"THOSE PEOPLE"

Learning to love, care for and respect people struggling with mental illness

Judy Davis

Praise for *"Those People"*

"Those People" by Judy Davis is a wonderfully educational treatise on what it means to know and work with people that suffer with mental illness. As a practicing physician, I see people every day that must cope with mental illness, either in themselves or in caring for a loved one. Judy's book is filled with practical knowledge, insight, and empathy; I certainly learned "a thing or two" – wisdom that I can use every day in my general practice. – *Michael Peters MD (Dr. Peters is Board Certified in Family Medicine and a Fellow of the American Academy of Family Physicians).*

In "Those People" Judy Davis has picked a title that speaks volumes. Most of us do not know how to relate to the mentally ill; they are the Other, apart from us, alien and sometimes even feared.

Those afflicted feel this separation so keenly and with such great pain that they come to believe that they are indeed worthless outcasts.

The Rev. Davis, an Anglican deacon with long experience counseling and helping the mentally ill, steps into this gulf of misunderstanding with a book that bridges it. She gives the reader a clear understanding of mental illness in its many forms, with life examples that show the specific symptoms that accompany the various forms of mental illness.

She tells us how these people think and feel, and we are moved; they can be the Other no longer. And she shows us how to accept, love, and support them as well.

This is a book not only for pastors and counselors but for anyone who wants to help the millions who suffer such pain. – *Bill Blundell (former prizewinning writer, editor and national correspondent for "The Wall Street Journal")*

"Those People" is the perfect book for pastors, teachers, ministry team members, or anyone who interacts with people where it might be helpful to identify and advise those with varying degrees of mental illness. "Those People" describes each mental illness using real life examples and then goes on to list the typical symptoms and effects, giving practical counsel on how to advise people who need help. I have not seen a book that does this so well and with such plain language. For me it is a must-have. – *Randy Fisk, author of The Presence, Power and Heart of God*

Davis presents sensitive, perceptive and wise advice for anyone who has contact with or questions about various forms of mental illness. I find the content accurate and useful for interacting with those I may know or meet in the course of my profession. – *Carol J. Kraft, Deacon / Spiritual Director, St. Barnabas Episcopal Church, Glen Ellyn, Illinois*

“Those People”

Learning to love, care for and respect people struggling with mental illness.

A gentle, wise and informative guide for family, friends and caregivers.

Judy Davis

Published by

Northwoods, Illinois

"Those People" Learning to love, care for and respect people struggling with mental illness.

First printing May, 2012.

ISBN13: 978-0-9777226-6-2
ISBN10: 0-9777226-6-X

Additional resources and author contact:
www.ByronArts.com

Cover design by www.2FacedDesign.com
Back-cover photo of Judy Davis by David Kiesa

Published by Byron Arts, Northwoods, Illinois, USA. Printed in the United States, England and Australia.

Visit www.ByronArts.com for quantity discounts of this and other Byron Arts publications.

Copyediting by George August Koch
GeorgeAugustKoch@aol.com
www.GeorgeAugustKoch.com

This book is dedicated to the Rev Dr George Byron Koch, whose constant encouragement and challenge to get it done helped this book to become a reality, and to all the wonderful people who so willingly shared stories of their struggles with me.

ACKNOWLEDGEMENTS

There are many people I would like to thank for their help in bringing this book into being. I am grateful to Andrea Hill for her very helpful input, to Amanda Martinez for her dealing with the small stuff to give me time to work and for her outstanding research, to George August Koch for his thorough and thoughtful editing, to the people of Resurrection Anglican Church in West Chicago, IL, for their prayer support, and *especially* I thank God for His continual encouragement to keep going.

I'm also very thankful to those folks who helped bring to fruition the earlier book on this topic, *Pastoral Care of the Mentally Ill*, which I wrote in 2000, and some parts of which are used in this new and expanded book.

TABLE OF CONTENTS

TABLE OF CONTENTS i
Preface iii
1. Why even bother to get up? 1
A look at depression 1
Caregiving Considerations 5
2. Ooohh, let's buy this and this! 9
Bipolar (manic-depressive) disorder 9
Caregiving Considerations 14
3. But what if? 17
Issues related to anxiety 17
Caregiving Considerations 21
4. Quick, get under the table now! 27
Post-traumatic stress disorder 27
Caregiving Considerations 31
5. I wanna do it my way! 34
Eating disorders and other controlling behaviors 34
Caregiving Considerations 39
6. But they told me to do that 45
Schizophrenia and schizoaffective disorders 45
Schizoaffective Disorder 48

Caregiving Considerations 49
7. It would be easier just to make cookies 53
Involvement of family and friends 53
8. Is there anybody out there who "gets it"? 59
What we can do to help 59
Glossary of Common Terms 63
Appendix A: Depression 73
Characteristics of depression as reported by those suffering from it 73
Appendix B: Bipolar Disorder 75
Characteristics of bipolar disorder as reported by those suffering from it 75
Additional observations from patients 78
Index 79

Preface

Doris (not her real name) looked at me with tears in her eyes and pleading in her voice. “Will you please call my pastor and explain to him what ‘bipolar’ means? He just doesn't get it.”

At that moment, the first seed was planted that led to this book. After ten years of working as a chaplain in hospital psychiatric units, I came to realize several things. First, we all know people with psychiatric problems. Secondly, pastors, teachers, employers, coaches, and most everyone else we know have not been trained in working with people who have mental illnesses. For example, even in the best Clinical Pastoral Education programs, such training is virtually nonexistent.

Let’s look at 100 hypothetical people in a hypothetical group. Of these 100 people, it is very likely that there are up to five folks suffering from a panic disorder, at least one person suffering from schizophrenia, two or three suffering from a bipolar (manic-depressive) disorder, seven or so suffering from depression serious enough to warrant medical intervention, perhaps another three or four suffering from post-traumatic stress disorder, one or two with eating disorders, and yet another two or three with an obsessive-compulsive problem.

Many of these people will be told by someone, at one time or another, that they should talk to their pastor, or to a coach, teacher or other leader—and these leaders are often the first ones to be approached by people with problems. That’s where this book comes in. What do we tell them? What advice can we give them? How do we keep them safe? And how do we keep from becoming enablers?

Following are some stories—stories of people suffering from mental illness. These stories are composites drawn from the experiences of more than just one person. Names have been changed to maintain privacy but all of the stories are based in fact. My hope is that through them, you will come to see what works and what doesn't, and what might work and what might not, as we seek to give useful and appropriate loving care to all of God's children.

1.
Why even bother to get up?

A LOOK AT DEPRESSION

Glenn approached me one day on the way out of church. "Do you have some time this week that you could come over to our house and talk to Claudia and me? We're worried about Amy." I could tell from the look on his face that something serious was going on and that "some time this week" had better be soon. I told them I could see them the next evening.

When I got to their home, they skipped the usual pleasantries and got right to the point. "Amy has been cutting herself. She does it where no one can see it—on her breasts and on her stomach. We just don't understand. What have we done wrong? Why is she doing this?" Their words came tumbling out, and their anguish was evident.

These people were solid church members. Their two children, Amy and David, had been active in Sunday School and in the high-school youth group. They were good kids who had gotten through high school with no more than the usual problems and were now both in college.

AMY

Amy was a musician. She'd played violin since 4th grade and wanted to be a professional musician when she graduated. She was very talented—not exceptional, perhaps, but certainly very good. She did have a fallback plan—she had a minor in library science—but her first love was music. And speaking of love, she had a boyfriend. They had been together for three years. He was about to graduate, and she had one more year to go, so they faced a major separation. This put stress on their relationship; Amy had broken up with him twice before. Yet both times, she felt guilty and lonely and wished she hadn't severed the relationship.

Glenn and Claudia told me all of this and asked what they should do. They were worried about Amy cutting herself—they simply didn't understand how anyone could do that—but they were also worried about the fact that the "spark" had gone out of her. She seemed to be just existing rather than living.

Amy was clearly depressed. Clinical depression, I explained, isn't a character flaw but rather a chemical imbalance in the brain—an imbalance treatable with medication. I suggested that therapy might also be indicated to help Amy deal with the many stresses in her life at the time.

Within a week, Glenn and Claudia had taken Amy for evaluation at a nearby hospital with a well-respected psychiatric unit. She was admitted to a four-week outpatient day program where she would get group and individual therapy, and was also put on an antidepressant drug by the psychiatrist.

Amy felt better after the month in the program. Her parents were convinced she was no longer hurting herself and noticed she had a renewed interest in life. But a month before she graduated—a stressful time for anyone—another downward spiral began. She had been trying without success to find a job as a violinist, and was growing so discouraged and distraught that her parents again feared for her safety. Once again they called me and asked what to do. I asked if they thought she was in danger. They weren't sure. I stated that if they feared for her safety, they should take her to the emergency room. Patients who are suicidal will not be turned away. Amy's parents didn't think she was suicidal, however, so I suggested they immediately contact the psychiatrist for a possible medication adjustment. Ultimately the dosage was increased, Amy got better, graduated, and got a position as a librarian. She is staying in touch with her music by playing in a volunteer community symphony—for now.

The caregiving issues in the case are several. First, the parents were in need of comfort, support, information and prayer. They put Amy on their church's prayer list, but she didn't want anyone to know what was wrong with her. As is so often true, the stigma of mental illness was an issue. Amy didn't want anyone to know she'd been in a hospital outpatient program or was seeing a psychiatrist.

Pastoral support of Amy was more difficult. I saw her in the outpatient setting and assured her of confidentiality. I also offered my listening ear if she ever needed it. When she had her setback prior to graduation, I gave her reassuring hugs after church services, but never mentioned her illness to her. Because of her desire that no one know, any mention of the situation would have to come from her. It never did.

Glenn and Claudia continued to talk with me from time to time. I was the person with whom they could share their fears safely and confidentially. And because of my job at the hospital, they saw me as their local source of mental-health information. Amy's battle is likely not over. But as long as she learns to

recognize the signs of the onset of a depressive period, she should be able to live a good life—even though she may need to be on medication the rest of her life.

MARIE

Various life situations may contribute to the onset of clinical depression. Marie's husband of 17 years left her. She hadn't seen the breakup coming and was overwhelmed with the responsibilities of raising two teenage boys, keeping the house running, and staying financially stable. Marie attended church almost daily, and each day I saw her changing. First her wardrobe went from stylish clothes to dark, mismatched sweats. Then she stopped wearing any makeup—not even lipstick. After that she stopped fixing her hair, which hung stringily onto her shoulders.

Trying to open the lines of communication, I frequently asked Marie how she was getting along, but she would only smile and say, "Well, just fine." But each time she answered, her voice became flatter and flatter. Finally one morning there was a message on my answering machine. "This is Marie. Can we talk?" The dead tone in her voice was even more evident in the voicemail than it had been in person. I called her right back and made an appointment with her for that afternoon.

Marie looked like she had just gotten out of bed. Her hair and clothes were disheveled. She sat down and blurted out, "I don't know how I can go on." Then, shoulders shaking, she sobbed and sobbed. When she was cried out and began to talk, it was evident that she was seriously depressed over her husband's departure. I suggested that she might want to talk with a psychologist. I also explained that depression can be often be caused by medical issues rather than situational ones.

Whether they are suffering from a bipolar disorder or clinical depression, people who are depressed don't want or need to be told to 'snap out of it' any more than diabetics need to be told that. I cringe when I hear people say things like, "You have a beautiful home, great kids, a wonderful spouse and lots of money. What could you possibly be depressed about?" Such comments come from ignorance, not educated concern. They are harmful because they minimize what is a very real illness. They are as insensitive as saying to a cancer patient, "Why are you worried about a little lump? We all have some lumps and bumps."

I told Marie that I cared about her but didn't feel qualified to deal with the deep issues she was facing. I assured her of my support, telling her I would pray for and with her and be available to her. I made certain that she knew she could continue to call on me. Then I gave her the names of three psychologists I respected and whom I knew would guide her to a psychiatrist should medication be called for.

Marie was so despondent that she was willing to try anything. She made an appointment, started therapy with an appropriate professional, got on an

antidepressant medication, and slowly began to recover. It was a joy to watch her progress, to finally hear a lilt in her voice, and to see her once again caring about her appearance. I eventually urged her to join a small study-group at the church, knowing she needed to reestablish relationships with other adults.

Many years have passed since Marie called my answering machine. She still attends church regularly, and is active in many small groups—both women's groups and mixed groups. She has gone back to school and started a whole new career. Her two boys turned out well, with, I might add, good professional counseling to help them deal with their father's abandonment of the family. Both sons are happily married with several children each. Marie enjoys her career and loves being a grandmother. Occasionally something triggers a return of her depression, but she now knows the symptoms and promptly contacts her doctor, who prescribes antidepressants for a relatively short period of time. And so she carries on with her life in a generally joyful and upbeat manner.

Marie's faith has always been an integral component of her recovery, and her psychologist had to be someone who could understand the importance of God in her life. In referring patients, it is most helpful to have some knowledge of where the psychologist stands in the matters of faith. I was told about one psychologist who thought that God was a crutch, all men should have mistresses, and all women should take lovers. The patient seeing that person quickly changed to another counselor who shared her values. It is important to assure people seeking help that if, after a few sessions, they don't feel that their professional is the right one for them, they should change. A good match is very important.

ELMER

Depression is no respecter of age. The elderly are frequent victims of depression. Elmer had fallen and seriously injured his back. Gradually he got better, but he was in constant pain. One day, deciding that he was a burden to his wife, he jumped out of a third-story window. He didn't die; instead he further injured himself and ended up in a wheelchair.

When I met Elmer, he was so depressed that he could barely talk. He didn't want to live. He'd been a printer in his working life, so one day I started talking with him about computers and all the fun one can have on them with all of the available fonts and layout options. He said he was too old to learn, that he was finished, and that he just wanted to die. He had been a faithful member of his church all his life, but he felt so guilty about his suicide attempt that he was embarrassed to even talk with his pastor. Elmer was given various oral medications, but nothing seemed to do much good. He still wanted to die. Meanwhile, he was receiving physical therapy for his back, but was making little progress because he refused to do the exercises.

Finally his psychiatrist recommended electroconvulsive therapy. Elmer reluctantly agreed, secretly hoping it would kill him. It didn't—he got better. He decided to work on his physical therapy. His desire to die went away. And when I last saw him, the day he was being discharged from the hospital, he was planning to go back to work part-time and to learn all about computer graphics. He had a whole new lease on life. As an added bonus, his back pain was largely gone.

EDITH

Too often people think depression is a natural part of aging. It isn't. Many people in their nineties and beyond are living active, fun-filled lives. Edith is 95, healthy, bright, active in the church, loves to travel and go out to eat, delights in her grandchildren and great-grandchildren, and is an avid fan of her college football team. She enjoys shopping, gardening, reading, boating and getting together with friends. She serves on the governing board of the church and participates in the annual women's retreat as well as a book group and a dinner group. Edith has had the normal losses that someone her age might expect to have. Her husband of 67 years died when they both were 90, and the loss was difficult. But her attitude was, "I can sit around and mourn, or I can get on with my life. I think he'd rather that I got on with my life." The next year she and one of her daughters traveled to London and Paris, and two years later they took a trip to Italy. Edith is not depressed. She enjoys each and every day.

CAREGIVING CONSIDERATIONS

Depression is probably the most prevalent mental illness, striking one in ten people at some point in their lives. Women are more prone to depression, but men are far from immune; according to the National Alliance on Mental Illness, one in 15 men will suffer from major depression at some time in his life. For women the numbers are one in five. This is a serious as well as widespread illness, but it is a generally treatable one, as we can see in the cases of Amy and Marie.

We need to remember that there is a difference between the disorder of major depression and the normal "down times" most people have. It is normal to be sad when someone dies, when one loses a job, when lack of money becomes a major issue. This depression is a human emotion. The disorder of major depression is a biological disease that, in most cases, is treatable with medication usually coupled with "talk" therapy with a psychotherapist or other qualified counselor. Medications are prescribed by a psychiatrist or family doctor who can also recommend a therapist.

Symptoms of depression include hopelessness, sadness that won't go away, emptiness, changes in sleep patterns, difficulty concentrating, weight loss or gain, lack of interest in doing anything, and diminished enjoyment in anything that is

attempted. A trip to the grocery store can be overwhelming because of the decisions that must be made. Even just getting out of bed in the morning may seem like way too much work.

Depressed people often feel defeated by life and believe that most suggestions made to them are useless. Many depressed people have very low self-esteem and will tell you they don't want you to waste your time on them. They feel they aren't worth much, and this prevents them from sticking up for themselves. They're convinced that nothing will ever get better, so they see no reason to try. Often they feel trapped.

Adolescents and children, not just adults, also become depressed. Adolescents may deal with their depression by taking drugs or drinking, by running away, or by attempting suicide. Children act out, are moody, and often can't control their temper. Thirteen percent of teenagers, and about three percent of children under 13, suffer from depression, according to Mental Health America (formerly known as the National Mental Health Association).

The classic symptoms of depression in children and teenagers include sleep and appetite problems, concentration difficulties leading to poor school performance, sudden changes of habits, irrational fears, and thoughts of death. If a child or teen appears to be unusually sad most of the time over an extended period, it is very possible that he or she is suffering from major depression.

Parents see their children every day and often don't notice a gradual slide into depression. They tend to think the child is just being "difficult" or "going through a phase." Often a pastor or teacher or coach will have serious concerns about a young person. It could be helpful, possibly even lifesaving, to approach the parents with those concerns.

Use non-threatening statements such as, "I've noticed Sam doesn't seem to participate in outdoor activities and is having a hard time staying focused. Is anything going on that we can help with or that we should know?" It is not up to you to diagnose, only to be supportive and alert to what is going on.

There are many older people who are bright, alert and healthy—and there are those who suffer from depression, just like their younger friends. Their depression is usually treatable with medication—Elmer was an extreme example—but sometimes they don't receive the medicine they need because family members assume they are depressed simply because they are old or because the medication is too expensive. Once again, intervention might be in order. "Elmer seems really depressed and withdrawn. Have you mentioned this to his doctor?" This may be all his family needs to become aware of the situation. For example, statistics on grieving show that about 80 percent of those still grieving at one year after a serious loss will not be recovered one or two years later. This is not normal grief. A referral to a grief counselor or psychiatrist would be helpful and appropriate. Edith grieved normally, and her quality of life was not diminished. But I've seen

others who received loving, caring attention and sympathy when grieving and got so used to this newfound importance that they took on widowhood as their permanent identity. If this sort of behavior continues for more than a year or so, a gentle suggestion of a grief recovery group, a grief counselor, or a psychologist specializing in grief issues would be appropriate. Most hospice programs very willingly provide a resource list of appropriate counselors.

Pastors and other respected leaders are often among those best able to help because people generally will at least listen to what they say. So, be direct with people when you suspect a problem with depression, whether they are five or ninety-five. Help is available. No one has to suffer from this debilitating disorder.

2.
Ooohh, let's buy this and this!

BIPOLAR (MANIC-DEPRESSIVE) DISORDER

SUSAN

I first met Susan my second day working at the hospital. A nurse had suggested I talk with her, so I knocked on her door. "Yeah. What?" she mumbled. I went in and introduced myself, telling her that Jane had suggested she might like to talk to me. Acting her toughest, she said, "Fine. Okay. But don't give me any of the God stuff." And that's where we started.

Susan was an attractive, if somewhat overweight, young woman of 19. She had gang symbols tattooed on her hands, nine earrings in each ear, and angry red cuts on her arms and legs. We talked a little about mundane things—the temperature on the locked unit, the hospital food, and how much she was sleeping. I didn't bring up any "God stuff."

After a while, Susan must have decided I was okay because I wasn't preaching at her. She got friendlier and started to tell me a little about herself. An alcoholic and cocaine addict, she belonged to a street gang. Bipolar (manic-depressive), Susan was psychotic, with delusions and disorganized thoughts, and hearing voices telling her to kill herself. She lacked self-esteem and had a tragic family history—her mother had died after a long illness when Susan was in high

school, and Susan had been physically and sexually abused by a family member. She had a baby at age fifteen.

During her ensuing days at the hospital, Susan told me more. She had attempted suicide several times. The voices she heard told her she was useless, no good to anyone. They told her over and over that the best thing she could do was kill herself. To try to stop the voices and the pain of her illness, she cut her arms and legs with knives or razor blades and burned her abdomen with cigarettes. She said the physical pain stopped the mental anguish, if only temporarily.

At age 8, Susan was hit by a motorcycle. Her legs were seriously injured, she was in casts for months, and her oldest brother began torturing and sexually abusing her. This went on for years, because, true to the pattern of sexual abusers, he threatened to kill her if she told anyone.

In high school, while trying to cope with her mother's cancer, which preoccupied the whole family, she found another family in a street gang. She even thought the gang could protect her from her brother. But the gang affiliation quickly led to drug use and sexual acting-out. One of the sexual encounters led to pregnancy, and the baby was born when Susan was just 15. It was given up for adoption.

Susan was not a child of poverty. In fact, she was from a wealthy, upper-middle-class family and lived in an upscale suburb of a big city. The family regularly attended church services and gave generously to the church. But Susan got lost in the shuffle. She was the youngest of nine, and the only child still living at home when her mother's cancer spread, so she was left to tend her mother. Her father was in such denial that he essentially did nothing for his wife, and all the responsibility fell to Susan. Her siblings, older and starting their own families, were "too busy" to help. And so Susan, once a straight-A student, cut classes, ran with the gang instead of studying, got arrested occasionally, started doing drugs and drinking, and grieved for her mother's deteriorating health.

Who knows what loving and caring intervention might have done. But there was none. After her mother's death, Susan stopped going to church. Grief support was focused on her father, leaving Susan to try to sort things out on her own. She couldn't understand why her mother had died in the prime of life. She began to drink and use cocaine regularly to dull the incredible pain. But it wouldn't go

away. It was then she began injuring herself. The suicide attempts followed; on one occasion she overdosed on her brother's medication and almost died. She was in a coma for several days. Finally, she got psychiatric help.

Susan had been a "mistake" baby—one that came ten years after her youngest sibling. She was alternately a pest or a plaything to her brothers and sisters. Her parents were tired from raising eight other children. They foisted her off on her older siblings, who, of course, resented both the attention she got and the work for them that she represented. After the motorcycle accident, she was even more of a problem to them. And, as children will do, they made no secret of their feelings. So the self-image she grew up with was *I'm a mistake; I'm a problem; I'm a nuisance. Everyone would be happier if I never had been born.* Add to this her bipolar illness and her mother's death, and it's hardly surprising that she joined a gang and got into trouble.

Part of the manifestation of bipolar illness includes reckless spending. One day, credit card in hand, Susan bought 11 portable AM/FM stereos and gave them away in a mall parking lot. She thought if she gave people things, maybe they'd like her and she'd be worth something in their eyes. She was trying to earn love from somewhere—anywhere. "But this didn't work," she told me tearfully. "People just thought I was crazy. So I started looking for love in sex. That didn't work either. They just used me." Her eyes welled up with tears. "You're a chaplain. I'm a horrible person. Why do you even bother talking to me?"

I was tempted to jump right in with stories of God's unconditional love, to say she was one of His children and that Jesus commanded us to love one another. But she had made the rules at the outset: None of that "God stuff." Now that she was opening up, I didn't want to lose her, so I just smiled and replied, "Because I care about you." Meanwhile, I was praying that God's love would shine through me and that eventually she'd put two and two together. I did not judge. I did not show shock at her sometimes-raw language. I just listened. And I really did care. I saw a spark behind the toughness. I saw potential. But most of all, I saw one of God's precious children who was in great pain.

Susan was in and out of the hospital eight times that year. Usually she was admitted in serious condition, hallucinating, hearing voices, and often after

another suicide attempt. I spent a lot of time talking with her, encouraging her, and believing in her worth as a human being.

Susan's family rarely visited. A friend or two might, but not often. She felt lonely and abandoned. The people who knew her best and cared most about her were those of us who worked in the hospital. Her family was still active and involved in their church, yet nobody from there visited her—a situation all too familiar in psychiatric hospitals. Either the patient is ashamed of being there and tells no one—often the case because of the stigma of mental illness in our society—or people are afraid to visit because they don't know what to expect. In many cases, the pastor tries to visit and is told that the patient is unavailable because of scheduled activities. Pastoral visits are sometimes discouraged because involvement in religion is seen as part of the problem and clergy are thought by staff to be meddling. Whatever the case, the patient is isolated from some of the very support he or she needs.

Through therapy, Susan eventually stopped drinking and doing drugs. When she finally stayed out of the hospital for a time and became somewhat stable on a large number of medications, she decided one Sunday to come to the church where I was on staff. Perhaps she wanted me to see her outside of the hospital setting. Perhaps she came because she was curious. Perhaps she came because God nudged her and something deep within her responded. Whatever it was that brought her there, it brought her back, thus making it possible for me to be in communication with her. (Hospital rules prohibited such contact once a patient was discharged, but her becoming a member of the church changed that chaplain/patient relationship to one of my being her pastor.)

Our congregation had been educated about mental illness. In the days when patients would stay in the hospital for two or three weeks, members of the adult class wrote notes of encouragement to them. They knew only their first names and that they were patients in a mental-health unit. They wrote to them and prayed for them. I took the letters to the patients when I went to do services on Sunday afternoons. It was a powerful experience for both writer and recipient. Therefore, when Susan came to church, had the congregation known of her illness, it would not have made any difference to them.

Susan and I continued to talk, and one day I suggested she take some classes at the local community college. She protested that no one would like her, or even talk to her, and that she couldn't afford it anyway. I suggested she apply for financial aid. I also told her that she was a very likeable person and that I knew she wouldn't have any problems being accepted.

Later that year, she called to ask if I would help her with the financial-aid paperwork. I was delighted and made an appointment to see her the next day. We got the forms done and mailed, and, lo and behold, she got the aid she needed—tuition and books! But because her family was unwilling to offer any help at all, she had no appropriate clothes to wear. And so the church provided gift certificates for clothes through the generosity of several folks who provide ongoing anonymous funds for just such things.

She got involved in school, studied hard, took her medications regularly, got straight A's, and was hospitalized only three times during her two-year program. She graduated with honors and got a job in the field she had studied.

I'd love to say she lived happily ever after, but that's not the nature of bipolar illness. At some point the job became very stressful, her family became very demanding, she stopped taking her medication, and again she was hearing voices telling her to kill herself. She came to see me and talked and talked about having no reason to live. By this point, we had long since talked about "the God stuff," and she knew I prayed for her daily. I told her that she was one of God's children and that she was loved, but that didn't seem to be enough. I'd run out of things to say. As I sat there with tears running down my face, she said, "If you care that much about what happens to me, then I guess I should go to the hospital." So we called her doctor, and I drove her to the hospital.

Susan's life will never be free of mental illness. Often people with bipolar disorder (and other chemical imbalances) stop taking their medications because they don't like the side effects or because of the almost prohibitive cost. The result of getting off of medication is hopefully hospitalization and not suicide.

Susan is older now and has found several reasons to live. First of all, she knows that she is loved. Her needs have been provided for when logic said otherwise. People she doesn't know have helped her. Prayers have been answered

in dramatic ways, from finding her an apartment to finding her a job. Her family relationships are still rocky, but she tries not to let that bother her. She accepts family members as they are, loves them, and doesn't let their behavior get to her. She knows now what she needs to do to take care of herself, and she does it because she has finally learned to love herself.

Susan is working part-time and living in subsidized housing. She will likely never be able to work full-time or fully support herself. Social Security disability payments help her live as a fairly independent, productive member of society. She sees a therapist weekly and her psychiatrist monthly. Her medication must be monitored to ensure the doses don't become toxic. But she has taken responsibility for her life, and her faith is a big part of that life. She knows from whence her help comes.

CAREGIVING CONSIDERATIONS

Bipolar disorder usually shows up in adolescence or early adulthood. It is estimated that this disorder affects 4.4% of the U.S. population. Worldwide, the percentage is said to be about 2.4%. Some experts, though, contend that this statistic is inaccurately low due to non-reporting in many countries because of the long-standing stigma associated with mental illnesses. Additionally, in many other cultures, people suffering from mental illness are just written off as crazy or weird, or they are locked up in a room. In some oppressive governmental regimes, such people are executed because they are considered "imperfect" and thus useless to the greater society. None of this attitude is based on truth. If they get treatment and consistently take their prescribed medications, people who suffer from bipolar disorder can take their place in society just like anyone else, and should not be discriminated against any more than someone who happens to be diabetic or have severe allergies and is reliant on medications to maintain wellness.

It is true that bipolar disorder is a lifelong medical illness for which there is not yet any known cure. The disorder, which tends to run in families, causes extreme mood shifts, and thus affects energy and overall ability to function. It is characterized by periods of mania and periods of depression. In a manic state the patient may be energetic, restless, not sleep, spend wildly and irresponsibly, talk

rapidly, abuse drugs and act out sexually. The manic state causes the patient to feel euphoric and to deny that anything is wrong, or to feel paranoid and angry.

A hospital coworker of mine was suffering from a bipolar disorder, and I never knew it until stresses in her life began to cause problems. Her mother was dying, and she broke up with her long-term boyfriend. She began having a difficult time at work, so she consulted with her psychiatrist, who adjusted her medication. As chaplain, I met with her and talked about her losses and offered the sort of care I would offer any other person going through such traumatic times. It is important not to blame situational depression on the illness.

In a depressive state the patient may feel hopeless, helpless and worthless. He or she may lose interest in doing anything—even getting out of bed, bathing, or eating. Concentration may be difficult, and there may be changes in sleep patterns, often involving excessive sleeping. The person may gain or lose weight. Thoughts of death and suicide are common, as are actual suicide attempts.

Bipolar patients can be very perceptive and often very paranoid. If a caring person is just "going through the motions" and doesn't really care, the person will pick up on that very quickly. Working with people like Susan takes a great deal of patience. When bipolar people are in a depressive state, they have a very hard time believing anyone could possibly care about them. They must be convinced.

Furthermore, bipolar illness is not a short-term problem that will simply just go away with time. Current medications go a long way in controlling symptoms, but they do not cure the illness. Loss, extreme stress, physical-health issues and financial problems may well trigger a setback.

There are effective treatments available for bipolar disorder, but unfortunately people with bipolar disorder often don't realize they need help. More than 13 million people in America, men and women alike, suffer from this disorder. It is a chronic and lifelong illness. When these folks or their loved ones do approach us for help, they should be encouraged to see a mental-health professional and, in some cases, must be taken to a hospital for treatment for their own protection. But medication is only one part of what they need. Understanding, support and education about the illness is essential. And as I've worked with people who suffer from mental illnesses, I have come to believe

strongly that an educated church family or other community important to them can be hugely helpful in just being there and loving people who are afflicted by such an illness. Everybody needs to be loved and heard. They are no different from the rest of us in that way! The bottom line is that anyone suffering from any illness seems to recover faster and get along better in life if they have understanding and loving friends to support them.

3.
But what if?

ISSUES RELATED TO ANXIETY

KYLIE

It was the winter of Kylie's sophomore year of high school, and she was sitting in math class. All of a sudden, a wave of nausea came over her. Here is her story:

"I got up and walked quickly to the bathroom, where my heart rate skyrocketed, my head spun, and I started hyperventilating. After what felt like an eternity, though was probably only 10 minutes, I calmed down and regained my composure. My hands and legs were shaky, and my face was tingly, but other than that, I felt just fine. I was still afraid it would come back though, so I called my mom and went home, where I fell asleep on the couch.

"When I woke up, I felt completely back to normal. That evening, I was watching TV, drinking a glass of water, when suddenly my throat seemed to close up. I couldn't swallow, nausea overtook me, and my chest tightened. Panicking, I started hyperventilating and crying. My face and legs went numb, and I got lightheaded. My grandma gave me some sort of medication to calm me down, and 30 minutes later, I was breathing normally and could feel my extremities again.

"When I went to bed that night, I laid there, wondering how sick I actually was. Obviously, I was losing control of my body. I tried to go to sleep, but the events of the day raced through my mind. Soon, I started choking for air again. Nausea, rapid breath, and tears followed. Then came hot and cold flashes, along with uncontrollable shaking. In addition to all that, I felt like I had lost control of the muscles in my face—they were tense and tingling, and I could hardly open my mouth. I called for my mom, who came in and tried to calm me down. She told me that I was having a panic attack. I told her I was dying. She assured me I wasn't. I told her I needed to go to the hospital, I needed medicine, that this was the third time today, and it had only gotten progressively worse. Still shaking and crying hysterically, I curled into the fetal position and tried to pull myself together. Each time I started to feel better though, I would think about the attack and start shaking and crying all over again. Eventually, my body was so exhausted from the panic attack that I just fell asleep.

"Over the next two weeks, I fought off two or three full-blown attacks per day. Sometimes they would start on the way to school—that's when my mom would turn around and drive home, and I would go to school an hour or two later. Often times, I would have one in the evening, before or after dinner, and another before bed, or be awakened by one in the middle of the night. The attacks all presented in almost exactly the same way: First would come nausea, followed by hyperventilating, dizziness, hot or cold flashes, and sweating. I would shake uncontrollably and cry hysterically, as thoughts of death or insanity consumed my mind. As I became exhausted, my hands, legs, and face would get a pins-and-needles sensation, which told me that the attack was on its way out. When I wasn't having a panic attack, I worried when the next one would surprise me. Wherever I was, I made sure that there was an easy way out if I needed it. The fear consumed me.

"Finally, after two weeks without improvement, I went to my family practice doctor, who diagnosed me with Panic Disorder (I realize this doesn't fit with the one-month criteria in the DSM, but I think my physician figured that the pattern would certainly continue unless I started treatment.) She put me on Zoloft, an

antidepressant also used to treat anxiety, and prescribed Xanax for me to take when I had a panic attack. She also referred me to a therapist."

Kylie was not pleased with the referral and readily admits that her mother had to drag her to the appointment. She continues:

"I was fine with taking medication, but if I had to see a shrink, that meant I was crazy, right? The first week, my mom came to counseling with me. The next week, I went, but refused to talk. The week after that, I refused to go into the office, so my counselor came and sat in the car with me. Slowly, I began to open up to her, and she gave me some coping mechanisms for when an anxiety attack presented, like breathing techniques and imagery. Music seemed to help as well. I also had to write down each attack and its physiological symptoms.

"For the first week or so [after starting treatment], I still had one or two attacks per day, and had to take Xanax each time. Gradually, though, the regular medication took effect, and my attacks began to become fewer and farther between."

Some weeks, Kylie and her therapist didn't talk about anxiety at all. Other weeks, it was the main focus. Regarding her therapist, Kylie says, "She became someone who I could confide in, and share my stresses with. Not only did she give me coping methods for my anxiety, but also for managing my life and my stress. For two-and-a-half years, I saw my counselor once a week, talking through the past, present, and future. I also took my Zoloft daily. The combination finally almost eliminated my panic attacks.

"When I got to college, one of the hardest adjustments was not seeing my therapist each week. In the past two years, I have definitely had some unexpected panic attacks, but nothing near the frequency of how I began."

Four years after this all started, Kylie told me, "During the 2nd semester of my sophomore year [in college] I think I only had 2 panic attacks, and I managed to survive them without taking Xanax. I have become much more open about my disorder. I know I still have progress that I can make—for example, I'm still not convinced that a panic attack can't kill someone, and the thought of having an unexpected attack still scares me. Despite those traces, though, I am in a better place than I have ever been. One day, I hope to be able to stop taking my

medication altogether, but for now, I'm happy with where I am as the attacks become fewer and farther in between. With the help of my therapist and my panic attack journal, I began to recognize the beginnings of an attack, and use my coping methods to keep it from advancing."

Kylie continues to use these strategies taught to her by her therapist along with prayer, music and other techniques that will likely always be a big part of her life.

TOM

Tom's experience with Panic Disorder started ten years after he graduated from college, although symptoms he'd had during college (which he blamed on too much caffeine) were probably early warning signs. Several of these "shakey times" ended up with him going to the university's medical center. His first major, identifiable panic attack, however, struck when he was working on an important and precise project for a major manufacturer. Tom was an engineer who was highly respected for his expertise in specialized fields.

Tom was working on the project when suddenly his head began to spin, he felt numb and unable to breathe, and couldn't even stand up. He was taken to the company's health center, where, after lying down for a while, he felt he could go back to work. But halfway down the hall to the project site, all the symptoms returned, so he called his wife to pick him up and take him home. There he made an immediate call to his family physician, who secured an immediate appointment for him with a psychiatrist. Tom says, "Then I curled up on the couch in a fetal position where I essentially stayed for 2 months."

Tom started taking medication, going to therapy, and eventually returned to work in a less-stressful position with a different company. His basic symptoms, however, continue to exist, with periodic shakiness, lightheadedness, and at times, what he described as "brain fog." Further, he reports that about once a year, when he really "overdoes it," he will have another full-blown panic attack.

SARAH

Panic attacks are not limited to teens and adults. When I was a chaplain in the children's unit at a psychiatric hospital, a young mother from my church called, worried about her 3-year-old daughter, Sarah. The family had just watched an innocuous animated movie on TV. When the mom put her daughter to bed, Sarah began screaming, "I don't want to die!" She was trembling, nauseous, and her breathing seemed labored. She seemed to be very upset.

The mom called me and asked if little ones can have anxiety attacks. I consulted with nearby staff members, and we concluded that was exactly what was happening. Nothing similar happened to Sarah until adolescence, when one night she suddenly had shooting pains in her arm, and pain in her thumb and finger. This woke her up, and her parents took her to the emergency room, where her condition was diagnosed as a panic attack. Sarah had other episodes in adolescence, at which time her doctor recommended she meet with a psychotherapist.

Now an adult, Sarah describes a panic attack as "one of the scariest experiences of your life. Out of nowhere, your heart starts racing and you begin to sweat. You feel shaky, cold, dizzy and nauseous. Your chest grows tight and you feel as if you are choking. You think to yourself, *I need to escape. I'm dying.*" But those suffering from panic attacks come to learn, through good psychotherapy, that they are not crazy or dying but are having a panic attack.

CAREGIVING CONSIDERATIONS

Anxiety is a normal reaction to stress, and we all experience it at one time or another. People often feel anxiety when they take an exam, go to a job interview, or are called upon in class. It is only when anxiety becomes an irrational and excessive dread of everyday activities that it can become a disabling disorder if left untreated. Panic Disorder is not the only manifestation of an anxiety disorder. Other types of anxiety disorders include Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder and Social Anxiety Disorder. According to the National Institute of Mental Health, scientists' current

thinking is that anxiety disorders probably result from a combination of genetic, developmental, psychological and environmental factors.

Some six million American adults live each day fighting to overcome Panic Disorder. Panic attacks can happen at any time—even when one is asleep! The good news, however, is that panic disorder is one of the most-treatable anxiety disorders. To many people, the thought of having a mental disorder is equivalent to being mentally incapable, and they see it as something shameful. Few people realize that they probably interact daily with someone who struggles with a mental illness. To control their panic and anxiety, most people learn to deal with their illness through therapy, medication, and relaxation techniques. Panic-Anxiety Disorder is a serious disease, and while it is life-altering, it is also a common and treatable mental-health issue.

Almost everybody experiences some sort of anxiety throughout their lifetime because anxiety is a common reaction to stress. However, when anxiety becomes extreme, many times for no apparent reason, it is no longer an ordinary experience, but instead a debilitating disorder. Some may argue that anxiety disorders aren't real, that "anxiety disorder" is just a term to make a normal emotion sound more serious than it really is. Those who suffer from anxiety disorders certainly beg to differ!

Because anxiety disorders are the most common type of mental illness in the U.S., chances are most people know someone with an anxiety disorder and don't even realize it. Many of those affected feel ashamed of their condition and tend to hide the fact that they have any problem with anxiety. Thus it is often difficult to discern that a person suffers from an anxiety disorder.

Panic Disorder is characterized by randomly occurring panic attacks and the constant fear of experiencing one without warning. The Anxiety Disorders Association of America defines a panic attack as "the abrupt onset of intense fear that reaches a peak within a few minutes and includes at least four of the [symptoms of a panic attack]." Physical symptoms can be a combination of any of the following: sweating, nausea, trembling, heart palpitations, a choking feeling, struggling to breathe normally, chest pain, dizziness or lightheadedness, chills or hot flashes, and tingling sensations in the face, arms, fingers and legs. Emotional

symptoms include an extreme fear and feeling of dying or going crazy and a sense of things being unreal. The symptoms become so intense people experiencing a panic attack often misinterpret their symptoms as those of a heart attack or breathing problem. Panic attacks strike out of the blue, so after one occurs, most sufferers constantly stress over when it will next happen. “It becomes psychosomatic,” says a health teacher at a large, top-ranked, suburban high school. “It’s debilitating and consuming, and I don’t think people realize that.”

There is no confirmed knowledge of the causes of anxiety disorder, whether it is a genetic issue or one that develops as a result of certain circumstances. Interestingly, however, Tom’s daughter and Kylie’s father have both suffered panic attacks. Despite how little is known about how anxiety disorders are acquired, clues to the sources of panic attacks may be found in the knowledge that they are sometimes triggered by nothing but a simple mistake by the body. Symptoms of sleep deprivation (muscle fatigue) or hunger (nausea, dizziness, muscle fatigue) may be misinterpreted by the body as symptoms of a panic attack. When this happens, the body thinks it is having a panic attack, thus increasing the intensity of those symptoms while bringing about other panic-attack symptoms.

In recent years, researchers have found that abnormalities in the brain’s limbic system may predispose people to the development of panic attacks. Other lines of research suggest that the brain chemistry of panic-attack sufferers may be off-kilter. Also, some Canadian researchers have found evidence that Panic-Anxiety Disorder may be genetic, so perhaps panic disorder is both predetermined and developed; nobody can yet say for sure.

While Panic-Anxiety Disorder is a serious mental illness, it is also the easiest to treat. Medication, therapy and relaxation techniques are all ways to help control anxiety. Medicines such as Zoloft or Paxil are often prescribed as preventatives for anxiety disorders. Others, such as Xanax, can be taken to subdue symptoms of panic attacks during an onset. While medicine has been proven effective, some controversy surrounds the prescribing of medication for adolescents and teens, considering that some anti-anxiety medicines can *enhance* suicidal thoughts. “We need to look at individual cases. They’re very different. Some people need the

medication," says the health educator. "Personally, I believe talking to someone should be the first thing."

Generally, panic-disorder patients are more relaxed and less susceptible to panic attacks when they feel they have control over what is happening to them. When the brain feels it does not have control, the patient begins to feel anxious and panicky. Counseling and cognitive therapy have both been proven effective in treating anxiety disorders. Many therapists recommend relaxation techniques such as meditation, controlled breathing, yoga or relaxation tapes. Many patients also find their own ways to relax, such as journaling or listening to music. All of the aforementioned treatments, when used properly, have proven very effective in treating anxiety disorders. There is no cure for panic disorder, but as researchers gain more insight on the disease, there is hope for more dependable treatment and preventive techniques.

Panic-Anxiety Disorder is a serious, common and treatable illness that affects millions of Americans. While the disorder is not yet fully understood, there is great hope for future improvements. "Our personal battles should not bring us down," Kylie says, "but instead should make us stronger." Her disorder is under control and no longer terrifies her because she understands what is happening. She reports that the coping skills take time and practice and a conscious choice to beat the effects of this disorder. She stresses the importance of prayer and music as being major weapons for her in this battle. She recalls, "The first thing that helped me was Mom prayed with me."

In a perfect world everyone would have praying parents like Kylie's mom, but in reality it is often pastors who are the ones called upon to do the praying, because parents think they don't know how to pray, are afraid they don't "pray right," or are so stressed and frightened by the family member's panic attack that they are simply overwhelmed and they themselves panic. There are often times that a pastor or other trusted support person will receive a frantic "I need you here" call regarding a serious panic attack. It could be a phone call reporting someone having what they think is a heart attack. A recommendation should always be made to immediately call 911 if it is a first-time thing, and then, of course, the support person should go to the hospital as soon as possible to be with the frightened family. When the event is diagnosed as

an anxiety attack, it is important not to be dismissive. “Hey, no big deal. It wasn’t a heart attack; it was just a panic attack” is definitely NOT what one should say. Those who attempt to help someone in an emergency should never trivialize the ultimate diagnosis of a panic attack. Doing so could make the patient feel he or she should never have bothered you and was overreacting or being stupid—and that is certainly NOT what we as caregivers ever want to imply. There still remains a very real physical disorder that needs to be named, respected and dealt with.

With increased understanding and awareness of Panic Disorder, those who fight each day to overcome their anxiety will become more familiar with their condition and have greater support from understanding people, which will ultimately give them the hope and strength they need to conquer their anxiety. May we who offer them support always be counted among those understanding people.

4.
Quick, get under the table now!

POST-TRAUMATIC STRESS DISORDER

MIKE

What began as a harmless prank gone awry ended with the kids, all recent high-school graduates, standing before a judge. Mike was faced with a decision: He could join the Army, or go to jail. So, at the age of 17, he became a member of the U.S. Army. After basic training and a few months of being stationed in the States, he volunteered to go to Vietnam. The first night there, he was assigned to guard a helicopter. He was the only guard, and for the first time he actually had a loaded rifle, with which he was to shoot another human being if that person was the enemy. As the night progressed, a heavy fog rolled in. Soon Mike realized he was completely unable to see the helicopter. In trying to find it and not get lost, he marched four, then five, then six steps back and forth in every direction, hoping to run into that large metal object. The night got darker, the fog got thicker, and he realized he had truly lost the helicopter. This was his first night in Vietnam, he was 18 years old, and he had lost an Army helicopter.

This young man was terrified. All he could do was stay where he was until daylight. He had no idea what would happen to him when he had to report to his sergeant that he had lost a helicopter. Mike says it was the first time he

remembers experiencing real fear. That fear was part of his training to be a soldier in Vietnam, where he saw his best friend die.

Mike was also an EMT in Detroit for three years. He still wasn't much more than just a kid. During those years there was a lot of civil unrest in the country's big cities. During the riots in 1967, cities were burning and shots were being fired. Another part of Mike's Army training was being taught to fall to the ground whenever shots were fired because otherwise he would likely be killed. Along with the other EMTs, he went in ahead of the cavalry, which was seven deep and followed by 500 troops marching behind in cadence. During that time as a first responder, Mike saw even more danger and death.

In the three years after Mike left active duty, he was jailed three times for assault. He'd been drinking heavily to try to make the sounds and scenes of war go away. When other patrons of the bar started jeering at him about his Army service, he went after them. He was a big guy and had been trained to kill. After a short while, his wife was ready to leave him because of his drinking and brawling, so he finally checked in to the Veterans' Hospital, where he started on the road to recovery from his alcoholism. Once Mike stopped drinking, he was able to get his life together, get a good job and raise a family. Although he still reacted whenever he heard something that sounded like gunfire, for the most part things were going well. He felt like that was all behind him.

Fast-forward about 25 years. One lovely fall day, he and his wife decided to go to a nearby park to see a Civil War reenactment. It was all set up very realistically. Mike and his wife were enjoying seeing all the uniforms and the fancily dressed women and children. Then came time for the battle to be reenacted. When the first shot was fired, Mike, sitting in the audience, fell to the ground and started sobbing uncontrollably. Finally, in this unlikely place, all the stress of war and death suddenly caught up with him. He and his wife realized that he needed some serious help. The very first thing they did was call their pastor for comfort and advice. Mike was suffering from Post-Traumatic Stress Disorder.

By the way, the helicopter-guarding incident, and the fear that came from it, was an intentional part of his training. When the light of morning came, Mike saw that the helicopter was surrounded by piles and piles of sandbags and a whole lot

of Marines and was probably safer there than anywhere in the world. The purpose of the exercise was to intentionally terrify a soldier as part of his combat training. But not all people are trained for the many events that trigger the stress button, and it is not just those who have been directly involved in life-and-death matters who suffer from PTSD.

ALINA

Alina was surprised when her therapist diagnosed her with PTSD. She'd never been in a war or a mass tragedy. Oh, sure, a semi had driven out right in front of her when she was driving a VW Beetle with her 5-year-old in the back seat, totaling the car and leaving her with long-term neck problems, but that had been years ago. Well, yes, she'd had an unpredictably abusive husband and never knew what to expect from him, but that was a long time ago. He had died suddenly 20 years ago, so what bearing did that have on anything? Her most recent problem was that she lost her job doing something she loved and had done for a long time. A person who she thought was a good friend, who happened to be her new boss of a couple of years, turned on her and took away all of Alina's work responsibilities. That really was very traumatic—in fact, the sudden shock sent her to the hospital with transient global amnesia. She completely lost seven hours of her life, remembering nothing that happened during that time. Even though it was not physical, the pain was major. She essentially felt like everything she loved and was dedicated to working hard for had been suddenly stripped away. Interestingly, she had offered to resign when the new boss came on board, but was told she was really needed because she knew all the people and dynamics of the organization where she worked.

Alina was a widow who lived alone. Her mother, one of her best friends, had died just a year earlier. Five years before that, Alina had sold the house she'd lived in for 40 years and moved to be closer to the only family she had in the area. A lot of good old friends, and the church she had been part of since its founding 35 years before, had basically been left behind. Her circle of friends in her new location consisted almost entirely of her coworkers.

When she woke up in the hospital after the amnesia episode, she had no idea what happened or where she was. She had no memory of her daughter taking her to the emergency room or of anything else from the previous evening. Ultimately her daughter and her pastor were the ones who helped her piece it all together. Before she was discharged, she had a psychological evaluation and was advised to seek therapy. It was that therapist who diagnosed her with PTSD.

TED

Ted had a totally different, yet similar, experience. He was a dedicated career military man with a spotless record. The officer under whom he served directly as a right-hand man inexplicably demoted Tom just as he was about to retire. Because of that, his pension was reduced, he felt shamed, and there was no retirement party as was customary. He was expected to just sort of vanish. It took ten years for the injustice to be righted, and by then his self-esteem was pretty much gone. When his rank was restored, the pension corrected, and a party thrown, everything *looked* right, but Ted grieved what he had lost.

He and his wife were accustomed to living in very close-knit communities with other military families who understood the military life. They both missed that acutely when they moved away from the base to a town where they only knew a few family members—and they were all busy with their own lives. Ted and his wife really didn't know how to learn to fit in to a nonmilitary living situation.

On top of this, Ted was a man who was always hopeful that one day his "time would come." He now feels that his time has come and passed and he missed it. His life is filled with negativity and hopelessness. He pushes away the people who love him and want to help him. Being betrayed by someone with whom he worked closely and trusted appears to have totally taken all the wind out of his sails. He's also mad at God. Like Alina, Ted too suffers from PTSD.

CAREGIVING CONSIDERATIONS

Post-Traumatic Stress Disorder is classified as an anxiety disorder with some similar symptoms to panic disorder. We all have a fight-or-flight response that, when healthy, protects us from harm. It is a completely normal reaction. In Post-Traumatic Stress Disorder, however, this instinctive reaction is changed or damaged. The person may feel stressed or frightened even when there is no longer any danger. This disorder can strike anyone at any age. It can be caused by physical or sexual abuse, accidents, disasters such as tornadoes and hurricanes, the sudden or unexpected death of a loved one, or seeing a friend or family member harmed or in danger.

Symptoms of PTSD include re-experiencing the event, flashbacks, bad dreams and frightening thoughts. Feelings are often expressed as emotional numbness, strong guilt, depression and worry. Many victims have trouble remembering the actual event that started the whole thing but stay away from things that remind them of the experience. Often people report feeling on-edge and having difficulty sleeping, eating or concentrating.

Also characteristic of PTSD is being easily startled, feeling tense and having inexplicable angry outbursts. The symptoms, rather than being triggered, are usually constant and can cause stress, anger and problems concentrating. Some of these, of course, are natural after a dangerous or traumatic event, but they normally go away in a few weeks. This reaction is called Acute Stress Disorder, and the onset of its symptoms is immediate. It is only when it continues for a long period of time, or shows up weeks, months or even years after the event, that it is considered to be PTSD. That is suspected when a person has what is called re-experiencing symptoms, avoidance symptoms, hyper-arousal symptoms and symptoms that interfere with the activities of daily living. Not just adults have these problems; children can also be affected by Post-Traumatic Stress Disorder. Very young ones might start to wet the bed, forget how to talk, or become very clingy to their parents. They may also act out the traumatic event while playing. Older children may show disruptive, disrespectful or destructive behaviors. They may feel guilty about not having been able to prevent an injury or death that occurred, or they may find themselves obsessed with getting revenge.

PTSD manifests itself on many levels. Eleanor, for example, was driving her car when she was hit from the left side by a speeding car that T-boned hers. She temporarily lost the ability to calculate or to remember, and for the first three days after the accident she constantly asked where her daughter (who had not been with her at the time of the accident) was. It was 30 days before she could return to work. Even now, 20 years later, when something approaches her from the left and surprises her, she is startled and jumps.

Many of those suffering from this syndrome may even have trouble remembering the actual event that started the whole thing. Alina's case of transient global amnesia was an extreme, but temporary, example of this, but even now, some years later, she only knows what happened because family and friends filled in the blanks. Most people who remember the event or events that caused the problem try to stay away from anything that reminds them of it.

Certainly not everyone who suffers a traumatic event gets PTSD. The incidence is based on resilience factors and risk factors. Resilience factors include seeking support from family, friends or support groups; feeling good about one's own actions in dangerous situations; having a coping strategy for getting through a bad event and learning from that experience; and being able to act and respond effectively in spite of feeling fear. Risk factors, on the other hand, include living through dangerous events, having a history of mental illness, being seriously injured, seeing people hurt or killed, feelings of horror, helplessness or extreme fear, loss of a loved one, loss of a job or home, and having little or no social support.

The most effective way to help people going through Post-Traumatic Stress Disorder is to encourage them to get diagnosis and treatment. It may even be necessary to make the appointment, take the person to it, and encourage them to continue treatment. We can offer emotional support by listening and by inviting them to join us in fun activities. These people need to be reminded that things can get better. Their own self-help should include exercise, and setting realistic goals and priorities. Helping them break down tasks from overwhelmingly long lists to a number of small, doable jobs can be very helpful.

It is important to know that survivors may feel vulnerable and confused about what is safe. This can make it difficult to trust others, even those they trusted in the past. Thus they may isolate. On the other hand, they may become overly dependent and try to take up far more of your time than you have available. It is, for the caregiver's wellbeing, always important to set boundaries such as ending times for meetings with them.

PTSD is usually treated with psychotherapy (talk therapy)—either individually or in a group—for 6-12 weeks or longer, medication, and/or cognitive behavior therapy. The latter includes exposure through mental imagery, writing or visiting the scene to take a realistic look at what happened and being able to realize that it was not their fault, or stress inoculation therapy, which teaches the person how to reduce their anxiety and be able to look at memories in a healthy way.

As supportive friends, we must be good, patient, compassionate listeners. People will often need to tell us the same story over and over to deal with it. (I have found this to be especially true when dealing with people who are grieving.) It is also very important to remember that we are NOT their therapists, nor should we allow ourselves to be used as such. I cannot stress enough that our job is to listen, love and REFER!

5.
I wanna do it my way!

EATING DISORDERS AND OTHER CONTROLLING BEHAVIORS

Many people are not comfortable unless they feel in control of every situation they face. Eating disorders and obsessive-compulsive disorders are two of the most prevalent problems faced by overly controlling people and are manifested in a wide variety of ways.

CAMILLE

Camille was a very pretty girl. At the ripe old age of two, she was featured in an advertisement for a department-store chain. More and more jobs were offered her, and by the time she was 13 she was an internationally recognized model. Her parents never worried about her extreme thinness. After all, models had to be thin. She was a good student, and her tutors kept her up with her classes as she traveled throughout the world.

When she was 17, she came to me one day and admitted she had been anorexic and bulimic since she was ten—and addicted to heroin since she was

fourteen. Heroin, she claimed, helped control her appetite. But she was bright enough to know that her addiction and eating disorders would kill her, and that she needed help.

Camille's parents were in denial. Even though she'd been hospitalized briefly for her eating disorders, they didn't really think there was a problem. "It's just because she's so concerned about her career," her mother said. "After all, we all have gone on diets." Camille was frightened. Without her parents' support, she didn't know if she would be able to overcome her problems. She felt very alone. Furthermore, she was ashamed and didn't want anyone to know that anything was wrong; she had an image to maintain. She was the famous Camille—a celebrity in her school, her church, and her neighborhood.

ELLEN

Superficially, Ellen seemed an entirely different case. A sophomore in college, she was grossly overweight. One day she called and asked if we could have lunch. I knew immediately that this wasn't a casual luncheon invitation but an "I've just got to talk to you" lunch. And so, looking at my packed calendar, I made a few changes and made a date with her for that very day. As she ate the last of her double cheeseburger, which she was downing with a chocolate shake, she looked at me with the saddest look I've ever seen. Her eyes filled with tears and she blurted out, "Can I tell you something? Something that you can't tell anyone?" I replied that of course she could, and she proceeded to tell me about an uncle who had sexually abused her from age eight to thirteen. She sobbed, "I never want another man anywhere near me. If I stay fat, they'll stay away." Food meant safety for her.

Ellen had every bit as much of a problem as Camille. Camille was obsessed with controlling her figure and her career. Ellen was set on controlling her relationships with men. And they both felt in control as long as they could control how much they ate.

Many people with eating disorders are very controlling people. Often they are also compulsively good students and real neatniks. They are obsessive about their eating patterns just as they are about studying, getting straight A's and being perfect.

Often they are trying to please a parent—one whom they will probably never please no matter what they do.

SANDY

Sandy was like that. She just wanted her dad to praise her. She got all A's and played on the winning varsity volleyball team. When she was elected captain, her dad's comment was, "I would have been disappointed if they hadn't elected you." When she made National Honor Society, her father said, "It's just what we expected of you." But Sandy wanted attention from her dad, so she started exercising. Soon she was exercising eight hours a night, sleeping little and eating less. She got thinner and thinner. She began to find that eating even a little food made her feel guilty and that making herself vomit after she ate tended to ease the guilt. And so a pattern developed; she binged, she purged, she exercised, and she felt in control. For a while Sandy wore big, baggy sweaters that covered up her increasing boniness—but then summer came. When she put on shorts and T-shirts, it was evident that she had become shockingly thin. It was then her mother called and invited me to lunch.

As she picked at her salad (without dressing), Sandy's pencil-thin mom told me of her daughter's behavior. Sipping a diet drink, she said she couldn't imagine why Sandy was so obsessed with what she ate. I gently suggested that perhaps she was trying to be like Mom and had gotten a little carried away. It was clearly time for Sandy to have a complete physical exam and probably some long-term counseling. I stressed to her mother the seriousness of anorexia, telling her very pointedly that some people actually starve themselves to death.

MELINDA

Melinda was a gymnast who, at age 16, became pregnant and had an abortion because her father made the appointment, took her to the doctor, and she felt she had no choice. After that, she believed her life had no meaning to anyone, and that's when she became bulimic. Her eating was the one thing she could control. She married at 18, got pregnant, had a miscarriage, and was told she could never

have children because of the scarring from the abortion. She felt she had lost everything, and became a flight attendant to get away. To her, "bulimia was a powerful enemy that consumes everything." She had a love/hate relationship with food. She was in so much psychological pain that she used bulimia to feel in control of something. She was beautiful, smart, suicidal and very unhappy. Her marriage was rocky, but then she became pregnant again. Even though she'd been told she could never carry a baby, she hoped and prayed that this time would be different. She stopped being bulimic as soon as she found out she was pregnant, and she gave birth to a normal, healthy baby. I'd like to say she lived happily ever after, but her husband deserted her and their child, and she ended up a single mom. Fortunately, she had computer skills and some training and was able to get a job to support that little family of two.

Her child is since grown and out of college. Melinda has found and married a man she loves and who loves her, and she has been able to put a lot of her past pain behind her. She is no longer bulimic but admits she still is often tempted by bulimia. Fortunately, she has a deep love for God, a strong marriage, a good job, an excellent relationship with her child, and is going to school part-time to complete the education she started so long ago. She knows that bulimia could have killed her. She was one of the fortunate ones who overcame her eating disorder and was left with no permanent serious problems from it.

Eating disorders are especially common among teenage girls and young adult women. However, they are not limited to young people, as evidenced by Sandy's mom. Compulsive eating behavior goes way beyond a teen's desire to be attractive, as we see in Ellen's case. Her obesity, Camille's anorexia and heroin addiction, and Sandy's anorexia and bulimia, are all life-threatening disorders.

BILL

Although most people with eating disorders are women, men are not immune. Bill was an obsessive-compulsive perfectionist. He used to be a really big eater. He was a chubby child who grew into a chubby adult. When he reached 265 pounds, a doctor who was seeing him for the first time told him, "Lose 100 pounds, and I don't care how you do it." Bill was the kind who was always

anxious to please. He'd spent his life trying unsuccessfully to please his father. He went on a crash diet. He ate nothing but fish and green vegetables and lost a lot of weight. But Bill really missed the extra-large pizzas he used to eat all by himself. And so one night he ordered one, ate it, got sick, and discovered bingeing and purging. From that point on he threw up every meal he ate.

Bill was also abusing thyroid medication at the same time. He was obsessed with getting thin. He eventually lost 135 pounds and looked like someone who had been a prisoner of war. Then he went into heart failure. He was hospitalized for several days, and then became irrational and belligerent; he had developed a toxic psychosis from the excessive consumption of thyroid medication. The hospital called his wife to tell her that Bill needed to be transferred. His wife called her pastor to ask what she should do. He volunteered to take her to the hospital so she could transfer Bill to a locked psychiatric unit in another hospital, as doctors had recommended. The staff made it clear that his wife wasn't "committing" him, but Bill became angry, hostile and threatening. As he begged her to take him home, her pastor gently took her by the arm, saying, "It's time to leave," and led her out of the hospital. Without this loving support she would have had a very hard time actually leaving.

Bill demonstrated many other controlling obsessive-compulsive behaviors besides control through eating. Everything in his house had to be "just so." He always knew if someone else had been in the house—if a towel had been moved, or something new was in the trash, he noticed. It was impossible for anyone to clean his bookshelves, because to clean them properly things had to be moved, and he didn't handle the stress of any change very well. He hated clutter and disposed of things he deemed unnecessary, such as the mail, even if it was addressed to another family member; their belongings if they weren't stored "squarely and properly"; and family heirlooms if he decided they were just taking up space.

FRED

Fred was just as OCD, but in an entirely different way. He never threw away anything. He worried that there might be something valuable amidst all the

clutter. He couldn't part with things, so when he totally filled up one house, he got a second one. That house soon became so cluttered that only his bed and one sofa-seat didn't have things piled high on them. He kept the sofa seat clear so he could watch all of his TV shows. He was so addicted to television that he wouldn't answer the phone or make appointments when any one of his many shows was on. Once he retired, his entire day revolved around watching TV while ordering countless things he didn't need from catalogs and home-shopping shows. He needed a place to put all of these things, so he rented a storage unit. Two houses and their garages were already full. People offered to help him clean things out, but his excuse was "there might be something valuable in there" that they would toss out by mistake. Fred was obsessive and compulsive about buying, hoarding and watching TV. He was a classic hoarder, but he never let anyone into his home, so hardly anyone outside of the family had any idea what was going on. In fact, he did his level best to keep even family out, meeting them instead at a restaurant or some other place so they wouldn't go to his house.

Caregiving Considerations

People with eating disorders are often easier to spot than those with some of these other control issues because of the physical characteristics manifested by anorexia, bulimia and overeating. Extreme thinness almost to the point of emaciation or extreme and increasing obesity can be symptoms. However, we must be careful; some people are just naturally thin and wiry, and others are heavier than most. To assume that all people with these physical characteristics have an eating disorder is as bad as closing our eyes to the disorder.

For example, Sarah, an adult, weighed only 89 pounds. She told me that whenever her family was transferred to a new place, every new doctor always assumed something was wrong with her. Nothing was wrong; she was healthy, ate normally and was just thin—probably due to genetics. Larry, on the other hand, is quite round. So are his sister, cousin, and one of his children. But they are all healthy. He once explained to me that diets didn't work for any of them because their metabolisms adjusted so efficiently to having less food. His other sibling and

three other children are of what we would call "normal" weight. All of this must be considered in a caregiving relationship.

In the case of folks with eating disorders, care often doesn't take place until the person has reached a crisis point, often hospitalization, as in Bill's and Camille's case. However, it is often a non-family member who first notices the signs of dysfunction. Family members see one another every day. It is difficult to notice weight loss or gain from day to day. Pastors or other support people may see these folks weekly, or, in some cases, even less often, and so the change will be more noticeable.

If a teen becomes painfully thin and eats only lettuce at the spring picnic, it's appropriate to gently ask the parents if their child has been ill, mentioning that he or she looks extraordinarily thin. They truly might not have noticed; anorexics and bulimics are very clever at hiding their weight loss and their eating habits. The problem is compounded by the hectic pace of modern life; fewer families than ever eat meals together these days.

Generally, it is a crisis that brings the patient to you. He or she may ask to meet you for lunch, as Ellen did, or perhaps a parent, spouse or sibling will seek your counsel. When you learn of the problem, it is vitally important that you make clear that any eating disorder is a life-threatening illness and that a doctor should be seen immediately.

Though men can suffer eating disorders, such disorders are much more common in women. Both men and women, however, can be hoarders, television addicts, shopaholics, and so on. Controlling behaviors are not limited by age or gender.

Many girls develop eating disorders during early adolescence when they are trying to find their identity. However, eating disorders have been diagnosed in younger children and in older adults. Some of the psychological issues that influence the development of eating disorders include low self-esteem, control issues, unrealistic expectations, a desire to please or to get attention, or, in the case of obesity, sexual abuse of some sort. Often eating disorders are accompanied by depression, substance abuse or severe anxiety.

Anorexia and bulimia can lead to heart problems, erosion of tooth enamel, cessation of menstruation, dehydration, anemia, osteoporosis and other serious conditions. Overeating to the point of obesity may strain the heart, elevate blood pressure, limit mobility, and trigger back and joint pain. None of these conditions is to be taken lightly. They are not just eating patterns, but rather an obsession with food. Again, any of these disorders can be life threatening, even fatal. Anorexia alone has a 15% early-death rate.

It is never easy to tell a person that he or she needs help. However, most of us are not trained to deal with problems of this magnitude, and gently asking if the person has thought about entering into therapy, stressing the benefits of a therapeutic relationship in whatever the case may be, is something that family members or others close to the person may simply not have the nerve to do. If you are a pastor or other confidant, it is up to you to not only listen to them, but often to refer them to the professional help they need.

When someone is hospitalized for an eating disorder, what this person needs is not advice. They are getting that from doctors and therapists. What they need to experience in your visit is unconditional love. Trusted confidants are not called to diagnose, or to tell people how to get well. We are there to remind them that they are important, to love them, and to listen to them and hear what they are and are not saying.

Many people with eating disorders will be hospitalized, sometimes for quite a while. I do not recommend visiting at mealtimes, as those times are a great source of embarrassment and stress. Eating-disorder patients' meals are closely monitored and recorded, so a visitor should never bring any kind of food to the patient. It is also unwise to visit right after meals, because for those who are bulimic, that too is a time of great stress because they are not permitted to be out of sight of hospital staff. They are used to throwing up their food and do not feel in control when someone else is watching them. At other times, a visit may be welcomed. Even then, though, they often do not want others to know anything about their illness. They may be embarrassed because in their attempt to control they have lost control. Or they may ask you to talk with their family members and

explain what they are going through. Each case is as individual as the person involved.

The important thing is that the person be visited and caring support be offered. The illness need not be discussed unless the patient mentions it. Perhaps the best approach is to assure the person that he or she is missed and to discuss what is going on in their absence. In addition, pastors or others might want to offer prayers for strength and healing. It is very important to stay in touch with the person without specifically asking how they are coming along with their problem. If they bring up the issue, then that opens it up for conversation, but if not, then they are probably still very embarrassed about the whole thing and would like to talk about almost anything else! What they need is what we all need—the reassurance that God's love is unconditional and that we are there for them, also loving them. They certainly don't need ANY comments or advice regarding their weight; they are all too obsessed with that already. Our role is to listen to them, pray with them, if they desire, and reassure them that we are and will be walking with them through this difficult time and, more important, that they will never be alone. The truth is, no matter what people do to try to be in control, it just isn't going to happen. Life doesn't work that way.

Many people with Obsessive-Compulsive Disorder can now sometimes be helped with medication and/or psychotherapy. Most hoarders are obsessive-compulsive, so medication might help, but I haven't seen much evidence that such people even realize they have a problem, much less seek treatment for it. However, we still can continue to love them and be there for them in whatever way they need us. Constantly offering to help clean up the clutter doesn't help, because if they even let you in to work for a while, the situation will become even worse as soon as you stop. One family I knew of had an elderly father who was a hoarder with several houses. His heirs are now providing a local nonprofit resale shop with enough merchandise to last them for two years, if not longer. Most of the items are brand-new, still in the shipping boxes.

It is hard for most of us to begin to understand any of these control issues. Probably the best we can do, in most cases, is to be supportive of the family and continue to show loving care to the hoarder/neatnik/control addict who doesn't

even like to have anyone take a tissue out of the box because it will disturb the way he had the tissues arranged. People tend to excuse their controlling behavior by joking about it and telling others that they are really exaggerating. Very few will admit to how things really are. And so we love them as they are as we pray for them to be set free from whatever makes them feel the need to be so controlling.

6.
But they told me to do that

SCHIZOPHRENIA AND SCHIZOAFFECTIVE DISORDERS

Mildred's voice was stressed; in fact, I could barely hear her. "He tried to kill me—my son tried to kill me." She was calling from the hospital. Her 23-year-old schizophrenic son thought she was an alien spy and tried to choke her. What precipitated this attack? She asked him if he had taken his medication.

RICHARD

Richard's problems began when he was 19. He was away at college and ended up in the hospital. Richard was an honor student, salutatorian of his high-school class. He had gone away to a prestigious university, and it was there he had his first psychotic break. He started hearing voices and thought people were talking about him and plotting against him. To try to stop the voices, he would drive all night, the car stereo blasting, but the voices got louder and louder. He finally was hospitalized when he refused to get dressed for days and accused his roommate of being a foreign spy.

Richard came home from college and was in the hospital for several months. He was put on multiple medications which made the voices quieter and less frequent but he hated the side effects. They made him feel tired, like a zombie, he said. Some made his face and neck stiff, but he took them for a while anyway. He stayed home with Mildred and worked part-time moving boxes in a warehouse.

One day Richard left work without explanation. He was found 160 miles from home, disoriented, out of gasoline and out of money. Mildred called a good friend, who drove her to where Richard was stranded so she could drive him back in his car.

Richard continued to live at home, working from time to time, until the night he attacked his mother. For a brief moment, when he had her pinned to the ground, a flicker of recognition passed through his head and he said, "You're hurt. We'd better call someone." She escaped his grasp and called 911. When the response team arrived, the police arrested Richard, and Mildred was taken to the hospital. Richard subsequently spent a year and a half in the state mental facility. When Mildred was released from the hospital, she soon had a security system installed in her home and obtained an order of protection so her son couldn't come to the house.

When Richard was released from the state hospital, he began living in a group home monitored by the county, where the staff made sure he took his medications, administering them by injection. (One of the main problems in treating schizophrenia is patients' tendency to stop taking their medication. They presume that because they are feeling better, they don't need to keep taking the drugs.)

Richard has been back in various hospitals a number of times. At one point the voices were telling him he needed to touch people. Obviously, such behavior doesn't work well in society. When I visited him in the hospital one day, he suddenly stood up, let out a guttural moan, and came charging toward me. We were in the day room with other patients and staff present, so he was intercepted by staff members. It is important to remember that psychiatric patients can be very unpredictable, and when visiting a hospital, it is always a good idea to tell a staff member where you will be.

Another time, Richard was working in a sheltered workshop. He was convinced the sounds coming from the intercom were messages from secret government agents, telling him that other workers were dangerous spies. For those suffering from severe schizophrenia, the voices they hear sound very real to them, and can cause them to harm themselves or others. These folks need to have someone monitoring them to ensure they take their medications. Also, care professionals should be aware that the patient can be docile and friendly one minute, and may suddenly turn on them (or anyone else) the next minute.

Schizophrenic delusions can cause violence. Delusions are false ideas that the patient believes to be true. Patients with paranoid delusions believe they are being watched or followed or persecuted, and may attack someone in perceived "self-defense." Others believe that they are powerful political or religious figures. One patient in the hospital where I worked had a white robe, long hair and a beard, and was convinced he was Jesus. Most untreated victims of this terrible disease have hallucinations, usually auditory but sometimes visual, or a combination of the two. They may think that their body parts have lives of their own. They become incapable of logical or rational thinking.

Schizophrenia often causes highly unpredictable behavior. Because of this, people who are affected by it and not effectively treated are often shunned or ignored. The National Alliance on Mental Illness (NAMI) says "erratic behavior is generally caused by delusions and hallucinations that are symptoms of schizophrenia." Schizophrenia interferes with a person's ability to manage emotions, make decisions, think clearly, and relate to others appropriately, thus impairing their ability to function to their full potential.

When I was a high-school teacher, one day I was tutoring a young man who was waiting to get into a mental-health facility. My job was to keep him up with his schoolwork until then. He refused to leave his room unless his parents left, so when I went to visit, I discovered I was alone in the house with him—not a great idea. But everything was going well—until he suddenly turned to me and started accusing me of spying on him and trying to get information out of him. The hair on the back of my neck stood up. I quickly gathered my belongings and left, telling him I had another appointment. I was feeling very frightened and refused

to ever go back. The people I worked for agreed with my decision and were appalled that the parents had left me alone with their unpredictable, explosive, 6'2" son who was awaiting hospitalization for treatment for schizophrenia.

Another example of unpredictable behavior came from a patient who periodically was an inpatient in order to get his medications stabilized. He was generally docile and friendly, and he spent much of his time playing the piano beautifully. One day, out of the blue, he picked up a chair and went running down the hospital corridor, smashing the doors' wire-reinforced windows. I was in my office in the back of the unit and quickly locked the door, then called the front nursing station to make sure they knew what was going on. The staff got him restrained and then medicated him. When I saw him the next day, he kept apologizing for what he had done. He was very embarrassed by his behavior and didn't want us to think he wanted to harm any of us.

SCHIZOAFFECTIVE DISORDER

Schizoaffective Disorder is very similar to schizophrenia. It is one of the more common, chronic and disabling mental illnesses, according to NAMI. It is characterized by symptoms of both schizophrenia and a mood disorder. There are two subtypes: depressive and bipolar. The mood symptoms generally last longer than the schizophrenia symptoms. Hallucinations or delusions last longer in Schizoaffective Disorder than they do in schizophrenia alone. To further complicate matters, the diagnosis of a person with a mood disorder or schizophrenia may switch to a diagnosis of schizoaffective disorder or vice versa. Not nearly as much research has been done on these disorders as has been done on the various mood disorders and thus there aren't as many types of treatment currently available.

Schizoaffective Disorder causes psychosis—a loss of contact with reality. It is more common in women than in men and is very rare in children. Symptoms include illogical or disorganized speech, delusions, hallucinations, mood swings, inability to care for even basic personal needs, and changes in energy and appetite. Many people with Schizoaffective Disorder socially isolate themselves

and often feel depressed, hopeless and helpless. They may also have very strange perceptions or thoughts of harming themselves or others.

One of the major complications facing those with schizophrenia or Schizoaffective Disorder is having problems cooperating with therapy and medical treatment. It is not uncommon for a person to start feeling good on medication and so to stop taking it, which can cause a severe chemical instability, which then causes a downward spiral. Some sufferers, on the other hand, abuse drugs in an effort to self-medicate. Suicidal behavior is not at all uncommon in people who are not properly medicated.

Steven is a brilliant scientist who ended up living on skid row due to his Schizoaffective Disorder. His strange behavior made it difficult for him to keep a job. Though he has numerous patents and has owned several businesses, his unrealistic grandiosity drove his businesses into the ground. Now a senior citizen, he spends most of his time writing long scientific papers and posting them on the Internet. In another time, he probably would have been considered just a "mad scientist"!

Steven's social skills are quite limited because he tends to go on and on, with long and complex ideas of how to do just about anything that happens to be being discussed. People tend to avoid him either because they have no idea what he is talking about, or they don't want to get "trapped" listening to him for long periods of time. The ideas he expresses are often far too convoluted to make any sense to anyone but him. He makes people nervous because, for the most part, they just don't "get" him. But Steven, Richard and all the others with schizophrenic disorders are still people, and they need to be loved just like the rest of us.

Caregiving Considerations

The care issues here are primarily ones of support and understanding. Mildred was visited in the hospital and offers were made to visit Richard, but he didn't want anyone to see him in "that place." When Richard had a Sunday pass, Mildred, accompanied by a friend, took him to church. The task facing the pastor and members of the congregation in such a situation was to be friendly and

welcoming to this person, who may barely resemble the carefree young man who grew up in the church.

Changes in emotional response may signal the onset of schizophrenia. The person may develop unreasonable fears or inappropriate responses to emotions; he or she may seem to be "slowed down" and withdrawn, and may be suspected of abusing drugs. Withdrawal is common because external stimuli become too much to handle for someone with schizophrenia.

Schizophrenia usually strikes young adults between the ages of 17 and 25. It is a biochemical disorder of the brain and is not caused by how the person was raised or by any other environmental factor. Drug or alcohol abuse does not cause schizophrenia. It is a disease, every bit as much as heart disease or cancer is. There is no known preventive and no known cure. However, today's medications can often control the symptoms so that some patients can live a relatively normal life.

About one-third of schizophrenic patients who are diagnosed and hospitalized will recover completely, and another third will be significantly improved, needing only occasional hospitalization. The other third will not respond to current therapies and will remain quite ill. Richard falls somewhere in between the last two categories. He will always have to live in a group home but he is able to work in a sheltered workshop much of the time.

People suffering from schizophrenia or Schizoaffective Disorder are frequently shunned because those uneducated about the characteristics of these disorders are often scared away by the odd behavior exhibited. For those of us who are likely to work with folks suffering from either of these conditions, it is critical to be knowledgeable enough to treat them as we treat any other sick person. Based on my experience, though, I would generally recommend a third person be present, or at least within seeing or hearing distance, in the event the person takes a sudden turn for the worse and decides you are the enemy. After her son attacked her, Mildred never again put herself in the position of being alone with him.

Most people who suffer from schizophrenia do best living away from home in an atmosphere of calm and quiet. Though they like to be around people from time to time, large groups are difficult for them. Strong emotion can be

overwhelming to them, and many people who have schizophrenia don't understand jokes or other attempts at humor.

In my experience, it is often the schizophrenic person's family and close friends who need the most tender loving care at first. Generally patients are being cared for by mental-health professionals until they are stabilized on medications. Meanwhile, it is very likely that family members know next to nothing about schizophrenia and the ways it can affect their loved one. It seems that parents in particular either jump to the conclusion that their son or daughter will have to spend the rest of their life in a state institution—or they are on the complete opposite end of the spectrum, and figure the doctor will prescribe a few pills and life will continue as usual. While it is true that some with very mild forms of the disease will be able to function quite well with medication, a greater number face a difficult life.

Schizophrenia is a tragic disease that affects the entire family. To watch a formerly bright, articulate young person turn into a withdrawn, paranoid young adult is heartbreaking for parents, siblings and friends. Often a patient who is quite ill, such as Richard, will need a lifetime of custodial care. Community support of both family and patient are extremely important. The patient should be treated as we would treat anyone—with love. Family members will need to feel included and loved, not blamed. Congregations and other groups likely to interact with patients should be educated about mental illness so they understand the causes of schizophrenia and no longer have an irrational fear of those suffering from it. Families should be guided to organizations such as the National Alliance for the Mentally Ill, which has local chapters in many cities. They offer information and support for people trying to deal with the mental illness of a family member.

One of the greatest challenges for those of us trying to help people affected by schizophrenia is to get over all the misconceptions and stereotypes, and learn not only about what the illness actually is, but also as much as possible about the form it is taking in the life of the individual we know who suffers from it. Our actions should always stem from knowledge and wisdom rather than from misinformation or fear. However, it is also wise to maintain a healthy respect for possible ramifications of the disease and keep ourselves in a safe environment.

7.
It would be easier just to make cookies

Involvement of family and friends

In previous chapters we've seen some glimpses of family involvement but have not really gotten into the actual issues facing families of people suffering from mental illness. It is really too bad that this matter needs to be addressed differently from dealing with folks who have a family member hospitalized for physical illness or injury, but the fact unfortunately remains that most people who are hospitalized for mental illness don't want anyone to know it. The stigma of days of old still remains in the minds of many. "What will people think of us if they know our daughter is in a mental-health hospital? What will they think we did wrong?"

Clergy are generally not too surprised when a member of the church calls to talk about a problem with a family member's behavior. It often becomes obvious long before the family realizes it that a person needs more help than they're receiving. Also teachers, counselors, coaches or other leaders may be the first ones to notice changed behavior. This brings us to the awkward point of knowing

from observation or instinctively or intuitively that a person is walking into dangerous territory.

If the troubled person is not already working with a psychiatrist or a therapist, then that's the starting place. If you don't know, a gentle leading question such as, "Do you know what John's therapist thinks about this?" can help clarify the situation. Responses range from "Oh, he doesn't have a therapist; do you think he needs one?", followed by a request for a referral, or, "Oh my, do you think it's that bad?", to the person taking offense that you would even suggest his family member needed professional help. Whatever the reaction may be, at least you've planted a seed.

Assuming the family agrees that professional intervention is needed, then the job of the pastor or other role model is to be supportive and encouraging but to let the professionally trained person do the psychological counseling. Our job is to provide the moral support and, for pastors and often others, to deal with the "why is God doing this to me?" questions.

When we have trusting relationships with our parishioners or students or employees or team members, they will likely tell us when things are not going well in their lives.

For several months Eleanor had been telling me that her son, Miles, had given up looking for a job after being fired several years ago due to his bad attitude and somewhat unpredictable moods. When Miles had the job, he had been previously diagnosed with bipolar disorder and was taking medication that kept him quite stable. But he stopped taking his medication, became moody and unpredictable, and lost the job. He had not taken medication since that time and became increasingly agitated and volatile as time went on. He stayed up all night, slept some during the day, and became violently angry if anyone made so much as a sound that awakened him. Eleanor became increasingly afraid of him because he screamed at his family, threw furniture and household items at them, and threatened to kill his mother.

Because Miles was legally an adult, his parents' hands were pretty much tied. He had effectively taken control of the household, causing the rest of the family to lock themselves in their rooms so he wouldn't stomp in in the middle of the night to

demand money for whatever he thought he needed at the moment. The only times he even verged on being somewhat in control of his own behavior was when he self-medicated with alcohol or illicit drugs.

Eleanor talked with a county social-service agency and was advised to call the police and press charges the next time something violent happened. (The police had been called before, but Miles usually got out of the house before they arrived.) The next time Miles erupted and became violent, Eleanor called the police, and Miles was taken to a local psychiatric hospital. By law, they could only keep him there 72 hours unless he signed himself in. He angrily refused. He had previously told his mother that if she ever tried to hospitalize him, he would kill her when he got out.

She called me Mother's Day night from the hospital. She also called another member of our church. Both of us, from different directions, got to the hospital as quickly as we could to be with her at this terribly difficult time. Mostly she talked and cried. We listened. We all prayed.

When we were certain Miles had been admitted and would be there for at least 72 hours, everybody went home. The next day, Eleanor moved into the safe haven of a parishioner's home with a gated entry where Miles would have no access to her when he was released. Eleanor fortunately had pastors and a church family who would go through this with her and who knew a lot of the background. However, this is often times not the case.

Don and Tammy had a different issue. Their daughter, Linda, was exhibiting symptoms of schizophrenia. They had taken her to a psychiatrist, who recommended hospitalization to get her stabilized on medications. She had never been hospitalized before.

I was working on the psychiatric unit when she was admitted. Linda and her family didn't want anyone to know she was in the hospital—especially the members of her church—and I think they all were fearful that I would blow their cover. Of course, there were all sorts of reasons for them not to fear disclosure—strict hospital rules and clergy confidentiality being the primary ones. I think they were also afraid I might tell their head pastor, whom I knew well, but that too would have been a violation of confidence. That information was the family's to

share with whomever they chose, not mine. I assured the patient and her family that their privacy was secure and offered my availability to them all if they wanted to talk.

The sadness of this whole scenario is that there is still a stigma associated with mental illness. The first edition of this book was written ten years ago, and, unfortunately, not much has changed in that area. Oh yes, people will talk more today about being on antidepressants or other similar medications, but they don't really want to talk about hospitalization.

A friend of mine with bipolar illness recently checked herself into the hospital to get her medications regulated. She hadn't required hospitalization in four years and was managing her illness very well. However, a drug she was given for an unrelated issue threw off her chemical balance, making her extremely manic.

The people she works for do not know that she has a mental illness. She had some vacation time due her, so she took that time to be hospitalized and get her meds straightened out. She told no one at work where she went "on vacation" for fear of losing her job. Only her sister and I, as her pastor, knew, and that was it.

What a sad commentary that is on society's reaction to mental illness. People suffering from mental illness have a hidden disability that, because of society's reaction to it, they, for the most part, have to keep hidden if they want to keep their jobs. If they know us well enough to trust us, then just maybe they'll let us in on the secret so we can be there for them and visit them. Unfortunately, often they particularly don't want their pastors or others in leadership roles to know, especially if they are really active in the church or sports or jobs, for fear that we will think they have let us down and think them unqualified to do the jobs they've been called to do. Furthermore, they're afraid that they will be treated differently when they return.

Sadly, this is sometimes true in situations in which members of a group know that a person is in a psychiatric hospital. People are hesitant to ask how Linda is doing, and they avoid conversation with her parents, because it might be awkward. But Jesus told us to *"love one another"* (John 13:34). To not be there for people in their darkest moments is to not do what we are commanded to do.

Mental illness is difficult for families and friends of people afflicted with the disorder. Shame is an emotion that both those who are mentally ill and their families often feel. Families may feel they must have done something wrong for this to have happened, especially when the one hospitalized is their child. Perhaps astute teachers or counselors had suggested counseling a while back but they didn't follow through with it. Perhaps they knew deep down that their child was crying out for help, but were in such denial that they didn't respond. The patient may feel he has let his family down and the condition is all his fault. Or he may be in a state of mind that he sees nothing wrong in his life and blames his family for everything that has gone wrong. All of these reactions are very common.

What if the patient is the spouse or mom or dad or a grandparent or aunt or uncle of someone you know or work with or coach? Sometimes the greatest support we can give a person faced with hospitalizing any family member is our presence, our support, our encouragement, and our listening. This will probably be one of the hardest things they will ever have to do. They need to be assured they are doing the right thing and that it really is the right and best thing for the patient—and the family. They may be pressured at the last minute by the patient or by other family members to not go through with hospitalization, but first and foremost the patient's well-being must be kept in mind. One of the things we can do is assure them that Suzi or John is out of control and in serious need of help, and that at this time, hospitalization is the only way it will happen, and then gently take their arm and guide them away from the patient and out of the hospital. Next, turn on your best radar and try to figure out if the family member(s) needs to go have coffee and talk, or if they just need to go home to unwind. If the person is extraordinarily upset and lives alone, it would probably be wise to make sure that someone will be able to be there with them (unless, of course, they plan to keep this all a secret, in which case you should probably follow them home and go in briefly to make sure they are okay).

In addition, if the patient had become particularly disruptive at home, then the family may feel guilty because they feel relief once the person is hospitalized. This is an area that sometimes puts friends, especially friends of the whole family, in awkward positions. It is very important for us to be nonjudgmental listeners

and to not take sides. As treatment moves on, each will probably be pointing a finger at the other and looking for someone to be "on their side." It is not our job to fix the problem; it is our job to be the kind of supportive friends they can count on to walk with them through the hills and valleys of life.

8.
Is there anybody out there who "gets it"?

What we can do to help

We've met some people with some very real problems. These problems, however, do not keep them from seeking companionship with others, singing in a choir, participating in community activities, offering to serve on committees, or attending services at their favorite place of worship. Some are married. Some are single. Some have families. Most have jobs. All these folks suffer from some form of mental illness and all of them are regular people just like you and me

There is so much misunderstanding and stigma associated with mental illness that people suffering from one of these diseases need to know they are loved and supported by their community. Congregations, teams and students need to be educated about mental illness and understand that mentally ill members of their group need loving care every bit as much as those who suffer from a physical illness. They need to be included. People must learn not to fear them. Often they have gotten their information from stereotypical representations in movies or on television. People must understand that they, without knowing it, are probably friends with or work with those who are mentally ill.

Telling someone they might benefit from a visit to a therapist or psychiatrist is not an easy thing to do. Often people seek guidance from pastors, counselors, chaplains, coaches, teachers and other leaders when they are troubled. It is important to know when the situation calls for professional intervention and when the person might be a danger to himself or others. One tactful way to approach this matter of referral with an adult is to say something like this: "You know, I think I'm in a little over my head here. It might be really helpful for you to talk to someone else. A couple of people I know of who are really good are (make referrals—include phone numbers.)" And then follow up. See if the person has followed through. Continue to show loving concern, but don't be moved into the role of therapist if you're not trained for it. We all can be compassionate friends and listeners, but people suffering from mental illness need the expertise of mental-health practitioners. Pastors, in order to have a good list of referrals, should check with psychiatric nurses or chaplains of mental-health facilities. These professionals know which doctors and therapists are sympathetic to the spirituality of patients.

It is very important not to get drawn into a patient's illness in an unhealthy way. We can be loving and caring and know when to say, "I think you need to check in with your doctor" or "I think this is a matter for your therapist." I have heard patients call their pastors from the hospital eight or ten times a day. This is not healthy for either pastor or patient. When people are becoming clingingly dependent, we must be wise and discerning. There is a fine line between being firm and being rejecting. Again, I must stress, *refer*. That is the kindest, most loving thing we can do for a person with mental illness.

We must realize most people at some time get sick. Diabetics can have unstable blood sugar and may take insulin daily; people with high blood pressure may have to take daily medications. Those suffering from mental illnesses are no different. They may have flare-ups and require hospitalization, just as diabetics or people with heart conditions or stomach problems may from time to time. When a mentally ill person is having an especially hard time, it is good to ask if any help is needed. Often it is close friends who notice the first symptoms of a decline. However, when people seem to be having problems, it is NOT a kindness to ask if

they are taking their medication. This could make them feel like we view them as abnormal. People suffering from mental illness should be allowed to express normal, human emotions without others immediately assuming a relapse. These people are not ill because they are "bad." They are ill due to the fact that they have a mental illness.

Our treatment of them all comes back to loving one another, to treating one another as we would like to be treated. Today ignorance and misunderstanding often make people shun those who are mentally ill and treat them as outcasts. Not only must we reach out to these children of God, but we must do all in our power to educate others so that they will do the same. This does *not* mean violating the confidence of our brothers and sisters afflicted with mental illness, but rather, educating people to love and accept all sorts and conditions of humankind.

Many churches and schools have substance-abuse groups that meet in their buildings. There are also many groups that deal with mental illness—both support groups for them and for their families. Perhaps hosting one of these groups would be a starting place for educating the people in your school or church or workplace and helping to remove the stigma that mentally ill people live with every day of their lives.

In the meantime, we, as leaders (and sometimes role models) can treat every mentally ill person with the same love, concern and respect with which we treat every other person we encounter. We must not be afraid of them. We must avoid labels and ill-chosen expressions. Often an innocent remark such as "I was really feeling schizophrenic" (as in *double minded*) or talking about "a real nutcase" or someone being "loony" can be devastating to someone who is mentally ill. They will turn you off and not hear anything else you say. These expressions should be considered just as inappropriate as racial slurs and sexist remarks. They only hurt people.

We should be as comfortable talking with people about their depression as we are talking with them about their broken leg. If Joe is having a particularly difficult time and is in a deep depression, we should be as willing to talk about it with him as we are to talk to Mary about how cumbersome her leg cast is. If Fred has

pneumonia and Sally has had a psychotic break, we must minister to them with equal confidence, love and concern.

It is important to remember that most mentally ill persons lead normal lives. They have families, jobs, and, incidentally, must take medication every day—just like millions of other people. Let us not contribute to the problem by being judgmental or fearful.

The National Alliance for the Mentally Ill has a helpline for patients, families and all others seeking information or help. The number is 1-800-950-NAMI (6264). With 1200 state and local affiliates, they stand ready to help and to educate. Their mailing address is: NAMI, 3803 N. Fairfax Drive, Suite 100, Arlington, VA 22203. Their Web site is http://www.nami.org. I encourage you to contact them if you need help or seek further information.

May you be truly blessed as you seek to offer compassionate care to those suffering from mental illness and to educate others to do the same.

Glossary of Common Terms

There are thousands of terms used by mental-health professionals in their care and treatment of people struggling with mental illness. Below are the most common you are likely to encounter. Additional resources are listed at the end of the Glossary.

Acute Stress Disorder. Acute Stress Disorder is characterized by the development of severe anxiety, dissociation, and other symptoms that occur within one month after exposure to an extreme traumatic stressor (e.g., witnessing a death or serious accident).

Alcoholism. Alcoholism is an illness characterized by significant impairment that is directly associated with persistent and excessive use of alcohol.

Anorexia. Anorexia nervosa is an eating disorder that causes people to obsess about their weight and the food they eat. People with anorexia nervosa attempt to maintain a weight that's far below normal for their age and height. To prevent weight gain or to continue losing weight, people with anorexia nervosa may starve themselves or exercise excessively.

Antidepressant. Antidepressants are medications administered by a physician or psychologist tending to relieve or prevent depression.

Anxiety Disorder. Anxiety is a diagnosable mental health condition that requires treatment, and is usually characterized by persistent worry about major or minor concerns.

Auditory Hallucinations. The experience of internal words (people speaking or multiple people conversing) or noises that have no real origin in the outside world and are perceived to be separate from the person's mental processes.

Avoidance Symptoms. Avoidance is when a person tries to avoid those things that trigger feelings and distress symptoms. It is hard to realize that we may unconsciously hold back feelings because we are not emotionally safe enough to deal with them.

Biochemical Disorder. Changes occurring in the brain are thought to affect mood and other aspects of mental health. Naturally occurring brain chemicals called neurotransmitters play a role in some mental illnesses. In some cases, hormonal imbalances affect mental health. It's thought that inherited traits, life experiences and biological factors can all affect brain chemistry linked to mental illnesses.

Bipolar Disorder. Bipolar disorder—sometimes called manic-depressive disorder—causes mood swings. A person suffering from this disorder may feel sad or hopeless and lose interest or pleasure in most activities, and on the other side of the mood shift may feel euphoric and full of energy. This is a lifelong disorder.

Bulimic. Bulimia nervosa is a serious, potentially life-threatening eating disorder. People with bulimia nervosa may binge and purge, eating large amounts of food and then trying to get rid of the extra calories in an unhealthy way. For example, people with bulimia nervosa may force themselves to vomit or do excessive exercise.

Coping Strategy. Coping strategy is a form of behavior a person adopts to try to deal with or conceal an illness or disability.

Counselor. A counselor is generally a person trained to give guidance on personal, social or psychological problems.

Day Room. The Day Room serves as the family room of a psychiatric facility.

Delusions. Delusions are false beliefs with absolute certainty that the believed circumstances are real, even if evidence is shown to the contrary.

Depression. Depression is a medical illness that involves the mind and body. Also called major depression, major depressive disorder and clinical depression, it affects how one feels, thinks, and behaves. Depression can lead to a variety of emotional and physical problems. A person suffering from depression may have trouble doing normal day-to-day activities, and depression may make one feel as if life isn't worth living.

Depressive Period. A period in someone's life that causes a depressive (saddened) state. This may be caused by an event or a trauma; however, there also may be no apparent reason.

Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR). ("DSM 4") A reference book published by the American Psychiatric Association, used by clinicians and psychiatrists to diagnose psychiatric illnesses. The DSM-IV TR covers all categories of mental health disorders for both adults and children. The manual is focused mostly on describing symptoms, the effects of treatment, and common treatment approaches. Originally published in 1994, the DSM-IV listed more than 250 mental disorders. An updated version, called the DSM-IV-TR, was published in 2000 and contains minor revisions in the descriptions of each disorder. Mental-health providers use the manual as a tool for assessment and diagnosis and also so that they may better understand a client's potential needs.

Dysfunction. Dysfunction refers to any impaired or abnormal functioning.

Eating Disorder. Eating disorders are a group of serious conditions in which a person is so preoccupied with food and weight that it becomes difficult to focus on much else.

Electroconvulsive Therapy. Electroconvulsive therapy (ECT) is a procedure in which electric currents are passed through the brain, deliberately triggering a brief seizure. Electroconvulsive therapy seems to cause changes in brain chemistry that can immediately reverse symptoms of certain mental illnesses. It often works when other treatments have proven unsuccessful.

Enabler. An enabler is person who through his or her actions allows someone else to achieve something. Most often the term enabler is associated with people who allow loved ones to behave in ways that are destructive. For

example, an enabler wife of an alcoholic might continue to provide the husband with alcohol. A person might be an enabler of a gambler or compulsive spender by lending them money to get out of debt.

Grandiosity. Grandiosity describes the feelings of superiority that often show up during manic episodes.

Grief Counselor. Grief counselors practice a form of psychotherapy that aims to help people cope with grief and mourning following the death of loved ones, or with major life changes.

Hoarding. Hoarding is the excessive collection of items such as pets, newspapers, useless items and items of worth, as well as the inability to discard them.

Hospice. Hospice, also known as Palliative Care, is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Hyper-Arousal Symptoms. These include a persistent expectation of danger. It is as if body and mind have not computed that they are no longer in danger. The inability to relax, constant worry, irritability, sleep difficulties, hypersensitivity to noise, smells, and taste actually are reflections of your body's fight-or-flight response to danger.

Intervention. An intervention is a carefully planned process involving family and friends and sometimes colleagues, clergy members or others who care about a person struggling with addiction or destructive behavior.

Limbic System. The Limbic System denotes areas of the brain that are vital for memory processing.

Manic-depressive. A mood disorder, also known as Bipolar Disorder.

National Alliance on Mental Illness. The nation's largest grassroots mental-health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, supports and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need. (From the NAMI Web site at www.nami.org.)

Obsessive-Compulsive Disorder. Obsessive-compulsive disorder (OCD) is an anxiety disorder characterized by unreasonable thoughts and fears (obsessions) that lead one to do repetitive behaviors (compulsions).

Order of Protection. An Order of Protection is a legal document signed by a judge designed to stop abusive, violent, and harassing behavior. If the abuser violates the order that person can be arrested.

Panic Attack. A panic attack is a sudden episode of intense fear that develops for no apparent reason and that triggers severe physical reactions. Panic attacks can be very frightening. When a panic attacks occurs, it may include feelings of losing control, having a heart attack or even dying.

Panic Disorder. A disorder where someone has had four or more panic attacks and has spent a month or more in constant fear of another panic attack. This is a type of chronic anxiety disorder.

Paranoia. A thought process believed to be heavily influenced by anxiety or fear, often to the point of irrationality and delusion.

Paranoid Delusions. Paranoid delusions create fearfulness or anxiety, amplified by feeling/believing things that are false. This can also be when people believe they are secretly or obviously someone extremely important (made-up or historical), that others including those otherworldly are attempting to harm them, that they have a special relationship with someone, particularly someone famous, or that they believe a specific person is hurting them by behaviors like infidelity.

Post-Traumatic Stress Disorder. Post-traumatic stress disorder (PTSD) is a mental-health condition triggered by a terrifying event or events that may have happened any number of years back. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about what happened.

Psychiatric. Psychiatric refers to anything related to mental illnesses or disorders.

Psychiatrist. Psychiatrists are medical doctors who specialize in mental health.

Psychologist. Psychologists are trained specialists in psychology—a science that deals with thoughts, emotions and behaviors. Like licensed counselors, psychologists provide psychotherapy in one-on-one or group settings.

Psychosis. Psychosis is a loss of contact with reality, usually including false beliefs about what is taking place or who one is (delusions) and seeing or hearing things that aren't there (hallucinations).

Psychosomatic. Psychosomatic is a descriptive term relating to a reaction involving both mind and body, especially due to an emotional or mental disturbance or upset.

Psychotherapy. Psychotherapy refers to any form of therapeutic interaction or treatment contracted between a trained professional and a client or patient, family, couple or group.

Psychotic Break. A psychotic break is a loss of contact with reality.

Restraining Order. See Order of Protection.

Schizoaffective Disorders. Schizoaffective disorder is a condition in which a person experiences a combination of symptoms of schizophrenia such as hallucinations or delusions, and of mood disorder symptoms such as mania or depression.

Schizophrenia. Schizophrenia is a group of severe brain disorders in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions and disordered thinking and behavior. The ability of people with schizophrenia to function normally and to care for themselves tends to deteriorate over time.

Schizophrenic Delusions. People suffering from schizophrenia who believe ordinary events occur especially for them are suffering from delusions. Delusions can manifest themselves in a variety of ways. Some may believe that current events are happening "for" them or because of something they did. Others may believe that the things strangers or celebrities do or say are meant as a message especially for them, even when they have never met or spoken to those particular people.

Situational Depression. Situational depression refers to a depressive state that specifically centers around an certain event or circumstance (such as loss of a

loved one, relocating to a different town or country, break-up of an important relationship, or being diagnosed with a terminal illness).

Social Anxiety Disorder. Social anxiety disorder is a chronic mental-health condition, also called social phobia, in which everyday interactions cause irrational anxiety, fear, self-consciousness and embarrassment.

Stress Inoculation Therapy. Stress-inoculation training (SIT) is a cognitive behavioral treatment for PTSD with the basic goal of helping patients gain confidence in their ability to cope with anxiety and fear stemming from trauma-related reminders.

Suicidal Behavior. Suicide is not a mental illness in itself but rather a serious potential consequence of many mental disorders, particularly major depression. Many people threaten to kill or hurt themselves. Many people also actually frequently attempt to kill themselves and may also repetitively hurt themselves. Below are some common warning signs of suicidal thoughts and behavior:

- **Changes in personality and/or appearance.** A person who is considering suicide may exhibit a change in attitude or behavior, such as speaking or moving with unusual speed or slowness. In addition, the person might suddenly become less concerned about his or her personal appearance.
- **Dangerous / self-harmful behavior.** Often a person considering suicide will take extreme risks.
- **Excessive sadness or moodiness.** Long-lasting sadness and mood swings can be symptoms of depression, a major risk factor for suicide.
- **Making preparations.** Often a person considering suicide will begin to put his or her personal business in order. This might include visiting friends and family members, giving away personal possessions, making a will, and cleaning up his or her room or home. Some people will write a note before committing suicide.

- **Recent trauma or life crisis.** A major life crisis might trigger a suicide attempt. Crises include the death of a loved one or of a pet, divorce or breakup of a relationship, diagnosis of a major illness, loss of a job, or serious financial problems.
- **Sudden calmness.** Suddenly becoming calm after a period of depression or moodiness can be a sign that the person has made a decision to end his or her life.
- **Threatening suicide.** Not everyone who is considering suicide will say so, and not everyone who threatens suicide will follow through with it. However, every threat of suicide should be taken seriously!

Toxic Psychosis. Toxic psychosis is an altered mental state that results from the poisonous effects of chemicals or drugs, including those produced by the body itself. Overdosing on any of a number of medications can cause toxic psychosis.

Transient Global Amnesia. Transient global amnesia is a sudden, temporary episode of memory loss that can't be attributed to a more common neurological condition, such as epilepsy or stroke. During an episode of transient global amnesia, recall of recent events simply vanishes, so people suffering from this can't remember where they are or how they got there. With transient global amnesia, people do remember who they are, and recognize the people they know well. TGA episodes usually don't last more than about 8 hours and are way more frightening to those close to the folks who have them than to the actual person who goes through the episode.

Visual Hallucination. A visual hallucination involves seeing something that is not present in reality.

Withdrawal. Choosing to be alone and avoiding friends or social activities also are possible symptoms of depression. This includes the loss of interest or pleasure in activities the person previously enjoyed.

Additional definitions are available from the following resources:

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

Psych Central
www.psychcentral.com

Mayo Clinic Libraries
www.mayoclinic.com

Merriam-Webster Dictionary
www.merriam-webster.com

Appendix A: Depression

Characteristics of depression as reported by those suffering from it

Low self-image.
Self-deprecation.
Not bathing.
Tired all the time.
Poor sleeping habits.
No self-worth.
Isolating—not wanting to be around other people.
Paralysis—"This is all too overwhelming so I won't even start."
Pessimistic regarding things connected to self. ("I'll never be able to do this, so why even try?")
I wear "comfort clothes" that are old and shapeless.
I find it difficult to leave the house.
I hate grocery shopping.
I think, "If I don't try, I won't fail."
I have difficulty making decisions—what if it's wrong? (Even simple decisions, like what to eat, or whether to eat at all, etc.)
Fear (of failure? of being found out to be the scummy worm you really are?)
I'm surprised that people remember my name or even who I am.

I don't consider myself worth buying anything for, but am often generous to a fault with others.

"Nobody would want to do anything with me because I'm no fun; I don't even know what fun is right now and I'm not sure I ever did."

I won't spend money on myself; I should leave any money I have to heirs.

I always seek approval (second opinion) on anything I do.

"Manicures and pedicures (etc.) are nice, but I'm not worth spending money on myself."

I only spend money on things of daily living (like a computer and other work necessities), but not on movies, CDs books or other things that aren't work-related.

I often feel overwhelmed by having to do anything—it's too much trouble and it doesn't really matter to anyone anyway.

I answer "How are you?" with "same old" or "tired" or "alive, unfortunately."

I know I'll be the last one picked for anything, because that's what happened in elementary school. (Sets self up for failure to prove they are no good, useless, and that nobody wants them around.)

I order the cheapest thing on the menu (lack of self-worth—don't *deserve* any better).

Appendix B: Bipolar Disorder

Characteristics of bipolar disorder as reported by those suffering from it

Depressive Side of the Cycle

Lack of energy.
Unable to function.
Cannot make a decision regarding anything.
Either cannot sleep or sleep all the time—very up-and-down in sleep patterns.
Either binge eating or cannot eat.
Never leave the house except for work. Very isolative.
"If this is what life is, then I don't want it."
I feel like nobody likes me.
I feel like "the world is against me."
I am unable to connect (very important!). I do things but don't feel like I just did them. I say things but wonder if it was me. There is no connection. I can laugh at something and not feel the joy. I can cry and not feel the sadness.
Desperation—everything is a reason to kill myself.
I plan and plot suicide all the time—writing letters, giving things away, listening to sad songs, etc.

An overwhelming sense of "nobody understands me."

"Nobody even sees me." "I feel invisible. I could die today and nobody would even notice—so utterly unimportant."

Every task is overwhelming—taking a shower, getting gas in the car, walking down the hall to the bathroom, answering the phone.

I don't want to talk to the people who don't understand me.

I am worried that people are figuring out that I am sick.

My sickness is my secret.

I don't ever see a way out.

It's like I'm carrying another person around—it is such a heaviness that nobody can understand. Even if someone has been through it before, unless they are going through it at that moment, they won't get it. It is such an unbearable burden.

I blame myself. "I never see it as depression even though I know I am bipolar." "I am lazy, fat, stupid, unable to cope, etc." "I don't see that I am depressed."

Rage can happen. I snap at other people. They don't understand and they say stupid things, so I snap at them. Then I hate myself even more. What a vicious cycle.

I've convinced myself that this is what is supposed to be happening. "God made me this way. He wants me to suffer! He wants me to 'burn in hell' like this."

Instead of the racing thoughts of mania, I'm kept up all night with an empty void of nothingness going on. There are no thoughts! Imagine turning off the lights at the end of a chaotic day to go to sleep, and there's nothing in your head—that is frightening!

I cry all the time out of desperation—so I don't have to go to work because I don't have the energy. I cry because nobody gets it or sees my suffering, because I'm so overwhelmingly lonely, because I want to die but am too afraid to kill myself, because I feel trapped, because life wasn't supposed to end up this way, because I want more than to suffer.

Manic Side of the Cycle

Energy!

At first I thought this was normal, but then I realized I'm a freak.

I talk too much. I can sense that other people think I'm talking too much, so I tell myself to shut up, but I can't stop talking. I feel embarrassment all the time! I talk over people all the time. The pressure to talk is overwhelming! Nobody can see it, but it's like someone is holding a gun to my head and telling me to talk or else I will die.

I have to work, but know I cannot be normal in public. What do I do?

I constantly talk in my head about space issues. I keep proper distance from people. I don't get too close. (Manic people actually don't keep proper distance.)

I have a million (and I mean a *million*) topics going through my head at one time and they are going *fast*. I can't grab just one topic and stay to it. Before I know it, I grab another. Nobody can follow my conversation—not even me.

Sleep—what is that? I have no time for sleep! Too many thoughts, too many things to do.

I've gone from depressed—where I haven't seen anyone for months—to manic, so now I'm seeing *everyone*. Lunches, dinners, movies, etc. Constantly on the move.

I spend money I don't have and am panicked about it all the time.

In trouble all the time at work for inappropriate behavior.

Anxiety is overwhelming!

I can't handle music—it adds to the noise in my head.

Pacing—I can't sit still.

I avoid talking to people on the phone because I know I will probably say something inappropriate.

Inappropriate anger—nobody understands. "And that is a true statement! I often go off my meds (to be manic). I don't like to be normal or slowed down!"

Psychosis—hearing voices that aren't really there.

ADDITIONAL OBSERVATIONS FROM PATIENTS

"A bipolar person prefers the beginning stages of mania to depression! We often go off our meds to be manic. We don't like to be normal or slowed down. We don't remember that it often gets out of control."

"You cannot go without sleep and remain normal."

"Oftentimes, bipolar people take street drugs to self-medicate—to keep our highs not too high but be able to sleep. We don't like medication prescribed by doctors—they suck. It is a very hard realization that you will have to stay on those meds for the rest of your life – so many side effects."

"I think the colors of mania are bright—yellow, orange, etc."

"I think there is only one color of depression and it is black!"

Index

A

Acute Stress Disorder, 31, 63
alcoholism, 28, 63
ALINA, 29
amnesia, 30, 70
AMY, 1
anger, 31
anorexia, 36, 37, 39
Anorexia nervosa, 63
anorexic, 34, 63
antidepressant, 2, 4, 19
Antidepressants, 63
anxiety, 17, 19, 21, 22, 23, 24, 25, 31, 33, 40, 63, 67, 69, 77
Anxiety Disorder, 21, 63
Auditory Hallucinations, 64
Avoidance, 64
Avoidance Symptoms, 64

B

BILL, 37
binge, 64, 75
Biochemical Disorder, 64
bipolar, iii, 9, 11, 13, 14, 15, 48, 54, 56, 64, 66, 75, 76, 78
Bipolar Disorder, 64, 75
Bulimia nervosa, 64
bulimic, 34, 36, 37, 41, 64

C

CAMILLE, 34
cannot sleep, 75
Changes in personality and/or appearance., 69
chaplains, 60
Clinical depression, 2
Clinical Pastoral Education, iii
coaches, iii, 53, 60
cocaine, 9, 10
cognitive behavioral treatment, 69
color of depression, 78
colors of mania, 78
comfort clothes, 73
community, 2, 13, 16, 59
Coping Strategy, 64
counseling, 4, 19, 36, 54, 57
Counselor, 64
counselors, 7, 53, 57, 60, 66, 68

D

Day Room, 64
delusions, 9, 47, 48, 64, 67, 68
depressed, 2, 3, 4, 5, 6, 49, 76, 77
depression, iii, 1, 2, 3, 4, 5, 6, 7, 14, 15, 31, 40, 61, 63, 65, 68, 69, 70, 73, 76, 78

Depressive Period, 65
Depressive Side of the Cycle, 75
Desperation, 75, 76
Diagnostic and Statistical Manual of Mental Disorders, 4th edition text revision (DSM-IV TR)., 65
difficulty making decisions, 73
dissociation, 63
dizziness, 18, 22, 23
DSM-IV, 65
Dysfunction, 65

E

eating disorder, 37, 39, 40, 41, 63, 64, 65
ECT, 65
EDITH, 5
Electroconvulsive Therapy, 65
ELLEN, 35
ELMER, 4
Enabler, 65
euphoric, 15, 64
Excessive sadness or moodiness, 69

F

fear, 18, 22, 28, 32, 51, 55, 56, 59, 73
flashbacks, 31, 67
FRED, 38
full of energy, 64

G

genetic, 22, 23
global amnesia, 70
Grandiosity, 66
grief counselor, 6, 66
guilt, 31, 36

H

hallucination, 70
Hallucinations, 48
hoarding, 39, 66
hospice, 7, 66
hyper-arousal, 31
Hyper-Arousal Symptoms, 66
hypersensitivity, 66
hyperventilating, 17, 18

I

immune, 5, 37
Inappropriate anger, 77
Intervention, 66
invisible, 76
irrational fears, 6
irritability, 66
Isolating, 73

K

KYLIE, 17

L

Lack of energy, 75
leaders, 7, 53, 60, 61
life crisis, 70
lightheaded, 17
Limbic System, 66
Low self-image, 73

M

Making preparations., 69
manic, iii, 9, 14, 56, 64, 66, 77, 78
Manic-depressive, 66
MARIE, 3
medication, 2, 3, 4, 5, 6, 11, 13, 14, 15, 17, 19, 20, 22, 23, 33, 38, 42, 45, 46, 49, 51, 54, 61, 62, 78
MELINDA, 36

mental illness, iv, 2, 5, 12, 13, 14, 22, 23, 32, 51, 53, 56, 59, 60, 61, 62, 63, 69
MIKE, 27

N

neurotransmitters, 64
nightmares, 67
nobody likes me, 75
nobody understands me., 76

O

obsessive-compulsive, iii, 34, 37, 38, 42
Obsessive-Compulsive Disorder., 67
OCD, 38, 67
Order of Protection, 67, 68
Overdosing, 70
overweight, 9, 35
overwhelming, 6, 51, 73, 76, 77

P

Palliative Care, 66
panic, iii, 18, 19, 20, 21, 22, 23, 24, 31
panic attack, 18, 19, 21, 22, 23, 24, 67
Panic Disorder, 18, 20, 21, 22, 25, 67
Paralysis, 73
Paranoia, 67
paranoid, 15, 47, 51
Paranoid Delusions, 67
pastors, iii, 24, 42, 54, 55, 56, 60
Pessimistic, 73
post-traumatic stress disorder, iii, 21, 28, 31, 32
Post-Traumatic Stress Disorder., 67
Protection, order of, 67
Psychiatric, 65, 67
psychiatric units, iii
psychiatrist, 2, 3, 5, 6, 14, 15, 20, 54, 55, 60, 67
psychologist, 3, 4, 7, 68
Psychosis, 68, 70, 77
psychosomatic, 23, 68
psychotherapist, 5, 21
psychotherapy, 21, 33, 42, 68
psychotic, 9, 45, 62
Psychotic Break, 68
PTSD, 29, 30, 31, 32, 33, 67, 69
purge, 64

R

Rage, 76
Recent trauma or life crisis., 70
Restraining Order., 68
RICHARD, 45

S

SANDY, 36
SARAH, 21, 39
Schizoaffective Disorder, 48, 49, 50
Schizoaffective Disorders, 68
schizophrenia, iii, 45, 46, 47, 48, 49, 50, 51, 55, 68
schizophrenic, 45, 49, 50, 51, 61
Schizophrenic Delusions, 68
Self-deprecation, 73
self-esteem, 6, 9, 30, 40
self-medicate, 49, 78
self-worth, 73, 74
sexual abuse, 31, 40
Situational Depression, 68
Sleep, 77
sleep all the time, 75
sleep difficulties, 66
Social anxiety disorder, 69
spend money, 74, 77
street drugs, 78
stress, iii, 1, 15, 19, 21, 22, 23, 27, 28, 29, 31, 33, 38, 41, 60
Stress Inoculation Therapy, 69
Sudden calmness, 70
Suicidal Behavior, 69
suicide, 2, 4, 6, 10, 11, 12, 13, 15, 23, 37, 69, 70, 75

SUSAN, 9

T

teachers, iii, 53, 57, 60
TED, 30
TGA, 70
the world is against me., 75
therapy, 2, 3, 5, 12, 20, 22, 23, 24, 30, 33, 41, 49
Threatening suicide, 70
Tired all the time, 73
TOM, 20
Toxic Psychosis, 70
transient global amnesia, 29, 32
Transient Global Amnesia., 70

U

unable to connect, 75
uncontrollable thoughts, 67

V

Visual Hallucination, 70

W

Withdrawal, 50, 70
worry, 31, 63, 66