THE Round Table

Spring
2007

"...a path from where we are to where we should be." --Peter Maurin

Awareness and Healing:

A Discussion on Mental Illness

Why This Issue?

Like many other Catholic Worker houses, we have many guests that live with mental illness. There are as many different presentations of illness as there are diagnoses. People with depression, personality disorder, schizophrenia, and bipolar disorder live with us. Some want help. Some, because of the very nature of mental illness, find it difficult to accept help. All of these women are very different, but what they ALL have in common, regardless of their particular situations, is that it is very difficult, if not impossible for them to receive mental health care.

Living at Karen House, I've learned that mental illness, like some physical diseases, can strike anyone at any time. All our accumulated wealth, education and experience cannot defend us – we've had guests with Master's degrees, professional experience, and incredibly wealthy families. The stigma of mental illness is described well in Alice's article. Unlike diabetes or high blood pressure, or even alcoholism, the illness these people live with is considered so fearful, and so repugnant, that they are judged to deserve their fate. People with mental illness could be described as twenty-first century lepers, or maybe in the words of Peter Maurin, ambassadors of God.

Often, we will ask a guest to consider getting mental health care if she may be dangerous to herself or others, or if she is unable to care for herself. In the past few years, we have noticed a dramatic shift in the number of options available to our guests with mental health issues. Because of funding cuts, even the last safety nets are frayed. Even outreach services focused on mental health care for homeless individuals are largely unable to serve people without Medicaid. When one of our recent guests told us she had a plan to kill herself but didn't know if she wanted to go to the hospital, the ambulance wouldn't take her – they weren't convinced that she really meant to kill herself, and they didn't want to "violate her rights".

This issue is a discussion on the issue of mental illness- we hear personal stories from Alice Adcock and Bill Gruhn. Teka Childress, Lou Kimmell, and Annjie Schiefelbein address the issues of access, medical treatment, and helping relationships around mental health, while Jim Allen describes one more disgrace related to our war on Iraq- the multitude of untreated U.S. veterans with Post-Traumatic Stress Disorder.

In the wealthiest country in history that possesses the most advanced medical technology in the world, it's infuriating to witness the yearly decrease in funding for social spending and mental health services. As a society, we continue to marginalize "the least of our brothers and sisters" (Matthew 25) and their needs. Our priorities maintain a preferential option for the violence required to satiate our materialistic thirst for the latest Ipod, cheap oil, bigger and bigger SUVs, and upward mobility. At Karen House, it's both maddening and heartbreaking to witness the consequences of these priorities.

You'll find the word "relationship" in many of this issue's articles. Whether in family, friendship, or helping relationships, I think one thing that saves us is our love for each other.

-- Jenny Truax

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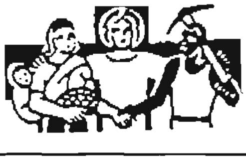

A Life with its Share of Pitfalls

by Bill Gruhn

The Round Table committee asked me to write about my life because I've had a mental illness since early childhood. I am now fifty-eight. I was first diagnosed with bipolar disorder in the early 70's. I have known some stable times and was happily married for eleven years. I have two grown sons. More often, though, I've experienced turmoil. I was almost institutionalized as a young man, and after my marriage failed, I spent ten years homeless.

Mental disease is not the same as an emotional disturbance. Someone may face difficulty during a particularly stressful challenge and benefit from a short interval of therapy, but a mental disease is hard-wired, like color blindness, and perhaps a person never utterly overcomes it, although he can learn more healthful behaviors. Mental disease stems from this hard-wiring in the brain and also from poor emotional examples, irresponsible and counter-productive habits, and cultural dislocations. I'll give examples of all of these in my life account.

My childhood had its share of pitfalls. By the time I entered kindergarten I was so estranged from my family that I built a fort of cardboard boxes in the basement and moved all my things in. I would not eat with my family. I collected toy guns and re-fought the Indian Wars, slaughtering white settlers and blowing up train tracks. My younger sister Sue was my perennial target. When I wasn't threatening to scalp her, I found a benevolent side. By the time I was in fifth grade, I was in demand as a weekend babysitter. I cut neighbors' lawns in the summer, shoveled snow in the winter, and dutifully saved money until I bought a motorcycle when I was sixteen.

When I was little, we lived outside Pittsburgh, in a suburb called Whitehall, on a hill overlooking the city. I transformed my swing set in our backyard into the arch of a church and pondered. On some Sundays, I would dress up my younger brother Paul and my sister Sue as Medieval saints and then parade them into Dad and Mom's room and force them to take us to church. My older brother George refused to be confirmed because the church did not persuade him by their response to evolution. We stopped attending church when I was about nine.

By the time I was fourteen, I decided life was too somber and sterile and tried to lighten up, but my personality started to disintegrate. In my family, everything was work. Nothing was rewarded. Nothing was punished. Nothing was celebrated. I don't remember anyone's birthday. I don't remember any New Year's. I don't remember any Fourth of July. I don't remember any Christmas. Every day we did our work. My parents had little ability to feel happiness.

Yet my father was one of the most virtuous men I have ever met. When he died in 1998, his co-workers gave Mom a plaque saying that Dad was everything a human being should be. My mother cared about everything under the sun. George pondered everything beyond it. Nevertheless, we were all a bit displaced. We had moved to an upper class neighborhood outside Chicago called Oak Park River Forest. Mom was a Jew in a totally Gentile area. George was a beatnik in the straightest Republican enclave. Dad was a socialist idealist amidst careerists. My mother didn't help by following a very lax and permissive approach to parenting. She allowed George to not bathe or change his shirts. He was regarded as odd. He never took a shower, but only sponge-bathed himself occasionally. Mom always picked up after us. I never had to clean my room. Dad was a pathologist and struggled to secure a leading position over a hospital laboratory. He was little involved in our development. Mom was so challenged by my failures that she went to Northwestern University and became a vocational counselor. She helped hundreds of people, but I was hopeless.

By my sophomore year in high school, I experienced debilitating depression in springtime and mania in the Fall, the reverse of the average pattern of manic depression. By my senior year, my mood swings had morphed into periodic episodes lasting a number of weeks, a rapid cycling process atypical of males. This was 1967. Bipolar Disorder was not clinically identified until 1971. I was an honor student, but would wander away from school and just walk for miles until the principal of the school had to suspend me and my parents sent me to a psychia-

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Bill Gruhn is a faithful housetaker at Karen House.

trist.

Certainly nothing became lighter. I abandoned the best of my family heritage of learning and became quite silly. This was the worst mistake of my life. I tried to become the all-American care-free teenager, with a blond girlfriend and a bunch of fun-loving friends. I didn't like partying. I'm too introverted. I was so antagonistic toward my family. This hindered them from finding the best course of action. Therapy can encourage a person to criticize his parents and alienate him from his family. This is crazy in itself.

I became plagued by uncertainty and inertia. Therapy was unavailing. I do not remember any therapist asking me what I proposed to do with my life or holding me to any course. Nothing was required. Little was aimed at. Self-esteem was supposed to spring from some primordial mist. Psychology can give a window to be disgruntled with one's environment instead of seeking how to grow together with others in happiness. What psychologists write doesn't translate into how therapists conduct their sessions. Therapists are in a bind. If they don't challenge a person, he will not change, but if they do, he may grow uncomfortable and leave therapy.

When I graduated from high school, I told my father and mother I would not be able to succeed at college due to my instability. Yet, during the Vietnam War, there seemed like nothing else to do with me. What a mistake! I should have been shipped off to a supervised workshop. Instead, I was shipped off to college and after a number of weeks, forged some checks, just on impulse, and ended up in prison. Soon I was shipped off to a mental hospital. My father placed me in the best hospital in the region. The more therapy I received, the more debilitated I became. After my first hospitalization at nineteen, I almost never saw any of my family again, until I was married at thirty-two.

People tended to discount my reports of mood swings. Once I was diagnosed with Bipolar Disorder things didn't change. The worst feature of mania is that a person doesn't sleep and his mind becomes unraveled. Sylvia Plath killed herself after she was up for two solid weeks. No effort was made to make sure I slept. My behavior was so erratic at times, I was hospitalized throughout my twenties two to three times a year. The most capable doctors in the Midwest determined I was Bipolar, but whenever I showed up at a hospital or clinic; I was counted Schizophrenic. Enough said about the quality of programs and treatments.

I ran away from hospitals so often that I was almost shipped off to Menard Hospital for the criminally insane. When I wasn't in mental hospitals I lived in warehouses (programs for the homeless that were later phased out). Some were capably managed. Others were too big to adequately manage. There was no way to prevent murders and suicides. Liability was probably too great. No one can be tried when a homeless person dies.

One time I was in the state hospital west of Chicago and met an aid who was a student at Moody Bible Institute. He convinced me Jesus was more than a spiritual teacher. I began to recover my senses, but I got tired of preachers saying that no born again person would call himself sick. Fortunately, I was accepted at a small residential treatment center called Roscoe House, a few blocks from Wrigley Field. I met a mathematician and poet, named Oren, and a past principal of a Rabbinical school, named Meyer. Life began to brighten. I seek friendship like some people seek love, money, or power. While at Roscoe House, I met a beautiful woman, named Debbie, and soon we moved in together. Once we broke up I eventually got my own place, learned to play guitar, and lived quietly enough.

My parents had arranged for me to see the therapist who had directed the intern program at the state hospital. Life went routinely enough until I met the Jesus People and found their lives stimulating. I became manic. The Jesus People were a small movement that started in Kankakee, Illinois and planted a settlement on Chicago's north side near my apartment. Everything would have been quite good if they didn't insist I be healed. I was better, but a mental disease doesn't go away without some

practiced habits and growth.

I left Chicago at the end of 1978 and moved to St. Louis to avoid the Jesus People, and began working at New Life Evangelistic Center with Ray Redlich and Larry Rice. During 1979, I was hospitalized three times briefly until I started a regimen of prolixin, which stabilized me. Nevertheless, I saw no potential to marry and have children after completing the two year program at New Life given the level of menial work Larry gave me and no income whatsoever, and so I left after one year. I met Karen Heisey at a Christian bookstore on Jefferson Ave. and she invited me to Murphy Blair Reformed Presbyterian Church. I began avidly reading Puritan writers and joined the Church.

I started to work part-time with a church group, as a laborer, rehabilitating properties in Murphy Blair. I lived in a small apartment near Sullivan and 14th Street. Following Christ began to integrate my personality. Many years later the wonderful humanness of the people in the Catholic Worker, especially Teka and Becky's unconditional acceptance four years ago, attracted me and helped further round out my potential. Back in 1982 I intended to finish a degree in literature at UMSL and attend Covenant Presbyterian Seminary. My goals beyond that were unrealistic and my work habits erratic. I wanted to work in ecumenical efforts between the Eastern Orthodox, Protestants, and Catholics, but didn't realize how much preparation that would require and no one was able to advise me how to go about a project they deemed futile. People said little and were just eager to see me emotionally stable. I'm not convinced therapists know the parameters of mental health or how to guide people toward them, nor do they much respect the limits of simple health. Therapy cannot contain mood swings or psychotic manifestations like hearing voices. Sometimes even medicine is ineffective in doing that.

I had no history of being able to support myself; nevertheless, I wanted a family. I visited young adult fellowships to find a wife. Gina was one of the worship leaders in an Assembly of God church in Webster Groves. We went on our first date on my birthday in 1981, got engaged in November, and married in June of 1982. Gina had given the most thought to family life and raising children. It was a big mistake not knowing whether I could hold a job before getting married, but I assumed I was getting better and better. How can you have children and no ability to earn an income? I should have finished UMSL and tested my ability to work first. Nevertheless, Gina taught me how to be a good father and my years of married life were the best period of my life.

Gina loved the country, so I chose to go to a college at Rolla and live on a farm, instead of going to UMSL and living in the city. We planned that Gina would work, while I attended school, but at the time she didn't have an idea where to work, so we scrapped that plan, lived very simply and started having children. I busily did course work and rarely even walked around the farm, but my children loved it. Dan later studied biology and Ben loves hunting. After I graduated in economics we bought a house in Union and attended the Franklin Reformed Presbyterian Church. Gina home-schooled our two sons.

Over the years it was discovered that Prolixin carried risks of debilitating side effects. Once I was taken off it I became sick again. I experienced five years of hypomania, a mild elation impervious to facts, also very atypical in such duration. My marriage failed and I became homeless. Episodes of moods prevented me from working consistently at any job, but I could routinely study and spent mornings and afternoons reading church doctors, a select group of thirty-three saints, who best express the Catholic faith. I, too, endeavored to be worthy of canonization, but no one has been convinced.

I started Zyprexa in 1998, and as the dose was increased, my hypomania ended. Naturally, I became more anxious, but I endured it because I was able to again see my children. Abilify was approved by the FDA in 2002 and I started it last year in February. I no longer need as much sleep, so I can accomplish more, and it is more effective in controlling mania. I don't know what will happen next. Acquiring a means of livelihood is one of the fundamental challenges of life and health. No one should be adrift. I don't know if I'll ever be able to support myself and get off Disability. The encouragement and friendship of many people helps keep me motivated.

Since I've been more stable, I've become more productive. I've begun a massive volunteer effort. I research subjects for local state representatives, health care for Jeanette Oxford, criminal justice for Jamilah Nasheed, and Medicaid reform for Susan Schoemehl. I'm trying to expand my range of acquaintances in the legislature and among social advocacy groups and hope one day to be hired to do policy research. I work needed posts at Grace and Peace Presbyterian church and at Karen House. I'm trying to stimulate more contact between Catholics and Fundamentalists, and more dialogue between Catholics and Moslems.

I would not say I'm altogether happy because I often have to spend so much time in idle, so to speak, because my symptoms prevent me from doing anything and I lose out on many enjoyable happenings. My symptoms are always associated with a lack of sleep, but sometimes even Ambien CR only nets me three hours of sleep a night, instead of eight.

Four factors work in favor of progress toward health for people. Medication is certainly helpful in containing many symptoms, but isn't effective for everyone. Therapeutic programs help people maintain, but cannot determine anyone's ultimate potential, and sometimes limits it. Relationships shape a person's outlook. The examples one heeds determine what one will aspire to. Spirituality is the key. God's love constrains us. Faith that doesn't train our behavior and outlook is flawed. Psychologists are woefully unable to spiritually guide individuals. Many are unbelievers. There is a great need for spiritual directors to partner with therapists. I'll end this account on that point.

From Asylums to Homelessness

by Teka Childress

I recently met a delightful man with a post-graduate degree. He has been homeless for quite some time. I first met him at a church where he had gone to eat lunch. He accepted my approach easily. He shared his delusions freely. He also shared that he had no where to stay. He happily accepted my assistance in helping him find shelter. He has never accepted any of my attempts to have him see a psychiatrist. He was very clear that the FBI has forbidden him to get psychiatric care. Because of his illness, he recently ended up in a local hospital, for just such care anyway. The psychiatrist, for a reason not clear to me, discharged him before he was fully well. He now plans to leave town. He is once again clear that the FBI is forbidding him to see a psychiatrist. After all of this, the only thing that I am clear about is that my hopes for him having a home and a fuller life have fallen to my feet, like the leaves in Autumn, as I have watched his rationality (which must have been stunning once), also fall away.

Last year, Reverend Ray Redlich from New Life Evangelistic Center told me about a young man who slept in a certain spot near the entrance to Highway 55. Several of us were participating in a Winter Outreach, to check on folks on nights when the temperature got frigid. This man became a concern for all of us. We weren't sure we could count on him to make sound judgments to stay warm. He would rarely accept our appeals to go to a shelter. One night when the temperature was near eleven degrees I found him with few blankets. This year we worried about him, because his spot from the previous year became unavailable to him. We found him, however, south of downtown, under a highway and behind a pillar. We checked on him all Winter. He barely spoke a word to us.

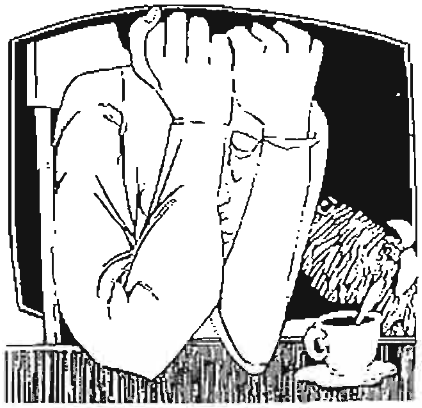
I met a woman while we were out one night. She at first agreed to go to the Winter Shelter on this very cold night. After we got there, I began to watch her. I could tell she wasn't going to make it. She became more and more uncomfortable and afraid, deciding she couldn't possibly stay with all the people gathered to enter the shelter. She wouldn't let us take her to another shelter. I ended up walking alongside her until she finally agreed to let us take her to a place where there might be a heating grate and she accepted blankets and a bus ticket. I thought at least she could get on a Metro link train, if all else failed.

How has this happened? How and why do so many people with mental disorders end up in such circumstances? There are numerous reasons. Obviously some have to do with the nature of the illnesses themselves. But certainly some of the reasons relate to lack of access to needed services and resources.

The New Freedom Commission issued a report in 2003 that described the problem of finding treatment and services: "For too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected, and often inadequate, frustrating the opportunity for recovery." (1)

One element of change in mental health services has been a shift from spending on State Hospitals and long-term hospitalizations toward community mental health care.(2) This is a trend that began after the Second World War, when the horrid conditions of "asylums" were exposed. This trend accelerated in the1970's and has continued to this day, aided by medications that have made life outside of the hospital more possible.(3) The Bazelon Center for Mental Health Law issued a report in Dec., 2001 that showed this pattern. In Fiscal Year 1997 community mental health services received 56% of mental health expenditures, up 31% from 1993, while spending on State Hospitals was 41% of expenditures in'97.(4)

While the movement toward community treatment



Teka Childress works part-time on the Shelter Outreach Team of BJC Behavioral Health Services.

and away from institutionalization has been a tremendous step forward, there is still a lack of sufficient resources in the community to assist those with mental illnesses and spending for hospitalizations is still a great need.

As I was writing this article in mid March there was a television news report citing the planned closing of Hawthorne Children's Hospital in St. Louis. This hospital, part of the State Hospital system, has been a treatment option for children for several decades. The parents of the young people in the hospital were asking for the hospital to remain open at least another year while they found alternatives for their children.

Some provision for mental health services has moved to the private sector. In 1997, private sources paid for 43% of the total mental health care expenditures, divided into 17% out-of-pocket, 24% from private insurance, and 2% from other private sources.(5)

In the private sector, one of the crucial issues currently is parity from private insurance companies. Mental health advocates have been trying for the past five years to pass legislation that would make sure that people living with a mental illness are given the same level of insurance coverage that is provided for a physical illness.

Many, without resources to pay out-of-pocket, or without access to private health insurance, depend on public financing of mental health services. But, these funding sources have been very precarious over the last several decades.

States have long borne the greatest responsibility for providing mental health care. In 1890, the State Care Act gave states this role.(6) However, state spending on mental health services was 30% less in 1997 than in 1955, when adjusted for inflation and population growth, according to a 2002 report "The State of State's Public Mental Health Systems." Certain states had severe cuts. Arkansas, for example, cut funding for mental health centers by 50%.(7)

Does the cut in funds play a role in the reason that the man was released early from the hospital? Even though the doctor was very conscientious, he was perhaps under a great deal of pressure to discharge some patients and the man was more than willing to go. In the last couple of months I have sent three different people to the hospital who were homeless and experiencing psychotic episodes. None of them was admitted. There were perhaps other mitigating circumstances, but it is difficult to imagine that some of the obstacles were not financial.

In addition to a likely financial strain is an apparent narrowing of the interpretation by the court of the law that allows people to be committed. Unless someone is an extreme danger to themselves or others, it is unlikely they will be kept in the hospital. I have seen this policy carried out recently in regard to several people who were very ill and kept very briefly, immediately returning to homelessness and having to live with untreated symptoms.

In 1955, people with mental illness were often living in poor conditions, sometimes warehoused in State Hospitals. Now we have the combination of less funding and more complicated needs while people are living in the community. This is partially eased with the assistance of programs like SSI, Social Security Disability, Medicare and Medicaid. Yet the $623.00 per month sum from SSI, a frequent income of those with mental disorders, generally leaves a person living in poverty. There is the further difficulty of obtaining this income. I cannot tell you how many people I have met who are homeless, well into midlife, most likely eligible, and yet still without SSI. Typically they were denied the first time or two they applied and gave up. Sometimes they are waiting a year for a hearing. In the cases of several people, the difficulty in obtaining income relates to admitting they have a mental disorder when they do not believe this to be the case.

Over the last several years, the most serious threat to accessing treatment and services comes in the form of Medicaid cuts. Medicaid has been one of the favored ways for states to fund mental health services because with Medicaid the states receive matching funds from the Federal government. Medicaid's portion of public funding for mental health care has increased to 60% in 2007.(8)

In April of '05, the United States House and Senate voted to put binding spending limits that would require $10 billion in reductions in Medicaid over the next five years.(9) This has had devastating effects on Missourians. Governor Matt Blunt cut Medicaid and two hundred thousand people had their benefits effected. One hundred and fourteen thousand people lost their Medicaid in the year ending in July of '06.(10) Governor Blunt, under criticism for these cuts, joined other governors in calling for an increase in Medicaid, but it is expected that only a small percentage of those who lost their Medicaid are likely to have it re-instated.(11)

Another threat to potential Medicaid recipients is a rule that Medicaid applicants must provide a birth certificate and State ID as part of the application process. A recent article in The New York Times stated that tens of thousands of people in this country who were eligible for this needed insurance were not obtaining it because of this rule.(12)

Trying to obtain Birth Certificates and ID's can be an incredibly difficult process for many people. I have been trying to assist a homeless woman in her fifties who could be housed at a lovely apartment tomorrow if she could obtain her birth certificate. She has been waiting over ten weeks to hear back after sending her application to California.

It is very difficult to get psychiatric services without Medicaid. One of the main providers for people without Medicaid is Hopewell Services. But, to be eligible for Hopewell you have to live on the North side, and because of their use of resources to provide psychiatric care, there is less provision for case management services, which can offer great assistance to those living with mental disorders. BJC Behavioral Health, which offers a great deal of assistance through case management services, has been requiring their clients to have Medicaid, with some exceptions. They have decided to make more exceptions which will be a great help. Community Alternatives and St. Patrick's Center also offer some services for people without Medicaid, but under certain grant restrictions and only as available. Unfortunately, the Department of Corrections has become a major provider for mental health care.

The scarcity and difficulty of obtaining Medicaid and the difficulty of services without it, cause a tremendous strain for people seeking medicines, psychiatric services and assistance. I regularly meet people needing assistance who don't have Medicaid. We begin the application process, but there is a long wait and they may not be found eligible. In any event, they must find ways to obtain care in the meantime. Many of these folks end up seeking assistance from primary care providers at federally funded clinics, a topic which Annjie Schiefelbein addresses in her article.

This article has dealt primarily with access to services but has not addressed what type of services people require or desire. This is a crucial issue and is being addressed more and more as people with mental illnesses, commonly known as "consumers," are becoming more involved in their treatment and advocacy. Groups like the Empowerment Center, the Self Help Center and NAMI (National Alliance on Mental Illness), have aided this movement and have offered education and support for family members of persons with mental disorders. Those interested in addressing the issue of access to services, as well as a host of other issues can consider joining NAMI and their efforts. (www.namistl.org)

Lastly, it is most important to note that while the focus of this article is on access to resources and treatment, equally important is the role that relationships play in all our lives and no less in the lives of persons with mental disorders. It is essential that we continue to take away the stigmas too-long attached to these illnesses and reach out to those who live with them. Then, finally, our healing will begin. ✝

Notes:

1. "Achieving the Promise: Transforming Mental Health Care in America", New Freedom Commission Report, 2003. (mentalhealthcommission.gov)
2. "Stressed Budgets Lead to Cuts in MH Resources", Christine Lehmann, reported on in <u>Psychiatric News</u>, Feb. 1, 2002, Vol 37, #3, American Psychiatric Assoc. (pnpsychiatryonline.org)
3. "20th Century History of the Treatment of Mental Illness", Ann Palmer (www.mentalhealthworld.org)
4. "Stressed Budgets... ," Christine Lehman
5. "Achieving the Promise...," New Freedom Commission
6. "20th Century History...," Ann Palmer
7. "Disintegrating Systems: The State of States' Mental Health Systems", Brazelon Center for Mental Health Law, Psychiatric News.
8. NAMI Handout "Class 11" #3, "This Is Progress!"
9. "Medicaid Cuts", www.namistl.org
10. The Missouri Budget Project, www.mobudget.org
11. Firedupmo.com
12. "Citizens Who Lack Papers Lose Medicaid", Robert Pear, <u>The New York Times</u>, March 11, 2007.

Christ's Broken Body

she stands in the doorway
talking to herself
in words she can only understand
all her possessions by her feet
passerbys by pass her
and she is... Christ

he sits on the steam grate
trying to keep warm
bottle clutched to his chest
arm outstretched
asking begging for help
and he is... Christ

she looks tired rundown
bruised a black eye
smile on her lips
curses under her breath
trying to survive
only way she knows
and she is... Christ

he lies in the hospital
thin too thin to be alive
pain in his heart
fear in his eyes
talks about dying
and rising
and he is... Christ

--paul dyba

Accompaniment in the Journey Toward Health

by Lou Powers Kimmell

At the age of eighteen, I was drawn to working in a small local nursing home that repelled guests upon entry by enveloping them in a crush of smeary pink walls, and the pervasive smell of mop water mixed with urine and a dash of Pine Sol. Upon conquering the inclination to flee immediately, most people visited their family member in a cursory manner and left. Weeks, months, years might pass before the next visit occurred, perhaps when the passage of time dimmed their memories of the elder's current situation and capabilities. Eventually the longing for their elder as they used to be in healthier days overcame the desire to remain distant and safely immersed in the day to day routine of their own lives. Often the grief that was visible in the face of a daughter or son as they shrank weakly toward the nursing home exit struck me. The urge to stop each visitor and encourage them to stay longer and observe the small victories of health that occurred regularly is a vivid remembrance that I associate with my first experience in a healthcare role. I longed for family members to maintain the intimacy with their elder that staff in the nursing home experienced and enjoyed. Residents described seminal moments from their past and shared personal wisdom that continued to impact their sense of well being. Each day was filled with moments when a resident rediscovered a strength that contributed to his or her experience of health.

The word "health" can refer to a person's HDL level, their ability to sustain aerobic exercise for 30 minutes, or the demonstration that they process information in a logical sequence and choose behaviors based on their thought process. Health can also be a terminally ill hospital patient feeling present to a gentle breeze wafting across their arm or a dying parent holding the hand of their grandchild as they take their last breath.

As a casemanager working with people experiencing symptoms of mental illness, I have learned that health can be an ongoing dialogue between individuals, an evolving process that at different times will manifest as continuing stagnation, radical change and alarming setbacks.

A person that experiences mental health symptoms is very likely to be judged unhealthy in mainstream American culture. The stigma that a mental health consumer must face daily reveals underlying assumptions that consumers are sick, incompetent, and dangerous. For example: when searching for housing, landlords become dubious about renting to a consumer with an intermittent work history or sustained by Social Security disability based income. Apartment managers state that they don't want to rent to a person that will make the neighborhood unsafe or draw the attention of police to the property. Intake staff at nursing homes, transitional housing programs, and assisted living programs will close the door to mental health consumers explaining, "We're not a psychiatric unit, we aren't equipped to take care of those people." Stigma associated with people experiencing mental illness creates barriers that thwart the consumer's attempts to obtain the basic needs that people without disabilities often assume are readily available to all.

The optimal environmental conditions that contribute to an individual's health are all too often unattainable

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Lou Powers Kimmell came to Karen House for years in her role as an outreach worker with BJC Behavioral Health Services.

for those with mental illnesses. Employers hire following a traditional model of one employee for one job. Inclusion of people experiencing the chronic ebb and flow of mental illness symptoms into the work force would be greatly facilitated by widespread acceptance of job sharing strategies. But accommodating the special needs of some mental health consumers is rarely seen as a central priority in our current cultural context. At best we can hope that the current gestures made by policy makers toward inclusion will not be undermined by budget cuts and bureaucratic implementation.

The Department of Mental Health and Medicaid reimburse mental health agencies for providing case management to people experiencing severe and chronic mental illness symptoms. In the context of the case management relationship, the consumer is encouraged to identify and work toward goals that they wish to attain. The case manager assists the consumer by linking them to resources, advocating on their behalf and providing support and counseling. During the initial dialogue about the work that is to be undertaken, the case manager must earn the privilege of working with the consumer. Qualities that consumers look for in another person when seeking to cultivate health-promoting relationships include truthfulness, reliability, and empathy. The consumer will expect to be heard, respected unconditionally, and offered accurate information that relates to their personal situation and concerns.

Cultivating health through the intimacy of relationship requires that trust and safety are a central theme that is addressed initially and continuously. The consumer should be asked to recall past helping relationships and describe what seemed to work and what was detrimental. A discussion can ensue where possible problems in the relationship are anticipated and various solutions are generated. The inevitable clash of viewpoints can be acknowledged and the consumer's right to self determination recognized. As the relationship deepens, both participants will need to work at respecting the unique perspective of the other. Ultimately the relationship will mature and become a safe haven for the consumer where they feel that they can express concerns without fear of harmful repercussions. It is important for individuals to be able to retreat into a relationship that is calm and supportive. The consumer can then express his or her frustrations. From that experience people can understand themselves better and develop strategies for addressing their underlying concerns.

Change toward health can be nurtured when goals are truly meaningful to the consumer. In addition, early successes are important for engaging the consumer in ongoing treatment. In a health promoting relationship, disappointments and difficulties are examined for the information they can give about how to make the next effort fruitful. Most importantly, calling another to seek personal health requires planting the seeds of hope that change is possible. Sometimes a consumer's frame of reference needs to be expanded by learning about opportunities in the community that are available to them. Joining the consumer in daily activities forges the collaboration toward health.

A feature of the convergence of symptoms of several mental illness disorders is difficulty recognizing that one is experiencing mental illness symptoms. When you combine this with the stigma that is associated with mental illness, it is not surprising that many consumers do not want to participate in the treatments available to them. Initiating a helping relationship with a consumer does not require the consumer declare that they experience symptoms. A far more successful approach is to explore the consumer's strengths and to move toward health by focusing on how existing skills can improve quality of life. Often a person's strengths are also their most challenging weakness.

For example, a personal strength of seeking the companionship of others can accompany the challenge of not allocating enough time to pay bills or care for a household. Consumers can deepen their personal understanding when the many aspects of their strengths are reinvented and fine tuned. Offering the individual stories of how other people have creatively used their strengths to address problems normalizes the troubles they are facing.

So what does health look like? When a consumer contemplates taking medication for mental illness symptoms, I suggest that they identify what they want to achieve and reflect on their ability to attain their dreams. Medication can help a consumer focus on their goals and make their effort increasingly instrumental. Symptoms that are perceived as uncomfortable by the consumer should direct medication treatment. Many symptoms are a benefit to the consumer, helping them manage the stress of their day to day reality. Before these symptoms are modified with medication treatment, replacement coping skills must be discovered by the consumer. Diminishing mental illness symptoms, however, is hardly a sufficient or necessary component to health. Health can be best described by the individual, and only through the intimacy of a healing relationship can a person truly know it.

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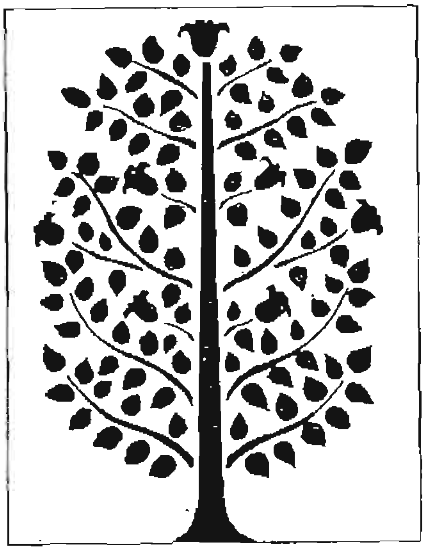

Post Traumatic Stress: An Invisible Wound of War

by Jim Allen

Recall for a moment your worst nightmare. Remember the experience of the nightmare. Relive the feelings accompanying the nightmare. Remember the feeling of relief when you realized it was a nightmare. Now, imagine for a moment that the nightmare won't go away. Fear of the nightmare makes it difficult to sleep. The struggle to sleep becomes regular. No matter how tired you are or how hard your try, sleep doesn't come. Night after night the struggle goes on. This is a common experience of those suffering from Post Traumatic Stress Disorder (PTSD).

The Nature of PTSD

PTSD develops in response to terrifying situations in which individuals experience actual physical harm or the threat of such harm. Traumatic events such as assault, rape, torture, abuse, natural disasters, or war can result in PTSD. Those experiencing PTSD report a variety of symptoms that may last from minutes to days.

Intrusive thoughts, nightmares, or flashbacks that involve a recurrence of the trauma and the associated feelings are among the most commonly reported symptoms. Anxiety associated with situations that are like that in which the trauma took place, or recall the trauma, is another frequently reported symptom. If the traumatized individual is unable the leave the anxiety producing situation, intense distress may occur. The fear of encountering situations that may trigger recalling the trauma frequently leads to avoiding anyone or anything even remotely associated with the trauma. Because of the pain associated with the trauma, some PTSD victims develop "amnesia" around the trauma as a means of protecting themselves. PTSD victims may also report shutting down emotionally and not allowing themselves to experience feelings. Other reported symptoms include hyper-vigilance, problems with memory or concentration, angry outbursts, and at times survivor guilt.

Those suffering from PTSD are also at high risk to experience other significant problems. Depression and substance abuse are frequently reported by those diagnosed with PTSD. PTSD is also closely associated with difficulty in social and family life. High levels of marital problems, frequent divorces, difficulty finding and holding jobs, and legal problems are among the difficulties most frequently reported by those diagnosed with PTSD.

PTSD and Military Combat

Military combat, by its very nature, exposes those involved to extremely stressful situations that frequently lead to PTSD. Consider for a moment the environment in which military serving in Iraq operate. Combat in Iraq is frequently described as "urban warfare." Unlike other combat situations in which the "enemy" is clearly identified, everyone becomes a potential "enemy" in an urban warfare environment. The threat of being attacked by unrecognized enemies dramatically increases stress. That stress is further compounded by dealing regularly with the reality of death. Killing others is particularly traumatic. The risk of PTSD increases as service members serve multiple tours in Iraq.

Estimates of the occurrence of PTSD in the general population range from 10% to 15%. By comparison, current estimates suggest that as many as 1/3 of service members returning from Iraq manifest symptoms meeting the criteria for a diagnosis of PTSD. This figure represents a scale of troops suffering from PTSD not seen since Vietnam, and is directly related to combat.

Of particular concern is the rate of PTSD among female military personnel. Research indicates that women are more likely than men to experience some kind of trauma or multiple traumas prior to joining the military or being deployed

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Jim Allen was a social work officer in the US Army for twenty years.

Mental Health: A Chancy Path to Stability

61 Having trouble adjusting to your new meds, the emergency rom staff refuses to commit you because you are not suicidal.	**62**	**63** You are upset, the emergency room staff call the police and you are arrested; You spend 3 nights in jail (unmedicated).	**64**	**65** You continue this cycle of non-treatment and homelessness. START OVER	**66** You receive proper medication with few side-effects; family and friends support you and find subsidized housing.
60	**59** Your doctor prescribes new medication. This medication has severe side effects. You stop taking it.	**58**	**57** The police take you to a shelter. The shelter staff makes an appointment for you to meet with your doctor.	**56**	**55** You find a place to sleep outside in a city park; you are arrested by the police for loitering.
49 Your social worker helps you to get Perscription Assisrance.	**50**	**51** Your spouse/partner is exhausted; your only sister invites you to live with her.	**52**	**53** Unmedicated, your symptoms still persist.	**54**
48	**47** Without your medication your symptoms become uncontrollable; you loose your new job because of your behavior.	**46**	**45** Funding is cut for social programs- you loose coverage for your medication.	**44**	**43** Your decide with the support of your social worker and family to begin attending AA meetings
37 Your family cannot afford to pay for your medication without insurance; you stop taking it again.	**38** Your symptoms are so terrible that you begin to self-medicate with alcohol.	**39** You apply for Medicaid; your medication is covered once again. You resume taking your medication.	**40**	**41** Your family takes you to meet with a social worker.	**42**
36	**35**	**34**	**33**	**32**	**31**

25 Unable to make your mortgage payments, your home is foreclosed on.	**26**	**27** The side effects of your medication are too severe; you stop taking it again.	**28** Your symptoms worsen, and include paranoia; you trust no one.	**29** Your family takes you to back to the doctor for new medication.	**30** Your spouse/partner's insurance company cancels coverage for your medication.
24	**23** You and your spouse/partner begin to fight over money and your behavior.	**22**	**21** The cost of your medication increases the pressure on your family's budget.	**20**	**19** Your family convinces you to resume taking your medication.
13 Your boss allows you to work part-time.	**14**	**15** The side effects of your meds make you unable to do your job; you stop taking them.	**16**	**17** Your symptoms erupt at work one day; you loose your job.	**18**
12	**11** Your medication has serious side effects, your work begins to suffer.	**10**	**9** Your boss is sympathetic; you can keep your job so long as you stay on your medication.	**8**	**7** You visit a doctor, get a diagnosis and receive proper medication.
1 You first discover your symptoms. You feel ashamed; you try to hide them.	**2**	**3** Your symptoms get worse, you can no longer conceal them.	**4**	**5** Concerned friends and family do an intervention, provide support.	**6**

Start Here

to a combat environment. Physical assault, sexual assault, and rape are the most commonly reported traumatic experiences. These experiences predispose women to PTSD when subjected to additional trauma. The potential for trauma while on active duty is significant. According to a 2003 report, funded by the Department of Defense, nearly 1/3 of a nationwide sample of female veterans seeking health care through the Veterans Administration said they experienced rape or attempted rape during their service. Thirty-seven percent (37%) of those experiencing rape indicated they were raped multiple times and 14% reported gang rape. A Veterans Affairs study indicated that sexual harassment and rape increase during wartime. With these threats, the risk of PTSD among female military personnel serving in combat increases dramatically.

> THE CHOICE TODAY
> IS NO LONGER
> BETWEEN VIOLENCE
> AND NON-VIOLENCE.
> IT IS EITHER
> NON-VIOLENCE OR
> NON-EXISTENCE.
> Martin Luther King, Jr.

Treatment

Early intervention is critical in dealing with PTSD. Continued exposure to the traumatic situation further compromises the physical and psychological welfare of the individual. The immediate effect of traumatic events is most evident to the person experiencing them. In the absence of self identification, the compromised condition of the victim is overlooked and the deterioration continues. This scenario is particularly prevalent among military personnel. Fear of the stigma associated with mental health issues frequently keeps service members from seeking help even when they recognize the severity of their problems. The most severely affected are the least likely to seek help. Help is frequently sought at the point where coping mechanisms fail and a crisis occurs.

Many of those seeking treatment for PTSD do so through the Department of Veterans Affairs. During FY 2005, the Veterans Hospitals provided care to 317,000 individuals with primary or secondary diagnosis of PTSD. An additional 50,000 individuals received care through Veterans Centers. Between 2002 and 2005, 16,000 veterans of Operation Iraqi Freedom and Enduring Freedom received care for PTSD at Veterans Hospitals. Veterans Centers treated another 3,000 diagnosed with PTSD. The demand for medical services through the Department of Veterans Affairs has resulted in a backlog of 400,000 benefits claims. This backlog significantly delays the provision of needed services. As service members wait for their claim to be processed, their condition continues to deteriorate. Current plans call for a 9% increase in the Department of Veterans Affairs Budget. This increase will provide additional resources that can help to reduce the backlog. Plans for 2008 and 2009, however, call for cuts of about $1.8 billion. Thus, the long-term outlook for timely care for veterans diagnosed with PTSD is not good.

Conclusion

The war in Iraq continues, and as it does more service members become victims of PTSD. Because the physical scars of PTSD are less obvious than those of other types of injuries, its impact may be overlooked. Like any injury, however, if not properly treated, PTSD can become very debilitating. PTSD must be recognized for what it is: a traumatic condition that compromises the health and welfare of those who experience it.

One Family's Journey

by Alice Adcock

It was January 1994 when the phone rang and it was a hospital calling to say that she was there and could the family come for a meeting with her doctor and her. They wanted all of us, her mother and her two brothers and two sisters. And, we went.

She said she was really sorry for "all the things she had done." She said she was "going to do something about this illness." She asked for our support and that she had decided to put herself in a "residential care facility," that she had "a new diagnosis and different medication." The doctor told us she didn't have a bi-polar disorder but instead "had a schizoaffective disorder." I had never heard that term and he had a nurse give me some papers to take home with me. We said "Of course." We had always been there for her, even when she did not want us to be.

On reflection, that was the beginning. The beginning of her setting herself on a path to recover a life for herself and taking all of us with her.

At the time, we did not know that. It is hard to explain to those who haven't experienced it what it is like to live with a loved one who suffers from a severe and persistent mental disorder. Over the years I have heard it described as "always waiting for the other shoe to drop," or "an emotional roller coaster," or "an emotional jerking around." What I have come to know is this: it is highly emotional and it is cyclical. There is a pattern to it and it doesn't go away. It is the only disease, the only illness that requires the individual to go to total breakdown before receiving treatment. Overlaying this is the problem of stigma and in the case of mental illness that is defined as "the banishment and scapegoating of people whose conditions are considered so fearful, and so repugnant, that they are judged to deserve their fate." Are those who are diagnosed with cancer, or heart disease or diabetes burdened with this viewpoint? Why couldn't my daughter have been given the kind of compassion and understanding, knowledge and support that those who are diagnosed with those illnesses receive? Instead, she had been treated inappropriately for some seven years and as a result, she lost everything: her marriage, her two girls and her home. She was unable to work as a nurse, a treasured career that she had worked so hard to achieve. It is a terrible thing to watch your bright and promising young daughter unravel before your very eyes and be helpless to do anything about it. She had lived with Type I diabetes since she was 18 months old. She understood chronic illness. She had become a registered nurse, had married and had two lovely daughters. She regularly took the prescribed meds. It didn't work. She lost hope and following the loss of her marriage, she ran. That period lasted a very long six years. I knew she was putting herself in all kinds of danger and, on occasion, we would get a call like the one from the hospital, when she was in trouble. So, we did not think she would persist. But, this time, she did.

She signed a paper so that I could talk to her doctor. That was something she had refused to allow me to do so it was a real sign to me that she was serious about "doing something about it." But then we began experiencing system failure again. We discovered she could not continue with the doctor who had re-diagnosed her and put her on different medication. Being on disability, she was required to use the doctor that came to the RCF. The residential care facility was awful. The smoking room was the dining room where all the residents ate their meals and congregated. Whenever I would come by to pick her up, her clothes would reek of smoke. She, herself, did not smoke. The place would not provide a diabetic meal for her. I was afraid to complain or advocate for her for fear she would run again. Our relationship was fragile and I let her take the lead. When she lost her husband, all the paranoia she had directed toward him was turned on me. But the medications seemed to be helping somewhat, so we tried to solve some of the problems ourselves.

She began walking in the neighborhood everyday. The exercise was good for her diabetes and there were virtually no activities for the residents anyway. Her sisters and brothers found it hard to visit her there. One sister would cry uncontrollably after visiting her. I tried to sooth her by telling her what my daughter had said about living in what looked to us like a nursing home. When she had worked as a nurse, she liked working in nursing

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Alice Adcock and her daughter have moved to Edwardsville, IL to be closer to family members. She is planning to join NAMI Madison County to teach Family-to-Family classes in Illinois.

homes. And she had told me she could, in this new place, "do the part of nursing she had always loved best," she could talk to the patients. She would get some of them to walk with her. There was a small roadside vegetable stand about 2 blocks away from her residence. I would give her some money to purchase fruit and veggies. She was still very sick. When I would pick her up and bring her to my house, she would become very anxious and want to go back "home" after as little as 30 minutes. It broke my heart to think she viewed that place as "home".

The next big break came when a friend told me about NAMI, the National Institute on Mental Illness. Their mission (now mine) is to improve the lives of persons with mental illness and their families through education, support, advocacy, and research. They had a 12-week course called "The Journey of Hope." It has since been renamed "Family-to-Family." Trained volunteers, who themselves have a loved one who suffers from a mental illness, teach it once a week for two and a half hours. There is no charge for the course. I signed up reluctantly. I didn't think it would help. I had lost hope. My husband had been mentally ill and, as a result, I lost him. I became a single parent. I thought if you had a relative who is mentally ill, it meant you lost. It was the death of the person you knew before. But the person continues to walk around. I also believed, like most in our country, that mental illness was the result of some trauma in one's childhood. But, our daughter, who shared his illness, grew up surrounded by loving family. So, what caused this? What did it mean long term? Where could we go to get appropriate and knowledgeable care and support? I didn't know. So, in the fall of 1994, I took the course that was what all of us should have had back in 1979 when she was first diagnosed. But, it wasn't around at that time. It wasn't around in the 1950's either for my husband. NAMI didn't even exist until 1977. It had only been taught in Missouri a couple of times when I took it. A woman in Vermont, Joyce Burland, who grew up with a sister who was mentally ill told us that her parents died thinking they had somehow caused the terrible illness. How tragic! When Joyce's own daughter, approaching the prime of her career as a dancer, was stricken with the same illness, she thought surely things had changed.

But, they hadn't. She discovered, while working on her Ph.D program in clinical psychology that the psychoanalytic and family-system interpretation of mental illness still held sway, unchallenged. She went to work and joined NAMI and a local support group. She studied all the literature she could find. She has written her "story" in the Family-to-Family course. As she learned, she found she could act. She wrote the Family-to-Family course and worked within the NAMI organization to spread the word. She is now Dr. Joyce Burland, Director of NAMI Family-to-Family Education Program.

The course didn't take away the illness but it was immensely empowering for me. I found it contained answers to many mysteries and misconceptions. It helped me talk to her in a more helpful way. It helped me talk to my other children so that they could also understand. I signed up to be trained to teach the course. By this time, I was retired and I became a NAMI volunteer. I served on the board for eight years, began to teach Family-to-Family about twice a year, was on the speaker's bureau and served on several panels as a "family member" at the Washington University Medical School. After so many years of living in "silence," it felt strange to "come out." I had a lot of help. I met people who were enormously strong. People who refused to give up on their loved one, who fought the guilt and confusion that inevitably visit. What courage I saw in those who came to my classes! It continually "fed" me. And they have become forever friends.

In 2000, I was trained by Joyce Burland herself to be a Missouri State Trainer. About once a year, I travel to Jefferson City to teach a three-day intensive training for new Family-to-Family teachers. Today, there are four of us doing this. At another time of the year, we teach Family-to-Family Support Group Facilitators. This is a fairly new support group structure but much more effective than the way we used to do it. We avoid "ain't it awful" sessions where everyone leaves feeling worse that when he or she came. It is not a place to vent frustrations. It is a place to focus on the here and now difficulty and to network with others in the group for ways they have resolved these difficulties. I find it enormously satisfying. I will do this as long as there is a need and for as long as I am able.

My daughter has "done something about this illness". She spent 18 months in the residential care facility before she said she thought she didn't need to be there anymore. She found a small apartment nearby. I still took her to doctor visits and grocery shopping. She had a social worker from BJC who visited her regularly and kept in touch with me. This person was invaluable because it gave her some sense of control over her life, someone she could talk to that wasn't her mother. It let me be mother. To manage this illness, the individual requires a team. There should be a psychiatrist, a social worker, an internist (my daughter had an endocrinologist because of her diabetes) and, of course, family members. She lived in her apartment and worked three days a week as a chef's assistant for some eight years. I am humbly proud of her. I don't know if I could do what she has done with her life had it been my life. For the past three years, she has lived in a nursing home. It is one that we have chosen and one that she approved before we arranged for her to go there. Complications from having diabetes for 53 years have brought a condition called "Charcot's Foot" and this third chronic condition has made it too difficult for her to manage for herself. Yet still, she continues to "recover a life for herself." She crochets a lot and has made an afghan for each member of the family. There are a lot of us. Her two girls have completed their formal education and have joined us in caring for their mother, visiting and calling her nearly every week. She was mother of the bride for her oldest daughter last year.

When I was approached to write this article telling "the effects of mental illness on individuals and families," I did feel concern about how to approach it. I know that the story of our difficulties is quite common. I have heard it over and over in my classes. But my daughter struggles with guilt, feeling she is responsible for the difficulties that have come to her family and our family because of this illness. We try to help her let go of this but I know when she feels down, she struggles. I pray that one day she can let go of it. In the meantime, we will have to fight this stigma for her. There are many (an inadequate word) who do not have family members who can do this for their loved one. Speaking about our own cycling through hope and grief and disappointment with system failure and then hope again does make it easier to stand up for what needs to be. I invite anyone who has a loved one with a diagnosis of a mental disorder to join us at NAMI. ✝

NAMI national web www.nami.org
NAMI St. Louis phone number 314 966 4670

Uninsured and Underserved

by Annjie Schiefelbein

Many of our guests stood by shaking their heads as Teka and I sat outside with Claire. Claire is not allowed in Karen House right now, as she had a particularly violent episode a few weeks back, and is less stable now. The women were sympathetic to Clair but also protective of their kids and the house as they had seen the level of destruction her mental illness had caused. One of the women commented, "They should get her in to see a doctor." At that point it was time for me to shake my head. I very well know the frustration on the Karen House side of trying to get someone into care. But I also know the frustration from the other side, that of the city clinics which have become the place in the community for folks like Claire to go (or be sent) in hopes of receiving mental health care.

I work as a family nurse practitioner (FNP) for one of the city clinics in St. Louis. Working at the clinic and living at Karen House enables me to see this issue (and the people affected) from two perspectives. At Karen House, I am desperately trying to get Claire somewhere, anywhere for help. On the clinic side, a place where she could conceivably get help, there is little to do for her. Claire, who probably has schizophrenia, has few options. We may have convinced her to go to the hospital from Karen House that night, but even the last bastion, Metropolitan Psychiatric Center (MPC), where many of our guests have gotten crisis mental health medications, has become less of an option. They used to be one of the few places that would receive someone who was in a mental health crisis but did not have any insurance. Now they rarely admit people, even people who desire help or who are in active crisis. In the past someone like Claire could have gotten three days of medication and an appointment with a psychiatrist for follow-up. Now the people we send don't get any medication, and often no appointment, so MPC is less of an option. As far as mental health care for someone who's in crisis and without insurance, Hopewell Clinic or hospital care, and the limitations within those systems is about all there is. The options are even fewer for someone not in an acute crisis, but suffering nonethe-

In addition to her work at Karen House and Grace Hill, **Annjie Schiefelbein**, has been working on a six week plan to finish many of the essential projects at Teka Childress (TC) House.

less. But Claire still needs help, as our women identified. The next option, is primary care.

As a FNP, I have many patients every week who live with a mental illness. When I look at the patient's chart and see Medicaid or Medicare, I sigh a prayer of relief. There are some options for those folks. But at my clinic, most of the time, I see the word UNINSURED on my screen. That's when my resignation begins. For a variety of reasons, I (and many other health care providers) am uncomfortable treating any mental health issue aside from depression. Even treating depression in someone who is new to the clinic is an uncertain business. If they actually turn out to have bipolar disorder, and I am just happening to see them on the depressive phase, it could be extremely harmful to start them on an antidepressant. If a person has any other psychiatric disorder (diagnosed or undiagnosed), I can't treat them. I have neither the experience nor the skill (or time during an office visit) to perform an assessment and plan of care that would be of benefit, and may actually be harmful. We are primary care providers. When we see someone with renal disease, we don't treat them but send them to a nephrologist. A difficult skin disorder warrants referral to a dermatologist; heart conditions to cardiologists, etc. For each disorder there is a related specialist who deals with the issues that go beyond primary care. This is true for psychiatric disorders as well. But unlike the diseases listed above, there is relatively nowhere to refer a person with a psychiatric disorder and no insurance.

I recently sat with a large group of clinicians with whom I work and asked them what they do for folks with mental illness who come to the clinics, either for mental health care or medical care. This is not a new topic among us. The issue of mental health care in St. Louis has been a matter of great importance, and we have sat in many meetings where the frustration level has been obvious, because we feel so impotent as clinicians. I knew that I was not comfortable or able to help most folks with a mental illness, but I wondered what other clinicians, those with more training or more experience did in similar circumstances.

The answer was a chorus of aggravation. None of the city clinics has a psychiatrist or mental health specialist on staff. As primary care providers, the appropriate care would be for us to refer these folks, but to whom? We don't have any options available to us that are not available to Teka. So in resignation, we write a referral to Hopewell, hoping that they meet the criteria to get in, hoping they don't get hurt in the weeks or months before the appointment, and realizing that being in crisis prevents many people from making scheduled appointments. So the clinicians are desperate to have someplace to refer people like Claire for appropriate care.

But my question persisted to my colleagues, what do you feel comfortable treating? What are the diagnoses for which you would feel competent to prescribe medication? Everyone shook their heads, and it became clear that despite experience or education, almost all of us are not comfortable with assessing and treating most mental illnesses. Some agreed, that if pushed, they would rewrite short term medications that had previously been prescribed by a psychiatrist and only in an interim until a patient can return to a psychiatrist. The only people that includes are people who have already gained access into psychiatric care and have a plan to continue that care. This, admittedly, is very few of our patients. The only other circumstance under which the clinicians would feel comfortable treating a mental illness is if the patient has been under the care of that particular clinician for a long time (years), and has been in the clinic often enough to have given the clinician a good sense of the person, their baseline personality, life issues, and struggles. That, also, includes very few people.

It is disconcerting that, in an age where this country has the ability, to a fault, to provide cutting-edge medical care to so many, that one entire aspect of medical care, mental health care, is so completely ignored. It is not even a possibility to say, well, this one option isn't perfect, but it's all we have—we have nothing. We have no place to turn when we have someone desperate for mental health care, seeking help from their primary care provider.

The situation reminds me of being in Africa, actually. We would see people in the refugee camp health tents, diagnose them with things like Tuberculosis, and then tell them we were sorry there were no treatment options available. We are sorry you have a life threatening, debilitating illness. Good luck with that. There's nothing we can do. It is the same here.

There is no happy ending for this article. There is no optimistic view from which to see mental health care (aside from the thousands of people striving to change it). There are few to no options, more and more people suffering, and an empty void into which they fall. And we at the many different front lines, Catholic Worker houses, mental health outreach, primary care, family member, can only sit with a person like Claire, try to keep her from harm, and shake our heads that there is little to nothing to be done. ✝

Last Child in the Woods

review by Tim Pekarek

Today's children are not hard to find, just follow the noise. The din is produced by anything plugged in: TVs, video games, cell phones, and the kids will be on the receiving end. Even with wireless connections, their attention won't wander far from 21st century technology. As a result of spending so much time in front of a screen, "according to CDC data, the U.S. population of overweight children between ages two and five increased by almost 39% from 1989 to 1999." We have "four times the percentage of childhood obesity reported in the1960's." These quotations are found in Richard Louv's book Last Child in the Woods, which examines the impact of social trends that remove children from contact with nature and time spent outdoors.

Until 1950, a large portion of the population still lived on farms or in smaller towns. Much of childhood activity would have taken place outdoors, either involved in chores or in undirected play. Louv shows how much harder it has become for today's young people to even find nature, let alone the time to play in it. With the outward sprawl of our cities, many more families grow up surrounded by manicured lawns and flowerbeds containing no mature trees, all designed to create 'curb appeal' as seen from a car. There is little accessible open space and park creation has not kept pace with population growth and land development. Much of urban park space is designated for specific public use, such as a ball field or tennis and basketball courts.

Added to this is what Louv refers to as the 'Bogeyman Syndrome,' our general and exaggerated fear of "traffic, crime, of stranger danger – and of nature itself." Louv cites the work of Joel Best, a professor at California State University at Fresno. Best's book, Damn Lies and Statistics, took on the subject of how fear overruns reason. Specifically, Louv uses Best's work to examine the oft-quoted statement: "Every year since 1950, the number of children gunned down has doubled." Best points out the impossibility of this assertion, reminding the reader that, "By this doubling process, the number of American kids shot in 1987 alone would have been greater than the world's population." Small wonder kids are growing up afraid of the world outside their door. They have little or no chance to find any nature, even if it were hiding nearby, and therefore have no knowledge of it. How would such an individual derive any comfort from something so foreign?

The trend Louv follows in Last Child in the Woods is one that has developed slowly, as each generation moved further from nature. The effect of this, which he terms 'nature-deficit,' is an array of physical and mental health problems we suffer, and are related, in part, to the loss in our understanding of nature and its beauty. One manifestation is an irrational fear of anything not closely controlled. Louv interviewed Rasheed Salahuddin, a high school principal in San Diego County. Salahuddin heads the local school district's one week outdoor education program. Too many kids are associating nature with fear and catastrophe. Inner-city kids of all ethnic backgrounds show similar responces, says Salhuddin. Some have never been to the mountains or the beach or the zoo, even though it's within sight of their homes. Some of them spend their entire childhood inside.... living in fear. They associate nature with the neighborhood park which is controlled by gangs. "What does this say about our future?" asks Salahuddin. "Nature has been taken over by thugs who care absolutely nothing about it. We need to take nature back."

In other sections of the book, Louv ponders how we will find future stewards of nature. Over the years, a similar thought has had the effect of nudging me to take some of the Karen House youth outdoors. Inner City Outings is an outreach project of the Sierra Club, a prominent national environmental organization. The purpose of I.C.O., in St. Louis since 1992, is to provide the opportunity for disadvantaged inner-city children and youth to explore and enjoy the wildness of nature. I.C.O. trips vary from a simple day trip to a local site inside the St. Louis beltway, like Powder Valley Nature Center, to camping trips lasting several days. Some trips are as challenging as a week long backpacking and canoeing trip to Isle Royale National Park in Lake Superior.

I have co-lead more I.C.O. outings than I care to admit and though they have demanded a lot of work and a bit of patience, all of them have been worthwhile. I.C.O. leaders receive training and are prepared for the responsibility. The types of outings are determined by the two or three group leaders who are planning the outings, and are determined by their skill, knowledge and comfort level. Typical activities include canoeing, hiking, backpacking, caving, bicycling trips and all outings have an environmental education component. They have been as simple as a game or related reading, or as complex as a scientific water quality assessment of a backwoods stream. On a recent I.C.O. outing with some Karen House youth, the leaders were delighted to find our group interested in and skilled at nature photography. It was a delightful addition to a Spring trip! For Further information on the Sierra Club Inner City Outings, feel free to contact me at my home or the Karen House, or contact your local Sierra Club.

Tim Pekarek (314) 588-9010
Karen House (314) 621-4052

Tim Pekarek has recently formally rejoined The Karen House Community.

From Abroad

by Amy Gerth

In Guatemala, where the vast majority of land, wealth, and political power lay in the hands of fourteen families and international corporations, this is a story of one community, Nuevo San Jose, that struggled against the finca owner who was abusing them. This story was shared with me as I traveled there this year...

Abolino was born and grew up on the San Jose Finca near Columba. His family and forty-nine other families worked growing bananas and coffee there. The finca (plantation) was started in the 1950s.

By the 90's, the current owner of the finca disappeared. Workers continued, counting on his return and back payment, but after two years of no salary, sickness and death resulting from a nutritionally-poor diet of green banana, corn, and tortillas, Abolino and another man organized a meeting, although they had no organizing experience.

They wrote an act with the signatures of twenty-five families that said they would work together to struggle against the finca owner to get their rightfully-earned back pay. As it was the height of the civil war and dangerous to be affiliated with a union, the other twenty-five families decided to support the leaders, but not to sign on themselves. When Abolino, and the other man representing the organized families of San Jose arrived at the labor court, they were received well and listened to, but they had no written documents or proof. They arranged for a follow-up meeting, but the owner bribed the court to stop hearings.

When the people of San Jose heard news of what happened at the court they lost hope. No one had academic training beyond the 3rd grade and they had exhausted the only route to justice they knew. Would they be homeless and broke in a time of war?

A new priest with experience in this situation was assigned to their church and sent Abolino and the other man to paid labor union training in the city of Xela.

They arranged for a truckload of food for their community and for social workers and lawyers. Abolino was beginning to feel strong and ready for the labor court once again. They learned what forms they needed and formed a legal union bringing a formal document of complaint to court, this time with the volunteer lawyers.

The owner promised with smiles to pay in full, but once again abandoned his obligation. Throughout, they never abandoned the work on the finca - they couldn't or they would lose everything. In hunger, they would wake at six and worked hard until two, not allowing the owner a chance to fire them.

The union was angry and now wanted stronger measures. On Labor Day they organized a protest with the unions of two other fincas from the same area, marching and demonstrating at the owner's house. With flyers and return protests they struggled only for what they had fairly earned.

The owner scolded Abolino for "stabbing him in the back" and said that because of the protest they would continue to suffer. Abolino discovered the next day that the owner had fully repaid all the families who had not protested and then sold the finca so that they had to move off of the land.

Abolino demanded to speak to the owner, who took him and the other leader out to a lavish lunch and offered full compensation if they would abandon the union and the other families. When they refused, the enraged, and drunk, owner literally turned the tables and the two leaders fled.

They knew the only things of value left on the finca were bags of coffee, so they guarded them as collateral. When the trucks came to collect the coffee, the union blockaded the road with gasoline-soaked trees and rocks until the drivers called the owner who finally gave them their settlement. On the heels of this victory came the reality that they would have to leave their land of so many years.

The community remained strong and decided to buy land collectively with the settlement money, growing coffee and working with the Spanish Red Cross for donated cinderblock for houses, a school, a drainage system, and electricity. It was a kind of wealth, this collective living. They won their community.

✝

Amy Gerth, back in St. Louis, divides her time between farming at Urban Roots, teaching and entertaining the neighboor kids.

From Teka Childress House

by Jenny Truax

Imagine two Catholic Workers who have absolutely no construction or home maintenance skills, nor any desire to acquire them. Imagine they have no aspirations to move from the house of hospitality where they have lived for years, and of course, that they have no money. Probably you know Catholic Workers who fit this description. It was certainly true for the two of us.

Now imagine a Catholic Worker neighborhood that is being somewhat gentrified, the 100+ year-old homes are being torn down for rows of identical vinyl houses. Again, that probably doesn't take too much to imagine.

Those scenarios were our reality in 2004, when Annjie Schiefelbein was taking the dog for a walk one day and came upon a house for sale. This house is two blocks from Karen House, next door to Tony and Julie's sustainable living project, and a perfect size for the 2 of us plus a family or two. The fact that it was ugly (painted brick—white of all colors) didn't deter Annjie, who exclaimed in a wonderfully dramatic fashion that night, "I have news that may change our lives!"

And change our lives it has. We had a large clarification of thought with folks from the neighborhood and our community, and felt supported and encouraged. The idea was to slowly rehab the house for two years and then invite a large family from Karen House to move in. The idea of offering long-term hospitality as a complement to the short-term hospitality at Karen House was exciting. We decided to buy the house only after finding out it had a new roof and needed only minor aesthetic work. The plumbing and the electric were fine. Through the generosity of several friends, we were able to front the money to purchase the house.

As evidence to how ill-prepared we were for such an endeavor, the first things we talked about were paint colors and a name for the new CW House! We worked hard on the name. Each time the subject came up, we lamented that we couldn't name it after Teka. For years, she has provided an authentic and loving model for doing hospitality. We knew she would never allow it, so we dismissed it each time. In the end though, as painful as it was to her humility, she acquiesced, and we are now proud to call it the Teka Childress Catholic Worker.

Three years later, the plans are still plans. The rehab turned out to be a gut rehab. The 'new' roof needed replacing, the electric and plumbing all had to be ripped out and redone. At times it has seemed like the more progress we made, the more we uncovered what needed to be repaired or replaced. We've been blessed with help from high schools, church groups, and individuals, we've learned new construction skills, and certainly (and painfully) honed the Catholic Worker skill of begging.

From the beginning, we wanted Catholic Worker values to guide this house. Practically, this has meant doing a good deal of the work ourselves, depending on volunteer labor as much as possible, trying to support local businesses with our purchases, working on a shoestring and precarious budget, and trying to find less toxic options for building materials.

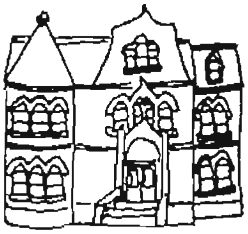
For us, sticking to Catholic Worker principles also meant grounding this new house within the wisdom and experience of the Karen House community. For a year, the Karen House community spent time each month discussing the formation of TC House. This initial process challenged and nurtured us, and provided wisdom and creativity that the two of us alone never would have managed. We formally decided that TC House would provide hospitality for one large or two small families. The money would not come from Karen House, but from groups and families interested in the more personal, longer- term hospitality.

We decided to create two groups of support for TC House. The first is a small consensus-based group that makes the major decisions for TC House, comprised of current and former members of the Karen House Community. The second group, which is still forming, will be a larger support circle of folks who are seeking a more intimate connection with a family. We envision families who have kids of the same ages, including the TC House kids in swimming lessons, outings, tutoring, etc. We hope that this will be a relationship-based way for all of us involved to enjoy life in a better way. Feel free to contact either of us at Karen House or by email (annjies@yahoo.com) if you'd like to get involved.

Hopefully the next time a "From TC House" article comes around, we'll be able to share the story of the housewarming party with you, and introduce you to the family with whom we will begin this new CW House! ✝

Jenny Truax has added budding chef to her repertoire of skills as a Jenny of all trades.

From Karen House



by Tony Hilkin

Karen House is, for most volunteers who come through the door, a school. A classroom for people who are trying to live a more loving life. A school of social and political justice taught by day to day work with the poor. For grade school children, Karen House offers a glimpse of poverty often with welcoming loving hugs from the children here. High-schoolers are given the opportunity to serve meals to the homeless or distribute clothing thus cultivating their compassion. For college students, it is theory put into practice - a chance to help out with something radically different and affect change along the way. For the individuals who stick around for a few years, we are realizing that this is a way of life and not just a volunteer experience. Each day it becomes harder to walk away from the beauty and pain we have encountered here.

I have found Karen House to be an edifying experience and will share ten significant things I have learned over the years –a few of my lessons learned from the Karen House classroom:

1. Our lives should incorporate manual labor. Though intellectual labor may be more glamorous, hard labor is very fulfilling and spiritual work. I have discovered the things that I have labored most at are the things that define my beliefs and values. The sustainable living project that Julie and I are working on is one such example.
2. If we want equality, we need diversity. I try to form relationships with people of varying income, race, and religious backgrounds. I feel this is needed for social equality.
3. I have found accompaniment at Karen House to be a radically different approach from service. Of course, we provide services to the poor here, but we as a community try to go beyond this point. We have all found here that change lies within love more so than service.
4. I try hard not to forget that I come from privilege. It is probably the largest obstacle that separates me from close relationships with our guests. My education, my race, my freedoms, and my access, can all hinder growth if I am not sensitive.
5. If we want social justice, we must commit to sustainability. Because our destructive environmental practices directly affect others, especially the poor (here and around the world), we must look toward more sustainable practices to truly move toward justice.
6. As we all aware non-consumption is the best route, but when we do "need" to consume, it should be organic, local, green, fair trade, natural, etc. These alternatives often have a higher price tag because they support better practices.
7. Resistance takes many shapes and forms from civil disobedience to offering hospitality. Resistance is always necessary to hold government, corporations, and people of power accountable. I believe in resistance that is inclusive, daily, and creative.
8. We must have fun. We must have fun. We must have fun. Julie and I are drastically improving in this area and are healthier people for it.
9. Living at Karen House, we try to accept precariousness of time. I am often late or miss things because of crises here. It is a difficult but necessary part of living here.
10. The above are all interconnected. Practicing one will only improve upon the others. ✝

Tony Hilkin and Julie are starting their garden this Spring after four years of working on their sustainable house.

Round Table Talk

by Mary Hargadon

Since February, groups across the country have been occupying the offices of Representatives and Senators, demanding their vote against further funding for the war in Iraq. The campaign is called the Occupation Project. The St. Louis chapter has been doing occupations and protests at the offices of Russ Carnahan and Claire McCaskill. On the anniversary of the Iraq war, 175 people marched downtown, ending at McCaskill's office. Many people have been active and supportive for this campaign, some choosing to risk arrest for the cause. The action I did with my affinity group last month ended in jail. As to what happened and why anyone would do an action like this, I can only speak for myself. This was my first action, and therefore stands as my favorite, by default.

My affinity group was named after my house, and therefore after the great Carl Kabat, so I guess we created a good omen for ourselves. To my advantage, the group included the famous Teka, whom I looked to as the leader, even though she characteristically refused that label. I also clung to the experience of Carolyn Griffeth, someone a bit young to be my mother-figure, but who does well as a guru. The other beautiful thing was that the group included all three of my roommates, whom I really see as my family. That day Lani, Jorj, and Sarah became the blood that ran through my veins as I tested the waters of civil disobedience.

I found myself alone in the lobby of Carnahan's office in the beginning of the action while everyone else was in the main conference room. Important issues did need to be discussed, but politics aren't exactly my element. I justified this choice, believing that there should be someone occupying the lobby at all times. It wasn't long before Sarah joined me. We talked, but she insisted that we talk loudly. I admired this leader persona coming out of her that day. She had a clear view of how she wanted to occupy the office. Of course it seemed that everyone did, but me. I just wanted a war to end and was looking to others for inspiration for how to stop it.

The day eventually picked up a rhythm that consisted of a few people sitting in the lobby, reading aloud names of Iraqi and American soldiers who have died, while others remained in the conference room, conferencing. But by the end of the day I was loosing focus. There was an idea tossed about that we should handcuff ourselves to the main desk. I won't say who was and who wasn't for this idea, but I will testify that it did bring tension to the group. After this and other tangential conflicts, there was still no sign that we were going to get what we came for. There was no promised vote from our representative, just empty statements disguised as agreements with our opinions.

At closing time we didn't leave, which meant the authorities were being called. We didn't get the statement we wanted, so we were going to make a statement of our own. The remaining seven of us, gathered in the lobby and continued to read names. We knew we'd be leaving in handcuffs at this point. I was more scared of not expressing my opinion clearly through my actions than I was of facing the police. I stopped reading long enough to witness one of my best friends being arrested. After he was asked the standard questions, I watched in fear as Jorj replied coldly to the police officer, "I'm not going anywhere." The brave words gave me clarity. I felt proud as he was carried out of the office.

When the police came to me I refused to walk with them. I wanted to resist this arrest, like I resisted the war. I tried to search for some spiritual notion to keep my body limp as the cops turned me over on the ground to handcuff my wrists together. The pain I felt in my arms and shoulders from being carried downstairs washed away when I was greeted by Lani's smiling face inside the wagon. We had done it. After the rest of my affinity group piled in the van, our fate awaited us in the cell... at least for a few hours. On the way we sang with our hand cuffs clanking, "I'm gonna lay down my sword and shield down by the river side. I ain't gonna study war no more."

Mary Hargadon can be seen sporting a dandy farmers hat as she works at the Urban Roots Farm.

Karen House News

Karen House will close for the month of June for a major rehab effort.

A huge thank you to all who responded to our recent appeal letter! Through your generosity, we raised over $20,000 toward the June Rehab.

We are helping the guests find other housing, and will NOT be accepting any donations that month.

Call 621-4052 if you're interested in helping out with: 1) Supplies (call us - we have a list), 2) Labor (people to purge, clean, paint and restock, and skilled folks for repair work), or 3) By adopting a room (furniture, paint, and beautifying).

Kabat House Needs

Donations towards a "New Window" fund, supplies and labor for a new fence, toiletries, milk, butter, sugar. Call 621-7099.

Teka Childress House Needs

Families or individuals interested in supporting one family in long-term hospitality.
Call Annjie: 621-4052

Further Resources on Mental Illness

- National Alliance on Mental Illness: nami.org
- American Psychiatric Assoc.: healthyminds.org, psych.org
- National Mental Health Consumers' Self-Help Clearinghouse: mhselfhelp.org

-Erasing the Stigma of Mental Health Problems: Two-day conference focused on those who journey with people who suffer from mental illness or who have lost someone from suicide. June 2-3, 2007 at the Shrine of Our Lady of the Snows in Belleville: 314-241-3400 x 6272 or snows.org/pdf/erase.pdf

The Round Table is the quarterly journal of Catholic Worker life and thought in St. Louis. Subscriptions are free. Please write to *The Round Table*, 1840 Hogan, St. Louis, MO. 63106. Donations are gladly accepted to help us continue our work with the poor. People working on this issue include: Joe Angert, Teka Childress, Sarah Sunseri, Mary Hargadon, Lauren Koenig, Christen Parker, Ellen Rehg, and Jenny Truax. Letters to the editor are encouraged; we'll print as many as space permits.

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