Breaking the stigma of silence.

Myths and Realities of Mental Illness

Bonnie J. Miller-McLemore

The members of a small congregation in a Midwest town have had some challenges typical of many congregations. A few years ago, the quiet husband of a prominent member was hospitalized with severe depression. A woman who experienced sexual abuse as a child sought therapy. A couple is worried about their adult daughter who is schizophrenic and has returned home to live with them. Another couple entered marital counseling because of alcohol abuse. A teenager attempted suicide and was temporarily institutionalized. A woman lives with her son who has Down syndrome. One member is in the beginning stages of Alzheimer's disease. On occasion, a resident of a nearby halfway house serving people with mental illness disrupts worship.

The ELCA Division for Church in Society works with the Lutheran Network on Mental Illness. The network assists pastors and helps them assess needs and make referrals. The network also focuses on ways to support the family members of someone who is mentally ill. Contact Dennis Busse, director of disability ministries, for information about the network and other congregational resources at (800) 638-3522, ext. 2692.

What Is Mental Illness?

Are all these persons mentally ill? If not—and they are not—what is mental illness? And how is it different from mental retardation? And what of the disturbances people in most congregations experience to varying degrees?

The *Dictionary of Pastoral Care and Counseling* defines mental illness as *enduring or recurrent disturbances in thought, mood, or behavior.* But not all disturbances qualify. Mental illness is indicated when: 1) symptoms are associated with marked distress, both acute and prolonged; and 2) symptoms interfere with daily living and perceptions of reality. By contrast, mental retardation is indicated by a more objective standard. An individual is mentally retarded when he or she scores significantly below average on standard intelligence tests and demonstrates behavior atypical for their age group. Mental illness and mental retardation, then, are separate issues. Mental retardation is not mental illness, and vice versa.

Using these rough parameters, it is clear that the man with Down syndrome is mentally challenged, not mentally ill. Likewise, the member living with Alzheimer's disease is not considered mentally ill.

The woman who was sexually abused and the couple struggling with alcohol addiction are examples of people with pressing emotional needs, not mental illness. Even so, emotional needs that are ignored or left untreated can trigger mental illness.

The other examples—the severely depressed husband, the daughter with schizophrenia, the suicidal teenager, and the resident of the halfway house—all live with mental illness of varying degrees of severity.

What might congregation members do to reach out to members and people with emotional problems and mental illness?

The Problem with Labels

People should think twice about using psychological labels. Even though modern psychology has become a popular self-help tool today, a great deal of stigma still surrounds emotional problems. Most of us want to consider ourselves normal, even if few can really define what that means. Ironically, to label someone mentally ill tends to ostracize him or her, rather than opening up avenues of healing and acceptance.

Part of the problem is the confusion about the causes of mental illness. When causes are unknown, people tend to search for a culprit—divine punishment, supernatural spirits, poor parenting. While ultimate causes for mental disorders are still unknown, most involve some combination of environmental and biological factors. New discoveries about the neurological, genetic, and biochemical dimensions of depression, schizophrenia, and some other mental illnesses have led to the development and increased use of symptom-suppressing medications. These often alleviate much acute suffering, as well as misplaced blame.

What might members of a local congregation do to reach out to those with emotional problems and mental illness? One way, with roots in Scripture, is to care actively for those marginalized, vulnerable, and outcast. Today, mental illness no longer means possession by evil demons, as it often appears in the Bible. But mental illness can still be frightening—especially when we lack understanding. Too often what seems strange to us also seems dangerous, contagious, or sinful.

Breaking the Silence

The essential first step in addressing such concerns is to break the stigma of silence. This is more easily said than done. Many congregations have a rather strict, unspoken code about what needs and concerns can be talked—and prayed—about.

Lifting the taboo on these subjects may mean the pastor addresses them from the pulpit or through educational programs. Members might organize an evening in which speakers from the mental-health community speak on topics like alcoholism, abuse, violence, and depression—with time for congregation members to share their own experiences, if they wish. Perhaps the best place for significant conversations is small groups: prayer or Bible study groups, women's and men's circles, and support groups.

A Source of Support

Second, the congregation can be an excellent source of support and referral. It can also collect and distribute information about mental-health resources in the community. It is especially important for the congregation to offer support for the families of people with mental illness.

When the congregation lovingly supports those who seek assistance for emotional problems or mental illness, it recognizes the need to honor, cherish, and sustain God's gift of abundant life. ✠

This article is in response to an action by delegates at the 1993 Second Triennial Convention of Women of the ELCA, who called for continuing education related to mental illnesses (as distinguished from mental retardation).

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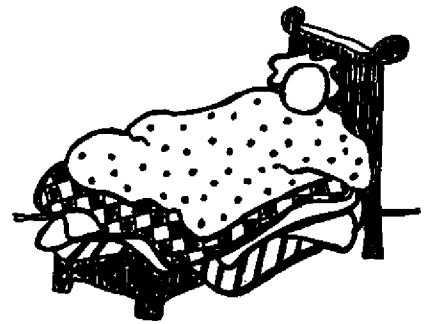
A Father's Day treat.

I Was Glad I Could Be There

Edwin DuBose



Just as I was about to go to work, you woke up feeling horrible. Your little body was so hot. I could feel as well as see that you were sick.

I was glad there were things I could do.

I gave you some medicine, rubbed your back, and held your hand. You were very patient with my efforts to help you feel better. You began to shiver, so I loaded on the blankets. One, two, three, four, five blankets! Finally you felt warm. We talked about where the blankets came from. The top one was from your great-grandmother in Texas. Mom made the pretty blue crocheted one for your Uncle Tom the year before he died. The bright pink fuzzy one came from your Nanna. The next one was from Target. That made you laugh.

The last blanket was pink on one side, and blue on the other, and it was given to you before you were born. It is hard to believe there was ever a time when we didn't know you. Now that we are such busy parents, we joke about what we used to do with our time before we had children. Today, I wonder how I ever felt content in life without loving you and your sister every day.

You told me you hoped your body had lots of white blood cells to fight the germs. I am impressed at what second-graders know.

Our love for each other is so strong, it makes me smile and cry at the same time. I think it is the same way that our Lord loves us. God cares for us like a parent for a child. *Yet it was I who taught Ephraim to walk, I took them up in my arms* (Hosea 11:3).

Thanks for letting me help you. We don't have enough quiet mornings together when we just sit and talk. I didn't even know that you like grapefruit juice as much as I do. How could I let even one little fact about you slip by? And thanks for your love. Maybe next time, I will be the one who is sick, and you can hold my hand. I know it will make me feel better than any medicine. G

The Rev. Edwin DuBose is pastor of St. Andrew Lutheran in Eden Prairie, Minnesota. He and his wife, Rosie, are parents of Melissa and Megan.