- Talk about it.
- Support those with mental illness and their families.
- Compile resources for the congregation.
- Get others involved.

Talk About It

Start the conversation by talking about mental health in your sermons, just like you would any other challenge that your congregation is facing. Search YouTube or Vimeo for short video clips that educate about mental illness. Identify appropriate speakers and invite them to your church to share about their personal experiences and their faith journey. Once you give people the freedom to talk about it, you will discover those in your own community with a story to tell. Include these testimonials with others that you share to bring hope to those who are struggling.

There are many mental health awareness programs that you can utilize to bring attention to the cause of mental health. Find creative ways to support National Mental Health month in May. Suicide prevention week is in September, and you can make your people aware of the

¹⁷ *Thomas S. Ranier*

activities taking place in your community. Every October your faith community can host a National Depression Screening Day, where people can come and get a mental health checkup. These are a few of the programs already in existence that you can bring to the attention of your church and find ways to get involved. You might be saving lives, even in your own church.

Provide Support for Those Living with Mental Illness and Their Families

People with mental illness and their loved ones need support as they learn to manage their illness. Mental illness is complicated and the road to recovery can be long and frustrating. In order for individuals to find the proper treatment, first they must educate themselves about what they are dealing with. The families also must learn about what their loved one is struggling with in order to support them in their illness. Everyone needs to understand what mental illness is, and you can do something about that.

One excellent education tool available is *Mental Health First Aid*. Mental Health America of San Diego offers a free 8-hour certification course, that helps communities better understand mental illness and how to respond to psychiatric emergencies. Your congregation could host a training for those in your church as well as your community. For more information, visit: www.mhasd.org.

NAMI – National Alliance on Mental Illness also offers free classes, both for those living with a mental illness and for their families. Here is a brief description of the education classes that your church could host:

- ***NAMI Peer-to-Peer*** is a free, 10-session educational program for adults with mental illness who are looking to better understand

their condition and journey toward recovery. Taught by a trained team of people who've been there, the program includes presentations, discussion and interactive exercises. Everything is confidential, and NAMI never recommends a specific medical therapy or treatment approach.

- **NAMI Family to Family** is a free, 12-session educational program for family, significant others and friends of people living with mental illness. It is a designated evidenced-based program. Research shows that the program significantly improves the coping and problem-solving abilities of the people closest to an individual living with a mental health condition. NAMI Family-to-Family is taught by NAMI-trained family members who have been there, and includes presentations, discussion and interactive exercises. For more information about NAMI programs visit: www.nami.org/Find-Support/NAMI-Program.

Spiritual Support Groups

In addition to the above listed classes, many churches host a faith based support group for those living with mental illness as well as their families. One organization that has developed a curriculum that is consistent with the Christian faith is *Mental Health Grace Alliance*, which offers two groups:

- 1) **The Living Grace Group** is a 12-week curriculum-based support group for those living with a mental health difficulty or disorder. The Living Grace Group, led by peers or lay leaders, provides psycho-education and practical tools within a supportive community. Preliminary research through Baylor University Psychology Dept. demonstrates that participants in the Living

Grace Group experience a reduction of symptoms, enhanced recovery, and restored personal faith.

- 2) **The Family Grace Group** is a 14-week curriculum-based support group for the families of those living with a mental health difficulty or disorder. The Family Grace Group, led by family members or lay leaders, provides psycho-education and practical tools within a supportive community.

Community is key to recovery, and these groups allow the participants to integrate the grace of God into the recovery process. Community support provides comfort through sharing, learning, and navigating the journey of mental health recovery. For more information, go to: <http://mentalhealthgracealliance.org/california>.

Stigma – Faith and Religion

Religion is a particular system of faith and worship. Religion usually promotes a creed and has a defined code of ethics; it is tangible.



Spirituality is more abstract than religion. Spirituality exists in the nebulous realm of the indefinable. In general, it includes a sense of connection to something bigger than ourselves, and it typically involves a search for meaning in life. As such, it is a universal human experience—something that touches us all. Why has the mental health profession so long ignored and pathologized spiritual experiences and religion? From the very beginning of the psychology movement, religion has been viewed more as an illusion and neurosis than a reality.

Two of the most influential constructors of the tenets of psychology stated the following:

- Sigmund Freud pathologized religion, as “A system of wishful illusions together with a disavowal of reality, such as we find nowhere else...but in a state of blissful hallucinatory confusion.”
- Albert Ellis stated, “Spirit and soul is horseshit of the worst sort. Obviously, there are no fairies, no Santa Clauses, no spirits. What there is, is human goals, and purposes...But a lot of transcendentalists are utter screwballs.” He further derided religion by saying, “the elegant therapeutic solution to emotional problems is quite unreligious...The less religious they (patients) are, the more emotionally healthy they will tend to be.”
- B.F. Skinner, who pioneered the understanding of behavior modification principles never, published a single word on the topic of spirituality. He approached humans as stimulus response boxes.

All along, the majority position of Psychiatry has been that Psychiatry has nothing to do with religion and spirituality. Religious beliefs and practices have long been thought to have a pathological basis, and psychiatrists over a century have understood them in this light.

Religion was considered a symptom of mental illness. Jean Charcot and Sigmund Freud linked religion with neurosis. DSM3 portrayed religion negatively by suggesting that religious and spiritual experiences are examples of psychopathology. But recent research reports strongly suggest that to many patients, religion and spirituality are resources that help them to cope with the stresses in life, including those of their illness.

Many psychiatrists now believe that religion and spirituality are important in the life of their patients and the importance of spirituality in mental health is becoming more widely accepted. As John Turbott puts it, rapprochement between religion and psychiatry is essential for psychiatric practice to be effective.

Despite the importance of religion and spirituality in most patient's lives, adequate training is not provided by most graduate programs and internship sites to prepare them to deal with these (spiritual) issues.

The same gap exists in the faith community when it comes to mental health. The faith community has long ignored and spiritualized mental illness. Most pastors are not provided with mental health training during their seminary studies.

Spirituality is important in the prognosis of psychiatric conditions. In the spiritual perspective, a differentiation must be made between cure and healing. Cure is the removal of symptoms and disease. Healing is

the healing of the whole person. Adversity often produces maturity. Hence in psychotherapy, the patient must be helped to accept the handicap and transform the handicap to a life of usefulness.

Practical Applications

- Psychiatric history should be catered to the patient's spiritual orientation and religious practices. What does religion and spirituality mean to the patient? What role does religion play in coping with life stresses? Recognize that some religious beliefs may seem to be in conflict with any type of (psychiatric) treatment.
- Respect and support the patient's religious beliefs if these help them to cope better and/or do not adversely impact their mental health.
- Partnership between psychology and faith-based communities will work towards the best outcome for the patient. For the partnership to be effective the mental health workers must be spiritually orientated, and the religious workers must be better informed about mental health.

How to Appeal to Your Patient's Spiritual Side

When you encounter a patient, who is struggling with their spiritual life, certain questions and examples of scriptures may be helpful.

Regarding Cognitive Behavioral Therapy

Do you know what the bible says about thinking? The bible has a lot to say about our minds and about thinking!

- Philippians 4:8 "Finally, brothers and sisters, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever

is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things.”

- Proverbs 23:7 “For as he thinks in his heart, so is he.”
- Romans 12:2 “Do not conform to the pattern of this world, but be transformed by the renewing of your mind, then you will be able to test and approve what God’s will is. His good, pleasing and perfect will.”

What does the Bible have to say about difficult times?

- John 16:33 “These things I have spoken to you, that in Me you may have peace. In the world you will have tribulation: but be of good cheer, I have overcome the world.”
- 1 Peter 4:12 “Dear friends, don’t be surprised at the fiery trials you are going through, as if something strange were happening to you.”

What does the bible have to say about the nature of God?

- Romans 8:35 “Who shall separate us from the love of Christ? Shall tribulation or distress or persecution or famine or nakedness or danger or sword?”
- 2 Timothy 2:13 “If we are unfaithful, he remains faithful, for he cannot deny who he is.”

During depressive episodes, a patient’s ideas and thoughts about God can become just as distorted as their worldview. A God that they once believed to be loving and kind may in their depression be a God who regrets the day they were born, is cruel and punishing – has deserted them completely.

The same way Pastors are not trained to provide therapy but need to refer clients to appropriate professional(s), Therapist need to refer clients to a person within their faith of choice, that can help them to overcome any crisis of faith.

Other Considerations

Churches and faith communities are excellent sources of connection for your patients. Most offer small group bible studies, support groups, volunteer opportunities, etc. This is an area that you as their provider can offer them encouragement to become involved in.

Help your patient navigate having appropriate discussions with their faith leaders about their mental illness and the needs they have. Those clergies that have taken the Faith Based Academy training will recognize their role verses the professional's role and be willing to work together for the benefit of the individual. The faith home that has become knowledgeable has become compassionate and prepared to offer caring support.

Mental Health Grace Alliance is a non-profit organization that has developed faith-based support groups for churches and other faith communities. Grace Groups are Christ-centered, psycho-educational support groups. The Family Grace group offers support to family members and others who have a loved one living with a mental illness. The Living Grace group offers support to those who are living with a mental health difficulty. The groups follow a guided curriculum with topics focused on biblical truth, psycho-education, and practical tools within a supportive community.

As practitioners looking for the methodologies that will provide the best outcome for your patients, it just makes sense to tap into the important spiritual aspects of your patient's lives.

Resources for Your Congregation

Since the church is the first place many turn to when they are experiencing a mental health issue, it is important that you have the appropriate resources to share with those who are coming to you for help. There are some basic resources you can compile and have on hand when needed.

List of recommended reading resources - a few are listed here:

- *Mental Health Resource Guide for Individuals and Families* was produced and published by Rick Warren of Saddleback Church to serve as a resource of hope. In the foreword of the booklet, he explains the purpose of the resource guide: "While this resource guide is drawn from highly reputable and trusted sources of information about mental illness, it is not a comprehensive study and it is not intended to be used as a diagnostic tool. Rather, it will serve as a quick reference for individuals and families seeking insight and information. Further clinical assessment may be needed. This guide provides basic information about mental illness—*potential warning signs, definitions of the most common diagnoses, and frequently asked questions.*" (For more information, visit: <http://hope4mentalhealth.com/act/resources>).
- *Grace for the Afflicted: A Clinical and Biblical Perspective on Mental Illness* by Matthew Stanford Ph.D

- *Troubled Minds: Mental illness and the Church's Mission* by Amy Simpson
- *When Someone You Love Has Mental Illness* by Rebecca Woolis
- *A Grace Disguised* by Jerry Sittser
- *Surviving Schizophrenia (5th Edition)* by E. Fuller, Torrey, MD
- *The Bipolar Disorder Survival Guide, Second Edition: What You and Your Family Need to Know* by David J. Miklowitz
- *You Need Help!* by Mark S. Komrad MD
- *I Am Not Sick I Don't Need Help!* by Xavier Amador, PhD
- *Change Your Brain, Change Your Life: The Breakthrough Program for Conquering Anxiety, Depression, Obsessiveness, Anger and Impulsiveness* by Daniel Amen MD
- *Don't Call Me Nuts: Coping with the Stigma of Mental Illness* by Patrick W. Corrigan and Robert Lundin
- *Don't Sing Songs to a Heavy Heart: How to Relate to Those Who Are Suffering.*
- *No Time to Say Goodbye: Surviving the Suicide of a Loved One* by Carla Fines
- *Grieving a Suicide: A Loved One's Search for Comfort, Answers and Hope* by Albert Hsu

Community Resources Available in Your Area

- CHIP – Community Health Improvement Partners have created a small booklet titled *The HELP Connection*- which is a roadmap for Behavioral Health & Related Service in the county. It contains a wealth of information that could provide assistance to those seeking support and services. The PDF is available in both Spanish and English through CHIP at: chipinfo@sdchip.org.
- North Inland Faith Partnership – Becoming an active participant (either you or a ministry leader from your church) allows you to stay informed of the services available in your area. Networking with other faith leaders and mental/behavioral health professionals will continue to create a valuable and comprehensive set of resources for your faith community.

Develop a List of Christian Mental Health Professionals for Referral

Not all mental health professionals will be a good fit for those in your care. Look for professionals who will respect your faith and who allow the client to integrate their faith in the therapy. Other churches might be a good resource for therapist that they feel comfortable offering as referrals. Finding an effective licensed mental health professional will be an integral part of recovery for those dealing with mental illness. You can support their healing journey by providing excellent referrals for those seeking treatment.

Chapter 7. Cultural Considerations

Focus on Latinos

7.1 Latino Communities in the United States

When we use the term “Latino,” it is important to keep in mind that the Latino culture is actually made up of a number of different ethnicities from different countries who have migrated to the U.S. at different times for different reasons and having different legal status. Puerto Ricans have been U.S. citizens since 1917, Cubans are considered political refugees and are given special status by the U.S. government, and some Mexican families have lived in their communities longer than their land has been a part of the United States. These are just a few of the differences that exist between some of the ethnicities that we refer to as Latino.

According to the U.S. Census Bureau, about 18.9 percent of the U.S. population self identifies as being Latino/Hispanic, or about 59 million Americans. By 2060 this number is projected to increase to around 129 million or 31 percent of the population. Of this population, 61.8 percent are of Mexican origin, with the next most numerous groupings being Puerto Rican at 9.6 percent and Central America at about 9.4 percent followed by the combined nations of South American countries at about 6.3 percent, Cuban at 4 percent and all other Hispanic/Latino at about 8.6 percent. This population resides throughout the United States but is mainly found in the southwestern states with California having the most Latinos, 15.6 million. This is about 28 percent of all Latinos living in the U.S. and makes it the largest ethnic group in California, about 38 percent of the population.

In Escondido, California the percentage of Latinos is higher and quickly growing. In 2004 Latinos made up about 42 percent of the population, ten years later census information shows the population has grown to 51.7 percent of those living in Escondido.

7.2 Facts about Substance Use, Domestic Violence and Latinos and Latinas

Domestic Violence and Sexual Assault in Latino Communities

- Between 20% and 25% of Latinas will experience domestic violence (DV) during their lifetime, and 1 in 20 in the previous 12 months.
- Immigrant women (including Latinas) who are married are more likely to experience DV than unmarried women.
- A study that included 2,000 Latinas found 63.1% of women identified being victimized in their lifetime.
- Across the United States a report of child abuse is made every ten seconds. More specifically, one in four girls will be sexually assaulted by the age of 18 and one in six boys will be sexually assaulted. Although there is a surge of reported cases, many families, especially Latino families, are unwilling to talk about the issue. “When we are talking about sexual abuse in the Latino community it becomes really difficult because there are a lot of taboos just around sex in general.”
- “Cultural barriers” has one of the factors contributing to the unknown number of sexual abuse cases, but states that on a national level, 700,000 children are abused in general in the

United States. Out of those numbers, 20 percent are Latino children. When it comes to child sexual abuse in the Latino population it becomes a lot harder to figure out.

- When a family doesn't address the issue of child abuse, that child, as they get older, becomes more inclined to go into a series of depression. Other risky behaviors include drug use, gang involvement, and running away from home.
- The longer a child goes on without receiving the support they need, for example, counseling or a support group, that child can become distressed. And what that means is that they could be potentially suicidal, or homicidal, that their symptoms are really to the point where they need more intensive services and without assistance it often impacts a lot of things. It impacts their academic performance, their social skills, and in the long run their mental health.

Substance Use among Latinos and Latinas

The National Latino and Asian American Study indicated the lifetime prevalence of alcohol use disorders was 16.7% for Latino men and 4.3% for Latina women.

Substance Use and Domestic Violence

- Although recent research shows a strong relationship between intimate partner violence and greater frequency of alcohol intoxication, the overall evidence regarding whether a woman's alcohol use increases her likelihood of experiencing intimate partner violence has been described as "weak".

- Experiences of interpersonal violence, the stress of living in a new country with different cultural norms and language, discrimination, socioeconomic pressures, loss of social support mechanisms upon immigration, and exposure to drugs and alcohol often lead to chemical use and dependency.
- Trauma is often the common thread running through a variety of co-occurring issues, ranging from mental health disabilities to substance abuse, poverty, and exploitation resulting from the sex industry, homelessness and incarceration.

Latina Survivors Who Shared Struggles with Substance Abuse

Initiation—An abusive partner first introduced them to alcohol and other drugs by forcing, threatening, and/or coercing them into using substances.

Consumption—Alcohol consumption was primarily a gendered practice in which abusive partners, as well as men in the family became primary consumers.

Care—Latina survivors did not consume alcohol or drugs understanding it would impair their ability to care for their children. They cared for their partners during and post intoxication.

7.3 How Latinos Cope with Mental Health Problems

Latinos in U.S. are no different from the rest of the population when it comes to instances of mental health conditions, however these conditions are understood and coped with in different ways by the Latino community. The most common mental health disorders among Latinos are generalized anxiety disorder, major depression,

posttraumatic stress disorder (PTSD) and alcoholism. Also, Latina high school girls have a disproportionately high rate of suicide attempts.

While Latino communities show similar susceptibility to mental illness as the general population, disparities exist in access to treatment and in the quality of treatment received. This inequality puts Latinos at a higher risk for more severe and persistent forms of mental health conditions.

Spanish-speaking Americans across the U.S. say they have a hard time finding mental health care services in their native language. Only 5.5% of U.S. psychologists say they're able to administer mental health care services in Spanish, according to a survey released by the American Psychological Association

(<https://www.apa.org/workforce/publications/15-health-serviceproviders/>) in September 2016, the most recent data available. In all, 44.9% of psychologists said they were “quite or extremely knowledgeable” about working with Hispanic patients. The demand for full-time psychologists within the Hispanic community is expected to surge 30% by the year 2030. That's second highest only to “other racial/ethnic minority groups” – including Asians, Native Americans and multiracial people – with a growth of 32%, according to the American Psychological Association

(<https://www.apa.org/workforce/publications/supply-demand/demandracial-groups.pdf>). African Americans will see an 11% increase, and whites a 2% decrease. Critics say mental health providers are simply not keeping up with the nation's growing Hispanic population, which reached 59.9 million in 2018, or roughly 18% of the U.S. population. This disparity is noteworthy, in part, because Latino Americans face unique mental health issues compared to the country's population at large.

As a community, Latinos are less likely to seek mental health treatment. A 2001 Surgeon General's report found that only about 20% of Latinos with symptoms of a psychological disorder talk to a doctor about their problem. Only 10% contact a mental health specialist.

7.4 Historical and Socio-cultural Factors That Relate to Mental Health

Historical and socio-cultural factors suggest that, as a group, Latinos are in great need of mental health services. Latinos, on average, have relatively low educational and economic status. In addition, historical and social subgroup differences create differential needs within Latino groups.

Central Americans may be in particular need of mental health services given the trauma experienced in their home countries. Puerto Rican and Mexican American children and adults may be at a higher risk than Cuban Americans for mental health problems, given their lower educational and economic resources. Recent immigrants of all backgrounds, who are adapting to the United States, are likely to experience a different set of stressors than long-term Hispanic residents.

The ECA study found that Mexican Americans and white Americans had very similar rates of psychiatric disorders (Robins & Regier, 1991). However, when the Mexican American group was separated into two sub-groups, those born in Mexico and those born in the United States, it was found that those born in the United States had higher rates of depression and phobias than those born in Mexico (Burnam et al., 1987).

The NCS found that relative to whites, Mexican Americans had fewer lifetime disorders overall and fewer anxiety and substance use disorders. Like the Los Angeles ECA findings, Mexican Americans born outside the United States were found to have lower prevalence rates of any lifetime disorders than Mexican Americans born in the United States.

A third study examined rates of psychiatric disorders in a large sample of Mexican Americans residing in Fresno County, California (Vega et al., 1998). This study found that the lifetime rates of mental disorders among Mexican American immigrants born in Mexico were remarkably lower than the rates of mental disorders among Mexican Americans born in the United States. Overall, approximately 25 percent of the Mexican immigrants had some disorder (including both mental disorders and substance abuse), whereas 48 percent of the U.S.-born Mexican Americans had a disorder (Vega et al., 1998). Furthermore, the length of time that these Latinos had spent in the United States appeared to be an important factor in the development of mental disorders. Immigrants who had lived in the United States for at least 13 years had higher prevalence rates of disorders than those who had lived in the United States fewer than 13 years (Vega et al., 1998).

It is interesting to note that the mental disorder prevalence rates of U.S.-born Mexican Americans closely resembled the rates among the general U.S. population. In contrast, the Mexican-born Fresno residents' lower prevalence rates were similar to those found in a Mexico City study (e.g., for any affective disorder: Fresno, 8%, Mexico City, 9%) (Caraveo-Anduaga et al., 1999). Together, the results from the ECA, the NCS, and the Fresno studies suggest that Mexican-born Latinos have better mental health than do U.S.-born Mexican Americans and the national sample overall.

Surveys in Mexican American Adolescents

A large-scale survey of primarily Mexican American adolescents in schools on both sides of the Texas-Mexico border revealed high rates of depressive symptoms, drug use, and suicide (Swanson et al., 1992). Like the adult epidemiological studies, this investigation found that living in the United States is related to elevated risk for mental health problems. More Texas youth (48%) reported high rates of depressive symptoms than did Mexican youth (39%). Also, youth residing in Texas reported more illicit drug use in the last 30 days (21%) and more suicidal ideation (23%) than youth residing in Mexico.

Together the data indicate that Latino children and adolescents are at significant risk for mental health problems, and in many cases at greater risk than white children. At this time, it is not clear why a differential rate of mental health problems exists for Latino and white children. Special attention should be directed to the study of Latino youth, as they may be both the most vulnerable and the most amenable to prevention and intervention.

Among Hispanics, foreign-born youth experience lower self-esteem and higher levels of suicidal thoughts than U.S.-born youth (e.g., Portes and Rumbaut, 2001). However, U.S.-born Hispanic youth exhibit more serious health risk behaviors and conduct problems than foreign-born youth.

Immigration as Trauma

Trauma, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), “results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse

effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

In many respects, immigration is trauma. It is a complete loss of identity and familiarity, and immigrants are often left without the proper tools or resources to help them cope in a new environment. That transition in itself, even if it ends well, can leave deep scars. In addition, immigrants coming from war-torn countries have often faced violence, rape, or the loss of family members, and immigrant children are often at risk for exposure to violence. Immigrants also face higher risks for health issues like diabetes, strokes, substance abuse, etc. In an intergenerational context, children of immigrants tend to show higher rates of anxiety and depression.

Latino youth face a multitude of challenges, including lack of socioeconomic resources, risk for behavioral problems (e.g., drug use and early pregnancy), and low educational attainment (Kuperminc et al, 2009; Rodriguez and Morrobel, 2004). Of particular concern is the mental and emotional health of Latino youth. CDC's 2007 national survey found that Latino youth were more likely to feel sad or hopeless (36.3%), to seriously consider suicide (15.9%), and to attempt suicide (10.2%) than white (26.2%, 14.0%, and 5.6%, respectively) and African American (29.2%, 13.2%, and 7.7%) youth. Furthermore, studies have shown that both depression and anxiety are positively correlated with increased rates of suicidal behavior, and adolescents who are depressed are 35–50% more likely to attempt suicide (Dopheid, 2006).

Major depression and anxiety disorders are two of the most prevalent mental health conditions affecting Latino youth. In one of the few existing national studies of Latino youth (age 11–15), Saluja and his colleagues (2004) found that Latino youth had higher rates of

depressive symptoms (22%) than white (18%), Asian American (17%), and African American (15%) youth. Other studies also consistently find higher rates of depression among Latino youth—especially Mexican American and Afro-Latinos—than among other ethnic groups (Choi et al., 2006; Mikolajczyk et al., 2007; Ramos et al., 2003).

Although no national data are available on the prevalence of anxiety disorders or anxiety-related problems among Latino youth, studies also suggest that Latino youth experience significantly higher levels of anxiety than whites but not African Americans (Glover et al., 1999; Roberts et al., 2006). Approximately, 8% of Mexican-American youth (age 11–17) have had an anxiety disorder in the past year (Roberts et al., 2006).

Gonzalez et al. (2009; 2002) and Umaña-Taylor and Alfaro (2009) summarize much of the research available on foreign-born and U.S.-born Latino youth; acculturative stress stemming from challenges related to adapting to life in the U.S. (e.g., learning a new language, adjusting to new social norms and family dynamics, and experiencing discrimination), affect psychological well-being. These studies find a positive association between acculturative stress and a variety of internalizing behaviors, including low self-esteem, symptoms of depression, and greater suicidal alienation. But they also find that Latino youth rely on protective factors, such as strong family connections, active coping strategies, and social supports, to minimize the detrimental influences of acculturative stress.

Other studies of Latino youth compare mental health outcomes across immigrant generations and attempt to explain differences, if any, by adjusting for socio-economic risk and protective factors (Gonzales et al., 2002). For example, Harker's (2001) and Harris' (1999) national-level

assessments indicate that first-generation Latino youth (i.e. foreign-born youth with foreign-born parents; ages 12–18) experience fewer depressive symptoms than their later generation peers (i.e. U.S.-born) and that a number of family influences (e.g., parental supervision and closeness) protect first-generation immigrant youth from experiencing the poor mental health outcomes commonly associated with low socioeconomic and minority status. But, Rumbaut (1995) found that English language competence predicted lower levels of depressive symptoms among Latino youth and argues that, at least initially, the stresses of immigration negatively affect psychological well-being until youth become accustomed to their new home and learn how to navigate their new environment.

Extending prior research, we found that the unique migration stressors (i.e. involuntary migration, exposure to traumatic events during migration, and discrimination) of immigrant Latino youth increased their risk for depression and anxiety. We have shown that documentation status, which is absent in most research, plays a significant role in the adaptation and acculturation process. Lastly, we found that migration supports (i.e. time in the U.S., and family and teacher support) minimized the stressors of migration.

Helping these populations to heal requires an acknowledgment of the impacts of mental trauma on physical health, and a treatment plan that involves all aspects of care.

Integrated Care & Faith as a Factor in Healing

Many immigrants can present mental health issues as physical symptoms, appearing with vague stomach pain, headaches, and other complaints, which often lead them to primary care settings.

Unfortunately, providers too often address physical issues as separate from mental health.

In addition, many physicians are not trained to question patients about their faith. Medical facilities frequently lack any support for patients of faith, despite the fact that faith and faith-based communities play a major role in the prevention of, treatment for, and recovery from mental illness.

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Acculturation

Some authors have interpreted these findings as suggesting that acculturation may lead to an increased risk of mental disorders e.g., Vega et al., 1998; Escobar et al., 2000; Ortega et al., 2000. It is not clear what aspect or aspects of acculturation could be related to higher rates of disorders. Is it the changing cultural values and practices, the stressors associated with such changes, or negative encounters with American institutions (e.g., schools or employers) that underlie some of the different prevalence rates (Betancourt & Lopez, 1993)?

The findings of these studies have raised intriguing questions about the role of acculturation in mental health among Hispanic adults in the United States. Vega and Alegría (2001) have interpreted the data to suggest that some Hispanics, such as Mexicans, Puerto Ricans, and Cubans, generally migrate to the United States with better mental health status than the U.S. population as a whole. As they spend time in the United States, however, they develop an increased risk of mental health problems.

7.5 Things to Consider

There are different reasons which prevent Latinos from seeking treatment and receiving quality mental health care. In general, the Latino community does not talk about mental health issues and they have little information about this topic. Many Latinos do not seek treatment because they don't recognize the signs and symptoms of mental health conditions or know where to find help.

This lack of information also increases the stigma associated with mental illness. Many Latinos do not seek treatment for fear of being labeled as “locos” (crazy) or “locura” (madness), labels that carry shame for both the individual and the family. One in 5 persons is affected by mental illness. This means that, even if not talked about, most of us either have one of these illnesses or know someone who does.

Research shows that minorities are less likely to seek mental health treatment until symptoms are more severe when compared to non-Hispanic white individuals. They are prone to turn more towards primary care and informal sources such as traditional healers, family, friends and/or clergy. This is another factor for their under-representation in health services.

Another factor to consider is mistrust. Mistrust has been seen as a barrier to mental health treatment for minorities. It ranges from historical persecution to present day racism and discrimination, even to documented cases of abuse and mistreatment. “A survey conducted for Kaiser Foundation shows that 15 percent of Latinos felt that a doctor or health provider treated them with disrespect because of their race or ethnic background. In the Commonwealth Fund Minority Health

Survey, it was found that 28 percent of Latinos felt treated badly by a health care provider because of their race.” (Brown et al., 1999; La Veist et al., 2000) Some of these attitudes can also be placed towards government-operated institutions based upon their fears of being deported.

The Latino community tends to be very private and often do not want to talk in public about challenges at home. The idea is expressed in the statement, “la ropa sucia se lava en casa” (similar to “don’t air your dirty laundry in public”). This idea is common in the Latino population.

Latinos in general tend to turn to their religion or the church when seeking treatment or aid with mental health. People are expected to be able to control their symptoms and to not be weak. They are told to lean on spiritual power. Having mental illness can be associated with loss of control, violence and incurability. Therefore, many can try to hide in denial or conceal their mental illness to protect their family reputation.

Language Barriers

Language barriers can make communicating with doctors difficult. Many medical professionals today do speak some medical Spanish, particularly in parts of the country with large Latino populations, but may not necessarily understand cultural issues. Patients have the right to request a trained interpreter and to receive forms and information in Spanish.

Misdiagnosis

Cultural differences may lead doctors to misdiagnose Latinos. For instance, Latinos may describe the symptoms of depression as

“nervios” (nervousness), tiredness or as a physical ailment. These symptoms are consistent with depression, but doctors who are not aware of how culture influences mental health may not recognize that these could be signs of depression.

Lack of Health Insurance

A significant percentage of the Latino population works low-wage jobs or is self-employed. Often these Latinos do not have health insurance. The Affordable Care Act is making it easier and more affordable for Latinos to become insured, but a significant portion of this population is not eligible because their legal status.

7.6 Conclusions

In conclusion culture can influence many parts of mental illness such as the expression of symptoms, how someone copes with them, the support from family and community members and the willingness to receive treatment. In response to this the culture of the clinician and the institution can also influence the treatment, diagnosis and service.

Culture plays a critical role in the understanding, response, and treatment of mental illness. It is ideal for the person to locate treatment in a culturally responsive health care setting.

The stigma surrounding mental illness and the reluctance to get treatment aren't unique to Latinos, of course. Less than one-third of the estimated 18 million American adults who have a mental illness that affects their day-to-day functioning receive treatment, according to a 2008 government survey. Research and anecdotal evidence suggest that stigma -- and what's known as self-stigma -- is a major factor standing in the way of mental-health care for Latinos.

In a recent study, Vega surveyed 200 depressed and low-income Latinos in Los Angeles; more than half said that depressed people weren't trustworthy and that they'd be unwilling to socialize with someone who's depressed. Those self-stigmatizing respondents were less likely to take medication and keep scheduled appointments with primary-care physicians, the study found.

Some of the reasons behind the reluctance to seek professional help are cultural. Religion is very important to the Latino community, and some Latinos turn first to their church -- or even to the folk healers known as *espiritualistas* -- for help with mental-health problems, some experts suggest. Even more so than American culture as a whole, Latino culture values self-reliance, which can discourage people from talking about their problems.

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Focus on Black/African Americans

One of the remaining taboos in many communities of color is the stigma around mental illness. Whether its depression or anxiety there is a longstanding belief in these communities that such concerns are taboo, and their impact is the problem of “the other.” Though communities of color, because of socioeconomic challenges, may be at higher risk for poor mental health, this stigma contributes to a reluctance to recognize the need for the help of a physician or therapist.

7.7 From an African American Therapist

For many in the African American community, our story is one of perseverance and resilience. After all, we survived slavery; surely, we can survive “sadness” or “anxiety.” In this mindset, anything less would be considered spiritual or moral weakness. The problem, in part, is that we often fail to recognize that mental illness is much more than feeling melancholy or anxious, it is not a sign of weakness, and it does not discriminate based on skin color. We fail to recognize mental illness as an “illness,” as we would cancer, diabetes, or high blood pressure.

According to the National Alliance on Mental Illness, 1 in 5 adults in the United States experience mental illness in a given year, this is irrespective of race, creed, or color. In addition, according to the U.S. Department of Health and Human Services Office of Minority Health, adult Black/African Americans are 20 percent more likely to report serious psychological distress than adult Whites. Despite this, African Americans are less likely than Whites to seek out treatment and more likely to end treatment prematurely.

On the one hand, this is due in part to long-held beliefs related to stigma, openness, and help-seeking, which can make African Americans and other people of color hesitant to reach out. On the other hand, we professionals in the healthcare community must do the work to establish ourselves as credible, reliable sources of support.

As healthcare providers in this age of “whole person care,” it is incumbent upon us to determine how to address and overcome this stigma. If we are to address the social determinants that impact health in communities of color, we must first understand not only the challenges but the attitudes and norms regarding these challenges. We must own up to the fact that underserved communities are underserved for a reason: The reason is that we (healthcare providers) haven’t been there.

It is arrogant to believe that we can decide to focus on communities that have gone underserved and be embraced and trusted, without earning that trust. We must start by listening and seeking to understand not only communities of color but all underserved or inappropriately served communities. We must also change the narrative from a conversation about mental illness to a conversation about mental wellness. Mental health is, after all, more than depression, anxiety, or a bipolar disorder diagnosis. It is your overall emotional and mental wellbeing, including both positive and negative elements.

Communities of color are no different than any other community in that everyone wants to live a healthy life: physically, mentally, spiritually, and emotionally. The challenge for communities of color and healthcare providers alike is defining what a healthy community looks like through the prisms of stigma and historical adversity, which includes race-based exclusion from health, educational, social, and economic resources. It is only by working together collaboratively as fully engaged partners that we can overcome this challenge.

7.8 Black/African Americans Demographics, Racism Then and Now

According to 2020 U.S. Census Bureau 12.4 % of the U.S. population, or roughly 41.1 million people, identify themselves as Black or African American. Most African Americans are descendants of persons brought to the Americas as slaves; others who came from Africa or the Caribbean differ in terms of culture, language, migration history, and

health. Historical adversity, which includes slavery, segregation, sharecropping and race-based exclusion from health, educational, social and economic resources, translates into socioeconomic disparities experienced by American born African Americans today. In San Diego County Black/African Americans make up 4.7% of the population, in North County these numbers are lower.

Despite progress made over the years, racism continues to have an impact on the mental and physical health of Black/African Americans. Negative stereotypes and attitudes of rejection continue to occur with measurable, adverse consequences. Historical and contemporary instances of negative treatment have led to a mistrust of authorities, many of whom are not seen as having the best interests of Black/African Americans in mind. This mistrust extends to medical professionals, people of color report experiencing disrespect, even push- back or disregard when they report symptoms.

To illustrate institutional racism in the late 60's early 70's under the Nixon administration the "War on Drugs" began and targeted more than drugs and created a long-held misconception that Blacks are more likely to be addicted than Whites.

"The Nixon campaign had two enemies, the antiwar left and Black people," Ehrlichman said (John Ehrlichman, counsel and Assistant to President Nixon on Domestic Affairs). "We knew we couldn't make it illegal to be either against the war or Black but by getting the public to associate the hippies with marijuana and the blacks with heroin and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did."

In the 80's the CIA-Contra actions allowed a flood of drugs to ravage the once peaceful, family centered, Black/African American neighborhoods of South Los Angeles. With the influx of money that

cocaine and crack generated, gang recruitment and violence grew exponentially. This was followed by an expansion of the War on Drugs, harsher longer sentencing for drug crimes, and in many States a three-strike law. These are only some examples of institutional racism that *continues to erode trust in systems that are supposed to serve all citizens; in 2017 25% of persons killed by police were Black. Currently 40% of adults incarcerated are Black/African Americans. In the juvenile justice system 40% of those incarcerated are Black youth.*

Black/African Americans are disproportionately more likely to suffer from mental health issues than white Americans. According to the US Department of Health and Human Services, in 2015 African Americans were 20 percent more likely to report serious psychological distress than white Americans, and African Americans are almost twice as likely to be diagnosed with schizophrenia as white Americans. Despite these statistics, African Americans are less likely to receive behavioral health treatment. In 2011, 73 percent of white Americans received treatment for major depressive episodes, while less than 55 percent of African Americans received treatment. Recently the theory of epigenetics, the expression of environment and experiences passed generationally through DNA, proposes that the past as well as contemporary experiences can trigger a traumatic response.

7.9 Societal Issues

Institutionalized racism in America has greatly influenced socioeconomic disparities faced by communities of color, and poverty is a high risk factor in behavioral health issues. **According to the Census Bureau from 1960 and 2013, African –American children who lived in single-parent homes more than doubled from 22% to 55%. The same research showed that white children from single-parent homes tripled from 7% to 22%.** Some would say there are disadvantages for both parent and child. Stress comes in because of one

person being the main responsible caretaker. The one parent having to shoulder all the decision making for the entire family can be overwhelming at times. Which then the pressure can trickle down to the children because of the stressful atmosphere of the home. Economics can certainly be a disadvantage when there is only one income.

According to the US Department of Health and Human Services' Office of Minority Health, African Americans are three times more likely to report psychological distress if they are living below the poverty line. As of 2014 around 6 percent more of African Americans were uninsured than white Americans. Without insurance, many cannot afford to treat their mental illness. Poverty is therefore both a risk factor in developing mental health issues, and a barrier to receiving treatment. A study conducted in 2008 revealed that even among African Americans who were already mental health consumers, more than a third felt that discussing their mild depression or anxiety would have them considered "crazy," and that they consider discussion of mental illness to be inappropriate even with their family.

Another factor is the lack of representation of African Americans in the medical field and lack of understanding of race issues' effects on mental health among physicians. Healthcare costs incurred by black patients is lower because there is a history of bias against black patients in general. This includes doctors spending less time with black patients, giving out less pain medications to black patients in pain, underserving black cancer patients, leading to less rigorous treatments ... and lower costs.

Only around 2 percent of the American Psychological Association members and associates identify as African American. White therapists have shown discomfort and dismissiveness with clients of color, particularly when discussing how the social factors around their clients' race could be affecting their mental health. Reports of comments have included allusions to the stereotype that African

Americans are lazy. Other counselors have tried to take a “colorblind” approach, which dismisses the link between social factors around race and mental health.

Fewer than half of adults in the U.S. with a mental health condition receive mental health services in a given year. African Americans however, utilize mental health services at about one-half the rate of Caucasian Americans.

We cannot rule out the impact of historical adversity, which has led to race-based exclusion from health, educational, social and economic resources. Many African Americans today still feel the socioeconomic impact of slavery, sharecropping, and Jim Crowism. Socioeconomic status is linked to mental health, in that people who are impoverished, homeless, or incarcerated are at higher risk for poor mental health. We also cannot rule out the impact of stigma associated with mental illness in the African American community.

7.10 Black/African Americans and Religion

Literature suggests that African Americans are much more likely to rely on their faith as a coping mechanism for dealing with depression and anxiety than they are to utilize a mental health professional. One study found that 90.4% of African Americans reported use of religious coping in dealing with mental health issues. In other words, many African Americans, rather than seeking support in the form of a mental health professional, go to the church. This is not surprising when one understands the traditional role of the African American Church. In African-American history, “the church” has long been at the center of Black communities. It has established itself as the greatest source for African American religious enrichment and secular development. There has always been a connection to faith and the emotional well-being of Black/African Americans. The late Dr. Martin Luther King Jr. stated “Darkness cannot drive out darkness, Only Light can do that” We must continue to live in the light and through

uneven circumstances let our light exhibit our inner peace and passion.

The black church continues to be a source of support for members of the African-American community. When compared to American churches as a whole, black churches tend to focus more on social issues such as poverty, gang violence, drug use, prison ministries and racism. A study found that black Christians were more likely to have heard about health care reform from their pastors than were white Christians.

All people of color tend to seek mental health support through their spiritual connection to God and turn to their clergy. Most pastors are very ill equipped to offer anything more than "take your cares to Jesus", "pray more", "read your Bible" as mental health advice. So, the people in need aren't able to receive the full spectrum of help they may seek. Also, the perception is that traditional Black church equates seeking mental/emotional health from a professional to an almost unpardonable lack of faith. For a social community who is so closely aligned with church, a church that is full of the same people that make up the previous points in this chapter, and a church authority that just doesn't know how to appropriately teach about or handle mental health issues without (unintentionally) putting their parishioners into bondage over how to proceed for themselves. It should be noted that seminary training only includes one class on counseling and it fails to cover even the most common mental health issues.

Three out of four people with a mental illness report that they have experienced stigma. Stigma is a mark of disgrace that sets a person apart from others. When a person is labelled by their illness they are no longer seen as an individual but as part of a stereotyped group.

Stigma can lead to discrimination. For Black/African Americans this often means additional stress and adverse effects on their health and well-being as a result of bias around their intersecting identities. Discrimination may be obvious and direct, such as someone making a negative remark about your mental illness or your treatment. Or it may be unintentional or subtle, such as someone avoiding you because the person assumes you could be unstable, violent or dangerous due to your mental illness. You may even judge yourself.

Some of the harmful effects of stigma can include:

- Reluctance to seek help or treatment
- Lack of understanding by family, friends, co-workers or others
- Fewer opportunities for work, school or social activities or trouble finding housing
- Bullying, physical violence or harassment
- Health insurance that doesn't adequately cover your mental illness treatment

It is the goal of this training to give clergy a greater understanding about the spectrum of mental health. We want to provide the tools and resources to open dialog that will focus light on mental wellness, eradicate the stigma of mental illness provide support to those suffering and their families, and be able to recognize when to refer congregants to a physician, a psychiatrist, or a licensed clinician. The overall goal is for the church to create a mental health ministry on campus that will provide caring support of all members as it does for other medical diagnosis.

FOCUS ON LGBTQ Community

LGBTQ is an acronym for lesbian, gay, bisexual, transgender and queer or questioning. These terms are used to describe a person's sexual orientation or gender identity. Simply being LGBTQ+ does not mean people will automatically experience mental health challenges.

However, there are certain stressors LGBTQ+ may face. These may include: stigma and discrimination; homophobia/biphobia/transphobia, bullying, harassment, hate speech, or violence. These experiences can be traumatic and hurtful, and stressors like these can affect the mental health and wellbeing of the LGBTQ+ population.

The stressors LGBTQ+ may experience are also affected by the intersection of other parts of their identity, such as their race/ethnicity, social class, culture, religion, age, disability, and more. Being subject to stressors and other traumatic experiences can contribute to mental health challenges.

Although the public estimates that 23% of the population are lesbian, gay, bi-sexual, transgender, queer (LGBTQ) a 2021 Gallup poll concluded that 7.1% of adult Americans identified as LGBT with 13.9% identifying as Lesbian, 20.7 Gay, 56.8% Bisexual, and 10% Transgender. A different survey in 2016, from the Williams Institute, estimated that 0.6% of U.S. adults identify as transgender. We acknowledge these numbers rely on self-reporting and may not represent the full population.

For decades, we've known that LGBTQ+ individuals experience a range of social, economic and health disparities — often the result of a culture and of laws and policies that treat them as lesser human beings.

They're more likely to struggle with poverty and social isolation. They have a higher risk of mental health problems, substance use and smoking. Sexual minorities live, on average, shorter lives than

heterosexuals, and LGBTQ+ youth are three times as likely to contemplate suicide, and nearly five times as likely to attempt suicide.

Current analysis of suicide deaths over two years among Americans 12 to 29 years old offers fresh insight into what factors are most likely to contribute to these fatalities, said study author Geoffrey Ream of Adelphi University in Garden City, New York. “We already knew, or at least suspected, that younger people are especially vulnerable to the stress of coming out.” “This is because they don’t have the psychological resources or personal independence to handle things themselves that they will have when they are older.” Youth 12 to 14 years old who identify as LGBTQ+ are much more likely to die by suicide than their heterosexual peers. The Journal of Adolescence Health reports 24 percent of the suicide deaths in the 12 to 14 age group were among LGBTQ+ youth in 2013-2015.

While Geoffrey Ream’s study wasn’t designed to prove whether or how the stress of coming out or living as a sexual minority might directly contribute to suicide, the results do show clear differences in how often certain circumstances are associated with these fatalities for young people with different sexual and gender identities. Family problems most often contributed to suicides among younger people and gay men in the study.

“I’m not out to my parents for safety reasons. If they found out I was gay, they would kick me out or force me into conversion therapy”

7.11 Youth on the Streets

Nearly 40% of homeless youth identify as LGBTQ+, compared to 7% of the general population. These youth may face homelessness for reasons connected to their identities, such as family rejection, prior abuse or

neglect, bullying in school, or social discrimination and marginalization.

**“If my parents found out I’m gay,
they would disown me and kick me
out”**

Youth without safe shelter and social supports are at higher risk of trafficking and exploitation. Traffickers exploit their needs and vulnerabilities to compel them into sex or labor trafficking. LGBTQ+ youth may be trafficked by intimate partners, family members, friends, or strangers. Until recently traffic victims were incarcerated which lead to further abuse and victimization. The coercion and control that traffickers hold over their victims, in combination with the stigma of commercial sex, may prevent youth from disclosing their situation. LGBTQ+ youth service providers may be in a unique position to recognize indicators of sex trafficking among the youth they serve and connect them with much needed services.

Even for those who are not trafficked there are many obstacles to health and well-being. Young people are extremely resilient and able to heal from severe trauma and go on to live healthy and full lives—if they are able to access housing, basic life needs, connections to caring and supportive adults, and have access to education, workforce development and long-term employment. Depending on what the young person experienced before becoming homeless and their length of time homeless, a wide range of physical, mental, emotional, and behavioral issues have been shown to develop as a result of homelessness and there is a risk of prior traumas becoming exaggerated.

LGBTQ+ youth experience what all homeless youth do, some likely at higher rates.

- Are at high risk of developing serious, life-long health, behavioral, and emotional problems.

- Suffer from high rates of depression and post-traumatic stress disorder.
- Are more likely to fall victim to sexual exploitation and human trafficking when compared to young people who are not living on the streets.
- Are more likely to contract HIV and/or STDs due to increased likelihood of sexual exploitation, rape, and sexual assault.
- Have higher rates of a variety of mental health symptoms including anxiety, developmental delays, and depression resulting in elevated risk for suicide attempts.
- Are likely to resort to illegal activity such as stealing, forced entry, and gang activity in order to survive.
- Homeless young women are five times more likely to become pregnant and far more likely to experience multiple pregnancies.
- Fifty percent of homeless youth ages 16 and older drop out of high school and face extraordinary obstacles in trying to finish. Homelessness is associated with an 87% increased likelihood of dropping out of school (the highest of all risk factors studied).

For the youth who are able to access housing and services, these negative outcomes can be mitigated through the provision of youth-appropriate interventions, safety, housing and connection to caring adults and/or reconnection to family.

7.12 LGBTQ Youth and their Family

Parents and family, church family, school family, and cultural family, play an essential role in promoting adolescent health and well-being. People with strong family or social connections are generally healthier than those who lack a support network. It is healthy for youth to make plans with supportive family members and friends, or seek out activities where they can meet new people, such as a club, class or support group.

Most LGBTQ+ youth are aware of their sexual orientation or gender identity by the start of adolescence. While coming out to their parents and close family members is an important and self-affirming developmental milestone, it is often fraught with worry. Many report coming out, being outed, or found out by their family as extremely stressful. 78% of youth reported they were NOT OUT to their parents as LGBTQ+. The same 78% hear their families make negative comments about LGBTQ+ people.

For too many LGBTQ+ youth, the real and perceived fear of rejection is compounded by the negative comments they hear about the LGBTQ community by their parents, family members and church family. These negative attitudes and beliefs may make them reluctant to come out or disclose their sexual orientation or gender identity to their families.

LGBTQ+ Youth of color often experience additional stress and adverse effects to their health and well-being as a result of the intersecting identities. This is particularly true for any immigrant, Latinx, and African American whose culture and/or religion reject those who identify as LGBTQ+. These cultural groups notably have strong ties to family and for some family relationships are more important than coming out. Racism, Hispanophobia and homophobia combined produce stress, fear, anxiety and can result in serious mental health issues including suicide.

Providing culturally responsive care for a young person identifying as LGBTQ+ and Black/African American or Latinx means understanding how these identities intersect to create added complexities. Culturally competent support of Latinx and Black/African American LGBTQ+ youth in addressing these unique challenges can create better outcomes and enhance their overall mental health and well-being.

7.13 LGBTQ Older Adults

Most people have an automatic, physiological response to discrimination, such as increased levels of anxiety, high levels of wariness/watchfulness, sweating, and/or increased heart rate. Rejection can make you feel angry, ashamed, afraid, or lead to a desire to hide and stay away from other people. Depression doesn't have to be a part of aging, and untreated depression can increase risk of suicide. Studies have shown that LGBTQ+ adults experience higher rates of alcohol abuse, drug abuse, smoking, suicide, and depression, often due to high levels of stress caused by systemic discrimination. For many older adults, feelings of depression or anxiety can express themselves through their bodies, taking the form of increased body pain, headaches, and fatigue. If someone is experiencing increased pain and fatigue, it's important to not just attribute it to normal aging but to seek a medical assessment.

Actions to take to live well

Connect with others. Lack of social relationships can have as much impact on physical health as blood pressure, or even smoking. Find an inclusive social or faith-based group where you feel welcome and safe and start connecting with others.

Move your body. The benefits of exercise on mental health can be as powerful as medication. Find a walking group, try gentle stretching or do deep breathing exercises.

Ask for Help. Reach out and ask for support, not only for physical and mental health, but for maintaining independence and quality of life. Start by calling 211 or going to their web site at 211.org. 2-1-1 San Diego is a resource and information hub that connects people with community, health and disaster services through a free, 24/7 stigma-

free confidential phone service and searchable online database. 2-1-1 serves the entire population of the County.

Help someone else. A 20-year study found that volunteering is associated with lower rates of depression and increased well-being. Find a cause you care about at www.volunteermatch.org or at justserve.org.

7.14 Where to find mental health support

Everybody has the right to be safe at school, home and work. You do not have to accept violence, threats, harassment, bullying or hateful speech. No matter what you're going through, it can be helpful to talk to a supportive friend, family member, school counselor, doctor or other person whom you trust. If you don't have anybody to talk to, there are online communities and local organizations you can reach out to for help.

- If you feel unable to stay or return home, services like the National Runaway Safe line (1-800-RUNAWAY or www.1800runaway.org) can help you find the resources and support you need to say safe.
- Talking to a trained counselor at The Trevor Project (1-866-488-7386 or thetrevorproject.org).
- Check out the Wellness Recovery Action Plan movement at www.mentalhealthrecovery.com.
- Find a local LGBT center in your area at www.lgbtcenters.org
- Call the National Suicide Prevention Lifeline at 1-800-273-8255.
- Visit the Know the Signs website to learn more: www.SuicideIsPreventable.org
- San Diego Access and Crisis Line: 1-888-724-7240
- Mental Health America, <http://www.mentalhealthamerica.net/find-affiliate>

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- The Network of Care, offers a directory of mental health and substance use services in California: www.networkofcare.org
- SAMHSA, <https://findtreatment.samhsa.gov/> locator
<https://findtreatment.samhsa.gov/locator>

Chapter 7 Notes

Chapter 8. Dealing with Resistance to Mental Health Treatment

8.1 Dealing with Resistance to Accepting Mental Health Treatment

Remember, the person *has* an illness; the person *is not* the illness. Mental health and illness involve multiple factors, including biology and neurochemistry, and are not the fault of the person, the family, or anyone else. Faith leaders are in unique positions to educate their congregations about mental health in order to overcome the stigma and shame often associated with mental illness with understanding and acceptance.

Acknowledging a problem—Resistance to treatment may come from the fact that the person does not think he/she has a mental health problem. Helping individuals understand that effective treatment is available for the issues that trouble them is an important 1st step.

Stigma—Realize that for many people the stigma about mental health conditions, involving stereotypes, prejudice, and discrimination, is a sign can't part of dealing with the illness itself. This encompasses both public stigma (general population reaction to people with mental illness) and self-stigma (prejudice that people with mental illness turn against themselves). Faith leaders should know enough about mental health conditions to understand the challenges an individual may be facing and be able to comfortably deal with stigma-related resistance.

Past experience with medication—People may have received mental health treatment in the past, but then decided on their own to stop taking medication. Stopping medication may have been prompted by bothersome side effects or because they felt it was no longer needed. Focusing the conversation on how they were functioning while taking medication as compared with their level of functioning without medication may be helpful in motivating individuals to consider resuming treatment.

Support team—A personal “support team” for someone who is resisting treatment is often a valuable resource. Such a team would be composed of several trusted people who could provide feedback whenever they observed the individual’s thinking or behavior interfering with his/her ability to function. A support team could help the individual over time to see the need to resume treatment.

Religious concepts—At times, religious concepts and understandings may be a source of resistance to treatment. People may “depend on God” for healing or regard receiving psychiatric services as a “lack of faith.” They may interpret their symptoms as a “curse” or a “punishment from God.” When engaging in conversation and counsel, a faith leader may usefully affirm that “God has given us the ability to develop medicines that are helpful in keeping us well.”

Hopelessness—People sometimes avoid or discontinue treatment because they can see no hope in their situation. In fact, hopelessness can be a significant symptom of the mental disorder itself. In some cases, faith stories from one’s religious tradition that illustrate how people have found “a way forward when there seems to be no way” can facilitate hope. Personal stories of those who have come through times

of crisis and resistance can also be effective in conveying an assurance that people can recover if they reach out for help that is available.

Perhaps the most helpful is the faith leader's expression of his/her own confident trust that the troubled individual can find the strength to take the next step toward his or her own healing.

If the resistance becomes extreme and if you think the person who is resisting treatment may hurt himself or herself or someone else, seek immediate assistance; call 911/Emergency Medical Services; ask if a person with Crisis Intervention Team (CIT) training is available. As a faith leader, you can convey that each person is sacred, is a person of extreme value, and is a person who is loved ultimately.

8.2 Building Resilience and Maintaining Wellness

Being resilient means a person is able to cope with challenges, trauma, threats, or other forms of stress. Getting help for mental health conditions can improve one's ability to take other steps to build resilience.

To strengthen resilience, people need to:

- Build connections with family and friends.
- Accept that change is a part of living—some goals may no longer be attainable as a result of changing situations.
- Reach out to help others.
- Develop realistic goals and take small, regular steps toward them.
- Look for growth in loss.
- Nurture a positive view of yourself.
- Trust instincts.

- Take care of themselves; they can't help others if they are unwell themselves.
- Boost mental health by remembering that the mind and body are connected—eat right, exercise, get enough sleep, and take care of health problems promptly.
- Avoid alcohol and other drugs.

8.3 A Holistic Guide to Whole-Person Wellness¹⁸

Wellness means overall wellbeing. For people with mental health and substance use conditions, wellness is not simply the absence of disease, illness, or stress, but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness. It incorporates the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. Each aspect of wellness can affect overall quality of life.

8.4 Approaching a Person with an Urgent Mental Health Concern

In many different occasions, faith leaders encounter individuals with mental health concerns that will need different ways of approaching the concern. Faith leaders can live exemplary lives of fortitude and honesty by encouraging an environment that emanates spiritual, physical and mental well-being. This also includes seeking help for mental health if necessary. This is important, considering that Faith leaders are likely to encounter individuals who suffer from mental health conditions, which will require different approaches.

¹⁸ American Psychiatric Association Foundation: *Mental Health: A Guide for Faith Leaders*.

How Can Faith Leaders Provide a Welcoming Environment?

Creating a welcoming environment is key factor when helping individuals with mental health issues.

A couple steps that can be considered are:

- Learning about mental illness and stigmas.
- Conduct workshops, lectures and sermons that will provide insight and knowledge of mental illnesses and stigmas, (Inviting a mental health professional to do this is also a good option).
- Providing a list of resources for community services.
- Encourage other faith leaders to train for Mental First Aid and how to respond appropriately.
- Faith leaders can also visit individual at hospital or home, offer prayers, offer help with childcare or transportation and network to support or advocacy groups.

Situations that Indicate Immediate Referral or Preventative Care

- When a person poses immediate danger to self or others.
- Suicidal behavior, severe aggression, self-mutilation such as cutting, or an eating disorder that has gotten out of control.
- Suicidal thoughts that individual expresses, or feelings that family members are aware of should be brought to immediate psychiatric attention and 911 should be called for assistance.

What to Assess in a Person?

- **Level of distress**—What is the level of distress, anxiety or anguish does the individual seem to be feeling? Does the individual seem to be able to cope or tolerate such feeling? Always ask questions about the individual's feelings and assess the responses.

- **Level of Functioning**—How well does the individual seem to be able to care for themselves? Are they able to make rational decisions?
- **Possible Danger**—Are their thoughts or actions that individual express that can be harmful to self or others? Suicidal thoughts?

Other situations that require referral are: developmental problems, family dysfunction, substance abuse/addiction, and severe changes in sleep that effect daily function or when you have worked with individual over behavior and emotional problems for eight sessions or more but no improvement is shown. If available, working with a mental health professional can provide the most appropriate resource for certain circumstances.

Observational Characteristics	Examples That Are Out of Context
Cognition: Understanding, memory and concentration.	Looks confused or disoriented. Person has an inappropriate answer to questions.
Affect/ Mood: Eye contact, emotional outburst or lack of emotion.	Suddenly switches emotions. Seems sad or depressed or exaggeratedly happy.
Speech: speed, stability and vocabulary	Speaks too quickly or slowly. Stuttering, long pauses in between words. Vocabulary is not consistent with age.
Logic: Grasp of reality and rationality	Seems to respond to voices or visions. Shows to have racing and/or disconnected thoughts. Unusual ideas
Appearance- Hygiene and attire	Poor Hygiene. Trembles and shakes uncontrollably. Attire is not appropriate to setting.

How to Approach an Individual with a Mental Health Condition¹⁹

It is important to first determine what kind of disruptive behavior should be addressed and develop protocol on how to manage the situation during a communal gathering.

Behavior that may need to be intervened can:

- Interfere significantly with task of gathering.
- Threatens to harm self or others.

Faith leaders will need to assess individual's uncommon behaviors and appearance to determine if individual will need pastoral counseling and/or a referral. This protocol should be addressed with everyone in a congregation, in order to maintain a welcoming and safe environment for individuals who are seeking help.

Before interacting with individual it is important to first consider the safety, of others, the individual and yourself, and also determine if individual has a family member or friend to help calm the individual. Lay leaders can be available to assist the individual during the gathering or to escort or appeal into a safer environment. The individual may have lost hope or perspective which can be a spiritual problem as a well as a mental health condition, so it is important for faith leader to address their will to be there for the individual in need.

Some questions to think about:

- Does there seem to be substance abuse? Has this been a past issue?
- Does the individual have a weapon?
- Are there indications of delusions, hallucinations or seems to show mistrust and suspiciousness towards other?

¹⁹ American Psychiatric Association Foundation: *Mental Health: A Guide for Faith Leaders*.

- Does the individual seem to be on the edge of losing control? If so, a referral to mental health professional may be required.

The National Suicide Prevention Lifeline: 1-800-273- TALK (8255), has trained counselors available 24/7 and has referrals to local resources.

8.5 A Holistic Approach from the Point of View of a Christian Professor in Psychology and Neuroscience²⁰

The person struggling with mental illness needs a holistic approach to treatment that takes into account all three aspects of his or her being, the body, the mind and the spirit. The mentally ill individual needs medical treatment, psychological counseling, and spiritual guidance. That is why comfort, encouragement, and support from those in the church are so important. Studies have shown that religious support offers the psychologically distressed individual resources that are unavailable through more general social support. In fact, it has been shown that religious support can play a key role in recovery from psychiatric illness.

The Body

The first step in the long process of healing is to determine the nature of the underlying problem. A good place to start is with the primary care physician (PCP). In addition, the PCP can likely make a referral to a psychologist or psychiatrist who will further evaluate the person. Once a diagnosis has been made, it is hoped the person will begin treatment. Treatment may include medication and some form of psychotherapy.

²⁰ Stanford, Matthew S., PhD; *Grace for the afflicted A Clinical and Biblical Perspective on Mental Illness*; Intervarsity Press, 2008.

Psychiatric treatment is a significant physical need that all mentally person has, they also have daily needs like: nutrition, shelter, finances and family.

The Mind

Mental disorders are often a battle between reality and wrong or negative thoughts that overwhelm a person's mind. Mental disorders are often treated through psychotherapy, while a relationship with the therapist is of enormous benefit, daily encouragement and support are more important. Is important to educate our self about the disorders, know what types of thoughts, feelings and behaviors are associated with it. This way we can help the individual challenge and change these negative thoughts and behaviors when they occur. One of the simplest and most effective things we can do is just be present with the person and listen. Talking through what is going on in one's mind can be very therapeutic.

The Spirit

Spiritual transformation is possible only by grace through faith. The treatment of physical and mental issues with no regard for a person's need for salvation is of little value.

Pray for those struggling with mental disorders, and pray with them. Be present with them before the Lord. Prayer is an amazing thing. It is an opportunity to interact physically with the almighty God.

James 5:13-16.

- 13 *Is anyone among you in trouble? Let them pray. Is anyone happy? Let them sing songs of praise.*
- 14 *Is anyone among you sick? Let them call the elders of the church to pray over them and anoint them with oil in the name of the Lord.*

- 15 *And the prayer offered in faith will make the sick person well; the Lord will raise them up. If they have sinned, they will be forgiven.*
- 16 *Therefore, confess your sins to each other and pray for each other so that you may be healed. The prayer of a righteous person is powerful and effective”.*

Each time we struggle with illness or weakness is an opportunity “that the works of God might be displayed” (John 9:1-3). This is not a punishment; it is God-ordained opportunity to know Him more intimately. Psychiatry and psychology offer only symptom relief (which is beneficial), but true hope for recovery and healing is found only in Christ.

The Challenge

We are called to share the Good News, to make disciples, to love one another, to bear each other’s burdens, and to pray for one another. The only difference with mental disorders is that we are dealing with thoughts, feelings, and behaviors rather than an observable physical illness or life issue.

People diagnosed with mental disorders often behave in strange and bizarre ways. Their perception of the world and those around them is very different from yours and mine. They maybe perceive your attempts to help them as a threat. They maybe deny that they have a problem. For these reasons the response within the church has been a tendency to withdraw from mentally ill either by categorizing them as sinful or by ignoring the problem altogether.

Our part in all this is to simply keep our heart submissive to God’s leading. That is the first step in ministering effectively to those with mental disorders. God has called us to “rejoice with those who rejoice, and weep with those who weep.” (Romans 12:15)

The involvement of the pastoral staff in ministering to the mentally ill in the fellowship is critical. Much like the pastor and congregational leaders set the course of the local Church; they should play the same role in ministering to mentally ill congregants. This is done by simply meeting with them and directing them to programs, services, and individuals in the church that will then do share the pastor care. The pastoral staff should give serious thought to this issue prior to someone seeking help from them – develop ministries, train lay counselors, and screen community services (e.g., psychiatrists, psychologists, Christian counselors) so they can facilitate the person getting effective Christ-centered treatment and care.

Prevention

Mental disorders are the result from an interaction between biological vulnerabilities and environmental factors. Risk factors such as family conflict, physical or sexual abuse, low self-esteem, and a negative outlook on life are common to a number of disorders. We in the body of Christ have an opportunity to help prevent or limit the development of these disorders. We may not be able to do much about our biology, but we can certainly alter our environment. We can do this by making Christ the central focus of our families and teaching our children how valued they are in the eyes of God.

Characteristics of a Christ-Centered Home Environment

- In developing a Christ-centered home, the parents must be fully committed to each other (Matthew 19:6).
- As parents, we must be humble before God, and recognize that we are powerless without Him. (John 15:5; James 4:6-10).

- God has given us a great responsibility as parents, and we must accept our roles as guardians and teachers (Proverbs 22:6).
- Be intentional in teaching your children about the Lord (Deuteronomy 6:6-9) Read the Bible and pray with them; have family discussions about the faith.
- Make your home and family a safe haven. A “safe haven” is a place in which your children are loved and accepted for who they are, not for how they perform. Children will be drawn to that type of environment, and they will have a better appreciation for the unconditional love and acceptance offered to us through Christ (Romans 8:1-2).
- Be transparent in your faith. Let your children see that Christ is your life. Show them that while the life of a Christian may have its ups and downs, Christ is steadfast in His love and unmovable foundation on which to build our lives (Luke 6:47-48).

The best advice is simply to let grace be your guide and remember that little things matter. If God has placed a mentally ill person in your life and you in his or hers, how will you respond? Will you treat this person the way you would want to be treated if you were suffering? Will you love this person the way Christ loves you?

Chapter 9. Wellness, Spirituality & Mental Health

9.1 Wellness and Spirituality

Spiritual wellness is the ongoing process of discovering and cultivating your spiritual inner self. Spirituality, spiritual wellness and faith can be defined as a belief in something and can take on many different and unique meanings and forms for each individual. Many factors such as religious faith, values, ethics, principles, morals, attitude and gratitude play a part in defining spirituality.

Spiritual wellness can grow into or strengthen a religious belief or have nothing at all to do with religion. Some people have a religious faith belief system, while others have little or none. Everyone is different and we're not to judge others. Everyone can benefit from having some type of spiritual wellness in their life. Regardless of whether or not you believe in a particular religious faith, there are always things to learn about yourself and the world around you.

Spiritual wellness is a wonderful process that can help you find meaning and purpose in your life. It may involve meditation, prayer, affirmations, or specific spiritual practices that support your belief system.

Spiritual wellness is really more about our intentions and how we view and treat ourselves. It's also about how we view and treat everything and everyone else around us.

9.2 Signs of Spiritual Wellness

- Development of a purpose in life.
- Ability to spend reflective time alone.
- Taking time to reflect on the meaning of events in life.
- Having a clear sense of right and wrong, and act accordingly.
- Ability to explain why you believe what you believe.
- Caring and acting for the welfare of others and the environment.
- Being able to practice forgiveness and compassion in life.

Spiritual wellness may not be something that you think much of, yet its impact on your life is unavoidable. The basis of spirituality is discovering a sense of meaningfulness in your life and coming to know that you have a purpose to fulfill. Many factors play a part in defining spirituality - religious faith, beliefs, values, ethics, principles and morals. Some gain spirituality by growing in their personal relationships with others, or through being at peace with nature.

Spirituality allows us to find the inner calm and peace needed to get through whatever life brings, no matter what one's beliefs are or where they may be on your spiritual journey. If we take care of our spirit, we will be able to experience a sense of peace and purpose even when life deals us a severe blow. A strong spirit helps us to survive and thrive with grace, even in the face of difficulty.

9.3 Spiritual and Mental Health

Spirituality and psychiatry, they do not seem to have much in common. But there are becoming increasingly aware of ways in which some aspects of spirituality can offer real benefits for mental health.

What Is Spirituality?

There is no one definition, but in general, spirituality:

- Is something everyone can experience
- Helps us to find meaning and purpose in the things we value
- Can bring hope and healing in times of suffering and loss
- Encourages us to seek the best relationship with ourselves, others and what lies beyond.

These experiences are part of being human, they are just as important to people with intellectual disability or other conditions, such as dementia and head injury, as they are in anybody else.

Spirituality often becomes more important in times of emotional stress, physical and mental illness, loss, bereavement and the approach of death.

All health care tries to relieve pain and to cure, but good health care tries to do more. Spirituality emphasizes the healing of the person, not just the disease. It views life as a journey, where good and bad experiences can help you to learn, develop and mature.

How Is Spirituality Different from Religion?

Religious traditions certainly include individual spirituality, which is universal. But each religion has its own distinct community-based worship, beliefs, sacred texts and traditions.

Spirituality is not necessarily tied to any particular religious belief or tradition. Although culture and beliefs can play a part in spirituality, every person has their own unique experience of spirituality, it can be a personal experience for anyone, with or without a religious belief. It's there for everyone. Spirituality also highlights how connected we are to other people and the world.

What Is Spiritual Health Care?

People with mental health problems have said that they want:

- To feel safe and secure.
- To be treated with dignity and respect.
- To feel that they belong, are valued and trusted.
- Time to express feelings to mental health careers.
- Meaningful activity such as creative art, work or enjoying nature.
- The chance to make sense of their life – including illness and loss.
- Permission/support to develop their relationship with God or the Absolute.

Someone with a religious belief may need:

- A time, a place and privacy in which to pray and worship.
- The chance to explore spiritual concerns.
- To be reassured that the psychiatrist will respect their faith.
- Encouragement to deepen their faith.
- Sometimes – to be helped with forgiveness.

What Difference Can Spirituality Make?

Patients say that they gained:

- Metter self-control, self-esteem and confidence.
- Faster and easier recovery (often through healthy grieving of losses and through recognizing their strengths).
- Better relationships – with self, others and with God/creation/nature.
- A new sense of meaning, hope and peace of mind. This has enabled them to accept and live with continuing problems or to make changes where possible.

A Spiritual Assessment

This should be considered as part of every mental health assessment. Depression or substance misuse, for example, can sometimes reflect a spiritual void in a person's life. Mental health professionals also need to be able to distinguish between a spiritual crisis and a mental illness, particularly when these overlaps.

A helpful way to begin is to be asked, *"Would you say you are spiritual or religious in any way? Please tell me how."* Another useful question is, *"What gives you hope?"* or *"What keeps you going in difficult times?"* The answer to this will usually reveal a person's main spiritual concerns and practices.

Sometimes, a professional may want to use a questionnaire. They will want to find out:

- What helpful knowledge or strengths do you have that can be encouraged?
- What support can your faith community offer?

- A gentle, unhurried approach is important – at its best, exploring spiritual issues can be therapeutic in itself.

Setting the Scene

What is your life all about? Is there something that gives you a sense of meaning or purpose?

The Past

Emotional stress is often caused by a loss, or the threat of loss. Have you had any major losses or bereavements or suffered abuse? How has this affected you?

The Present

Do you feel that you belong and that you are valued? Do you feel safe and respected? Are you and other people able to communicate clearly and freely? Do you feel that there is a spiritual aspect to your current situation? Would it help to involve a chaplain, or someone from your faith community? What needs to be understood about your religious background?

The Future

What do the next few weeks hold for you? What about the next few months or years? Are you worried about death and dying, or about the possibility of an afterlife? Would you want to discuss this more? What are your main fears about the future? Do you feel the need for forgiveness about anything? What, if anything, gives you hope?

The Next Step

What kind of support would work for you? How could you best be helped to get it? Is there someone caring for you with whom you can explore your concerns?

Spiritual Practices

These span a wide range, from the religious to non-religious. You may:

- Belong to a faith tradition and take part in services or other activities with other people.
- Take part in rituals, symbolic practices and other forms of worship.
- Go on pilgrimage and retreats.
- Spend time enjoying nature.
- Give of yourself in acts of compassion (including work, especially teamwork).
- Spend time in meditation, deep reflection or prayer.
- Read scripture.
- Listen to singing and/or playing sacred music, including songs, hymns, psalms and devotional chants.
- Join team sports or other activities that involve co-operation and trust.
- Spend time in contemplative reading (of literature, poetry etc.).
- Appreciate the arts.
- Be creative - painting, sculpture, cookery, gardening etc.
- Make and keep good family relationships.
- Make and keep friendships, especially those with trust and intimacy.

Spiritually-informed Therapies

Over recent years there has been increasing interest in treatments that include the spiritual dimension. In addition to established 12-step programs for alcohol and substance misuse, new approaches such as mindfulness-based cognitive therapy for the treatment of stress, anxiety and depression (MBCT), compassion-focused therapy and forgiveness therapy are now being actively researched and supported.

Spiritual Values and Skills

Spiritual practices can help us to develop the better parts of ourselves. They can help us to become more creative, patient, persistent, honest, kind, compassionate, wise, calm, hopeful and joyful. These are all part of the best health care.

Spiritual skills include:

- Being honest – and able to see yourself as others see you.
- Being able to stay focused in the present, to be alert, unhurried and attentive.
- Being able to rest, relax and create a still, peaceful state of mind.
- Developing a deeper sense of empathy for others.
- Finding the capacity for forgiveness.
- Being able to be with someone who is suffering, while still being hopeful.
- Learning better judgment, for example about when to speak or act, and when to remain silent or do nothing.
- Learning how to give without feeling drained.
- Being able to grieve and let go.

Spirituality emphasizes our connections to other people and the world, which creates the idea of “reciprocity.” This means that the giver and receiver both get something from what happens, that if you help

another person, you help yourself. Many careers naturally develop spiritual skills and values over time as a result of their commitment to those for whom they care. Those being cared for, in turn, can often give help to others in distress.

How to Start?

Spirituality is deeply personal. Try to discover what works best for you.

A three-part daily routine can be helpful:

- A regular quiet time (for prayer, reflection or meditation)
- Study of religious and/or spiritual material
- Making supportive friendships with others with similar spiritual and/or religious aims and aspirations.

You can find out about spiritual practices and traditions from a wide range of religious organizations. Secular spiritual activities are increasingly available and popular. For example, many complementary therapies have a spiritual or holistic element that is not part of any particular religion. The internet, especially internet bookshops, the local yellow pages, health food shops and bookstores are all good places to look.

The Place of Chaplaincy / Pastoral Care

Times have changed. Hospital chaplaincy now involves clergy and others from many faiths, denominations and humanist organizations. Chaplains (also called spiritual advisors) are increasingly part of the teams that provide care both in and outside hospital.

A modern mental health chaplaincy or department of spiritual care should:

- Get on well with local clergy and faith communities.
- Provide information about local religious groups, their traditions and practices.

- Recognize that in some circumstance for an individual to be focusing on religious beliefs and activities can be unhelpful and even harmful.
- Work closely with the mental health team so that spiritual needs can be recognized and helped.
- Make sure that patients know about the help available from departments of spiritual care.

Education and Research

There is evidence that people who belong to a faith community, or who hold religious or spiritual beliefs, have better mental health. So, the relevance of spirituality is now being recognized in courses for mental health care students and practitioners.

9.4 Distinguishing Religious or Spiritual Problems from Mental Illness²¹

A person might express to either a clinician or more likely to a faith leader experiences such as receiving a message from “God,” punishment for sin, a calling to a “great holy cause,” possession by “evil spirits,” or persecution because of a conviction of “spiritual closeness.” It is important to distinguish whether these are symptoms of a mental disorder (for example, delusions, auditory or visual hallucinations, and paranoia), distressing experiences of a religious or spiritual problem, or both.

Mental health illnesses that may have symptoms with a religious or spiritual content include psychotic disorders (for example,

²¹ Reprinted with permission from *Mental Health: A Guide for Faith Leaders* (Copyright ©2016). American Psychiatric Association Foundation. All Rights Reserved.

schizophrenia, schizoaffective disorder), mood disorders (for example, major depression, bipolar disorders), and substance use disorders, among others. Also, for a person of faith, having a mental illness may be seen as a spiritual concern or problem, just as having cancer or a heart attack would.

Clinical needs and spiritual concerns are often inextricably intertwined among people of faith. People of faith who have a mental health condition may experience distressing spiritual concerns (for example, has God forsaken me? Why doesn't God heal me? Is taking medication evidence of a lack of faith?). They may also express distress in a spiritual term consistent with a DSM-5 Religious or Spiritual Problem that is not a mental health condition (for example, prayers not answered, possession by an evil spirit, anxiety over an unforgivable sin, and so on).

In dealing with individuals with both spiritual and mental concerns:

- Meet with the individual and/or family to assess the needs and problems they are experiencing. Faith leaders should be clear about the difference between religious/ spiritual support and professional clinical treatment.
- Consult the policies and guidelines for pastoral care and counseling adopted by your denomination or faith group. These will usually delineate boundaries for both clergy and congregants regarding how pastoral care is to be practiced.
- Take particular note of issues or concerns that require urgent clinical care. For example, suicidal intent or behavior, despondency, impulses to self-harm or harm others. Immediate referral to a clinical care professional is critical when these concerns or issues

arise. The person should be assured that you will be there with spiritual care and support.

- Attend carefully to the language a person uses with you as a faith leader to describe her/his distress. Be aware that mental health conditions are sometimes expressed as religious or spiritual concerns such as committing an “unpardonable” sin, vocational indecision, family problems, and distress that one’s prayers are not answered. Recognize that cultural differences exist in understanding mental health versus religious or spiritual issues.
- Resist prematurely understanding a complex situation as entirely related to religion or spirituality. When mental health issues are not readily apparent, a faith leader may appropriately decide to offer religious counsel and spiritual guidance. If after 4 to 6 sessions, the issues still persist and the congregant exhibits a sense of hopelessness and undiminished distress or additional areas of life dysfunction, referral to a clinical professional should be made for further diagnosis, assessment, and treatment with ongoing support from you.

9.5 Mental Illness & Medication vs. Spiritual Struggles & Biblical Counseling²²

Part of the Christian belief system is that God changes everything, and that because Christ lives in us, everything in our hearts and minds should be fixed. But that doesn't mean we don't sometimes need medical help and community help to do those things.

One might wonder why we can't just read enough Scripture or pray enough. Why can't that cure us? Because the reality is that in some cases, there are physical, chemical, or physiological issues. Yes, prayer

²² *Christianity Today*, Ed Stetzer

can help, and yes, God does still heal in miraculous ways. But more often than not, more prayer and more faith are not the only remedy for mental illness. Medicine is still needed.

There are spiritual struggles. People do go through spiritual darkness, and all people of faith recognize that. It's not perfectly delineated, but there is a difference between a spiritual struggle and a physical mental sickness. They do relate-- yet they are also not the same.

When it comes to spiritual struggles or personal struggles (what some would call "a down time"), faith-based counseling (what we call biblical counseling) is a wonderful tool. But, at the same time, faith-based personal and spiritual struggles are not the same thing as mental illness. And it's exceedingly important for us to identify the difference between them.

If I'm struggling with grief, with sin, or with any host of issues, having people who can encourage me or even counselors in the Christian tradition are wonderful. But there is a difference between that and mental illness, which is a physiological reality. We wouldn't shame someone for getting a virus. Why do we shame someone for having a chemical imbalance that leads him or her to a lifelong struggle with depression? Often there is an expectation-- because we really do believe, as the Apostle Paul writes to the Philippians: "I can do all things through Christ who strengthens me." But that doesn't mean that we don't need the support of the community to do those things. It doesn't mean we don't need medical help to do those things. Christians have to break the stigma and the shame of mental illness.

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Chapter 10. Trauma and Spirituality

An estimated **89.7%** of individuals have experienced at least one traumatic event.

Trauma exposure for individuals experiencing homelessness has been reported at **90% and higher**, **97%** of homeless women with Severe Mental Illness have experienced severe physical and sexual abuse – **87%** experience this abuse both as children and adults.

Current rates of PTSD in people with Severe Mental Illness range from **29 – 43%**

In US, a woman is beaten every **15** seconds, a forcible rape occurs every **6** minutes. Which contributes to persisting physical health, mental health and addiction problems.

An individual's experience of trauma impacts every area of human functioning — physical, mental, behavioral, social and spiritual.

10.1 What is trauma?

Trauma occurs when a person is overwhelmed by an event, a series of events or set of circumstances that are experienced by an individual as physically or emotionally harmful or life threatening and the individual experiences intense fear, horror, and/or helplessness. Extreme stress overwhelms the person's capacity to cope. Which contributes to persisting physical health conditions such as diabetes, heart disease, cancer, and high blood pressure; mental health and addiction problems. An individual's experience of trauma impacts every area of human functioning mental, physical, social, emotional, or spiritual well-being. Trauma causes short and long-term effects, affect coping responses, relationships, and/or developmental tasks.

According to the Diagnostic and Statistical Manual of Mental Disorders, 5th. Edition (DSM-5) traumatic event is one in which a person experiences (witnesses or is confronted with):

- Actual or threatened death
- Serious injury, sexual violence or
- Threat to the physical integrity of self or another

10.2 THE THREE “E’S” OF TRAUMA: EVENT(S), EXPERIENCE OF EVENT(S), AND EFFECT

Events

Events and circumstances may include the actual or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, life-threatening neglect for a child that imperils healthy development. Feelings of humiliation, guilt, shame, betrayal, or silencing often shape the experience of the event. How the event is experienced may be linked to a range of factors including the individual’s cultural beliefs or to the developmental stage of the individual (i.e., an individual may understand and experience events differently at age five, fifteen, or fifty). **It is not the event that determines whether something is traumatic to someone, but the individual’s experience of the event and the meaning they make of it.**

Potential Traumatic Events come from:

Abuse: Emotional, sexual, physical, domestic violence, witnessing violence, bullying, cyberbullying, institutional.

Loss: Death, abandonment, neglect, separation, natural disaster, accidents, terrorism, war.

Chronic Stressors: poverty, racism, invasive medical procedure, community trauma, historical trauma, a family member with substance use disorder.

Traumatic Events are:

- Sudden, unexpected, and extreme
- Usually involve physical harm or perceived life threat (research shows the perception of “life threats” are powerful predictors of the impact of trauma)
- People experience these events as out of their control

Experience

The individual’s experience of these events or circumstances helps to determine whether it is a traumatic event. A particular event may be experienced as traumatic for one individual and not for another. How the individual labels, assigns meaning to, and is disrupted physically and psychologically by an event will contribute to whether or not it is **experienced** as traumatic.

Effects

Traumatic effects, which may range from hyper vigilance or a constant state of arousal, to numbing or avoidance, can eventually wear a person down, physically, mentally, and emotionally. Survivors of trauma have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences. Examples of **adverse effects** include an individual’s inability to cope with the normal stresses and strains of daily living; to trust and benefit from relationships; to manage cognitive processes, such as memory, attention, thinking; to regulate behavior; or to control the expression of emotions.

Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect.

10.3 Trauma Types:

There are three main classifications of Trauma:

Acute trauma (Type I) results from exposure to a single overwhelming event.

Examples: Rape, death of a loved one, natural disaster

Characteristics: Detailed memories, omens, hyper-vigilance, exaggerated startle response, misperceptions or overreactions.

Complex trauma (Type II) results from extended exposure to traumatizing situations. Examples: Prolonged exposure to violence or bullying, profound neglect, series of home removals

Characteristics: Denial and psychological numbing, dissociation, rage, social withdrawal, sense of foreshortened future, suicidal ideation, toxic shame, detachment, self-harming behavior, insomnia, memory problems, fear.

Crossover trauma (Type III) results from a single traumatic event that is devastating enough to have long-lasting effects.

Examples: Mass casualty school shooting, car accident with fatalities involved, refugee dislocation

Characteristics: Perpetual mourning or depression, chronic pain, concentration problems, sleep disturbances, irritability.

Signs of Trauma Responses

Behavioral: Blowing up when being corrected, fighting when criticized or teased, resisting transitions or change, very protective of personal space, reckless or self-destructive behavior, frequently seeking attention, reverting to younger behaviors.

Emotional/Physical: Nightmares or sleeping problems, sensitive to noise or to being touched, fear of being separated from family, difficulty trusting others, feeling very sad, angry, afraid; emotional swings, unexplained medical problems.

Psychological: Confusing what is safe and what is dangerous, trouble focusing or concentrating, difficulty imagining the future.

Long-term Consequences of Unaddressed Trauma

Disease and disability

Ischemic heart disease

Cancer

Chronic lung disease

Chronic emphysema

Asthma

Liver disease

Skeletal fracture

Sexual transmitted disease

Serious Social Problems

Homelessness

Prostitution

Delinquency, violence,
criminal

Inability to sustain
employment

Re-victimisation: rape,
violence

Compromised ability to parent

Negative alterations in self-
perceptions and relations with
others

Poor self-rated health

10.4 Impacts of trauma:

No one is immune to the impact of trauma. Trauma affects the individual, families, and communities by disrupting healthy development adversely affecting relationships, and contributing to mental health issues, including substance abuse, domestic violence, and child abuse. Everyone pays the price when a community produces multi-generations of people with untreated trauma by an increase in crime, loss of wages, and threat to the stability of the family.

The impacts of trauma can also be considered on a continuum:

Traumatic Stress — —PTSD— —Delayed PTSD— —Complex PTSD

- **Traumatic Stress:**

An individual may have a traumatic stress response to a traumatic event but not go on to develop Post Traumatic Stress Disorder (PTSD). A traumatic stress response may include an involuntary reaction to a situation that is experienced as highly stressful but the body is able to fairly quickly regulate itself after the stressful event. For example having a medical procedure that may trigger a significant stress response but it does not interfere significantly in the person's quality of life.

- **PTSD (Post Traumatic Stress Disorder)**

Post-Traumatic Stress Disorder is a more significant intrusive response to a traumatic event. This would include the ongoing experience of: **1) Reliving of the traumatic events, 2) Avoidance of the reminders of the event and 3) Increased arousal as a result of the event.** These three factors are relevant in the formal diagnosis for PTSD. The symptoms are ongoing and become the organizing principle of the individual's life. They interfere significantly with the person's quality of life and can be very debilitating.

- **Delayed Post Traumatic Stress Disorder**

Delayed Post Traumatic Stress Disorder would include all of the symptoms and experiences listed above in the PTSD response but what is relevant to this response/impact is the symptoms may occur much later after the traumatic event has occurred. This can be very confusing and frightening for people who experience a traumatic event and months or maybe even years later begin to develop symptoms of a PTSD response. Epigenetics suggests that trauma can be passed down genetically from generations past, meaning that a traumatic response could be to a trauma one never experienced themselves.

- **Complex Post traumatic Stress Disorder**

This would be considered the most severe form of PTSD. It is directly connected to trauma that occurred and was experienced at an early age in development. The trauma was chronic and ongoing. The trauma would have had a direct impact on brain development as well as the attachment process. The trauma itself involved an individual in a close relationship (i.e. - parent, caregiver, person in a position of authority). This traumatic experience is profoundly disrupting as it can impact the individual's ability to form healthy relationships across the lifespan.

The effects of being traumatized are very individual, and people who have experienced trauma are impacted physically, emotionally, behaviorally, cognitively, spiritually, neurobiologically and relationally. The person may experience aspects in each of these areas or only one or two.

Physically:

Alcoholism and alcohol abuse, chronic obstructive pulmonary disease (COPD), depression, fetal death, health-related quality of life, illicit drug use, ischemic heart disease (IHD), liver disease,

violence, multiple sexual partners, sexually transmitted diseases (STDs), smoking, suicide attempts, unintended pregnancies, early initiation of smoking, early initiation of sexual activity, adolescent pregnancy, sleep disorders, eating disorders, poor immune system, cardiovascular disease, shorter life span.

Emotional:

Depression, feelings of despair and hopelessness and helplessness, guilt, shame, self-blame, self-hatred, feeling damaged, feeling like a "bad" person, anxiety, extreme vulnerability, panic attacks, fearfulness, compulsive and obsessive behaviors, feeling out of control, Irritability, anger and resentment, emotional numbness, frightening thoughts, difficulties in relationships, excessive worry

Behavioral

Self-harm such as cutting, substance abuse, alcohol abuse, gambling, self-destructive behaviors, isolation, choosing friends that may be unhealthy, suicidal behavior, aggression, poor impulse control.

Cognitive

Memory lapses, especially about the trauma, loss of time, being flooded and overwhelmed with recollections of the trauma, difficulty making decisions, decreased ability to concentrate, feeling distracted, withdrawal from normal routine, thoughts of suicide.

Spiritual

Feeling that life has little purpose and meaning, questioning the presence of a power greater than ourselves, questioning one's purpose, questioning "who am I", "where am I going", "do I really matter", thoughts of being evil, especially when abuse is perpetrated

by clergy, feeling disconnected from the world around us, feeling that as well as the individual, the whole race or culture is bad.

Neurobiological

An overproduction of stress hormones that when activated do not return to normal but can endure for hours or days as identified below:

Jittery, trembling, Exaggerated startle response, Alarm system in the brain remains "on"; creating difficulty in reading faces and social cues; misinterpreting other people's behavior or events as threatening, sleep difficulty and the need to avoid situations that are perceived to be frightening, Part of the brain systems change by becoming smaller or bigger than they are supposed to be, Fight, flight, freeze response (which may look different from person to person), Responses are involuntary.

Relational

Difficulty feeling love, trust in relationships, Decreased interest in sexual activity, Emotional distancing from others, Relationships may be characterized by anger and mistrust, Unable to maintain relationships, parenting difficulties.

Effects of Trauma on Children

Children who have suffered trauma are impacted in the following areas:

Attachment

Physical and Psychological development

When a traumatized child does not cope with trauma in a healthy manner, the child may be prone to:

Substance abuse

Mental health issues (such as depression and suicide)

Promiscuity

Criminal behavior

What is Child Traumatic Stress?

A traumatic event can affect the way children view self, the world around them, and their future. A child who is traumatized may not be able to trust others, may not feel safe, and may have difficulty handling life changes. In **early childhood**, trauma can reduce the size of the cortex, which is responsible for complex functions such language and memory. **ACE Study (Adverse Childhood Events)** 2010. The higher the ACE Score, the greater the likelihood of: Severe and persistent emotional problems, health risk behaviors, serious social problems, adult disease and disability, high risk health, behavioral health, correctional and social service costs and poor life expectancy.

Other Contributors of Stress are:

Poverty, discrimination, separations from caregivers and family members, frequent placements (or moving around often), problems at school/work, immigration issues.

10.5 Fight, flight or freeze survival response

Adults, children and youth commonly react to a traumatic event with a fight, flight or freeze survival response. Children and youth often do not understand how their bodies work and the way they responded or continue to respond. Their ability to learn, sleep and make connections with others may be impacted as the majority of their attention and energy is focused on their ongoing survival responses. Children and youth often feel confused by and sometimes shameful about their responses. Helping identify and explain these responses, and

beginning to develop control over them, can help a child or adult make sense of their experience.

Fight:

Crying, hands in fists, desire to punch, rip, flexed/tight jaw, grinding teeth, snarl, fight in eyes, glaring, fight in voice, desire to stomp, kick, smash with legs, feet, feelings of anger/rage, homicidal/suicidal feelings, knotted stomach/nausea, burning stomach, metaphors like bombs, volcanoes erupting.

Flight:

Restless legs, feet /numbness in legs, anxiety/shallow breathing, big/darting eyes, leg/foot movement, reported or observed fidgety-ness, restlessness, feeling trapped, tense, sense of running in life- one activity-next, excessive exercise.

Freeze

Feeling stuck in some part of body, feeling cold/frozen, numb, pale skin, sense of stiffness, heaviness, holding breath/restricted breathing, sense of dread, heart pounding, decreased heart rate (can sometimes increase). Children with toxic stress live much of their lives in fight, flight or fright (freeze) mode. They respond to the world as a place of constant danger. With their brains overloaded with stress hormones and unable function appropriately, they can't focus on learning. They fall behind in school or fail to develop healthy relationships with peers or create problems with teachers and principals because they are unable to trust adults. Some kids do all three. With despair, guilt and frustration pecking away at their psyches, they often find solace in food, alcohol, tobacco, methamphetamines, inappropriate sex, high risk sports, and/or work and over-achievement. **They don't regard these coping methods as problems. Consciously or unconsciously, they use**

them as a solution to escape from depression, anxiety, anger, fear and shame.

Culture and Trauma

When assessing a client's trauma history culture can influence how the child's trauma was perceived by the client and his or her family and how they reacted to the trauma.

Culture also shapes the healing process in the aftermath of trauma and loss in the form of rituals and healing practices.

A few things to consider when assessing trauma history and considering the cultural influence include:

- How the client (and family) communicates
- How the client (and family) responds to the trauma (shame, guilt, blame, denial, acceptance)
- Any stress or vulnerability the client and/or family is experiencing because of their culture (discrimination, stereotyping, poverty, less access to resources)
- How the client (and family) feel about interventions regarding the trauma

"You can never overstate the importance of culture in any relationship"

Intergenerational Trauma

Intergenerational trauma can negatively impact families, as a result of:

- Unresolved emotions and thoughts about a traumatic event
- Negative repeated patterns of behavior including beliefs about parenting
- Untreated/poorly treated substance abuse or severe mental illness

- Poor parent-child relationships and emotional attachment
- Loss of safety (emotional, physical, financial, equity)
- Learned traumatic responses or adaptations to survive may now interfere when situations and relationships are safe.
- Content attitude with the way things are within the family

Case examples: Native Americans, Black/African Americans, Latinos

10.6 Trauma Informed Care (TIC)

*“Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma informed care also emphasizes physical, philological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment. **Trauma-informed care shifts the focus from “What’s wrong with you?” to “What happened to you?”**”*

The key is: The understanding of the traumatic experience, to have empathy, compassion and support for the person.

What it means to be Trauma-Informed

It does not mean to treat the trauma

It does mean to:

- Recognize high level of trauma among those you serve
- Practice self- care
- Look at the whole person, not just the behavior
- Understand the role that victimization plays in the lives of trauma survivors
- Understand that the behaviors you are observing may have protected them in the past.
- Is present focused and aimed at increasing safety.

Trauma “symptoms” as adaptations

It is useful to think of all trauma “symptoms” as adaptations.

Symptoms represent the clients’ attempt to cope *the best way they can* with overwhelming feelings.

When we see “symptoms” in a trauma survivor, it is always significant to ask ourselves: what purpose does this behaviour serve?

Every symptom helped the survivor cope at some point in the past and is still in the present – in some way.

As humans we are incredibly adaptive creatures. If we help the survivor explore how behaviours are an adaptation, we can help them learn to substitute a less problematic behaviour.

Symptoms are Adaptations

Drinking= Self Medication

Cutting= release of pressure

Isolating= avoidance of fear

Aggression= protecting oneself

How do we provide TIC?

Listen

- What is the survivor saying to you?
- What is the survivor not saying?
- How is the survivor saying it?

Inform

- What information do you have that may help?
- What will happen next in the process?
- Why is the information important for them to have?
- How your services can help?

To the best of your ability and within your given time constraints:

- Lose the labels
- Let them tell their story
- Give them time and space to tell their story
- Let the survivor lead
- Respect their voice and choice
- Recognize the survivor's comfort level
- Provide quality interactions and active listening
- Aim to avoid re-victimization
- Appreciates many problem behaviors began as understandable attempts to cope
- Strives to maximize choices for the survivor and control over the healing process
- Seeks to be culturally competent
- Understands each survivor in the context of life experiences and cultural background

The Four R's of Trauma-Informed Care

- **Realize**, realize the widespread impact of trauma and understand potential paths for recovery,
- **Recognize**, recognize the signs and symptoms of trauma in clients, families, staff, and others in your personal sphere.
- **Respond**, respond by fully integrating knowledge about trauma into policies, procedures and practices,
- **Resist Re-traumatization**, resist re-traumatization of children, as well as the adults who care for them. You do this by: Listen more, see more and learning more.

10.7 Psychological treatment for trauma

In order to heal from psychological and emotional trauma, you'll need to resolve the unpleasant feelings and memories you've long avoided, discharge pent-up "fight-or-flight" energy, learn to regulate strong emotions, and rebuild your ability to trust other people. A trauma specialist may use a variety of different therapy approaches in your treatment.

Somatic Experiencing focuses on bodily sensations, rather than thoughts and memories about the traumatic event. By concentrating on what's happening in your body, you can release pent-up trauma-related energy through shaking, crying, and other forms of physical release. The reason to do this is to restore the nervous system's normal cycling between alertness and rest. In order to bring the autonomic nervous system back into alignment and relieve emotional and bodily distress, Somatic Experiencing encourages you to release destructive energy and learn new skills to promote self-regulation.

Trauma-Focused Therapy approaches involve recalling distressing memories with the support of the therapist. This "safe" confrontation with the traumatic experience aims to make the memories less frightening. The therapist also gives the patient tools and advice with which to process the traumatic experience. The aim is to understand and process what happened, and then find a way to better deal with it. This gives the patient the opportunity to realize that remembering and thinking about the traumatic event isn't as frightening as they thought it might be.

Cognitive-Behavioral Therapy (CBT): Helps you process and evaluate your thoughts and feelings about a trauma. The aim of CBT is to learn to change the way you see and interpret experiences, behaviors and

feelings. For instance, you might try to change the way you deal with flashbacks – vivid memories that suddenly overwhelm you and you can't suppress. The therapist will help you identify and interrupt negative thoughts and beliefs and replace them with more accurate, productive, and positive alternatives.

Psychodynamic Therapy: Psychodynamic therapy is a combination of various psychoanalysis-based approaches. Like CBT, it involves gradually revisiting and talking about the traumatic experience(s). The therapist helps the patient to understand how past traumatic events are affecting their current behavior. The aim of this type of therapy is to identify and change the thoughts, feelings and relationship patterns that are currently causing problems.

Eye Movement Desensitization and Reprocessing (EMDR):

Incorporates elements of cognitive-behavioral therapy with eye movements or other forms of rhythmic, left-right stimulation that can “unfreeze” traumatic memories. This technique follows a set plan in eight treatment phases¹. In one of the phases, the therapist moves one finger steadily from side to side in front of the patient. The patient follows the moving finger with their eyes while focusing on a traumatic memory. Instead of (or as well as) using a moving finger, the therapist can use rhythmic sounds or touch – for instance, tapping on the patient's wrist. It is thought that the eye movements or rhythmic touch can help people process information and reduce the fear associated with traumatic memories.

Traumatic Incident Reduction therapy: Can be regarded as a **type of exposure technique**. Its goal is to help clients become more aware of a traumatic event in order to desensitize them, leading the client to dis-identify with the thoughts, emotions and other inner experiences resulting from the trauma. The client begins to see the trauma and inner

experiences as separate from the self. This can occur with just one session, or it can take five or more sessions, depending on the severity of the trauma and how many traumas are being addressed.

A Traumatic Incident Reduction therapy session typically lasts between one and two hours. During TIR, **the client is made to feel safe and secure** in the session, which starts with an assessment to determine what the ideal outcome will be. Then, while the therapist listens without distractions, interjections or judgments, **the client re-tells and re-experiences the trauma** to completion, then does it again, and again. During the re-telling, **clients examine how their emotions and behaviors interact** and how the trauma has affected them and the people in their lives.

10.8 Growth after trauma

Post-traumatic growth (PTG) is a theory that explains the kind of transformation following trauma. It was developed by psychologists Richard Tedeschi, PhD, and Lawrence Calhoun, PhD, in the mid-1990s, and holds that people who endure psychological struggle following adversity can often see positive growth afterward.

Post traumatic growth is defined as the “experience of individuals whose development, at least in some areas has surpassed what was present before the struggle with crises occurred. The individual has not only survived, but has experienced changes that are viewed as important, and that go beyond the status quo” (Tedeschi and Calhoun, 2004). Individuals have described profound changes in their view of “relationships, how they view themselves and their philosophy of life (Joseph and Linley, 2006)... The research suggests that between 30-70% of individuals who experienced trauma also report positive change and growth coming out of the traumatic experience (Joseph and Butler, 2010). What is essential to keep in mind is that post traumatic growth is

not a direct result of trauma but rather related to how the individual struggles as a result of the trauma (Tedeschi and Calhoun, 2004).

There appear to be two traits that make some more likely to experience PTG, says Tedeschi: openness to experience and extraversion. That's because people who are more open are more likely to reconsider their belief systems, says Tedeschi, and extroverts are more likely to be more active in response to trauma and seek out connections with others.

Signs of post-traumatic growth

To evaluate whether and to what extent someone has achieved growth after a trauma, psychologists use a variety of self-report scales. One that was developed by Tedeschi and Calhoun is the Post-Traumatic Growth Inventory (PTGI) (*Journal of Traumatic Stress*, 1996). It looks for positive responses in five areas:

- Appreciation of life
- Relationships with others
- New possibilities in life
- Personal strength
- Spiritual change

Traumatic Grow and Spirituality

People describe things such as an increased sense of personal strength, increased spirituality, improved relationship, an increased appreciation for life and a realization of new possibilities in life. Spirituality is very interesting because it is both a process and an outcome for growth. By that, I mean it is an outcome or end state, but it is also one of the tools which helps cultivate growth.

Post-traumatic growth has been reported across a range of traumas to include physical health problems, accidents, bereavement, abuse, homelessness and combat. The following statements were made by

veterans in regard to their growth. They explained that they experienced a shift from being aware or familiar with their God to a new level of understanding, experiencing, and trusting. They described that spirituality was a tool they developed through trust, practice, and faith. They explained that they felt a difference between knowing about religion and feeling the experience firsthand.

Veterans described not only an increase in spirituality, but that being able to rely and trust in their spirituality supported them. Veterans explained that connecting with their church and feeling supported by others contributed to their growth.

Will described a reinforcement of his spiritual beliefs as well as how they contributed to his growth:

I just trusted in my faith. I knew my beliefs were right...just what I believe in. It's a hard question to elaborate on, but I would say that for growth, I would rely on it more. I knew that if I connected to what I believed in, I could get through a lot of things, and that proved solid and true.

10.9 Resilience

The term resilience has come to mean an individual's ability to overcome adversity and continue his or her normal development.

*"In the context of exposure to significant adversity, resilience is both the capacity of individuals to **navigate** their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to **negotiate** for these resources to be provided in culturally meaningful ways."*

Dr. Michael Unger

Some ways psychologists can help their clients build resiliency is to:

Encourage them to have or develop supportive relationships,

Help them create narratives of their lives to help boost their sense of identity and control,

Hold training workshops for teachers and others who can pass along resilience skills, stressing how people need to learn to be flexible and take risks.

Teach them mindfulness techniques, such as focused breathing.

Taught at-risk boys at an elementary school breathing technique they could use if faced with a situation where they felt angry or hurt.

"Kids who are more resilient are able to get down to zero" on the arousal scale.

Explain that there is no answer to "Why me?" but instead, ask themselves: "What steps can I take to deal effectively with the situation?"

Teach parents to pause before rushing in to solve their kids' problems. Instead, parents should listen to how their children would fix the problem, offering, when indicated, questions that provide direction.

Tell people that mistakes or setbacks are experiences to learn from, not be defeated by.

Protective Factors that Support Resilience:

- Reliable presence of a positive, caring, and protective parent or caregiver.
- Sense of safety at home, school, community
- Cognitive development/problem-solving skills
- Self-regulation
- Coping skills, like physical recreation, relaxation, listen to music, write (poetry, stories, and journal).
- Talent or skill (art, music, sports, academics)

- Spiritual/cultural beliefs
- Stable and nurturing environment
- Self-efficacy

Resilience is different from post-traumatic growth (PTG) in that it involves the ability to more easily rebound from trauma and quickly return to one's normal state of being. Someone who has achieved PTG is likely to be resilient if and when future trauma strikes—but a resiliency mindset can be taught before trauma occurs. "Most everyone has the potential to be resilient if basic adaptive systems and protective factors such as community and family supports are in place," says Teresa LaFromboise, PhD, of the Stanford University Graduate School of Education. Someone who is already resilient when trauma occurs won't experience PTG because a resilient person isn't rocked to the core by an event and doesn't have to seek a new belief system, explains Tedeschi. Less resilient people, on the other hand, may go through distress and confusion as they try to understand why this terrible thing happened to them and what it means for their world view.

10.10 What Is Spirituality?

Spirituality is a personal experience with many definitions. Spirituality might be defined as, "an inner belief system providing an individual with meaning and purpose in life, a sense of the sacredness of life, and a vision for the betterment of the world." Other definitions emphasize "a connection to that which transcends the self." The connection might be to God, a higher power, a universal energy, the sacred, or to nature. Researchers in the field of spirituality have suggested three useful dimensions for thinking about one's spirituality:

- 1) Beliefs
- 2) Spiritual practices
- 3) Spiritual experiences

Currently in the U.S., opinion surveys consistently find that most people endorse a belief in God or higher power. In a 2017 Gallup Poll 89 percent of respondents indicated a belief in God, while only 10 percent stated they did not believe in God. Many of these individuals would describe religion or spirituality as the most important source of strength and direction for their lives. Because spirituality plays such a significant and central role in the lives of many people, it is likely to be affected by trauma, and in turn to affect the survivor's reaction to the trauma.

Historically, there have been differences between the beliefs of scientists and healthcare practitioners and those of the general population. For example, one study indicated that only 66 percent of psychologists report a "belief in God." These differences in viewpoint may contribute to the lack of research on spirituality. The beliefs and training experiences of practitioners may also influence whether and how spirituality is incorporated into therapy.

Relationship of Trauma to Spirituality

Evidence suggests that trauma can produce both positive and negative effects on the spiritual experiences and perceptions of individuals. For example, depression and loneliness can lead to feelings of abandonment and loss of faith in God. These effects may change as time passes and a person moves further away from the acute phase of trauma recovery.

On the positive side, some individuals experience increased appreciation of life, greater perceived closeness to God, increased sense of purpose in life, and enhanced spiritual well-being even following devastating events such as disasters and rape. For others, trauma can be associated with loss of faith, diminished participation in religious or

spiritual activities, changes in belief, feelings of being abandoned or punished by God, and loss of meaning and purpose for living.

Aspects of spirituality are associated with positive outcomes, even when trauma survivors develop psychiatric difficulties such as Post Traumatic Stress Disorder (PTSD), Military Sexual Trauma (MST) or depression. Research also indicates that healthy spirituality is often associated with lower levels of symptoms and clinical problems in some trauma populations. For example, anger, rage, and a desire for revenge following trauma may be tempered by forgiveness, spiritual beliefs, or spiritual practices.

Suggestions have been made about the pathways by which spirituality might affect the recovery trajectory for survivors of traumatic events.

Spirituality may improve post-trauma outcomes through:

- 1) Reduction of behavioral risks through healthy religious lifestyles (e.g., less drinking or smoking).
- 2) Expanded social support through involvement in spiritual communities.
- 3) Enhancement of coping skills and helpful ways of understanding trauma that result in meaning-making.
- 4) Physiological mechanisms such as activation of the "relaxation response" through prayer or meditation.
- 5) Feelings of isolation, loneliness, and depression related to grief and loss may be lessened by the social support of a spiritual community. Being part of a spiritual community places

survivors among caring individuals who may provide encouragement and emotional support, as well as possible instrumental support in the form of physical or even financial assistance in times of trouble.

What Issues Most Often Involve Spirituality?

- **Making Meaning of the Trauma Experience**—Spiritual beliefs may influence the trauma survivor's ability to make meaning out of the trauma experience. In turn, the meaning drawn can have a significant impact on the survivor's symptoms and functioning. Several studies have indicated that negative thoughts or attributions about God, such as "God has abandoned me," and "God is punishing me," or, being angry at God are associated with a number of poor clinical outcomes. Research suggests that these types of thoughts can be associated with poorer physical and mental health, and increased use of substances. One study of Veterans being treated for PTSD and MST found that negative religious coping and lack of forgiveness were both associated with worse PTSD, MST and depression symptoms.

Recovery of meaning in life may be achieved through changed ways of thinking, involvement in meaningful activities, or through rituals experienced as part of religious or spiritual involvement. Some researchers have suggested that traumatic events frequently challenge one's core beliefs about safety, self-worth, and the meaning of life. For individuals whose core values are spiritually grounded, traumatic events may give rise to questions about the fundamental nature of the relationship between the creator and humankind. Survivors may question their belief in a loving, all-powerful God when the innocent are

subjected to traumatic victimization. In this way, traumatic experiences may become a starting point for discussion of the many ways in which survivors define what it is to have "faith." Discussions of faith should be encouraged by therapist but referred to faith leaders.

- **Guilt and Moral Injury**— additionally, in certain types of traumatic events, such as war, an individual can be both victim and perpetrator of trauma. For example, a soldier during their war-zone service could be exposed to the injury and death of others, be wounded himself or herself, and have a role in killing the enemy. It is also possible for two core elements of a person's world-view - for example, patriotism and faith - to be in conflict, creating doubt and uncertainty about the right course of action. These experiences can sometimes lead to long-lasting difficult spiritual and moral questions. The result may be loss of faith, increased guilt and self-blame, and alienation from other people and from God. Individuals may experience a disconnection between the beliefs they were raised with, their expectations about what military service would be like, and their actual war-zone experiences.
- **Grief and Bereavement**— Grief and loss can be significant issues that survivors must cope with in the aftermath of trauma. In US society, spirituality is frequently utilized to cope with traumatic death and loss. Researchers noted after the 9/11 terrorist attacks that 90% of respondents reported turning to "prayer, religion, or spiritual feelings" as a coping mechanism. In general, research suggests there is a positive association between spirituality and grief recovery for survivors of traumatic loss. Researchers suggest that for many spirituality provides a frame through

which survivors can "make sense" of the loss. Additionally, survivors may benefit from supportive relationships often provided by spiritual communities.

Suggestions for Pastoral Care Professionals

- **Learn about trauma and PTSD and MST**—providing spiritual guidance following a traumatic event can be challenging. Pastoral professionals should keep up to date with the latest in research and treatment for trauma, PTSD and MST. Being knowledgeable about the effects of trauma enables providers to better serve those seeking care. Pastoral professionals can refer those who are dealing with trauma to therapist who are trained and understand PTSD and MST treatment.
- **Collaborate with and refer to mental health care providers**—If someone under pastoral care has a history of trauma exposure and appears to be struggling, consider referring him or her to a mental health care provider. Refer to Where to Get Help for PTSD <http://www.ptsd.va.gov/public/where-to-get-help.asp>. It is especially important to get help if the survivor is suicidal.

Suggestions for Mental Health Care Professionals

- **Assess spiritual beliefs and needs**—Depending on their beliefs, trauma survivors may benefit from adding a spiritual dimension to their recovery. A brief assessment of the impact of trauma on spirituality and the role spirituality might play in recovery has been suggested for use following disasters. These questions are likely a useful starting place for survivors of other types of trauma as well.

- Are you affiliated with a religious or spiritual community?
 - Do you see yourself as a religious or spiritual person? If so, in what way?
 - Has the event affected your religiousness and if so, in what ways?
 - Has your religion or spirituality been involved in the way you have coped with this event? If so, in what way?
 - Providers interested in assessing these issues more systematically can use a brief questionnaire measure of multiple domains of religion and spirituality that was created by the National Institute of Health.
- **Collaborate with and refer to pastoral care professionals –** Spirituality may affect a number of important PTSD and MST symptoms. Mental health care providers may wish to consult with a pastoral care professional on the best ways to incorporate a survivor's spiritual beliefs and practices into treatment. Alternatively, you could encourage the survivor to consult directly with a pastoral care professional.

For clients with PTSD and MTS, their spirituality could affect important clinical issues, such as:

- **Isolation and Social Withdrawal –** Defining spirituality as a connection to the sacred, and encouraging trauma survivors to seek supportive, healthy communities can directly address these symptoms.

- **Guilt and Shame**—though not part of the diagnostic criteria for PTSD, guilt and shame are recognized as important clinical issues. Spirituality may lead to self-forgiveness and an emphasis on compassion toward self.
- **Anger and Irritability**—Beliefs and practices related to forgiveness can address anger and chronic hostile attitudes that lead to social isolation and poor relationships with others.
- **Hyper vigilance, Anxiety, and Physiological Arousal**—inwardly directed spiritual practices such as mindfulness, meditation, and prayer may help reduce hyper arousal.
- **Foreshortened Future and Loss of Interest in Activities**—Rediscovery of meaning and purpose in one's life may potentially have enormous impact on these symptoms

Research suggests that for many trauma survivors, spirituality may be a resource that can be associated with resilience and recovery. However, for some, the circumstances of the trauma may lead to the questioning of important and previously sustaining beliefs. This can lead to spiritual struggle or even loss of faith. It is important for helping professionals to be comfortable asking about how spirituality has been affected by trauma, and to what role spirituality is playing within the recovery process following trauma and to help connect the person with appropriate spiritual services.

10.11 Christian Spiritual Perspective

The Scriptures teach five significant principles about trauma and suffering:

- God is present and in control of our suffering
- God is good and cares for us
- Suffering is an opportunity to grow closer to God
- Jesus understands our suffering
- Our identity—who we are—is not defined by traumatic events or suffering but is grounded in Christ.

First, God is present and in control of our suffering. We often feel the furthest from God in times of great suffering and pain. From our limited human perspective, pain and suffering seem contrary to our idea of a sovereign God. Suffering should not cause us to question God's sovereignty. God is sovereign, despite our circumstances. He created all things, and He controls all things. God is in control of our circumstances.

Second, God loves us, and that love is evident in our redemptive history. He is patient and gracious. God is indeed good, and He longs to be in an ever-deepening relationship with us. In James 1:2, we are told to “consider it all joy” when we go through difficult times. We must understand that trials or difficult times in our lives are opportunities God allows so we will recognize our need for complete dependence on Him (John 15:5).

The **third** truth we are called to recognize is that through our trials and suffering we have an opportunity to draw closer to God. During the easy times we often become self-reliant, forgetting our need for God. It is in the hard times, when our faith is tested, that we recognize our need for complete dependency on Him. James tells us that persevering

through the difficult times develops a mature and complete faith (James 1:4). Suffering is a necessary process of progress. Draw near to Him during difficult times and submit to the Holy Spirit within us; he draws near to us, and the intimacy of our relationship grows (Galatians 4:6).

A **fourth** truth is that we do not worship an unapproachable God. We worship a God who knows what it is to be human. Jesus knows what it is to suffer. Just think about Jesus' life for a moment. He didn't experience just one traumatic event during His time on earth—His whole life was full of suffering. We can take great comfort in the fact that God can relate to us on our level; He understands what it is to suffer.

Finally, our identity is grounded in Christ. God does not see you as a victim. He sees you as His child. We sit at the right hand of the Father! We have His righteousness! We must not allow tragedy or circumstances to define who we are or how we live. We have His very life within us, and we must choose to live out of that truth.

The Church can help – but how?

The Church is brilliantly positioned to help trauma survivors find their way back to community – we just don't know how.

Churches should be:

- Places to grow, heal, and change
- Safest place to be ourselves, no matter what “ourselves” may be
- Best place to recover from tragedy
- Places that promote “not judging” or looking down on others

Safe churches:

- Protect the vulnerable
- Welcome and accept each other
- Prayer requests
- Don't gossip

- Discourage cliques
- Consider the impact of our words

Safety sounds like:

- “Would you like to join us?”
- “I believe you”
- “I’m sorry that happened to you”
- It might sound like . . . silence

Safety Doesn’t Sound Like:

- “What was she wearing?”
- “He’s a guy; he probably liked it”
- “Why didn’t you fight? Or run?”
- Beware of church-y platitudes

How do we connect with people who aren’t even raising their hands and asking for help?

Invite People into Healing Spaces:

- Bible Studies
- Supportive Ministries
- Workshops
- Celebrate Recovery
- NAMI meetings
- Grace alliance group

Resources:

<https://www.traumainformedcare.chcs.org/>

<https://www.acesconnection.com/>

<https://www.helpguide.org/?s=trauma>

<https://store.samhsa.gov/system/files/sma15-4912.pdf>

<https://www.parentcenterhub.org/trauma-informed-care/>

<http://www.traumainformedcareproject.org/>

<http://www.yourlifeyourvoice.org/Pages/home.aspx>

<http://trauma-recovery.ca/>

<https://www.emdr.com/what-is-emdr/>

<https://www.integration.samhsa.gov/clinical-practice/trauma-informed>

<https://mentalhealthgateway.org/>

Chapter 10 Notes

Chapter 11. Faith and Spirituality

11.1 Principles and Values in Mental Health and Spirituality

The purpose of this document is not intended to expect pastors or religious community leaders to become psychologists, psychiatrists or mental health professionals in county agencies. Rather, it is to help them in their pastoral work with those who suffer from mental illness. We also want to express to mental health professionals the spiritual principle and values that govern pastoral counseling in a community of faith.

The growing need for the care of people with mental health problems has generated a dialogue between those organizations working in this field and communities of faith. In response to this dialogue we have prepared this document.

11.2 Fundamental Principles in Spiritual Life and Biblical Counseling

1. *Human beings are a creation of God, made in the Creator's image and likeness.* Human beings were created with a singular mental and spiritual capacity that distinguish them from any other creature.
 - a. ²⁶ Then God said, "Let us make man in our image, after our likeness..."²⁷ So God created man in his own image, in the image of God he created him; male and female he created them. Genesis 1:26a, 27.

- b. ³¹ God saw everything that he had made, and behold, it was very good. Genesis 1:31.
 - c. ⁴ I say: "What is man that you are mindful of him, and the son of man that you care for him? ⁵ Yet you have made him a little lower than the heavenly beings, and crowned him with glory and honor. Psalm 8:4-5.
- 2. *Man failed to fulfill the purpose for which he was created.* This means in the Hispanic culture rooted in Christianity, that although man and woman were created in God's image and likeness, in their disobedience to God they moved away from their Creator, the relationship to one another and to creation was damaged and continues to deteriorate to this day. This was in its infancy in the context of a life which had everything and was in perfect harmony.
 - a. ⁹ But the Lord God called to the man and said to him, "Where are you?" ¹⁰ And he said, "I heard the sound of you in the garden, and I was afraid, because I was naked, and I hid myself." Genesis 3:9-10.
 - b. ¹¹ He said, "Who told you that you were naked? Have you eaten of the tree of which I commanded you not to eat?" ¹² The man said, "The woman whom you gave to be with me, she gave me fruit of the tree, and I ate." ¹³ Then the Lord God said to the woman, "What is this that you have done?" The woman said, "The serpent deceived me, and I ate." Genesis 3:11-13.

3. *God is sovereign creator.* No matter what man does, God does not change his love for his creation and for humanity in particular. His love does not depend on the actions of human beings.
 - a. ¹⁶ For God so loved the world, that he gave his only Son, that whoever believes in him should not perish but have eternal life. John 3:16.
 - b. ³ The Lord appeared to him from far away, "I have loved you with an everlasting love; therefore, I have continued my faithfulness to you." Jeremiah 31:3.
4. *God is love,* and in his love He is determined to rescue his human creation. This develops from primitive times of Creation to restore his image in human beings out of love. God's love does not depend on what humans do or undo, God's love is infinite, infallible, and inerrant.
 - a. ⁹ In all their affliction he was afflicted, and the angel of his presence saved them; in his love and in his pity he redeemed them; he lifted them up and carried them, all the days of old. Isaiah 63:9.
 - b. ³ He restores my soul. He leads me in paths of righteousness for his name's sake. Psalm 23:3.
 - c. ³⁵ For I will defend this city to save it, for my own sake and of the sake of my servant David. Isaiah 37:35a.
5. *God has a historic plan of redemption and restoration.* In this context of God's Historic Plan for Salvation, we must talk about two Adams,

the old and the new. Old Adam, who failed in his obedience and who brought with it condemnation and misery to the human race when he lived in the context of beauty and perfection. The second Adam in his obedience he brings redemption and wellbeing to humanity, living in the context of a World already in decline and chaos.

- a. ²² For as in Adam all die, so also in Christ shall all be made alive. ⁴⁵ Thus it is written, "The first man Adam became a living being"; the last Adam became a life-giving spirit. 1 Corinthians 15:22, 45.

6. *Spiritual Disciplines.* The biblical ministry requires spiritual disciplines of great benefit to all. Biblical pastoral counseling as its name indicates is founded in the Bible. Hence we draw the disciplines. When we speak of these spiritual principles and disciplines, we must take into account that our society in general, is looking for solutions to its problems in an easy and practical way but without serious commitment that is based on these principles and values.

- a. ¹¹ For the moment all discipline seems painful rather than pleasant, but later it yields the peaceful fruit of righteousness to those who have been trained by it. ¹² Therefore lift your drooping hands and strengthen your weak knees, ¹³ and make straight paths for your feet, so that what is lame may not be put out of joint but rather be healed. Hebrews 12:11-13.

7. The mental and spiritual health of each person is serious and should not be taken lightly, but with the seriousness it deserves, dedicating the necessary time for complete healing and restoration.
8. The person with mental health problems should be treated with the dignity of someone who bears the image of God.
 - a. ¹ O Lord, you have searched me and known me! ² You know when I sit down and when I rise up; you discern my thoughts from afar. ³ You search out my path and my lying down and are acquainted with all my ways. ⁴ Even before a word is on my tongue, behold, O Lord, you know it altogether. ⁵ You hem me in, behind and before, and lay your hand upon me. ⁶ Such knowledge is too wonderful for me; it is high; I cannot attain it. ⁷ Where shall I go from your Spirit? Or where shall I flee from your presence? ⁸ If I ascend to heaven, you are there! If I make my bed in Sheol, you are there! ⁹ If I take the wings of the morning and dwell in the uttermost parts of the sea, ¹⁰ even there your hand shall lead me, and your right hand shall hold me. ¹¹ If I say, "Surely the darkness shall cover me, and the light about me be night," ¹² even the darkness is not dark to you; the night is bright as the day, for darkness is as light with you! ¹³ For you formed my inward parts; you knitted me together in my mother's womb. ¹⁴ I praise you, for I am fearfully and wonderfully made. Wonderful are your works; my soul knows it very well. ¹⁵ My frame was not hidden from you, when I was being made in secret, intricately woven in the depths of the earth. ¹⁶ Your eyes saw my unformed substance; in your book were written, every one of them, the days that were formed for me, when as yet there was none of them. ¹⁷ How precious to me are your

thoughts, O God! How vast is the sum of them! Psalm 139:1-17.

9. The total restoration of a mentally ill person is of divine interest and should be of the Christian community as well.
 - a. “More than ever, I think of the gift people with disabilities or mental illness possess to create such a community. Their weakness is God’s strength; their dependency is God’s invitation to create bonds of love and support; their poverty is one of the ways in which God brings us the beatitudes of his Kingdom.” Henry Nouwen, “The Gulf between East and West.” New Oxford Review, May 1994.
10. As a community of faith in a God who has spoken in different ways through history, we believe that the Bible is the rule of faith and conduct of our daily lives.
11. The Bible is a book, rich in real examples, of which we can learn to help those with mental health or behavioral problems.
 - a. King Saul and his outburst of anger
 - b. Zacchaeus and self-esteem
 - c. Cain and Abel and violence in the family

11.3 Core Values & Spiritual Life in Biblical Counseling

Biblical pastoral counseling seeks to help mentally ill people to strengthen the following values in their personal, family, and social life, which will be key in how they face their illness.

Love The love that existed before any other human love touched us, is God’s love. God’s love is evident in the sacred texts. It is an

unconditional love. To know we are accepted as we are, by a loving God, can heal our brokenness and free us to live our lives more fully. People with mental disorders are absorbed in the symptoms of their illness, they commonly feel guilt and shame, and feel less deserving of God's love. Those of us who live with them, whether it be their relatives, their friends, or their spiritual leaders, can be instruments of God's unconditional love, giving comfort and assuring them they are not alone in times of personal darkness.

And if I have prophetic powers, and understand all mysteries and all knowledge, and if I have all faith, so as to remove mountains, but have not love, I am nothing. 1 Corinthians 13:2. So now faith, hope, and love abide, these three; but the greatest of these is love. 1 Corinthians 13:13.

Faith, Faith in God fills us with Hope! Faith in a God who comes to redeem helps us to see into the future with a strong character. Now faith is the assurance of things hoped for, the conviction of things not seen. Hebrews 11:1.

Hope, ¹³ May the God of hope fill you with all joy and peace in believing, so that by the power of the Holy Spirit you may abound in hope. Romans 15:13.

⁵ For God alone, O my soul, wait in silence, for my hope is from him. Psalm 62:5.

⁵ For you, O Lord, are my hope, my trust, O Lord, from my youth. Psalm 71:5.

³ Not only that, but we rejoice in our sufferings, knowing that suffering produces endurance, ⁴ and endurance produces character, and character produces hope,

⁵ and hope does not put us to shame, because God's love has been poured into our hearts through the Holy Spirit who has been given to us. Romans 5:3-5.

Joy, Hope enables the believer to rejoice in the midst of suffering. And do not be grieved, for the joy of the Lord is your strength." Nehemiah 8:10.

Peace, Peace is essential in our daily lives. True peace is the one that begins when God is at peace with us. San Augustine said, "We find ourselves until we meet our Creator." That encounter with our God guides us to a reconciliation with those around us. The concept of Peace is Shalom which includes those traits of wellbeing and plenitude, to live and enjoy an inner peace manifested in our lives. Peace I leave with you; my peace I give to you. Not as the world gives do I give to you. Let not your hearts be troubled, neither let them be afraid. John 14:27.

Patience, The letter to Hebrews says: "We have this as a sure and steadfast anchor of the soul, like the anchor holds firm the ship." (Hebrews 6:19). Hope is not linear, something that we can expect to happen in the future. Hope is not simply a positive thought that everything will be all right. Hope is not an escape. It is not tied to any religious doctrine or dogma, but arises from the depths of our being.

To hear stories of triumphs of our faith traditions, or stories of real-life people who have persevered despite their personal struggles, can give us hope. We may compare them with our dark times and find that we have also persevered. This will give us hope when we confront a new crisis. Louisa May Alcott describes it in this way: "I am not afraid of storms, for I have been learning to sail my ship."

A very particular role to be played by communities of faith, is to be recipients of hope for all of those who are afflicted. These communities can remind us that God does not surrender or abandon us. It is to have the love and support of others which give us the strength not to give up, even if the future looks bleak.

Hope is founded on the unwavering love of God, which has been at our side in the past, is still with us in the present, and will be with us in the future. God is present in our pain, and brings out from there our transformation. To believe in the future with hope is a conscious decision of faith, living each day with a positive attitude and expectation of what will come.²³

Meekness, Meekness does not imply weakness. Even more, meekness is home to a quiet strength that confuses those who consider it a weakness. Blessed are the meek, for they shall inherit the earth. Matthew 5:5.

Temperance, Reaching a level of maturity that helps us to be even-handed when temperance is required! It's not easy, but let's consider the old Roma phrase, "Roman perseverance never signs peace with defeat. For God gave us a spirit not of fear but of power and love and self-control. 2 Timothy 1:7.

²³ Rev. Susan Gregg-Schroeder. *Mental Illness and Families of Faith: Diverse Ways Congregations Can Respond. Resource / Study Guide for Clergy and Faith Communities*, 2010. Mental Health Ministries Coordinator.

11.4 Roles Differences between Pastoral Counseling & Secular Psychotherapy

Pastoral counseling is a term that has different meanings depending on the context. Many people think of it as the spiritual or Biblical guidance offered by the pastor of a church, primarily to members of the congregation but also, at times, to non-church members who may come to the church seeking spiritual help during times of crisis or uncertainty. In this specific context, pastoral counseling is a typical and very frequent part of the job – i.e., part of “tending the flock” – for any member of the clergy. As a general rule, however, this type of pastoral “counseling” isn’t to be construed as formal psychotherapy or mental health counseling.

Pastoral counseling also refers to a specialized form of psychotherapy or counseling offered by licensed mental health professionals who have been formally trained in pastoral counseling (which is the primary focus of this article). In addition to their training in psychology or a related field, these professional counselors have in-depth graduate level training in theology and religion.

This enables them to address the psycho spiritual issues, as well as the mental health issues, with which many people struggle. It also gives them a unique qualification and perspective that most secular counselors and therapists lack.

Although the terms “pastoral counseling” and “pastoral psychotherapy” are often used interchangeably, some prefer to establish a distinction between the two.

This is primarily due to the fact that counseling, as a general rule, is usually a more short-term, solution-focused approach to dealing with a problem. Psychotherapy, on the other hand, usually implies a longer-term, more in-depth therapeutic relationship between therapist and client. (This distinction is not meant to diminish either term, nor make one seem superior or more important than the other.)

In many ways, pastoral counseling is very similar to traditional counseling and secular approaches to psychotherapy. However, there are several things that set it apart and make it truly distinct in its own right.

These include:

- The vast majority of pastoral counselors believe in the Biblical God or some other higher / divine power.
- Spiritual issues, faith, and personal beliefs play a prominent role in the counseling process; pastoral counselors help you use your beliefs to resolve and / or cope with the challenges in your life.
- Pastoral counselors have a strong background in theology or a related field, and are well-trained to handle issues related to faith and spirituality.

Pastoral counseling differs from other forms of therapy and counseling in other significant ways as well. For example, it's not uncommon for pastoral counselors to encourage prayer and use it in the session in a therapeutic way (depending on the client). They may also encourage clients to establish a connection (or strengthen the one they have) with their religious community. It should be noted that the role of a pastoral counselor does not include preaching, judging, shaming, blaming (e.g.

“you’re suffering because of sin in your life” or “God’s punishing you”), or disrespecting their clients’ beliefs. Like other mental health therapists and counselors, they are expected to create a safe and caring environment for their clients; one that includes genuine support, empathy, compassion, and sensitivity to their clients’ needs and concerns.

11.5 Advantages of Attending a Community of Faith

The Communities of Faith have in their center of beliefs and values; Love, Faith and Hope. These three values are essential and fundamental in the life of the community. They are distinguished by having a sense of family. They care for each other, taking care of one to another and encouraging one another.

And he answered, “You shall love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind, and your neighbor as yourself.” Luke 10:27

A place where that the one of low mood, finds joy and a reason of being and to continue with strength and enthusiasm. Where the widow, the fatherless and foreigners find a warm home. A place for those who are tired and seek an encouraging and invigorating rest.

We who are strong have an obligation to bear with the failings of the weak, and not to please ourselves. “Let each of us please his neighbor for his good, to build him up”. Romans 15:1-2

A place where there is empathy with one another. It suffers with those who suffer and rejoice with those who rejoice. It is one of the most beautiful calls of God, being there for others.

“Rejoice with those who rejoice, weep with those who weep”. Romans 12:15

With regular expressions of love, as being inclusive communities, meaning that those who are visiting are welcome and invited to a fellowship in the Lord.

Through its various ministries / groups of children, youth, women, men are invited to become part of the family of God and to walk together with Him. In this journey of God with common and ordinary people, God does extraordinary and shocking things.

Most of these communities offer various activities such as retreats, Sunday school classes, Bible study groups, workshops, etc. for each age or group of people. Each of these activities are aimed at strengthening the Faith, Hope and Love of its members and sympathizers.

“And let us consider how to stir up one another to love and good works”, Hebrews 10:24

Small churches are important in the sense of the manifestations and bonds of love are very strong, there is a stronger fellowship. Large churches probably have more services and greater diversity. In large churches there are still departments of biblical counseling services and even in some cases they have their own accredited professional therapists in the state.

The faith community is a therapeutic community, a community healing, restorative community.

Spirituality is not a single personal matter, but has its realization in the community of God. This goes against the current trend, where a growing selfish individualism despises community life, and plunges into a dangerous solitude to a pace of life devoid of family and moral values, to become involved in disappointments, frustrations, setbacks of life and other adverse situations, has no *damping* in his fall.

Therefore, the importance of living in a community of faith is essential for every person. We must find a community of faith near the home of the person in need.

Ask for the ministries that this community has. In case it does not have a ministry of interest to the person, look in another community of faith that is not far from home.

For you were called to freedom, brothers. Only do not use your freedom as an opportunity for the flesh, but through love serve one another". Galatians 5:13

Chapter 11 Notes

Chapter 12. Using Faith and Spirituality as Part of Recovery

12.1 Using Faith and Spirituality as a Part of Recovery

The Christian community has a role in the recovery process for the individual and families. They are **NOT** the answer, rather an integral part of the process. Faith support can help individuals experience the abundant life Christ offers.

Content of this chapter:

- 1) Why mental illness is not just a spiritual issue
- 2) Churches appropriate response
- 3) Where is God in the process?
- 4) Providing spiritual support

12.2 Why Mental Illness Is Not Just a Spiritual Issue

Mental illness affects the body, mind, spirit (Matt 22:37 - Love the Lord your God with all your heart, with all your soul and all your mind.)

According to the Bible, mankind is distinct from all the rest of creation, including the animals, in that he is made in the image of God. As God is a tripartite -- Father, Son and Holy Spirit -- so man is three parts -- **body, soul and spirit.**

Man is made up of physical material, the body that can be seen and touched. But he is also made up of immaterial aspects, which are intangible—this includes the soul, spirit, intellect, will, emotions, conscience, and so forth. These immaterial characteristics exist

beyond the physical lifespan of the human body and are therefore eternal.

These immaterial aspects -- the spirit, soul, heart, conscience, mind and emotions—make up the whole personality. The Bible makes it clear that the soul and spirit are the primary immaterial aspects of humanity, while the body is the physical container that holds them on this earth.²⁴

Mental illness is a complex medical condition that presents with a variety of symptoms that keeps a person from functioning normally. Mental illness affects the body, mind, and spirit. Addressing and treating mental illness from this holistic understanding has proved to be most effective in helping people find recovery.

Up to 80% of those treated for depression show an improvement in their symptoms generally within four to six weeks of beginning medication, psychotherapy, attending support groups or a combination of these treatments. (National Institute of Health, 1998)

Body

There is a physiological component to the illness which affects the brain, an organ of the body. Much like diabetes which stems from the pancreas not working correctly, mental illness is a function of the brain not working correctly. Because the brain is an organ, it needs to be treated physically which includes medication, diet, exercise, proper sleep and rest, as well as relaxation.

²⁴ <http://www1.cbn.com/questions/what-are-the-three-parts-of-man>

Should Christians Use Psychotropic Medications?

It's interesting that the use of psychotropic medication is often debated among Christian leaders, yet medications for a myriad of other diseases and illnesses are not.

Contrary to popular belief, antidepressants are *NOT* happy pills. If a person who does not suffer from depression were to take antidepressants, they will not be happier in six weeks. They will however suffer the many side effects of the medication - nausea, tremors, dry mouth, fatigue, lack of libido, weight gain, insomnia, etc. Let's contrast what's going on in the body of someone with diabetes to someone with a mental illness:

When you have diabetes, your body either doesn't make enough insulin or can't use its own insulin as well as it should. This causes sugars to build up in your blood. Diabetes can cause serious health complications including heart disease, blindness, kidney failure, and lower-extremity amputations.

When you have mental illness, the underlying biological basis is a depletion in the levels of neurotransmitters such as serotonin, norepinephrine, and/or dopamine in the central nervous system. Antidepressants increase the brain's concentration of various neurotransmitters. Antipsychotics can alter the effect of certain chemicals in the brain, called dopamine, serotonin, noradrenaline and acetylcholine. These chemicals have the effect of changing your behavior, mood and emotions. Dopamine is the main chemical that these medicines have an effect on.

Untreated mental illness can have devastating consequences not only in the life of the sufferer, but in the lives of their families and friends.

The Mind

The mind is also affected when someone struggles with a mental health disorder as a fierce psychological battle wages between reality and negative thoughts that overwhelm the individual. Cognitive dysfunction and distorted thinking can lead to unusual behaviors.

Some of the dysfunctional behaviors can include: lethargy, isolation, extreme mood swings, overspending, and hyper sexuality.

Distorted Thinking Patterns as Identified by Dr. David Burns (Cognitive Distortions)

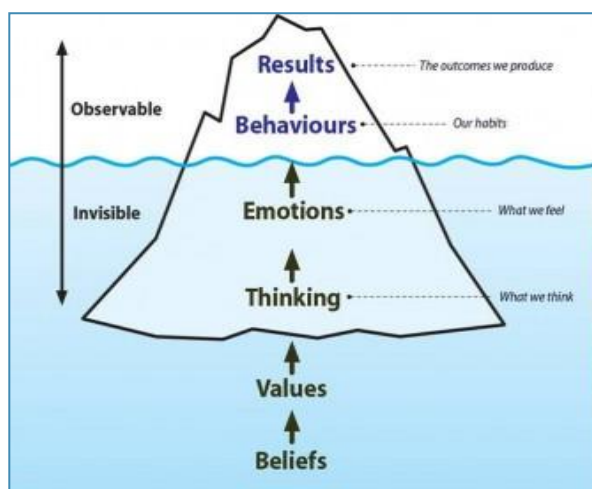
- 1) **All-Or-Nothing Thinking**—You see things in black-and-white categories. If your performance falls short of perfect, you see yourself as a total failure.
- 2) **Overgeneralization**—You see a single negative event as a never-ending pattern of defeat.
- 3) **Mental Filter**—You pick out a single negative defeat and dwell on it exclusively so that your vision of reality becomes darkened, like the drop of ink that colors the entire beaker of water.
- 4) **Disqualifying the Positive**—You dismiss positive experiences by insisting they “don’t count” for some reason or other. In this way you can maintain a negative belief that is contradicted by your everyday experiences.
- 5) **Jumping to Conclusions**—You make a negative interpretation even though there are no definite facts that convincingly support your conclusion.

- 6) **Mind reading**—You arbitrarily conclude that someone is reacting negatively to you, and you don't bother to check this out.
- 7) **The fortune teller error.** You anticipate that things will turn out badly, and you feel convinced that your prediction is an already-established fact.
- 8) **Magnification (Catastrophizing) or Minimization**—You exaggerate the importance of things (such as your goof-up or someone else's achievement), or you inappropriately shrink things until they appear tiny (your own desirable qualities or the other fellow's imperfections). This is also called the "binocular trick."
- 9) **Emotional Reasoning**—You assume that your negative emotions necessarily reflect the way things really are: "I feel it; therefore, it must be true.
- 10) **Should Statements**—You try to motivate yourself with should's and shouldn't's, as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct such statements toward others, you feel anger, frustration, and resentment.
- 11) **Labeling and Mislabeling**—This is an extreme form of overgeneralization. Instead of describing your error, you attach a negative label to yourself: "I'm a loser." When someone else's behavior rubs you the wrong way, you attach a negative label to him: "He's a goddam louse." Mislabeling involves describing an

event with language that is highly colored and emotionally loaded.

12) Personalization—You see yourself as the cause of some negative external event which in fact you were not primarily responsible for.

The combination of talk therapy and medication produce the best outcomes for those suffering from mental illness. The diagram (herein) illustrates the thought process and outcome thereof. At the root of our thinking are core beliefs and values, established at a very young age. They are rooted in our family of origin, culture and environment.²⁵ Every thought we have is filtered through our core beliefs and values. In turn, our thoughts drive our emotions and our emotions drive our behavior.



The Spirit

Although mental health disorders are not the result of a spiritual failing, a person's spirit is deeply impacted by the illness. A distorted concept of who God is can lead to a crisis of faith while the constant struggle with negative thoughts can lead to spiritual exhaustion.

²⁵ <http://www.coaching.net.nz/how-not-to-act-insanely/>

Distorted thinking shapes what they believe about God, and they begin to believe that the mental illness is their fault, or God is angry at them. Being assured that God is for them, and that sin is not the cause of mental illness any more than it's the cause of cancer or heart disease, is vital to helping a person find recovery.

The Bible has a lot to say about our mental health!

- Philippians 4:8 is often referred to as God's prescription for good mental health. "Finally, brothers, whatever is true, whatever is honorable, whatever is just, whatever is pure, whatever is lovely, whatever is commendable, if there is any excellence, if there is anything worthy of praise, think about these things."
- 2 Corinthians 10:5. "We demolish arguments and every pretension that sets itself up against the knowledge of God, and we take captive every thought to make it obedient to Christ."

The truth is, most people never think about their thinking. The way we choose to think and the things we choose to believe powerfully influence the quality of our life on this earth. When people are afflicted with mental illness, the organ that processes thinking is not functioning properly. Having been created in the image of God, God has empowered man with creative ability. That creative ability includes developing medical treatments to bring healing to our diseased physical bodies.

12.3 The Computer Analogy

The human mind is an intricately complex bioelectric supercomputer, and just like a computer our minds have hardware and software.

The hardware is the actual physical component or structure. The computer is made up of the hard drive, video card, network card, processor, etc. In our mental computer, the hardware is the brain with all of its billions of neurons and neurotransmitters.

The software of a computer includes the operating system (a framework of rules that directs its functioning) and other programs installed to perform a variety of functions. The brain's operating system gets installed during childhood and is constantly being updated. The programming includes language, beliefs, values, morals and spiritual understanding.

Computers can have hardware and software but still will not run without an energy source. For the brain, blood is the energy source that brings the needed nutrients and carries away waste. For Christians, the Holy Spirit is the energy flow that helps repair any glitches in the software of our mind by instilling the truth, patching misunderstanding, and updating with hope.

12.4 Churches Appropriate Response

Studies show that the first place many go for help in a mental health crisis is not a loved one, friend, co-worker or healthcare professional, but rather to their pastor or priest. Too often, instead of receiving comfort and support, they are met with judgment, shame and misunderstanding.

Jesus modeled coming alongside the suffering and loving them just as they were. Jesus' model for us is compassion, grace, and mercy; not judgement.

What if instead of judgment and shame, the mentally ill found support and encouragement? People could stop hiding in their shame and emerge to seek treatment and find recovery. One of the greatest sufferings of the mentally ill is believing they are unloved. Imagine the change and healing that could begin when they are embraced and shown God's love and grace.

As they find the road to recovery, surrounded by God's grace, not only will they heal, but part of their healing will include reaching out to help others on a similar journey. They will have a desire to help, support and love with the help, support and love they were shown as illustrated in 2 Cor 1:2-3.

The faith community's role is to support the mentally ill, and not to fix them. Providing support and structure will help the mentally ill regain their lives and rebuild their families.

Where is God in the Process for Them?

Those struggling with mental illness often do not see God as the loving Father who loves, supports and ultimately as the source of the healing they desire. How they think about how God feels about them and their mental illness will have a direct impact on how they integrate their faith into the recovery process. Seeing God as a God of forgiveness is key. If they see God as for them and not against them, or as a loving Father and not a stern taskmaster, they will be able to integrate the grace of God into their healing process.

The bible is God's truth, a powerful tool for healing; however, when working with someone who is mentally ill, keep in mind how their illness is distorting their thinking process. Therefore, use scriptures of love, hope and comfort to reach them at the heart level.

Such as:

- John 16:33 - "I have told you these things, so that in me you may have peace. In this world you, will have trouble. But take heart! I have overcome the world."
- Psalm 34:8 - "God is close to the brokenhearted and saves those who are crushed in spirit."
- Matthew 11:28 - "Then Jesus said, "Come to me, all of you who are weary and carry heavy burdens, and I will give you rest."
- Psalm 46:1 - "God is our refuge and strength, always ready to help in times of trouble."

Things Not to Say

- "Snap out of it."
- "You have so much going for you!"
- "I know exactly how you feel."
- "Just don't think about sad things."
- "A lot of people have it worse off than you."
- "Have you taken your medication today?"

Empathic Responses

The goal in responding is not to "fix" the situation, but to connect to the person. Something as simple as a genuine smile, or appropriate acts of comfort, such as a hug can make a big difference in the moment.

Some simple responses may include:

- "This is not your fault."
- "I care about you and want to help you."
- "Mental illness is real; it is not in your head."

- "Help me understand what that is like for you."
- "What do you need right now?"

Providing Spiritual Support

Providing spiritual support to someone with mental illness is the same as you would for congregants with cancer, heart disease, or who have experienced a traumatic event. What would you say to them? Would you say...?

- "You just need to have more faith!"
- "You need to read your bible more"
- "What sin in your life is causing this?"

Of course not!

You would send notes of encouragement, call them, let them talk, pray with them or find verses of comfort for where they are. Those are some of the ways you can support those struggling with a mental illness and their families.

As the faith leader, continue to educate yourself about mental health issues. Speak about mental health from the pulpit. Invite speakers with lived experience to share their testimony. Model authenticity. If you have experienced mental health problems, be willing to talk about it. When you share your personal experience, you give permission to your congregation to come out of hiding and share their experiences and seek help.

As a congregation, you can establish mental health support groups at your church. Mental Health Grace Alliance has created a curriculum that integrates the grace of God into the recovery process for those struggling with a mental health disorder. If your congregation is not

equipped to host a Living Grace Group, refer your congregants to other groups in the area.²⁶

Consider starting a depression support group to provide tools for understanding the power of God's word to change distorted thinking. Using faith and integrating the grace of God into the recovery process is not just a nice idea, but is backed up by scientific research. An article in the Washington times, stated:

We found that committed religious belief and devout practice (such as prayer) are related to higher levels of emotional well-being, happiness, and life satisfaction. Three hundred and twenty-six separate studies had examined these relationships, and the overwhelming majority (79%) reported statistically significant positive relationships. The same is true for research examining optimism (83%), hope (73%), and having a sense of meaning and purpose (93%).²⁷

25% of the population experience mental health issues, including those attending church services. Consider the healing that is possible when mental illness is treated with compassion, love and God's grace. Hearts and minds will heal, people can live authentically and relationships will thrive.

As lives are restored and families rebuilt, the church grows stronger and more connected. A healthy church reaches out into the community

²⁶ <http://mentalhealthgracealliance.org/>

²⁷ <http://www.washingtontimes.com/news/2015/dec/30/power-of-prayer-where-faith-meets-mental-health-an/>

and touches the hurting. As God's grace and love works in and through lives, hope and healing become a reality.

Handouts:

- Image of God
- You Say, God Says
- Love letter from God
- No Casserole Disease

Resources:

- "Grace for the Afflicted" by Matthew Stanford
- "Could it be This Simple", Timothy Jennings, Ph.D.
- "God Distorted", John Bishop
- "Feeling Good", David Burns

Chapter 12 Notes

Chapter 13. Assisting Families in Finding Strength and Hope

Introduction

When a person is living with a serious mental illness, the whole family is affected.

The learning objectives for this chapter are:

- 1) Impact of mental illness on family members
- 2) Educating families and loved ones about mental illness
- 3) Assisting within the church
- 4) Connecting families with resources

13.1 The Impact of Mental Illness on Family Members

It has been said that a mental illness is not an individual diagnosis, but rather a family diagnosis.

The chronic stress that family member's experience, along with the practical demands of caring for their relative, have an impact on their day-to-day living, health, social and family relations, careers and financial situation. Family members often are ashamed, hurt, or embarrassed by a family member whose behaviors can be difficult to understand and deal with. Many people also feel anger at the circumstances and even at the person who has been diagnosed.

Mental illness alters the dynamics of a family, often suddenly. The effect of the shift that takes place in the family is both emotional and practical. The emotional toll includes a roller coaster of feelings such as

shame, anger, guilt, stigma, isolation and grief. The consequences are also practical as the family member moves into being a caregiver, at least part of the time. The relationship, whether it be parent, spouse, sibling, or child is changed by the illness.

Parents struggle with guilt as they blame themselves for their children's illness. In younger children, mental illnesses are poorly understood by most people and outsiders may view the parents of a mentally ill child as simply bad parents, poor disciplinarians, etc. Under-breath judgements take place as others look for a place to blame the unusual, abnormal behavior.

When the child is over 18, the system is reluctant to involve parents in the recovery process. As the mentally ill child demands more of their attention, these parents also deal with how their other children are coping. They wonder if their child will ever be able to hold a job, live alone or get married. In constant survival mode, they grieve the hopes and dreams they had for their child as well as their own dreams for life after children, future retirement, and grandparenthood.

Spouses experience the loss of partnership in their marriage, as the symptoms of the illness change the one they love at their very soul. The consequences can include financial worries, loss of jobs, sexual distance, and social isolation. They find themselves managing multiple roles, and often operating like a single parent, which leads to burnout and a depleted emotional state. Resentment grows in the ever-present uncertainties. In the midst of the turmoil, they are grieving the loss of what they imagined their lives together would be.

Siblings find themselves confused, stressed, angry, sad, and afraid. Their brothers or sisters changed behavior embarrasses them while

they simultaneously fear for their wellbeing. Jealous of their parents' attention towards their ill sibling, resentment grows that they are not like other families. Underneath it all, they live with the fear of also developing mental illness.

Children experience varying emotions and reactions when a parent or other family member is living with mental illness. Fear and confusion about changes they don't understand are the most common. They often feel isolated and alone. Communication is key, and it is important that children be allowed to talk about their emotions, to know that their feelings are normal.

Living in a family where one or more members live with mental illness will have a lasting impact on those individuals. If handled well, the family pulls together to cope with the illness. The consequences can lead to the family, and the individual members, discovering their unique strengths. Some of the outcomes can be a sense of self-reliance, a non-judgmental attitude, as well as increased compassion and caring.

Adult children report they had become better and stronger people. Their experience growing up with a parent living with mental illness led them to develop greater empathy and compassion, more tolerance and understanding, healthier attitudes and priorities, and greater appreciation of life.

13.2 Educating Families about Mental Illness²⁸

Family members can be an invaluable resource for individuals dealing with serious mental illnesses. Educating them about mental illness will improve their coping skills and their ability to more effectively support

²⁸ <https://www.nami.org/Learn-More/Fact-Sheet-Library>

their loved one through diagnosis and recovery. In what other illness is the family not informed about how to care for the ill person?

“When someone is diagnosed with a chronic illness, such as diabetes or heart disease, efforts are typically made by his/her doctor not only to educate the individual directly affected by the illness, but to educate and involve his/her family in treatment and care. Historically, this has not been the case with severe mental illnesses.”

As the faith leader, you can begin the education process with yourself and extend it to your congregation by making mental health the topic of sermons, bible studies and support groups.

Look for opportunities to host guest speakers who have lived the experience of mental illness and recovery. Host seminars to teach your congregants about the various aspects of mental illness.

Junior and Senior High Schools are facing mental health crisis on a level never seen before. Involve the youth in teaching. Get the youth pastors on board and create an atmosphere of transparency where students can be real without the fear of being shamed or judged.

Know the 10 Common Warning Signs

1. Feeling very sad or withdrawn for more than two weeks
2. Seriously trying to harm or kill oneself or making plans to do so
3. Severe out-of-control risk-taking behaviors
4. Sudden overwhelming fear for no reason

5. Not eating, throwing up or using laxatives to lose weight; significant weight loss or weight gain
6. Seeing, hearing or believing things that are not real
7. Repeatedly using drugs or alcohol
8. Drastic changes in mood, behavior, personality or sleeping habits
9. Extreme difficulty in concentrating or staying still
10. Intense worries or fears that get in the way of daily activities

Knowing these warning signs will help you be more aware when a congregant comes to you seeking help for a loved one whose behavior isn't quite right.

Help family members know how to start the conversation:

- "It worries me to hear you talking like this. Let's talk to someone about it.
- "I've noticed that you haven't been acting like yourself lately. Is something going on?"
- "I've noticed you're (sleeping more, eating less, etc.) is everything okay?"²⁹

²⁹ <https://www.nami.org/Learn-More/Fact-Sheet-Library>

Benefits of Family Education and Involvement

Numerous studies have shown that family involvement in these roles results in significant benefits – for both the individual and the health care system.

Some of those benefits include:

- Decreased rates of hospitalization and relapse
- Enhanced adherence to treatment choices
- Increased rates of recovery
- Decreased involvement with the criminal justice system
- Savings to the mental health and addiction systems

Mental illness is a chronic condition that usually cannot be cured, but rather managed, just like other chronic illnesses. Helping families to understand that their family member is dealing with a biological disease allows them to manage their expectations and reduce their stress levels. Learning that recovery is a process relieves them of the pressure to try to “fix” their loved one or the situation. Education about the mental illness promotes acceptance and rekindles hope for recovery.

Importance of Families Learning to Care for Themselves

Living with a family member who is struggling with mental health difficulties requires a lot of time and energy, especially in times of instability. All too often, the care givers devote all their energies to their loved one and neglect their own personal needs. Physical and emotional exhaustion are common. It is important for them to learn to take care of themselves. The individuals providing care need to care for themselves physically, emotionally and spiritually.

Physical depletion signs include, fatigue, poor nutrition, little exercise, agitation and cognitive fog. Ensuring they are getting adequate rest, exercise and proper nutrition is vital to keep them strong physically.

Even more common is emotional exhaustion as they struggle with loneliness and isolation. The discouragement overwhelms, as joy is hard to find. That is why it is so important for them to stay connected with family and friends, and to purposefully engage in activities that bring them joy. Families often feel guilty doing “fun” things for themselves when their loved one is struggling, but they must refill their emotional tanks in order to love and give good care.

The spiritual depletion signs include becoming discouraged and frustrated with God as their relationship with God becomes distant and blunted. It is understandable to grow hopeless when being consumed by the unrelenting nature of someone’s mental health difficulties. God can be hard to find and understand. Staying connected to a caring compassionate church family will bring comfort in these difficult times. Surrounding themselves with patient, kind and understanding members of their faith will give them the support they need to get built up spiritually. Focusing on recharging spiritually will inspire and encourage them to persevere and regain hope.

13.3 Assisting within the Church

Rick Warren’s *The Purpose-Driven Church* (1995) lists five purposes for the church:

- Fellowship
- Discipleship
- Worship
- Ministry
- Evangelism

Assisting families with mental health needs can accomplish all of these goals. We reach out in genuine *fellowship* to those in our congregations who are struggling. We grow in *discipleship* when we obey God's commandment to love one another without shame or judgment. We glorify God by including all people in the *worshiping* community. We *minister* to others when we support and encourage them. And the quality of our caring for families facing mental illness is a form of *evangelism* that will bring others to our congregations. Everything we do as the Body of Christ reflects our understanding of Jesus Christ, and his call to love our neighbors.

All people need to experience love and support at some level. Since the faithful life is often difficult and faces many obstacles along the journey, God designed the church to be an assembly of believers that would love one another and support one another spiritually, emotionally, and physically. When mental illness strikes within a family, the need for love and support is greater than ever.

People of faith rely upon one another in times of distress and need. While the government does offer some means of assistance, the church is called to personally care for the widowed, fatherless, homeless, mentally ill and all who have specific needs within the life of the congregation.

The greatest support the church can provide is to be a caring and compassionate congregation. Educating your church about mental illness will break down the stigma and shame, creating a safe and non-judgmental community for families dealing with mental health challenges. Not only will they be able to share their struggles, but people within the church will learn how to best support them in their time of need.

Because mental illness is a disease like any other disease, these families deserve the same support as others facing medical and emergency situations. They have physical, financial, emotional and spiritual needs. When someone has cancer or surgery, the church responds with an abundance of food, cards, phone calls, visits and all kinds of offers to help. However, when the problem is a mental health issue, the response is often... dead silence. That is why many have called mental illness the “No Casserole Disease.” When your congregation responds with love and caring to a family facing mental illness, you will be offering a gift of acceptance, grace, and love that goes far beyond the card or casserole!

Mental Health Point Person

Consider having someone in your congregation act as a mental health point person for times of crisis and for ongoing family needs. Investing in this person will be invaluable to you as the faith leader. You may already have a ministry with a leader than can assume this role quite naturally. You may need to create this position as either a staff position or volunteer position. Most people who have been through the storms of mental health look for ways to act as an advocate for others.

You will be assisting in two kinds of situations:

- First mental health crisis
- Second or ongoing mental health crisis/issues

First Mental Health Crisis

For those who are having their first experience with a mental health crisis, there will be much confusion. Typically, people don’t know where to turn or even what they need. Often the world of psychiatry is foreign to them and they don’t even know the basic diagnosis – major depression, bipolar, schizoaffective, schizophrenia, etc. They don’t

understand why their loved one is being held on a 5150 and they may never have heard of psychotropic medication much less stepped foot into a psychiatric hospital.

The psychiatric hospital can be just as frightening for the families as it is for the person being treated there. A psychiatric hospital is nothing like a normal hospital. If one is a danger to themselves, they won't be allowed to have shoelaces in their shoes or even a toothbrush in their possession. Anything that is perceived as a possible instrument of harm will be taken away from them. This type of environment can add anxiety to a family who may already be traumatized by the events that have led to the hospitalization.

Additionally, they may be dealing with a family member who is outraged or hostile for being in a mental hospital. There is a lot of resistance to accepting a diagnosis of mental illness and unlike diabetes or cancer there is no medical test that can provide a (quick) diagnosis of mental illness. A health care professional can do a number of things in an evaluation, including a physical exam and long term monitoring to rule out any underlying medical conditions that may be causing symptoms. Beyond that, diagnosis depends on self-reporting from the patient, the doctor's experience and the definitions of the Diagnostic and Statistical Manual of Mental Disorders, currently in its fifth edition. The DSM-5., published by the American Psychiatric Association, lists criteria including feelings, symptoms and behaviors over a period of time, that a person must meet in order to be officially diagnosed with an illness.

It's likely that medication will be prescribed to help with symptoms and the loved one will be referred to mental health professionals such as a psychiatrist and/or a psychologist.

The mental health care system is a confusing and often frustrating maze to get through. It is governed by what insurance companies deem qualifies for coverage and what doesn't. Often the care that is needed is limited to a constricted list of professionals in a given insurance network.

Families during this time need not only strong emotional support, but also practical support in the way of help with meals, carpools, doctor appointments, household chores and managing day-to-day responsibilities.

Second or Ongoing Mental Health Crisis

After experiencing the first mental health crisis, most people pray that they will never be faced with it again. Sadly, many do experience it again and again.

In the case of severe mental illness, a person may experience several hospitalizations and/or relapses on their way to the stabilization of symptoms. Diagnosing and treating mental illness is not an exact science. Medications affect each person differently and the medication that works wonders for one person may be completely ineffective for the next. Additionally, the medications have severe side effects that can cause many problems including compliance.

In depression it's not unusual for a person to have a positive experience with medication only to stop taking the medication and cycle back down. This is part of what can create a cycle of crisis for family members and create an atmosphere of uncertainty and fear.

This cycling requires the church to be a place of ongoing support. It cannot fall only to the faith leader to be this support – rather, it is a calling of the Body of Christ to come together to minister to their own.

Mental health conditions can be isolating for individuals and families. The church can and must cultivate a culture of acceptance and authenticity. Statistically, 1 in 4 people in church are experiencing a mental health difficulty. Such an overwhelming percentage of those who walk through your doors are struggling with this area of their lives, either for themselves or for someone they love. Include prayers for mental health conditions along with other health concerns during worship and prayer meetings. That type of inclusion will foster an atmosphere of safety and lead to more authentic spiritual living.

Mental Health Support Groups for families and loved ones are growing in the Christian community. These groups provide spiritual understanding, psycho educational materials, and provide community for families to connect and share. Making these groups available in your church, speaks volumes to your congregation about the value you place on supporting people living with mental illness.

One organization that has created curriculum for these types of groups is Mental Health Grace Alliance.

The Family Grace Group lessons include teaching how to communicate more effectively, rebuilding boundaries, crisis and problem solving, and understanding the difference between enabling and empowering. As the group discusses these topics, they learn about mental health disorders, the impact it is having on their families, and how to exhibit the grace of God to their family member. More importantly, these

families find a safe place to come together, share their struggles, engage their faith, and seek God's grace in community.

13.4 Connecting Families with Resources

- NAMI - National Alliance on Mental Illness provides mental health education to families - Family to Family and support to families through support groups. Resources and material available on website: <http://nami.org> and <http://namisd.org>
- Establish professional referral list - families also need mental health professionals to help them navigate the illness of their loved one.
- Mental Health Grace Alliance - an organization whose mission is to providing mental health strength, recovery and transformation accessible for anyone, anywhere, anytime. Resources available on: <http://mentalhealthgracealliance.org>.
- CAHM (Community Alliance for Healthy Minds) is a local nonprofit that holds an annual Mental Health Forum with a variety of presentations on mental health issues. Great resource for families and those living with mental illness. No charge for event. CAHM website: <http://cahmsd.org>

Suggested Reading

- Grace for the Afflicted: A Clinical and Biblical Perspective on Mental Illness by Matthew S. Stanford.
- Troubled Minds: Mental Illness and the Church's Mission by Amy Simpson.
- Blue Genes by Paul Meier M.D., Todd Clements M.D., Jean-Luc Bertrand D.M.D.

- When Someone You Love Suffers from Depression or Mental Illness by Cecil Murphey.
- Boundaries by John Townsend and Henry Cloud.
- Setting Boundaries® with Your Adult Children: Six Steps to Hope and Healing for Struggling Parents by Allison Botke.

Additional Resources

- “Mental Health: A Guide for Faith Leaders”; Free PDF download from American Psychiatric Association at: <https://www.psychiatry.org/newsroom/news-releases/apa-releases-new-resources-on-mental-health-for-faith-leaders>. Or available for purchase at: https://www.appi.org/Mental_Health.
- Hope for Mental Health Starter Kit available from Saddleback Church, \$69.00 at <http://store.pastors.com/products/hope-for-mental-health-starter-kit>.

Events

- CAHM Mental Health Forum, at California State University at San Marcos. <https://www.cahmsd.org/>
- The Gathering on Mental Health at Saddleback Church – <http://saddleback.com/event/20635544469/the-gathering-on-mental-health-and-the-church>.

Chapter 13 Notes
