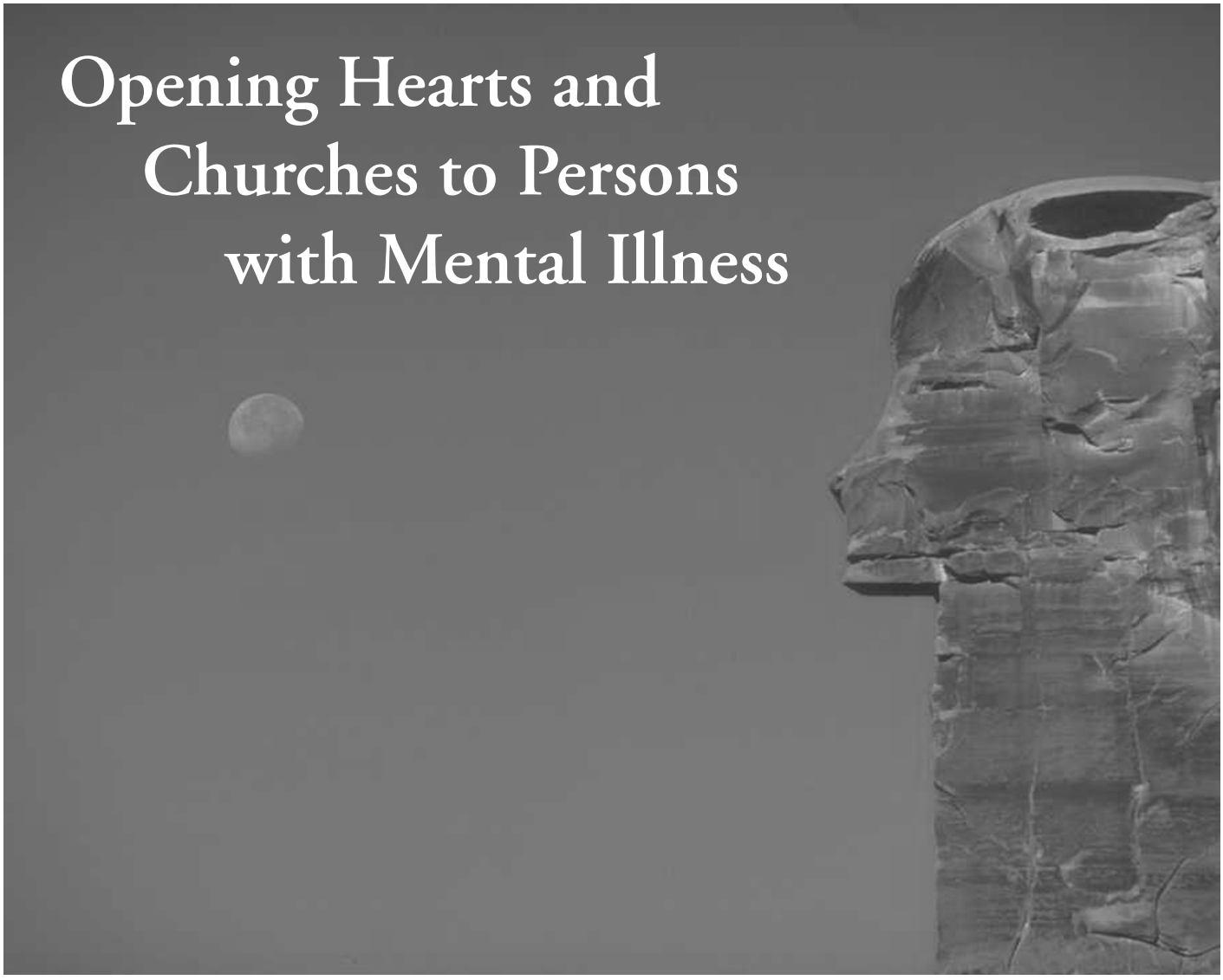
common lot

Journal supporting and stregthening the mission of The Coordinating Center for Women in Church and Society and United Church of Christ Women in Mission Fall 1999, No. 87

Opening Hearts and Churches to Persons with Mental Illness



- The Rev. Norma Mengel *"Fearfully and Wonderfully Made"*
- Myths and Facts About Mental Illness
- General Synod Mental Illness Resolution
- Resources for Domestic Violence Awareness Month
- Kelly Herr Strampe *"God Does Answer Prayers"*
- The Rev. Mary Albert *"Stepping Out in Faith to End Family Violence"*
- Are You in an Abusive and Potentially Violent Relationship?

Common Lot

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Common Lot welcomes unsolicited submission of articles, poetry, artwork, and resources. Manuscripts should be typed and double-spaced. If possible, submit on a Macintosh-compatible diskette. Send to the Editor at the address below.

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Contents

UCC Women in Mission is a national partnership of women in the Church dedicated to equality and the empowerment of women. If you wish to support the work and the mission of the **Coordinating Center for Women in Church and Society** (CCW) in a special way, you can become a partner in **UCC Women in Mission**. The work of CCW is in spiritual growth, advocacy, leadership development, empowerment and mission. CCW works globally, ecumenically, and in collaboration with other national UCC bodies to provide resources and advocacy for the numerous concerns of women. Partners receive a variety of helpful resources including *Common Lot*, program ideas, and a chance to make connections and support work of sisters in the Church.

CCW relies on subscriptions to continue the ministry of women to all. Subscription rates are printed in the box on the left; a subscription form is on page 27.

common ground

BY LOIS M. POWELL

MINISTER AND EXECUTIVE DIRECTOR

I ATTENDED a national conference on domestic violence in Chicago this month which brought together advocates, survivors, lawyers, medical professionals, governmental appointees and activists. "The Next Millenium Conference" afforded an opportunity to recognize the incredible work of the movement which has created shelters in local communities and legislation such as the Violence Against Women Act of 1994, currently up for renewal by Congress as VAWA II. (Call your Senators and Representatives and ask them to co-sponsor this bill!)

The conference was sponsored by the US Departments of Health and Human Services and of Justice so there were plenty of Washington folks around. It was diverse demographically —racially, age wise, abilities, and so forth; and there were a fair number of men, many of whom treat other men who batter, or who work in law enforcement or medicine.

At the opening plenary, a group of young people who had been meeting together for two days presented a message to the 1800 assembled participants, a statement they all agreed contained a summation of their discussions. They set the context right away by stating that young people should first of all be treated as people; people who can think for themselves, make decisions, and who are responsible. Then they outlined three points for effectively addressing issues of violence (date/acquaintance rape, violence within their relationships, etc.) which they experience as young people:
-Communities need to provide teen centers which are safe spaces.
-Schools should be places where issues of violence which they experience can be talked about with teachers, counselors, and among each other.
-Faith communities need to respond better to needs of teens and they should work collaboratively with community groups and agencies to provide assistance and to develop plans to address violence among youth, especially violence within their relationships.

Those of us attending the conference from religious communities all heard that third point loud and clear. Often in the domestic violence movement, the involvement of religious institutions and communities is not regarded as integral to the work of preventing, addressing, treating and healing those whose lives have been torn apart by domestic violence. But here were the youth, telling everyone that one of their three most important messages to us was to provide opportunities for them to talk about their issues within the context of a faith community!

Ah, out of the mouths of babes. Throughout the conference, we religious types caucused (convened by UCC minister Marie Fortune, Founder and Senior Analyst of the Center for the Prevention of Sexual and Domestic Violence in Seattle), made our presence known in workshops and plenaries, and encouraged those working on a presidentially appointed National Advisory Council on Domestic Violence (on which Rev. Fortune sits) to collaborate with those of us from faith communities. What we teach in our churches, synagogues, mosques, meeting houses and cathedrals about the role of women, about the role of men, about family relationships, about children, about self-worth and worthiness, about sin, about redemption, about God—all this and more contributes to both the conditions in which violence against women is accepted and the conditions in which it is not tolerated.

In this issue of Common Lot, you will find many resources for you and your local church around the continuing reality of domestic violence. Every nine seconds in the United States a woman is beaten by someone she loves or knows. Every nine seconds. Every day. Every hour. As we keep this issue before congress and push for a four year renewal of funding for VAWA II, we must also keep this issue on the table in our churches. We must not be afraid to name the sin of domestic violence. We must not be timid in our efforts to protect women and children, nor in our efforts to hold those who perpetrate the violence accountable for their actions.

And we must begin with our young people who are asking us to take them seriously as people and as spiritual beings who belong to the family of God.

Fearfully and Wonderfully Made

The Rev. Norma S. Mengel (RN, MPH, MDiv) is ordained to the healing ministry in the United Church of Christ. Now a retired pastor, Rev. Mengel leads retreats, provides spiritual direction, and consultation for ministry related to "mental" illness. Formerly, Norma was a President/CEO of a large home health care agency, an Associate for the UCC's Council for Health and Human Service Ministries, and a pastor of a local congregation. Rev. Mengel graduated from Lancaster Theological Seminary (MDiv), the Johns Hopkins School of Public Health (MPH) and Case Western Reserve University (BS in Nursing). Norma is a mother of a child with diagnosed bipolar illness at age 17, a sister to a brother who ended his life before the family knew about proper treatment, and herself is diagnosed with clinical depression.

THE WORSHIP service was about to begin. As the new pastor of two weeks, I had just shared the usual type of announcements of things happening in the life of the church. Suddenly the president of the consistory, without my prior knowledge, came to the pulpit saying he had something to share—asking me to be seated, because it would take a while. He proceeded to give his "testimony" of his experience of God's grace and provision for treatment in his life when, as a young man in college, he had been struck with the symptoms of severe "mental" illness, now known as manic depression of bipolar illness. He later revealed that this was the first time his two teenagers, in their usual front-row pew, had heard his story.

What prompted this church leader that morning to share his story? I can only believe it was this person responding to the prompting of the Holy Spirit. In being interviewed for this pastorate, I had been open in sharing about my personal, family and professional experience in coping with so-called "mental" illness, which we now know scientifically is a disorder of the brain, not the result of some personal weakness, or "poor parenting," or to whatever else society tries to attribute it. Perhaps, unknowingly, I had been a channel to provide a sense of safety for this man to share his story after all these years. Within the course of a year at this church, I had ministered to a young man diagnosed with schizophrenia and his aging parents, a wife coping with the suicide of her husband, improperly treated for bipolar illness, and several persons with major clinical depression. All this in a congregation claiming a total of 82 members! Can you imagine what needs there are (usually hidden) in a congregation of 200, or 600, or 1000?

Experiences like these prompted me to author a resolution for our conference's annual meeting (in the context of the "Healing and Wholeness Committee"), which went on to be presented and passed at General Synod 22, titled "Calling the People of God to Justice for Persons With Serious 'Mental' Illnesses (Brain Disorders)," printed elsewhere in this issue of "Common Lot."

These are illnesses which affect at least one out of five families in our society—and hence in our congregations. Yet in our "enlightened" age, people coping with these illnesses are too often left to struggle alone, surrounded by a "conspiracy of silence" because of the stigma and discrimination which still exists... everywhere, including the church."

THE FACTS ARE:

1. "Mental" illnesses are *biologically*-based brain disorders. Altered brain chemistry, structure and functioning, as well as genes, are among the causes. Much research is till needed to have precise answers.
2. The brain is an organ of the *body* (like the heart or pancreas).

by the Rev. Norma Mengel

3. Brain disorders are *physical* illnesses (as much as heart disease or diabetes) and are more common.
4. Brain disorders are *not* weaknesses of character, or the result of "bad parenting."
5. Brain disorders are *treatable*.
6. The effectiveness of treatment is as great or greater than for many other illnesses, such as heart disease.
7. Individuals receiving treatment for schizophrenia are no more prone to violence than the general public.
8. There are no grounds for stigma or discrimination.
9. There seems to be a "conspiracy of silence" surrounding these illnesses resulting from stigma.
10. Unequal health insurance coverage for these illnesses persists and is unjust discrimination.
11. All people are made in the image of God and are people of worth.
12. The church is called to take the lead in "normalizing" these illnesses and stamping out societal stigma and discrimination and to welcome and affirm all people as children of God.

IT IS TIME for our brains to be treated equally with out hearts. It is time for persons to receive the same kind of healing compassion and treatment when faced with a diagnosis of depression, bipolar disorder, schizophrenia, anxiety, obsessive-compulsive disorder, etc. as they would with a heart attack or diabetes or cancer.

Just because our brain is so complex and disorders can result in thinking, mood, and behavioral symptoms, is *no* reason to perpetuate the pervading stigma. Treatment is available and is more effective than treatment for many other common conditions, but is often not accessed because of the *stigma* attached or the *inequitable* insurance coverage, limiting *adequate* treatment.

We are "fearfully and wonderfully made." Nobel laureate and neuroscientist Roger Sperry gave this amazing description of the brain: "The brain contains 10 billion or so cells spitting chemicals at each other across gaps called synapses. These chemicals are known as neurotransmitters. Each second of life the brain performs about 5 billion chemical operations. In... [each] human head there are forces within forces within forces as in no other **cubic half foot** of the universe we know. There is nothing on earth so wonderful." It's what makes God's paramount creation, humankind, God's ultimate act.

Let's begin to appreciate more fully the wonderful organ the brain is to our whole existence, and be willing to compassionately minister to and **with** persons who experience some malfunction in this part of their body.

Please contact the UCC Mental Illness Network for resource persons and materials to increase awareness and ministry in our congregations for all persons suffering from these vexing and debilitating illnesses. Let us reclaim the healing ministry as Jesus demonstrated in his earthly ministry—and specifically as regards these disorders. ✝CL

PRAYER: SPIRIT OF TRUTH, GUIDE US INTO ALL TRUTH. SCATTER OUR DARKNESS AND LET YOUR LIGHT BE UPON US. IN YOUR WISDOM MAKE US WISE. DEEPEN OUR LOVE OF GOODNESS AND ESTABLISH OUR HEARTS IN THE FAITH OF JESUS CHRIST. AMEN.

SO GOD CREATED HUMANKIND IN HIS IMAGE,
IN THE IMAGE OF GOD HE CREATED THEM,
MALE AND FEMALE HE CREATED THEM,
AND GOD BLESSED THEM (GENESIS 1:27-28).

FOR IT WAS YOU WHO FORMED MY INWARD PARTS;
YOU KNIT ME TOGETHER IN MY MOTHER'S WOMB.
I PRAISE YOU FOR I AM FEARFULLY AND WONDERFULLY MADE.
WONDERFUL ARE YOUR WORKS; THAT I KNOW QUITE WELL.

Prayer from sermon preached on July 1997 at Maytown Reformed UCC, Maytown, Pennsylvania by The Rev. Norma S. Mengel.

Observe Mental Illness Awareness Week

Nurture and Congregational Care

During Mental Illness Awareness Week, Oct. 3-9 this year, people across the country will be challenged to broaden their understanding and acceptance of people struggling with mental illnesses. This year's theme, "From Discovery to Recovery", will help focus efforts on the critical role research and science have played in allowing individuals with severe mental illness to reclaim full, productive lives.

Contact your local Alliance for the Mentally Ill and Regional Mental Health Association for details concerning activities planned for your community.

Here are six things your congregation can do to observe Mental Illness Awareness Week:

1. Incorporate "Mental Illness Awareness" into your Sunday worship. Special worship resources are available through the Mental Illness Network or Pathways to Promise (the Interfaith Coalition on Mental Illness)

2. Study about mental illness in a Sunday school setting. The 21st General Synod passed a resolution on Mental Illness; distribute and study a copy of this resolution. Contact the Mental Illness Network or Pathways to Promise for this and other resources.

3. Sponsor an education program. Join other churches in your area and put on an education event for your community about mental illness. Combat stigma with fact! Your Regional Mental Health Association can help you with materials and possible speakers. Also include the local chapter of the Alliance for the Mentally Ill in your program. Learning about mental illness through the personal experience of a family member or someone who has struggled with the disease is important to understanding how the church can respond.

4. Publicly commend the special work of pastoral counselors and psychiatric chaplains. Invite a pastoral counselor or psychiatric chaplain to speak to your church about their work and ways your congregation can get involved. One congregation near a psychiatric hospital helps by donating new clothes (particularly shoes) to patients as they return to a community. The chaplain at the hospital has helped to coordinate the activity.

5. Invite the residents of a community group home to your church for a special meal. Some congregations in invite mentally ill people (many of them homeless) into their church weekly for a meal prepared and hosted by members of the congregation. Their outreach to the community has nourished more than the bodies of their guests. The congregation has grown in understanding and spirit.

6. Become a screening site for Depression Awareness Day. Churches, shopping malls, community centers and other places where people gather will become "screening sites" where psychiatric professionals invite passersby to take a few minutes to be evaluated for risk of depression, illness. For more information contact, contact the National Mental Health Association. ✝C L

Source: Mental Illness Network-United Church of Christ

Mental Health's Big Boost

By Claudine Chamberlain

When it comes to political "events" like this week's White House conference on mental health, the question seems inevitable: Is this just a lot of talk, or will it actually lead to something meaningful?

In this case, some observers say it already has led to something meaningful — a lot of talk. "People get cynical about what is seen sometimes as public relations," says Bob Carolla, spokesman for the National Alliance for the Mentally Ill (NAMI). "But no one should underestimate the power of just speaking out and being heard."

Conference organizer Tipper Gore, the wife of Vice President Al Gore, told of her own battle with clinical depression. So did CBS news personality Mike Wallace. So did Rep. Lynn Rivers, a Democrat from Michigan. And so did several ordinary, non-famous people.

Not Only the Lonely

"When you have it out in the open like that, it encourages people who are wondering if they have a problem to call their doctors and get help," believes Mark Oberg, the president of Walkers in Darkness, a popular Web-based support group for people with depression and other mood disorders.

"Some of the things that you think and feel when you're mentally ill seem crazy even to you," says Oberg, who himself suffers from manic-depression, or bipolar disorder. "It helps to know that other people have been through the same thing."

Continued on page 18

Myths vs. Facts About Mental Illness

Myths

1 - mental illnesses are not like physical illnesses & are all "in the head' of the sick.
2 - the mentally ill are bound to make second rate employees and shouldn't hold high level or important jobs.
3 - the mentally ill can never really be normal.
4 - everyone faces trouble in their lives so the mentally ill must be weaker in character than the rest of us.

Facts

1 - mental illnesses are brain disorders that alter how people feel, behave, & perceive the world, but, like physical illnesses, they are biologically-based.
2 - people who suffer from a mental illness can be just as effective as those with any other illness (ie. Abraham Lincoln suffered from severe depression)
3 - a surprising number of high level jobs are filled by people who have experienced mental illness
4 - many of our great works of art, music, & literature were produced by persons with mental illness
5 - while only 40-50% of people with heart disease will recover, 80% will recover from depression & 60% will recover from schizophrenia
6 - a person's character has nothing to do with whether they develop a mental illness
7 - mental illnesses strike those with all kinds of temperaments, beliefs, morals, & backgrounds
8 - the primary factor determining whether a person will develop a mental illness is their bio-chemical makeup
9 - a mentally ill person is just as frightened, upset, & physically ill as someone suffering congenital heart disease or any other physical illness
10 - learning the facts about mental illness is the first step to a fair attitude toward people with mental disorders

Used with permission from the National Alliance for the Mentally Ill.

Even people who know someone with mental illness, or who themselves have been diagnosed with it, often consider the condition shameful, which often hinders access to treatment. In a survey done by the Boston Globe, nearly 40% of those surveyed said that they believe most mental illnesses are the result of character flaws and personality defects, and that the cycles of the moon influence people with manic-depressive illness. Those are the type of myths and misperceptions that need to be changed. People who suffer from mental illness should not be ashamed. Treatments are available and are effective.

It is important to know that mental illness is very common. According to the National Institute of Mental Health, one in five people are affected by some form of mental illness during the course of a year. Only five percent of those suffering from a mental health disorder will seek the treatment of a mental health professional, even though 25 percent of all visits to a primary care physician involve patients with a diagnosable behavioral health disorder.

National Hunger and Homelessness Awareness Week
November 14-20
For more information, contact the National Coalition for the Homeless at (202) 737-6444

Mitos vs. hechos sobre la enfermedad mental

Mitos

1 - las enfermedades mentales no son como las enfermedades físicas y están "en la mente" del enfermo (no son reales)
2 - los enfermos mentales están determinados a ser empleados de segunda categoría y no deben obtener empleos importantes o de alto nivel.
3 - los enfermos mentales nunca serán realmente normales.
4 - todos enfrentamos problemas en nuestras vidas, por lo tanto, los enfermos mentales deben ser más débiles de carácter que el resto de nosotros.

Hechos

1 - Las enfermedades mentales son desórdenes mentales que alteran cómo la gente siente, se comporta y percibe el mundo, pero, tal como las enfermedades físicas, son físicas.
2 - Personas con una enfermedad mental pueden ser tan efectivas como aquellos que tienen otras enfermedades (Por ejemplo, Abraham Lincoln sufría de depresión severa).
3 - un sorprendente número de empleos de alto nivel son realizados por personas que han experimentado alguna enfermedad mental.
4 - Muchas de nuestras grandes obras de arte, música y literatura fueron producidas por personas con enfermedad mental.
5 - mientras que solo de un 40% a un 50% de la gente con enfermedad cardiaca se recupera, 80% se recuperará de depresión y 60% se recuperará de esquizofrenia.
6 - el caracter de una persona no tiene nada que ver con el hecho de que una persona desarrolle una enfermedad mental.
7 - las enfermedades mentales le ocurren a personas de toda clase de temperamentos, creencias, moral y trasfondo.
8 - el factor principal que determina si una persona desarrollará una enfermedad mental es su composición bio-química.
9 - una persona enferma mentalmente está tan asustada, preocupada y físicamente enferma como una persona que sufre de una enfermedad cardiaca congénita o cualquier otra enfermedad física.
10 - aprender los datos reales sobre enfermedades mentales es el primer paso para tener una actitud justa hacia las personas con desórdenes mentales.

Usado con permiso de la Alianza Nacional para Personas con Enfermedades Mentales.

Understanding Alzheimer's

Alzheimer's disease (pronounced Alz'-himerz) is a progressive, degenerative disease that attacks the brain and results in impaired memory, thinking and behavior. It was first described by Dr. Alois Alzheimer in 1906 and has been diagnosed in millions of people ever since.

Statistics

*Alzheimer's disease is a progressive, degenerative disease of the brain, and the most common form of dementia.

*Approximately 4 million Americans have Alzheimer's disease. A national survey conducted in 1993 indicates that approximately 19 million Americans say they have a family member with Alzheimer's, and 37 million know someone with the disease.

*14 million Americans will have Alzheimer's by the middle of the next century unless a cure or prevention is found.

*One in 10 persons over 65 and nearly half of those over 85 have Alzheimer's disease. A small percentage of people in their 30s and 40s develop the disease.

*A person with Alzheimer's lives an average of 8 years and as many as 20 years or more from the onset of symptoms.

*U.S. society spends at least $100 billion a year in Alzheimer's disease. Neither Medicare nor private health insurance covers the type of long-term care most patients need.

*Alzheimer's disease costs American businesses more than $33 billion annually—$26 billion is attributed to lost productivity of caregivers plus $7 billion related to costs for health and long-term care.

*More than 7 out of 10 people with Alzheimer's disease live at home. Almost 75 percent of the home care is provided by family and friends. The remainder is "paid" care costing an average of $12,500 per year, most of which is covered by families.

*Half of all nursing home patients suffer from Alzheimer's or a related disorder. The average per patient for nursing home care is $42,000 per year, but can exceed $70,000 per year in some areas of the country.

*The average lifetime cost per patient is estimated to be $174,000.

*The federal government estimates spending approximately $400 million for Alzheimer disease research in 1999. This represents $1 for every $250 the disease now costs society.

*The Alzheimer's Association is the only national voluntary health organization dedicated to research for the causes, cures, treatments and prevention of Alzheimer's disease and to providing education and support services to affected individuals and those who provide their care.

Who can help?

The Alzheimer's Association has a network of more than 200 local chapters nationwide, providing programs and services to families and professionals within their communities. Support groups, telephone helplines, educational programs, publications and information about local services are available locally or through the association's national office. ✝

Alzheimer's Association National Office
919 North Michigan Avenue, Suite 1000
Chicago, Illinois 60611-1676
(800) 272-3900 / Fax: (312) 335-1110

Alzheimber's Disease
Courage for Those Who Care
By Martha O. Adams
Pilgrim Press
160 pp.
ISBN 0-8298-1304-7
Paper—$16.95

This is a book for anyone who has been confronted with or will soon face Alzheimer's disease. Even as the medical world learns more about its cause, caregivers wrestle with the daily care of Alzheimer's patients. Written by someone who has witnessed firsthand the effects of every stage of this mysterious and devastating illness, *Alzheimer's Disease* offers encouraging words of hope for patients and those who care for them.

Martha O. Adams, a former teacher, has worked as a Christian educator.

Pilgrim Press
700 Prospect Ave.
Cleveland, OH 44115-1100
1 (800) 654-5129

A Prayer For Those Who Suffer from the Losses of Alzheimer's

Lord, this is a mystery to us: this suffering of spirit, this brokenness of body and mind, this loss of self. We want to trust you, but there are times when the pain is too great to hear your still small voice; times when the anguish of human loss overwhelms our faith.

O God, help us! Help us to find in our sorrow reason to trust: in our questioning, some understanding of the "why's" that wrench our souls; in our grief over unfinished business, some hope of healing other relationships before that opportunity is behind us as well.

God, _____ no longer knows her name. She no longer remembers her child[ren] who only now has tears and anger to offer you. Even you are seemingly vanquished in the victory of Alzheimer's which takes _____ from us. Help those of us who knew her in health find ways to remember her in our hearts, in our community, in our lives. And when the pain of remembering is too great for us, remember her for us, Lord, remember _____ for us. And remember us too, for we know our weakness before the mystery of suffering. Remember us, Lord. And have mercy. Amen.

Linda S. Whitmire

Culture and Mental Health

by Delores Perone, PhD

Demographers suggest that by the year 2050, half of the U.S. population will be of Hispanic, African American, Indian, or Asian descent. And as the general population becomes more culturally diverse, the incidence of mental disorders among individuals from diverse racial and ethnic groups will also increase.

Clinicians trained in traditional, Western biomedical psychiatry and other mental health professions will face new challenges in evaluating these individuals. This fact alone demands that our scientific understanding of social and psychological functioning and mental disorders must be based on knowledge of these varied groups.

The National Institute of Mental Health (NIMH) has been the primary source of support for research to more accurately describe the nature and prevalence of mental disorders among racial and ethnic minorities, and to improve both the accuracy of diagnosis and quality of mental health services.

One outcome of research supported by NIMH has been compelling evidence regarding ways in which the varied cultural backgrounds of individuals affect the context and content of both normal and abnormal behavior, the expression of symptoms associated with particular mental disorders, and the process of conducting a diagnostic evaluation. These results have been the scientific underpinning for important work on improving the outcome of the diagnostic process for individuals from diverse backgrounds.

NIMH and the American Psychiatric Association have collaborated to enhance the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or DSM-IV, to ensure the cultural validity and sensitivity of the diagnostic system. DSM-IV includes three types of information specifically related to cultural considerations: 1) discussion of cultural variations in clinical presentations of disorders included in the DSM-IV Classification, 2) description of culture-bound syndromes, and 3) outline for "cultural formation," an innovative approach that allows clinicians to describe the nature and extent of psychopathogy from the perspective of the patient's personal experience and social and cultural reference group.The inclusion of this information is expected to promote clinician sensitivity to the relevance of culture and racial and ethnic minority status to psychiatric assessment and the concept of comprehensive treatment. ✝CL

Dr. Delores Perone Associate Director for Special Populations of the National Institute of Mental Health.

Hispanic Outreach Initiative

Initiated by the Manhattan-based Blanton-Peale Institutes of Religion and Health (IRH), a new outreach project trains clergy and lay leaders to help Hispanic parishioners gain access to mental health services. Phase I began in January of 1993 with a series of Saturday "pastoral awareness" workshops to increase the knowledge of pastors regarding the emotional needs of those in their church communities. Led by six Spanish-speaking instructors, the IRH workshops attracted more than 100 clergy and lay leaders from across the city's diverse Hispanic neighborhoods.

In August, with a grant from the Robert Wood Johnson Foundation, Phase II was launched. This pastoral skills portion offered training for identifying parishioners in emotional distress, intervening in crises, providing short-term counseling, and making referrals for long-term professional counseling and treatment. Thirty classes plus retreats are now being offered over a two-year period for the 24 participants currently enrolled.

For many Hispanic immigrants landing on America's shores, the Church has been a source of comfort and stability. Skilled clergy will be able to reach out to help these newcomers adjust to the many problems that making the transition to inner-city life entails. ✝CL

For more information:
Blanton-Peale Institutes of Religion and Health
3 W. 29th St. 5th Floor
New York, NY 10001
212/725-7850

The Next National Eating Disorders Screening Day Will Be Held in February, 2000.

The National Eating Disorders Screening Program (NEDSP) is implemented during Eating Disorders Awareness Week and was held for the first time on more than 600 college campuses February 5-11, 1996.

Originally designed only for college students, the program was held again in February, 1998 and was expanded to include the general population. In the year 2000, the program will expand once again, incorporating a High School component designed to address eating disorders in younger individuals.

NEDSP represents the first large scale screening for eating disorders. The program includes an educational presentation on eating disorders and/or related topics (body image, nutrition, etc.), a written screening test and the opportunity to meet one-on-one with a health professional. It also provides individuals with information about how to help friends or family members who may be suffering from an eating disorder. NEDSP's national office provides each site with materials for the screening and ideas for ways the program can be modified for use by colleges, hospitals, schools, or eating disorders clinics.

The National Eating Disorders Screening Program materials focus on the three main types of eating disorders – anorexia nervosa, bulimia nervosa and binge eating disorder. The goal of the program is to both raise the level of awareness about eating disorders and to encourage people who may be suffering from eating disorders to seek further help and treatment. Participating sites are encouraged to network with community groups and other internal departments, thereby creating liaisons which can continue to be utilized throughout the year. In this way, NEDSP serves as a catalyst for ongoing outreach about eating disorders and other illnesses. ✝CL

Call (800) 573-4433 for more information

Calling the People of God to Open Wide their Hearts to Persons with Serious Mental Illnesses (Brain Disorders)

Resolution submitted and passed at the 22nd General Synod

Submitted by the Penn Central Conference.

Background

There exists in society and even in the church, great stigma and discrimination against persons with serious "mental illnesses" (Brain Disorders); this is both a ministry and a social-justice issue.

All people are created in the image of God and worthy of being treated with dignity, respect and love. "I give you a new commandment, that you love one another. Just as I have loved you, you also should love one another. By this everyone will know that you are my disciples, if you have love for one another"(I John 13:34-35).

Text of the Resolution

WHEREAS, serious mental illnesses—schizophrenia, bipolar disorder (manic depression), unipolar disorder (clinical depression), obsessive/compulsive disorder, panic-anxiety disorder—are biological brain disorders and need to be treated as any other biologically-based medical problem of any other organ of the body;

WHEREAS, the 1990's have been declared the decade of the brain and pioneering research has resulted in new knowledge and new effective medications;

WHEREAS, these brain disorders can now be treated as precisely and effectively as other medical disorders (e.g. a higher rate of success in such treatment than for cardiovascular disorders);

WHEREAS, there continues to be strong stigma and discrimination in society against people with these brain disorders in social relationships, health-insurance coverage, employment, etc.;

WHEREAS, there is great inequality in health insurance coverage for these medical conditions compared to coverage of any other physical, medical illness/disorder (diabetes, Parkinson's, etc.);

WHEREAS, at least one in four families (including church families) has a family member with one of these brain disorders;

WHEREAS, at least 30 million Americans, including at least 12 million children have these brain disorders; and

WHEREAS, the church is called to be a community which breaks through fear and isolation to offer love, hope, care and healing;

THEREFORE, BE IT RESOLVED that the Twenty-second General Synod requests the United Church

Implementation Plan For Ge

Goal:

In all settings of the UCC, to facilitate an awareness that "mental" illnesses, affecting one out of five families, are biological brain disorders that are treatable, thus eliminating the stigma and discrimination presently experienced by persons diagnosed with these illnesses and encouraging early treatment.

Strategies:

A. Education

Under the auspices of BHM, plan activities and distribution of resources at the national, conference, and local settings of the church.

Action Steps:

1. Publish four newsletters annually and mail to the MI Network mailing list, including all national ministries, conferences, resource centers and UCC-related seminary libraries.
2. Publicize, through the mailings, resources available through the network, "Pathways to Promise" and secular sources such as NAMI.
3. Write an annual article for "UC News".
4. Contribute articles and resources to the Fall !999 issue of CCW's "Common Lot".
5. Devise an educational kit patterned after NAMI's "Science and Treatment" Kit, providing a simplified tool for workshops in local churches and conferences.
6. Identify and publish names of resource persons in as many conferences as possible for leading workshops and preaching.
7. Working with OCLL, present a workshop to Conference and Association placement staff.
8. Present a workshop at CCW's National Women's meeting in 2000.
9. Plan and carry out one pilot regional conference within the next two years on ministry with and to persons with serious brain disorders.

Board for Homeland Ministries to make it a priority to educate congregations about these disorders and encourage congregations to be truly inclusive, welcoming churches, ministering with and to persons with these disorders and their families;

BE IT FURTHER RESOLVED that the Executive Council is requested to petition The Pension Boards-United Church of Christ to establish health insurance policies which provide insurance coverage for these brain disorders equal to any other physical illness; and

BE IT FINALLY RESOLVED that the Office for Church in Society is requested to promote advocacy in state legislatures and in Congress for equality in health insurance coverage and other anti-discrimination legislation which affects this population of people.

Subject to the availability of funds.

For Information and Support

The Mental Illness Network —UCC
c/o Bob Dell, 414 E. Pleasant
Sandwich, IL 60548
www.min-ucc.org

National Mental Health Association,
1021 Prince St.
Alexandria, VA 22314
(703) 684-7722
www.nmha.org

Pathways to Promise
5400 Arsenal St., M.S. 223
St. Louis, MO 63139
(314) 644-8400
www.pathways2promise.org

National Alliance For The Mentally Ill (NAMI)
200 N. Glebe Rd. Suite 1015
Arlington, VA 22203-3754
1-800-950-NAMI (6264)
www.nami.org

eneral Synod 22 Resolution

10. Educate CHHSM membership to the need for health and human service ministries in this field. (Eg. Mayflower Homes in Grinnell, Iowa has a residential program.)
11. Collaborate with other denominations in "Pathways to Promise" initiatives.
   a. published resources b. research project with the elderly
   c. proposed pilot project related to pastors with diagnosed illnesses—employee assistance type model
   d. research other denominational initiatives (eg. the Methodists had a national conference last year available by downlink sites.)

B. Advocacy
Under the auspices of OCIS and the Pension Boards work to bring parity in health insurance coverage and seek to end discrimination by supporting other legislative efforts at the national level.

Action Steps:
1. Seek to make presentation to the Executive Council who, in the resolution, is charged with petitioning the Pension Boards for parity in insurance.
2. Seek appointment with Pension Boards (Joan Brannick) to present current data re parity.
3. Meet with OCIS representative to sensitize to the issues nationally—parity bills, work incentives legislation, etc.
4. Encourage network members to access NAMI's news service via the internet. www.nami.org.
5. Respond to discriminatory, stigmatizing incidents as they occur personally, and in the media as time and energy permits. (e.g. mental illness resolution was omitted from "UC News" coverage of General Synod despite its floor support and unanimous passage and its affecting a large population of people compared to some of the other resolutions that were covered in the news releases. The question might often be raised: Would breast cancer, liver damage or heart disease be treated the same?).

National Depression Screening Day October 7

Find out your depression score and what you can do about it on National Depression Screening Day, October 7th. Free, anonymous screenings for depression and manic-depression are available at more than 3000 sites across the country.

People with depression often feel alone. They don't realize that depression affects more than 17 million Americans in any given year. And they probably don't know that:

* Many powerful and famous people have discussed their episodes of clinical depression, including Alma Powell, Mike Wallace, Tipper Gore, and Pete Harnisch;
* Twice as many women as men suffer from depression, but risks for bipolar disorder (manic-depression) are similar in men and women;
* Recent studies have shown that heart attack survivors with major depression have a 3-4 times greater risk of dying within six months than those who do not suffer from depression;
* Dysthymia is a mild form of depression that lasts 2 years or more;
* The World Health Organization estimates that by the year 2020, unipolar major depression will be the second-most burdensome illness in the world, surpassing respiratory infections and tuberculosis; and
* Teen suicide rates have increased more than 300% since the 1950's.

Attendees at the screening will hear an educational presentation on depression, take a written self-test and get to talk one-on-one with a mental health professional-all for FREE.

Call 1 (800) 573-4433 to locate a screening site near you (beginning Sept. 13).

Older Americans Rarely Tested for Depression

Some 68% of Americans 65 and older think they know only "a little" or "almost nothing" about the illness of depression, according to the National Mental Health Association. This National Depression Screening Day, October 7, offers a free program that will teach older adults about depression and give them the opportunity to test themselves for the illness.

Older Americans regularly learn their cholesterol numbers and blood pressure, but they rarely consider being tested for depression. This is unfortunate because seniors spend considerable time visiting doctors and have ample opportunity to discuss their moods. Often, they are embarrassed to broach the issue and their doctors don't ask. This is unfortunate because many older Americans with physical illness such as heart disease, Alzheimer's and cancer, are at greater risk for developing depression. In addition, seniors with depression have a higher risk of developing other physical illnesses. One recent study revealed that chronically depressed seniors have an 88 percent higher risk of contracting all forms of cancer than do not depressed seniors.

More than 2 million of the 34 million Americans age 65 and older suffer from some form of depression; however, depression is *not* a normal part of aging. Depression is a medical condition that involves feelings of sadness, loss of pleasure in usual activities, and hopelessness and can interfere significantly with an individual's ability to function. Unlike the blues or grief, depression persists and is not relieved by good news, the passing of time or by supportive friends.

Seniors can take the first step toward getting help by attending the free, anonymous screenings. Call 1 (800) 573-4433 for more information. They will have the opportunity to complete a written screening test, hear an educational presentation, and talk individually with a mental health professional. Referrals will be provided to those in need. All screenings are free and anonymous.

Overcoming Depression

I pray to you...
Gracious and Merciful God...
I pray to you even though
I dwell in darkness,
I pray to you because you
are the Light of the World.
Unable to escape from the
trap of myself,
I pray to you because you
are the Door.
Lonely and alone, I pray to you
because you are the
Good Shepherd.
Having Lost my way, I pray to you
because you are the Road.
Depleted empty, I pray to you
because you are the
Bread of Life.
Dying daily, I pray to you
because you are
the Resurrection.
Gracious and Merciful God,
I pray to you:
Enlighten me, open me,
comfort me, feed me, lead
me, and be my life. Amen.

Ieva Klavina
Latvia

What is clinical depression?

Clinical depression is a serious and common disorder of mood that is pervasive, intense and attacks the mind and body at the same time. Current theories indicate that clinical depression may be associated with an imbalance of chemicals in the brain that carry communications between nerve cells that control mood and other bodily systems. Other factors may also come into play, such as negative life experiences such as stress or loss, medication, other medical illnesses, and certain personality traits and genetic factors.

There are several types of depression—**major depression**, **dysthymia**, **bipolar depression**, and **Seasonal Affective Disorder**.

***Major depression** is the most common type of depression and is characterized by at least five of the major symptoms of depression. **Dysthymia** is a milder form of depression that lasts two years or more. It is the second most common type of depression but because people with dysthymia may only have two or three symptoms, may be overlooked and go undiagnosed and untreated.

***Bipolar depression** is the depressive phase of manic-depressive illness, in which there are both extreme highs and extreme lows. Bipolar depression symptoms are similar to those of major depression, with certain variations such as excessive sleep and increase in appetite.

***Seasonal Affective Disorder** is a type of depression that follows seasonal rhythms, with symptoms occurring in the winter months and diminishing in spring and summer. Current research indicates that the absence of sunlight triggers a biochemical reaction that may cause symptoms such as loss of energy, decreased activity, sadness, excessive eating and sleeping.

Recently, research produced as a result of the last several National Depression Screening Days has revealed that some people may experience depression without necessarily suffering from significant or very troublesome changes in sleep and appetite. This is an intriguing finding because changes in sleep and appetite are usually considered to be hallmarks of depression. Instead, the five most common symptoms in people being screened for depression during the past several National Depression Screening Days were:

*difficulty doing things done in the past,
*feeling hopeless about the future,
*difficulty in making decisions,
*feeling worthless and not needed, and
*no longer enjoying once enjoyable activities.

What are the signs and symptoms of depression?

The symptoms of depression include feeling sad and blue, not enjoying activities once found pleasurable, having difficulty doing things that used to be easy to do, restlessness, fatigue, changes in sleep, appetite or weight, inability to make decisions, feelings of worthlessness, and thoughts of death or suicide.

Symptoms of depression

**persistent, sad, anxious or empty mood*
**feelings of hopelessness or pessimism*
**feelings of guilt, worthlessness or helplessness*
**loss of interest or pleasure in ordinary activities*
**decreased energy, a feeling of fatigue*
**difficulty concentrating or making decisions*
**restlessness or irritability*
** inability to sleep or oversleeping*
**changes in appetite or weight*
**unexplained aches and pains*
**thoughts of death or suicide*

National Depression Screening Day is currently working to educate the public and health professionals about this new information. Individuals who are experiencing these symptoms should ask their doctor about clinical depression.

What is the difference between the blues and clinical depression?

Feeling downhearted and sad is often a normal reaction to a life situation. All of us feel this way sometimes, but in a few days, perhaps after talking to a good friend, we start to feel ourselves again. Clinical depression is very different. Clinical depression is an illness, and it requires specific treatment.

Unlike the blues, clinical depression persists and doesn't go away no matter how hard the individual wants it to. Clinical depression is not a weakness. It is an illness and can last for months or years if left untreated. The most serious and tragic consequence of clinical depression is suicide.

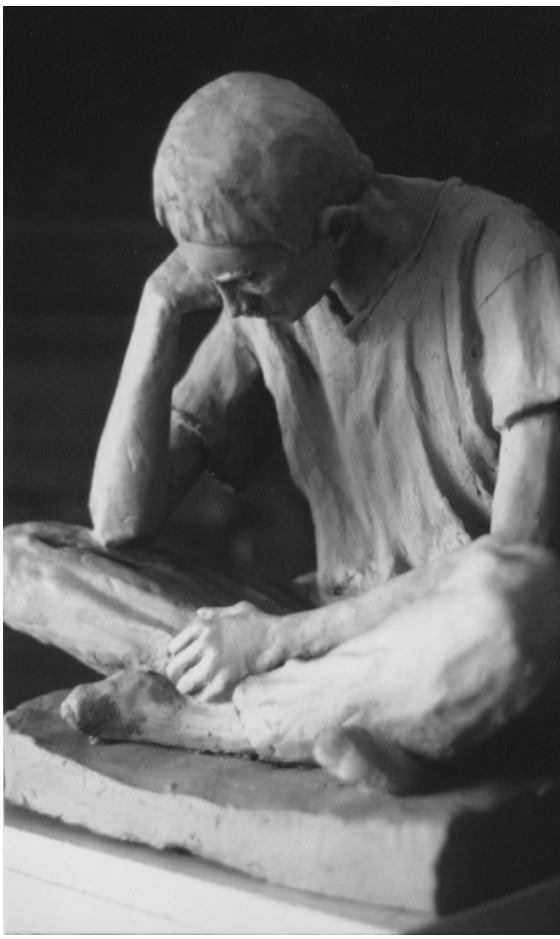
Who gets depression?

According to the National Institute of Mental Health, more than 17 million Americans each year develop depression. Recent research indicates the number may be even higher, closer to 20 million. One thing on which researchers agree is that less than half of the people suffering from depression actually receive treatment. Yet, one out of every five adults may experience a depression at some point in their lives. Twice as many women as men suffer from depression, although everybody, including children, can develop the illness.

God Does Answer Prayers

by Kelly Herr Strampe

Since 1992 my church has published a Lenten Booklet which contains devotionals written by members and friends of our congregation. The booklet is intended for use during daily reflection time during the Lenten season. It includes essays, poetry, Biblical reflection, etc. and oftentimes the devotionals are of a very personal nature. I have written something each year and in 1997, I wrote the devotional dealing with my brother's mental illness. That year I had a strong feeling that God's Spirit was leading me to "get down on paper" some of what I had experienced, in relation to my personal faith. About a month after writing my devotional, my brother died unexpectedly at the age of 47. I knew that this devotional was a way that God was helping prepare me for my brother's death. I also felt that my openness in sharing this very personal and painful experience helped my church family to respond at the time of my brother's death in very caring and meaningful ways. The past two years I have served as moderator of our church and I have seen a number of families dealing with the devastating effects of mental illness. I have witnessed their pain but I have also seen the blessings they and others have received when they are open and willing to share that pain with others. I give thanks for the church as it continues to be a vehicle of God's love, bringing healing, comfort and strength to those who need it.



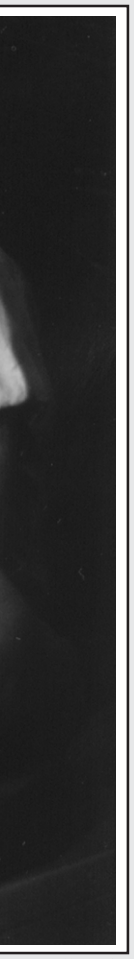
"Down" sculpture in bronze by Charles

LENT IS A SEASON in which we prepare for Easter by reflecting on our lives and our faith. I would like to share a time of great pain with you...a time of renewal in my relationship with God...a time when I experienced a resurrection of hope.

WHEN I WAS 18, I came home one weekend from college to find my brother Steve in a crisis unit at a mental hospital. When I saw him, he did not know who I was and was in a world where I could not reach him. At that point in my life I felt I had a strong faith in God. My mother had raised me with a strong belief in God and His goodness. I had been baptized at 13 and asked Jesus into my heart to be my Lord and Savior. I had regularly attended church beginning in junior high, participated in Bible studies and youth groups. But my faith was not able to help me understand why this was happening to my brother. My sole prayer was "God, please help heal my brother and make him like he used to be."

THAT DID NOT HAPPEN and life went on for me, my brother and the rest of the family. Steve was diagnosed with schizophrenia and the next five years were a time of great pain and confusion for all of us. For myself I wanted the pain to be gone, for life to be good again, and I wanted to be able to make sense out of something which made no sense. I still believed in God but I didn't know anymore what to believe about God. I didn't blame God for causing my brother's illness but I wanted to believe in a God that would take away his illness. Over and over again I asked myself, "Why was God allowing this to happen to my brother? to me? to my family? Why would't God answer my prayer... or the prayers of my mother? I think the hardest thing for me was to feel that there was no hope for my brother...no hope for a cure...no hope for a better life. I had always been an optimistic person, able to see the good in most situations but that wasn't the case now.

IT WAS AT THAT POINT that I was finally able to trust God again fully. I had no choice. I knew I couldn't fix things for my brother and so in my pain, I gave it all to God. In prayer I turned to God, telling Him that I needed Him, that I was scared and that I couldn't handle it alone. I wanted to be close to God again and to feel His presence in my life. And God did open my eyes and heart to His presence and His love at a time when all around me would have denied those things.



McCollough

Down

Down on the bottom
It looks so grim
Down in the darkness
The lights are dim.

You sink to sad center
That retreats from the hold
You crawl in yourself
Shaping a fold.

Down there's not wrong
We need it to stay
Sane in a world
Crazier each day.

But finally you'll move
Out from this rest;
The time will come
To forefeit your nest.

To another who's
Downed by sanity's claim
You'll give up your cave
So compassion can name

Your own center that's
lost now in its gain
When others replace
Your self with their pain.

Charles McCollough

The Rev. Dr. Charles McCollough is an author, sculptor and poet and is an Associate for Church Empowerment for the UCC's Office for Church in Society's Washington, DC office.

STEVE IS 47 NOW. He has lived with schizophrenia for 23 years now. Some of those years were "good", some were bad. But over the years I have been reassured of God's presence in my life and Steve's life. Although my first prayer for the healing of my brother was never answered (and may never be answered), many other prayers have been.

IN MY OWN LIFE, my hope was restored and I was able to find joy in the blessings I enjoy, which are many. Over the years there have been times in my brother's life which have been difficult for me, but God has given me strength to make it through those times. Sometimes that strength comes from within, a result of giving the situation to God as I pray "Thy will be done". Other times it has come from others as they have reached out with prayers, caring words or a loving touch. Either way it is a gift from God. God's goodness and His love are always there for me. I just need to open my heart to receive them.

I HAVE SEEN GOD'S presence in my brother's life also. The strength and courage to live with such a cruel disease can only come from God. My brother is my hero. When I prayed for Steve to have God's peace, doctors were able to find medications what helped control the voices he hears so that hopefully he can experience peace in his soul. When I prayed for him to know God's love, he was placed in a care home where he received much love and caring from the staff and other residents. When I prayed for him to have joy, I saw it on his face as he played cards with his niece Janelle. Does he have hope? I don't know the answer to that. I pray that God will help me with that one.

I KNOW FOR ME it is always comforting to have Bible verses nearby. During difficult times, God's promises as they are found in His Word may be all we have to cling to. Two that I would like to share with you are:

PSALMS 23:7
"The Lord is my strength and my shield; my heart trusts in Him and I am helped."

ROMANS 8: 35, 38, 39
'Who shall separate us from the love of Christ? Shall trouble or hardship or persecution or famine or nakedness or danger or sword?...For I am convinced that neither death nor life, neither angels nor demon, neither the present nor the future, nor any powers, neither height nor depth, nor anything else in all creation, will be able to separate us from the love of God that is in Christ Jesus our Lord."

Kelly Herr Strampe is a member of the Union Congregational United Church of Christ in Green River, Wyoming. She has served in many different capacities in her local church. She presently serves as moderator, Sunday School teacher and heads the prayer chain. She recently attended her first Synod as a delegate from the Rocky Mountain Conference. Her interests include Christian Education and Youth Ministries, Women's Groups, Prayer Ministries, and creating more caring communities. She is married and a stay-at-home mom, who will begin substitute teaching on a part-time basis this year. She is the mother of three sons and a daughter, who range in age from 7-13.

Resources
Mental Illness and the Church
Annotated Bibliography

Aging And God: Spiritual Pathways To Mental Health In Midlife And Later Years
By Harold G. Koenig, M.D.
Haworth Pastoral Press
10 Alice Street
Binghampton, NY 13904
Cloth/Paper—554 pp.
A book with appeal for middle-aged and older adults and their families, as well as mental health professionals, chaplains and other clergy. It promotes understanding of the spiritual needs of older adults, and the impact religion can have on facilitating mental health and successful aging. It covers major psychological problems older adults face, and offers discussion on how religion can be used to help alleviate these problems.

An Annotated Bibliography On Ministry And Prolonged Mental Illness
By Rabbi Jeffrey Cohen, H. Newton Malony and Jennifer Shifrin
Pathways to Promise
5400 Arsenal Street
St. Louis, MO 63139
Paper—9 pp.
Annotated listing of articles, booklets, books and videotapes. Earliest publication listed in from 1978; most citations are from mid and late 1980s. Includes key references from various faith communities.

Appropriate Language In Discussing Mental Illness
By Charlotte Hawkins-Shepard, Ph.D.
Health and Welfare Ministries Program of the General Board of Global Ministries
United Methodist Church
Room 330
475 Riverside Drive
New York, NY 10115
Paper— 1 pg. double-sided.
Available on the internet at http://gbgm-umc.org/disc/languse.html, this resource discusses the importance of using "People First Language" when speaking or writing about mental illness. Urges the Church community to help stamp out the use of demeaning terms such as "crazy," or "nut." Reviews types of mental illness and cautions against global use of specific terms that refer to only one disorder, but rather that people use such terms only when sure they are correct, both medically and legally.

The Church And Serious Mental Illness
Church and Society Vol. 81 (3)
Social Justice and Peacemaking Unit
Presbyterian Church (USA)
100 Witherspoon Street
Louisville KY 40202
Paper— 136 pp
Among the articles in this journal are "Witnessing: Diary of Depression,"by a Presbyterian minister who spent several months as a patient in a psychiatric hospital, "When the Devil Deserts You," by Ed Cooper, a person with mental illness, "Ministering—the Meaning of Hope in the Task of Shepherding," by Roy Fairchild, a Presbyterian minister and Professor, San Francisco Theological Seminary, "In Sickness and In Health - When a Partner is Mentally Ill," by an anonymous author, and "Care in the Congregation," by Larry Martens, President, Mennonite Brethren Biblical Seminary. A resolution of the Presbyterian Church on "The Church and Serious Mental Illness" from the 200th General Assembly in 1988 is reprinted in full, with excerpts from the background paper. The material concludes with resources for congregations.

Clergy: Mental Illnesses Awareness Guide
By the American Psychiatric Association Division of Public Affairs
American Psychiatric Press
1400 K Street NW, Suite 1101
Washington DC 20005
(800) 368-5777
Paper— 40 pages.

Continued on page 18

Women & Job Based Health Benefits
United States Bureau of Labor Statistics

According to the Bureau of Labor Statistics, the labor force is becoming more diverse, older and more female. Today, those changing labor force demographics are already evident in terms of the increased number of working women.

Working women are likely to be the primary decision maker for the family as well as the care giver when a family member falls ill. Therefore, women need adequate knowledge and tools to satisfy their multiple roles as decision makers and consumers of health care.

Women as Major Health Care Consumers:
Approximately 83% of women age 18-64 had health insurance in 1996. The remaining 17%—which translates into 14 million women—had no health benefit coverage.

Of the women with health insurance, at least 3 out of 10 obtained their insurance coverage from public insurance, including Medicaid, Medicare, CHAMPUS and governmental plans. The remaining 70% had private insurance, mostly through their own employer or as a spouse or dependent covered by an employer plan.

Women utilize more health care than men, in part because of their need for reproductive services. In 1996, women accounted for nearly 60% of all visits to doctors' offices and over 60% of outpatient hospital visits.

Women make three-quarters of health care decisions for their families and are more likely to be the care givers when a family member falls ill.

Data show that women are the primary seekers of information about their legal rights under private employment-provided health insurance, making 66% of the calls to the Department of Labor in the latest quarter of 1998.

Mental Health Parity Act

The Mental Health Parity Act (MHPA), signed into law on September 26, 1996, requires that annual or lifetime limits on mental health benefits be no lower than that of the dollar limits for medical and surgical benefits offered by a group health plan.

MHPA applies to group health plans for plan years beginning on or after January 1, 1998 and contains a so-called "sunset" provision that provides that the parity requirements do not to apply to benefits received on or after September 30, 2001.

The law:

Generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate lifetime and annual dollar limits under a group health plan; provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity).

The law also contains the following two exemptions:

Small employer exemption. MHPA does not apply to any plan or coverage of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year, and who employs at least 2 employees on the first day of the plan year.

Increased cost exemption. MHPA does not apply to a group health plan or group health insurance coverage if the application of the parity provisions results in an increase in the cost under the plan or coverage of at least one percent.

The law, however, does not apply to benefits for substance abuse or chemical dependency. CL

Mental Illness Resources (continued)

This guide on mental illness was reviewed by clergy and physicians throughout the country. Four sections of useful information follow an introduction and a fact sheet about mental illness. "Ideas for Ministry" has 11 steps a faith community can take to be in ministry with persons who have a mental illness, worship ideas, sermon starters and prayers. "Further Your Understanding" includes material on reaching out to someone with a mental illness, mental illness terms and crisis intervention information for clergy. The "Special Events" section has material on mental illness awareness week, mental health month, national depression screening day and world mental health day. A fourth section is entitled "Mental Illness Awareness Camera-Ready Materials."

Creating A Circle Of Learning:
The Church And The Mentally Ill
By Shirley H. Strobel
NAMI
P.O. Box 753
Waldorf MD 20604.
This is a curriculum designed to sensitize adults in church congregations to people with severe mental illness. Can be used as 12 one-hour lessons or six two-hour lessons. Teaching sessions are designed to build on a Biblical-based theological reflection. The publication includes material on being a friend to a person with mental illness, and model programs from other churches.

Dealing With Depression:
Five Pastoral Interventions
By Richard Dayringer, Byron Eicher, Myron C. Madden, and John J. O'Hearne
Haworth Pastoral Press
10 Alice Street
Binghamton NY 13904
Cloth/Paper— 175 pp.
The book offers definitions of depression, characterizations of effective interventions, and a discussion of the counselor's role. Authors include two hospital chaplains, two clinical psychologists and three physicians. Presents strategies clergy can use in identifying and helping persons with depression, and describes techniques, devices and interventions that help improve the mental health of persons with depression.

Helping Someone With Mental Illness: Compassionate Guide For Family, Friends And Care Givers
By Rosalynn Carter and Susan Golant
Times Books
Cloth— 348 pp.
Useful for clergy, families, social workers, doctors, consumers. Covers descriptions of different mental illnesses, and gives step by step suggestions on what to do after a diagnosis: seeking the best treatment, evaluating health care providers, managing the workplace, financial and legal matters, and more. Additionally, how to cope with the impact on the family, as well as connecting with the right support are discussed. Includes an excellent 20 page list of references.

Just For This Day: Meditations For Families Experiencing Mental Illness
By Project Religious Outreach of the Alliance for the Mentally Ill of Ohio
979 South High Street
Columbus OH 43206
(614) 444-2646
Paper— 124 pp.
A book of writings and drawings by persons with mental illness and family members of persons with mental illness. Sample titles of written pieces are: "Hope," by a mother of a son who has bi-polar disorder, "Acceptance and Serenity," by a mother of a son who has schizo-affective and bi-polar disorder, "Patience," by a daughter of a woman with bi-polar disorder, and "Acceptance," by a person with Schizophrenia.

A Path Through The Sea: One Woman's Journey From Depression To Wholeness
By Lillian V. Grisham
Wm. B. Eerdsmans Publishing Company
255 Jefferson Avenue, S.E.
Grand Rapids, MI 49503
Paper— 223 pp.
This book presents a first person account of Lillian Grisham's experience with a five year period of depression. She portrays the complexity of severe depression, and the complexity of its healing, giving full credit

Continued on page 18

Mental Health's Big Boost (Continued)

Besides bringing mental illness out of the closet, the conference will have at least one very tangible impact: President Bill Clinton informed all 285 health plans used by 9 million federal employees and their families that they must cover mental illness and substance abuse to the same extent they cover physical ailments.

The vast majority of insurance companies — whether they cover private or public sector employees — now treat mental health care differently by requiring higher co-payments, higher deductibles and restrictions on the number of visits.

Better Coverage Helps Productivity

"He was basically saying to insurance companies that this is the wave of the future, so live with it," says Raymond Fowler, chief executive officer of the American Psychological Association. "When millions of federal employees get a type of service, it shows that it can be done. Those employees will have a different life than they did before."

Alfonso Guida, vice president of governmental affairs for the National Mental Health Association, points out the conference also included testimonials from private companies that had beefed up mental health coverage in their employees' plans. That could prompt other companies to do the same, once they've heard how it helps increase worker productivity and decrease absenteeism.

"They don't do it because they're nice guys," he says. "They do it because it makes business sense."

Ending the Stigma

Perhaps the toughest goal of the conference, though, was to move toward ending the stigma of mental illness, and the tendency of many people to think that depression or other mental problems can be simply willed away or gotten rid of through prayer or positive thinking. Tipper Gore and others have compared mental illness to cancer, which was once a taboo subject.

"Stigma's a very intangible kind of thing," says medical historian and Rutgers professor Gerald Grob. "I wouldn't look to a White House conference to change people's minds about mental illness." With cancer, he adds, people were afraid to talk about it because they thought it was an automatic death sentence. Once treatments became more successful, that changed.

But the stigma against mental illness remains, even though the standard treatment of medication and talk therapy for depression is almost twice as effective as, say, the popular balloon angioplasty is for heart disease.

The White House plans to follow the conference with an anti-stigma campaign that will include a series of public service announcements. So maybe if a tearful Native American can get people to stop littering, and frying eggs can get kids to say no to drugs, there's hope that one day we'll all talk openly about mental illness.

Mental Illness Resources (continued)

for the latter to her pastor, her Christian psychiatrist, and her husband, Ray. In his own section of the book, Ray gives an account of his experience with her illness, and offers practical advice for family members and friends who would like to know how to help. The necessity of both psychiatry and spiritual counseling for persons with mental illness is underscored in the book.

Pathways To Partnership: An Awareness And Resource Guide On Mental Illness

By Jennifer Shifrin, Rabbi Jeffrey Cohen and Florence Kraft
Pathways to Promise
5400 Arsenal Street
St. Louis MO 63139
Paper— 26 pp.

Six section booklet. Content in Section I covers myths and realities and definitions relating to mental illness, possible signs and symptoms of mental illness, how to reach out to someone who has a mental illness, and the family and mental illness. Section II has suggestions on how a congregation can respond. Section III contains pastoral resources, sermon starters, hymn suggestions, and denominational statements and resolutions on mental illness. Section IV contains congregational resources. Section V provides education models for the congregation, covering adult education and lessons for children and youth. Section VI is a two page annotated listing of resource and support organizations and a brief bibliography.

Pathways To Understanding: A Manual On Ministry And Mental Illness

By Jennifer Shifrin
Pathways to Promise
5400 Arsenal Street
St. Louis MO 63139
Video & manual—238 pp.

Four section booklet. Content in Section I, "The Faith Community and Mental Illness" covers the history of the faith community's response to mental illness, an orientation to mental illness, a theological perspective in ministry with people with mental illness, and pastoral care and mental illness. Section II, "The Person and the Family," has information on such topics as when to counsel vs. when to refer, working with people with mental illness, what to do in a crisis situation, and working with the family. Section III contains 11 narratives illustrating situations a clergy person can face in the congregation and community. (On the video, this is a 60 minute section, and there is a pause between each narrative, allowing individual narratives to stand on their own.) Section IV, "The Community and Its Resources" has six sections, covering such topics as building bridges with and working with mental health systems and providers, sources of information and support, and insurance and legal issues.

Continued on the next page.

A Soul Under Siege: Surviving Clergy Depression
By C. Welton Gaddy
Westminster/John Knox Press
100 Witherspoon Street
Louisville, KY 40202
Wayne E. Oates has written an engaging foreword to this book. The author describes his recovery from depression, including a period of hospitalization. Sharing the understandings to which he came in the recovery process, he reflects on how we all are equal in God's eyes.

Souls Are Made Of Endurance: Surviving Mental Illness In The Family
By Steward D. Govig
Westminster/John Knox Press
Paper— 111 pp.
This book is a personal account of a family's struggle with their son's Schizophrenia. The book is divided into three parts: Finding Out, Holding On, and Letting Go. Notes at the end contain the titles of resource books and articles on serious mental illness and the family. Personal anecdotes form the base of the book's material. Govig states in the preface that the stories of personal struggle are not merely illustrations of suffering, but can become vehicles for rebirth and hope. Throughout, one finds the theme of endurance, which Govig characterizes as embracing hardship and tenacity.

With Cords Of Compassion: Ministry With Persons Affected By Serious Mental Illness
By The Rev. Jeffrey A. Hosmer, Ruth Drescher, & Eric Engel (Editors)
United Mental Health
PHSDS Building 3rd Floor
1945 Fifth Avenue
Pittsburgh PA 15219-5543
Paper— 29 pages.
The purpose of this publication "is to provide clergy and religious leaders . . .with a succinct reference to assist your ministry with persons challenged by mental illness." The material covers definitions, symptoms, misconceptions, common medications and treatment, information on legal issues and a brief bibliography.

Mental Illness Awareness Guide for Clergy by the American Psychiatric Association
Division of Public Affairs (Free)
1400 K Street, NW
Washington, DC 20005
(202) 682-6325
FAX (202) 682-6255

Violence Against Women Act

October 29, 1999 is the target adjournment date this year of the 106th Congress. There are only 46 days left until the end of the current Congressional session. Please sign our petition and send a message to Congress.

* Help end violence against women and girls
* Help stop rape and sexual assault
* Help keep battered women's shelters open
* Help make homes safe for women and children

The Need for Reauthorization

Why is another VAWA needed? Because we need to reauthorize and enhance the programs initiated by VAWA '94, which already have made a difference in millions of women's lives. VAWA '94 bolstered prosecution of child abuse, sexual assault and domestic violence; increased victim services; increased resources for law enforcement; and created a **National Domestic Violence Hotline**. If Congress does not begin the process to reauthorize these programs by the end of this year, their funding will be threatened.

VAWA must be reauthorized in 2000!! H.R. 357, VAWA '99, not only reauthorizes VAWA '94 in Title I, but also includes: legal services for battered women and victims of sexual assault; increased funding for rape prevention and education; funding for transitional housing programs for women escaping violence; increased attention to the impact of violence on women's work lives; provisions that address the effects of domestic violence on children such as supervised visitation centers for children in domestic violence situations; legislation on hate crimes prevention; and increased attention to violence in the lives of certain women, such as older women, disabled women, immigrant women and Native American women.

CALL (the Capitol switchboard at 202-224-3121), WRITE, OR E-MAIL YOUR REPRESENTATIVES AND SENATORS TO LET THEM KNOW THAT YOU SUPPORT THESE INITIATIVES ADDRESSING VIOLENCE AGAINST WOMEN.

October is Domestic Violence Awareness Month

Books Helping Children Deal With Domestic Violence

A Safe Place
By Maxine Trottier
Illustrated by Judith Friedman
Albert Whitman & Company
Hardcover—22 pp.
Emily and her mother must leave home. Her daddy has been hitting her mommy again. *A Safe Place* follows Emily and her mother as they move from home and to a shelter, searching for comfort and a place without fear.

To Tell the Truth
By Brian Ogawa
Illustrated by Renee Peterson
Volcano Press
Paper—31 pp.
In *To Tell the Truth* children are taken through the process step-by-step of testifying in court. Kids meet and become familiar with the deputy district attorney, the victim advocate, the judge, and many others who are involved in appearing in court.

Stepping Out in Faith to End Family Violence

It takes an act of great faith for a woman to leave an abusive relationship and to walk into an unknown future. She faces questions which have no easy answers. "Where will we go? Will we be safe? How can I support my children?" *Her doubts and fears are justified. Leaving is risky! Thousands have been killed trying to make it out. Others have tried and failed. We hold on to hope because some have departed for that unseen horizon and found their way to new land.*

One in three women have been abused during their lifetimes. We all have mothers, aunts, sisters, daughters or friends who have been beaten by a loved one. Whether the abuse is emotional, physical or sexual, the scars are deep and lasting. Most (not all) of the victims of family violence are women and children, although no one in the family wins. Violence hardens the heart and eats away at the souls of abusers as well, most of whom were abused as children. Boys raised in abusive homes are ten times more likely to abuse their partners as adults. Thus the sins of the fathers (sometimes mothers) are visited upon subsequent generations.

We are more aware of family violence now. Twenty, ten, even five years ago this was not the case. Many communities did not have shelters or police support, and those who tried to open safe houses were met with hostility. Then women were often blamed for the abuse they experienced (what did you do to cause the violence?), viewed as weak if they endured it (why don't you just leave?), or held responsible for breaking up a marriage if they left (why can't you forgive and forget?). Sadly, the church has been as much of a hindrance as a help in its response.

Times are changing. Now the issue is front page news. Police, prosecutors and social services agencies are collaborating to provide victims with the safety and support they deserve. More light is breaking into sanctuaries as clergy and lay leaders bring new awareness into their ministries. With new clarity we see domestic violence for what it is—a social justice issue of massive proportions. As the church, we are being called to step out in faith to fill our pastoral and prophetic responsibilities. Both require bold actions. Standing on the side of justice always does! but what does that look like and what are the risks?

Pastorally, we are called to love all but to stand in solidarity with the oppressed. Those with less power deserve our respect, support and care. What can church leaders do? Listen. Believe the stories, even if a respected member is the alleged abuser. Ask questions instead of assuming what is needed. "Are you in danger now? Do you need medical care or police protection? What do you need to be safe?" Rescuing a woman from a violent relationship is dangerous— it puts the woman and her children at risk of being killed. The safety of everyone involved is the primary concern. It is safest to discuss options and support the decisions victims make for themselves. Helpful responses include, "You do not deserve to be abused. It is not your fault. I am worried about you and your children." Referring victims to community services is crucial—the needs of a family are too great to try to be the only source of support. The national abuse hotline (1-800-799-SAFE) can help locate the closest services.

Our prophetic responsibilities can take us in several directions. Within congregations we can preach about domestic violence, lead Christian Education classes on the subject, and build youth programs around developing safe and healthy relationships. A church-wide mission project can raise awareness which might extend beyond the local church in work to influence legislative reforms or to advocate for more shelters and support services. Regardless of the forum, our proclamation is clear, "We are all beloved children of God. Everyone deserves to be treated with dignity and respect."

When we encounter abuse, we must hold abusers ac-

by The Reverend Mary Albert

countable for their behavior, and "speak the truth in love" to those who are hurting their partners. Violence has no place in intimate relationships. We would never tolerate abuse from strangers, nor should we from family members. It is a violation of human dignity and it destroys trust. It is impossible to heal a relationship which has been broken by violence unless the abuser demonstrates repentance and lasting change. It often takes a long-term counseling commitment to break a long-lasting pattern of abusive behavior. It requires courage on our part to confront an abuser and say "this must stop!' but if we don't, the violence will continue.

We can act in other ways. Forming partnerships with shelters and counseling programs sends the message that the congregation cares about the well-being of the entire community. Lydia's House would not be open and operating today without the hands-on help of many local congregations. Mission groups have sponsored educational programs. Men's groups have raised money and delivered donated furniture. Youth groups have collected school supplies, toys and books. Women's groups have cooked meals, sold House Pins (R), and gathered housewares and linens. Members of all ages have cleaned, painted and maintained our buildings. Each of these acts is a way of saying "you matter!" Each act models for our children that violence is not okay and moves our world one step closer to justice and peace.

Be warned: getting involved is risky. Once we take the reality of abuse into our conscious awareness, we will never look at relationships the same again. We risk admitting that we have harmed others and that we have been abused ourselves. We also open the door to healing and transformation we never imagined. We dare to become congregations that live the gospel in deep visible ways, and believe that together we can work to end domestic violence—one relationship at a time.

What step will you take? ✝CL

God of compassion, hear our cries for our mothers, sisters, neighbors and friends who live with torment and abuse, who are stripped of dignity and self-worth. Hear our cries for their children. Hear us cry "enough" when we see violence all around us. God of hope, use our tears to water the seeds of hope and peace. Bring us to new life in Christ. Amen.

The Rev. Mary Albert

Dios de compasión, escucha el clamor de nuestras madres, hermanas, vecinas y amigas quienes viven en tormento y abuso, quienes son arrebatadas de su dignidad y valor propio. Escucha nuestro clamor por sus niños y niñas. Escúchanos gritar "basta" cuando vemos violencia a nuestro alrededor. Dios de esperanza, usa nuestra lágrimas para hidratar las semillas de esperanza y paz. Condúcenos a una nueva vida en Cristo. Amén.

Rvda. Mary Albert

The Rev. Mary Albert is one of four women who have made a commitment to address the need for transitional housing for abused women and their children in St. Louis. Mary took a non-traditional path to ordination and was finally ordained in 1996 to serve in this ministry. Currently she serves as Executive Director/Chaplain of Lydia's House. Her local church is Epiphany UCC—a small congregation with a vigorous urban ministry in St. Louis. Prior to Lydia's House, she was interim minister of Spirit of the Shepherd UCC in Ellisville, MO. She is a "second career" pastor having worked in business for 15 years prior to seminary.

Lydia's House is a transitional housing program in which abused women and their children can stay for 6-24 months while they complete their journey to safety. During their stay they may work on educational or job training programs, find self-supporting employment, and save up apartment deposits or address other goals which help to re-stabilize their lives. With the help of over 40 local UCC churches, in five years time, Lydia's House went from an idea to a fully operating program with 12 transitional apartments which can serve 30 residents at a time (12 women + 18 children).

Lydia's House was named for Lydia in Acts 16. As a seller of purple cloth, she was a woman entrepreneur, a self-directed woman. She was a woman of faith who underwent a transformation of heart. She was also a woman of hospitality. These attributes are the guiding principles in Lydia's House's ministry. They have adopted her color, purple, to keep her story before them. As tradition has it, the church in Phillipi met in her home, a connection that is significant since a house church gave birth to Lydia's House.

Are You in an Abusive and Potentially Violent Relationship?

Answering the following questions will help the person already in a relationship in determining if it is an abusive one or becoming abusive.

Does Your Partner...

- ☐ embarrass you in front of people?
- ☐ belittle your accomplishments?
- ☐ make you feel unworthy?
- ☐ constantly contradict himself/herself to confuse you?
- ☐ do things for which you are constantly making excuses to others or yourself?
- ☐ isolate you from many of the people you care most about?
- ☐ make you feel ashamed a lot of the time?
- ☐ make you believe he/she is smarter than you and, therefore, more able to make decisions?
- ☐ make you feel that it is you who is crazy?
- ☐ make you perform acts that are demeaning to you?
- ☐ use intimidation to make you do what he/she wants?
- ☐ prevent you from going or doing commonplace activities such as shopping, visiting friends and family, talking to the opposite sex?
- ☐ control the financial aspects of your life?
- ☐ use money as a way of controlling you?
- ☐ make you believe you cannot exist without him/her?
- ☐ make you feel that there is no way out and that "you made your bed and must lie in it"?
- ☐ make you find ways of compromising your feelings for the sake of peace?
- ☐ treat you roughly—grabbing, pinching, pushing or shoving you?
- ☐ threaten you —verbally or with a weapon?
- ☐ hold you to keep you from leaving after an argument?
- ☐ lose control when he/she is drunk or using drugs?
- ☐ get extremely angry, frequently without an apparent cause?
- ☐ escalate his/her anger into violence—slapping, kicking, etc.?
- ☐ not believe that he/she hurt you nor feels sorry for what he/she has done?
- ☐ physically force you to do what you do not want to do?

Do You...

- ☐ believe that you can help your partner change the abusive behavior if you were only to change yourself in some way, if you only did something differently, if you really love him/her?
- ☐ find that not making him/her angry has become a major part of your life?
- ☐ do what he/she wants you to do rather than what you want to do out of fear?
- ☐ stay with him/her only because you're afraid he/she might hurt you if you tell?

If you said yes to many of the above questions, you have identified an abusive relationship and need to seek help and advice. Call one of your area domestic violence shelters.

Used with permission Templum House,Cleveland, Ohio

¿Está en una relación abusiva y potencialmente violenta?

Contestar las siguientes preguntas ayudará a determinar si se encuentra en una relación abusiva o que se está tornando abusiva.

Su pareja...

- ☐ ¿Le humilla frente a otras personas?
- ☐ ¿Minimiza sus logros?
- ☐ ¿Le hace sentir que no vale?
- ☐ ¿Se contradice a sí mismo/a constantemente para confundirle?
- ☐ ¿Hace cosas para las que usted inventa excusas constantemente a usted misma/o y a otros?
- ☐ ¿Le mantiene aislada o aislado de la gente a quienes más quiere?
- ☐ ¿Le hace sentir avergonzada o avergonzado la mayor parte del tiempo?
- ☐ ¿Le hace creer que es más inteligente que usted y, por lo tanto, más capacitado/a para tomar decisiones?
- ☐ ¿Le hace sentir que es usted quien está loca/loco?
- ☐ ¿Le obliga a hacer cosas que le denigran?
- ☐ ¿Usa la intimidación para obligarle a hacer lo que desea?
- ☐ ¿No le permite ir o hacer cosas comunes tales como ir de compras, visitar a amigos y familia, hablar a personas del sexo opuesto?
- ☐ ¿Controla los aspectos financieros de su vida?
- ☐ ¿Usa el dinero como una manera de controlarle?
- ☐ ¿Le hace creer que no puede existir sin el o ella?
- ☐ ¿Le hace creer que no hay salida y que si decidió estar con el/ella, ahora tiene que vivir con esta decisión?
- ☐ ¿Hace que ignore sus sentimientos en nombre de la paz?
- ☐ ¿Le trata bruscamente—le agarra, pellizca, empuja o estremece?
- ☐ ¿Le amenza —verbalmente o con un arma?
- ☐ ¿No permite que se vaya después de una discusión?
- ☐ ¿Pierde el control cuando está borracho/a o drogado/a?
- ☐ ¿Se enoja con frecuencia sin una aparente causa?
- ☐ ¿Su coraje aumenta hasta la violencia- dar en la cara, dar patadas, etc.?
- ☐ ¿No cree que le haya hecho daño ni se siente mal por lo que ha hecho?
- ☐ ¿Le obliga físicamente a hacer cosas que no quiere?

Usted...

- ☐ ¿Cree que puede ayudar a su pareja a cambiar la conducta abusiva con solo cambiar algo de usted, "cambiará, si realmente lo ama"?
- ☐ ¿Se da cuenta de que parte importante de su vida es no provocar su enojo?
- ☐ ¿Debido al miedo hace lo que quiere que haga en vez de lo que usted quiere?
- ☐ ¿Está con el/ella solo porque tiene miedo de que le haga daño si lo comenta con alguien?

Si contestó Si a varias de las preguntas anteriores, ha identificado una relación abusiva y necesita buscar ayuda y consejo. Llame a uno de los albergues de violencia doméstica en su área.

Usado con permiso de Templum House Cleveland, Ohio

Pilgrim Press Resources on Domestic Violence

Telling the Truth
Preaching About Sexual and Domestic Violence
BY JOHN S. MCCLURE AND NANCY J. RAMSAY, EDS.
ISBN 0-8298-1282-2
Paper—$15.95
McClure and Ramsay assemble wisdom of experts from across disciplines and denominations who analyze biblical and theological issues, present pastoral resources, and discuss preaching strategies as related to sexual and domestic violence. Four sermons are included to provide effective models for addressing this widespread and pernicious problem

Sexual Abuse Prevention
A Course of Study for Teenagers, Revised and Updated
REBECCA VOELKEL-HAUGEN AND MARIE M. FORTUNE
ISBN 0-8298-1082-X
56 pp./Paper—$8.95

Preventing Child Sexual Abuse
A Curriculum for Children Ages Five through Eight
KATHRYN GOERING REID
FORWARD BY MARIE M. FORTUNE
ISBN 0-8298-1016-1
160 pp./Paper—$11.95

Preventing Child Sexual Abuse
A Curriculum for Children Ages Nine through Twelve
KATHRYN GOERING REID
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Violence in the Family
A Workshop Curriculum for Clergy and Other Helpers
BY MARIE M. FORTUNE
ISBN 0-8298-0908-2
288 pp./Paper—$21.95

Sexual Violence
The Unmentionable Sin
BY MARIE M. FORTUNE
ISBN 0-8298-0652-0
256 pp./Paper—$15.95

To contact Pilgrim Press
to order or request a catalog:
call (800) 537-3394
fax (216) 736-3713
or mail order to 700 Prospect Ave.
Cleveland, OH 44115-1100

Women In Mission Partners enjoy a 40% discount. To join see form on page 27.

Choice and Hospital Merger Resource Available

There is a growing crisis in reproductive health care in many communities where secular hospitals are merging with religiously-owned hospitals and/or health care systems. After such mergers, the hospital or health care facility suddenly find themselves having to adhere to religious guidelines as to what kind of health care can be offered at that facility. Many of these mergers are completed before the community is even aware of it.

The Religious Coalition for Reproductive Choice has compiled a very helpful packet of resources of information about what is happening with these mergers and what action can be done by clergy and others in the religious community to bring the issue to public attention. A proposed merger in Poughkeepsie, NY, was almost done when local folks from the religious community found out and wrote letters to the editor and to the hospital board of directors expressing concerns that protecting access to a full range of services for women must be maintained, stressing the importance of religious liberty and diversity. The merger was scuttled.

You can request a copy of this packet by contacting RCRC and asking for their hospital merger information:
Religious Coalition for Reproductive Choice
1025 Vermont Ave., NW, Suite 1130
Washington, DC 20005
202-628-7700

Know what is happening in your local area!

POSTCARDS AND BUTTONS

Women's Bodies are NOT Battlefields
campaign was first developed to protest the treatment of women in the Balkans during the war in Yugoslavia, but the phrase is a resounding cry in the fight to stop all violence against women.

Logo in Red and Black
Buttons: 2"x2"
Postcards: 4"x6"
Use postcards in writing campaigns and buttons to raise awareness during October, Domestic Violence Awareness Month.

Postcards - 20 for $5.00
Pins - 12 for $5.00
Shipping & handling:
Up to $20.00.....$1.50
$25.01-$40.00..... $2.50
Send check, payable to *CCW*, to:
The Coordinating Center for Women
700 Prospect Ave., East
Cleveland, OH 44115
Raise Consciousness!

Violence Against Women

Powerlessness Defines Power
Biblical Reflection on violence against women
by a group from Jordan, Middle East

Genesis 16 and Psalm 46

Though Abraham prevails in Scripture as the symbol of faith, Sarah and Hagar shape and challenge faith. Their own stories diverge to give Sarah the better portion. Wife of a wealthy herdsman (Gen. 13:2), she holds privilege and power within the confines of patriarchal structures.

Without effort Sarah, along with her husband, enjoys divine favor. Yet her exaltation poses major tensions in Abraham's story because "Sarah is barren; she has no child." Her situation would seem to thwart the divine promise of an heir for Abraham. Hence, Sarah plans to secure a child through her maid Hagar, who becomes the other woman in Abraham's life.

As one of the first women in Scripture to experience use, abuse and rejection, Hagar, the Egyptian slave, claims our attention. She is single, poor and abandoned; she is also young and fertile. Power belongs to Sarah and powerlessness marks Hagar. Sarah speaks of building up herself through Hagar, rather than of bearing a child to Abraham. Further, she attributes her barren condition to the Lord and thus seeks to counter divine action with human initiative. What the deity has prevented, Sarah can accomplish through the maid whose name she never utters and to whom she never speaks. For Sarah, Hagar is an instrument, not a person. The maid enhances the mistress. Sarah has spoken, Abraham has agreed. She has acted and he has obeyed. "[Hagar] conceived." Although her conception is what Sarah wants, it prompts an insight on Hagar's part that her mistress has not anticipated. "When [Hagar] saw that she had conceived, she looked with contempt on her mistress." The exalted mistress decreases while the lowly maid increases. This unexpected twist provides an occasion for mutuality and equality between two females, but it is not to be. If Hagar has experienced a new vision, Sarah remains within the old structures. Still in charge, she speaks to Abraham, faulting him for the outcome of her plan and appealing to the Lord for judgment.

The mistress wants returned to her the superior status that she unintentionally had relinquished by using Hagar. Further, she demands that her husband rectify the wrong because he holds the authority over Hagar too. But Abraham chooses not to exercise power and thus remains passive by saying, "Your slave girl is in your power. Do to her as you please" (Genesis 16:6).

If Sarah's opening speech to Abraham ordered the use of Hagar, her words to him now, with his reply, lead to the abuse of the maid, "And Sarah dealt harshly with her" (Genesis 16:6).

Once again the two women meet unequally, vanquisher and victim, and this time Hagar has lost her name. Inequality, opposition and distance breed violence. In conceiving a child for her mistress, Hagar has seen a new reality that challenged the power structure. Hagar becomes the suffering servant. Yet no deity comes to deliver her from bondage and oppression; nor does she beseech one. Instead, this tortured female claims her own exodus: "Sarah dealt harshly with her, and she ran away from her. The angel of the Lord found her."

If the finding counters the harsh treatment, then the flight of Hagar in the middle of the sequence signals a new direction that the deity enhances, encourages and empowers.

"God is our refuge and strength, a very present help in trouble. Therefore we will not fear, though the earth should change, though the mountains shake in the heart of the sea; though its waters roar and foam, though the mountains tremble with its tumult " (Psalm 46:1-5).

This runaway pregnant maid has fled from the house of bondage to the wilderness. For her, it is a hospitable

Opposite page: "Hagar driven out;" left: "Hagar in the desert;" by Marc Chagall from Drawings for the Bible. and used with permissionDover Publications.

place, symbolized by a spring of water to nourish life. The messenger of God finds her by the spring of water in the wilderness. This Egyptian maid is the first person in Scripture whom such a messenger visits.

"Hagar, maid of Sarah, from where have you come and where are you going?" For the first time one speaks to her and uses her name. The deity acknowledges what Sarah and Abraham have not, the personhood of this woman. Yet, the expression "maid of Sarah" tempers the recognition, for Hagar remains a servant in the vocabulary of the divine, rather than being freed from a human bond of servitude.

"From where have you come and where are you going?" The question embodies origin and destiny. In answering, Hagar speaks for the first time. Exodus from oppression liberates her voice, though full personhood continues to elude her. And she answers, "From the face of Sarah, my mistress, I am fleeing." This indicates the continuing power of the social structure. Exodus from oppression has not secured freedom for Hagar. She continues, however, to resist. "I," she says emphatically. This "I" stands over against the "I" of Sarah. Powerlessness defies power.

"Where are you going?" is the second question. Hagar seems not to answer. Or is departure her destiny? After all, the wilderness signifies escape from oppression, nourishment of life and revelation of the divine. Hence, wilderness is not destination but point of return. "The messenger of the Lord" has found "the maid of Sarah" in order to tell her where she is going and the divine command merges origin and destiny. ✝CL

From "Hope Goes On: Extending the Ecumenical Decade of the Churches in Solidarity With Women" WellSpring XIV 1999 Church Women United

For discussion

1. Identify biblical passages that can be used to empower women who are in situations of despair as was Hagar.
2. How can women who are put into a context of struggle, as Hagar and Sarah were, be reconciled?
3. Women have been silent on the question of violence against them for a very long time. Can you discuss some ways in which this silence continues to be sustained and encouraged? What are some of the success stories of women breaking the silence over violence that you personally know about?
4. Reflecting on Hagar's experience, what do you think about today's "surrogate mothers"—a young woman who can be hired to have the fertilized ovum of a sterile married woman, implanted into her uterus. What insight might we get from Sarah's experience?
5. Sarah is one of many women listed as "matriarchs" in biblical history. Think of some stories of the matriarchs in your family. How have they influenced you?
6. Violence against women is often related to issues related to human sexuality. How can we as women and men of faith talk about these sensitive issues and respond to them?
7. As women and men of faith, how do we change such structures that oppress women?

UCC and Religious Leaders Support Release of Prisoners

By The Rev. C. Nozomi Ikuta

In response to yesterday's acceptance of President Clinton's offer of executive clemency by 12 men and women being punished for acts and beliefs in favor of independence for Puerto Rico, religious leaders today (Sept. 8) reiterated their support for the prisoners' release.

In a letter to President Clinton, the Rev. Paul H. Sherry, president of the United Church of Christ, said, "We are pleased that you agreed with so many of us — and with international human rights leaders such as Archbishop Desmond Tutu and Coretta Scott King — that the sentences received by these prisoners were excessive and disproportionate, given that they were not convicted, or even accused, of any bombing, injury or death. With you, we affirm the Constitutional presumption of innocence and insist that these prisoners should not be held guilty by association for violent acts for which they were neither accused nor convicted."

The Archbishop of Puerto Rico, Roberto Gonzalez Nieves, agreed. When the clemency offer was announced, his only criticism was that it didn't go far enough. "Although as Christians, we should be grateful that the wish of the Puerto Rican people was heard that our brothers and sisters return home, we lament that President Clinton did not grant unconditional freedom to all the political prisoners," he said. Others said that the prisoners' delay in accepting the President's offer had nothing to do with renouncing violence.

"In 1997, in a public statement to the House of Representatives, they committed themselves to peaceful means, and they re-affirmed this a few days ago because so many people seemed unaware that this was already their position," said Bishop Thomas Gumbleton of Detroit, former head of Pax Christi, a Catholic peace organization. The Rev. Eliezer Valentin-Castanon of the United Methodist General Board for Church and Society referred to last week's march in Puerto Rico in favor of these prisoners, which drew tens of thousands of people, including leaders from every religious denomination and political party. "This is obviously about peace and reconciliation. You don't get such a broad-based consensus for releasing people who are interested in violence," he said.

Sherry noted that one of the released prisoners, Alejandrina Torres, is the wife of a United Church of Christ pastor, and that one of the prisoners who would remain in prison is the son of the same pastor. "For us, this is not only a justice issue; it is also a pastoral one," he said.

Born in Puerto Rico, Alejandrina Torres migrated with her family to New York when she was eleven. In 1963, she moved to Chicago and one year later married the Rev. José Torres, a community activist and Pastor of the First Congregational Church of Chicago. Throughout the 60's Alejandrina was a leader in her community, first as a founding member and later a teacher at the Rafael Cancel Miranda Puerto Rican High School, now known as the Pedro Albizu Campos High School. She later helped found the Betances Clinic, and served as Secretary of the First Congregational Church of Chicago, where she organized a variety of community programs. She eventually became an active member of the National Committee to Free Puerto Rican Prisoners of War. She, herself, became a Puerto Rican Prisoner of War in 1983, and until her recent release, has been in Danbury Connecticut Prison. At General Synod 20, Torres was celebrated as an Honored Laywoman.

Since 1991, when its General Synod adopted a resolution in favor of release of the prisoners, the United Church of Christ has been involved intensively in this effort. "This issue has been a priority for several years, of our Council for Hispanic Ministries, our staff and many members," said Sherry. "We have visited and written to the prisoners, called and written to the White House, published educational resources and participated in numerous protests."

Sherry also said that he had personally met several of the prisoners. "More than two dozen leaders of our church have visited them, and they really are remarkable people. We are certainly looking forward to welcoming them home," he said. ✝C L

The Rev. Nozomi Ikuta is the Minister for Liberation Ministries for the American Missionary Association of the United Church of Christ. She is the featured preacher for the Fourth National Women's Meeting in Charlotte, North Carolina in April 2000. Alejandrina Torres is the mother of CCW board member Liza Torres.

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Fourth National Meeting Art Exhibit

There will be an exhibit of art by UCC Women at the Fourth National Meeting of UCC Women, April 27-30, 2000. If you are interested in displaying your work, please contact the CCW Office, call (216) 736-2150 or email uccwomensmtg@ucc.org, for more information.

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About This Issue...

The sun shall not strike you by day, nor the moon by night. *Psalm 121:6*

I was sharing my favorite Psalm with my family some years ago, when my father pointed out the importance of the sixth verse. A member of the family was going off to college and I thought Psalm 121 was encouraging and reassuring. I understood the harm the sun could do, but hadn't paid much attention to the latter part about the moon, only thinking how it aesthetically balanced the line. My father began to talk about the beliefs that the moon could affect people mentally, that the word "lunacy" came from the Latin word for moon, and how people who were "lunatics" were thought to be "moonstruck."

As I worked on this issue, I was ecstatic to find so much information on mental illness and how eager the many associations and organizations I contacted were to help me. I am especially grateful to the Mental Illness Network of the UCC and especially the Rev. Bob Dell and the Rev. Norma Mengel for all the resources, answers and direction they gave me. There are many people and groups willing to help, but as I gathered material I sensed that, for all the openness that there is, people still find it difficult to seek assistance.

The materials, resources and books on mental illness are very reassuring and shared stories of people who are suffering and dealing with the various diseases. Names of celebrities or historical figures are mentioned, meant to inspire sufferers and make others realize the mentally cannot be discounted. Such people as Abraham Lincoln, Winston Churchill, Patty Duke, Barbara Bush and Tipper Gore.

I took this opportunity to look at my own feelings and dealings (or lack of dealings) with people who suffer from mental illness. I thought about my best friend in high school with anorexia. I never spoke to her about the disorder though I'd visited her in the hospital. I reflected on the instances at my sister's church where a homeless man is a regular church member. I was proud to see him in church, but found myself "tuning out" when he would contribute to church announcements and the pastor's prayer requests.

Why did I choose to ignore a significant part of my friend's life and the existence and prayer petitions of someone I come in contact with infrequently. Am I too embarrassed, made uncomfortable, inconvenienced by these intrusions into my *mentally balanced* life? The answer is yes. I also fear ever being in the position to seek the help of all the wonderful people and resources that I've mentioned and included within this journal.

When being around the mentally ill many of us think "there but for the Grace of God..." but as you read through this issue you'll find how ludicrous and unjust that statement is. "The Lord is [our] keeper," God is not to blame for schizophrenia, Alzheimer's or depression anymore than those suffer from such diseases are.

I am learning to adjust and confront my own perspective and prejudices towards the mentally ill and I hope this *Common Lot* will make readers look at their misconceptions. This issue also includes articles on domestic violence, a subject that must get past the many hurdles that blocks the mentally ill. Although I want the reader to keep in mind that domestic violence and mental illness need to be brought out in the open, they are not a cause of one and result of the other. These are two very important topics that affect women without thought to ethnicity, religion or status.

The last verse of Psalm 121 reassures us that God will keep our going out and our coming in. God will be with us as we change within ourselves as well as when we physically journey. Attitudes toward mental illness and domestic violence need to be changed. There are reflections and resources within these pages to help churches and groups get started. Let us begin to make a move and make those changes.

Nathie J. Y. Malayang

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