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***2014 National Philoptochos Biennial Convention
Philadelphia, PA***

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**MENTAL ILLNESS:
OUR COMMUNITY'S JOURNEY TO
UNDERSTANDING, COMPASSION AND HOPE**

**A PANEL DISCUSSION PRESENTED BY THE
DEPARTMENT OF SOCIAL WORK
2014 NATIONAL PHILOPTOCHOS BIENNIAL CONVENTION**

**JULY 7, 2014
PHILADELPHIA, PA**

PANELISTS:

DEMETRIA DELIA, PH.D., LCSW, MA

Licensed Psychologist and Clinical Social Worker
Supervisor, Family Services in Morristown, NJ
Private Practitioner in Psychoanalysis and Psychotherapy

CHRISTINA KALLAS, ESQ.

Practicing Attorney and Mediator
Former President, New York Women's Bar Association,
Member of its Advisory Council and on the Board of its Foundation.

REV. PROTOPRESBYTER NICHOLAS G. ANCTIL

Proistamenos, Holy Trinity Greek Orthodox Church, New Rochelle, NY;
President, Archdiocesan Presbyters Council

MODERATOR:

PAULETTE GEANACOPOULOS, LMSW

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*This summary was compiled and written by Paulette Geanacopoulos
Reviewed and Approved by the Presenters and
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INTRODUCTION:

PAULETTE GEANACOPOULOS, LMSW

A panel discussion entitled *"Mental Illness: Our Community's Journey to Understanding, Compassion and Hope"* was presented at the 2014 National Philoptochos Biennial Convention in Philadelphia, PA.

Conceived of and moderated by Paulette Geanacopoulos, LMSW, the organization's Director of Social Work, the program offered eye-opening statistics and information about the prevalence of mental illness in society and our community, its impact on family members, cultural interpretations of demonic possession and exorcisms, and proposed actions that we, as a faith-based community, can take to ensure that we treat all of our brothers and sisters -- regardless how *"different"* we may consider them to be -- with love, kindness, and hope.

While one in four Americans suffers from mental illness, Geanacopoulos noted that nearly 40% of the cases that she addresses at the Philoptochos Department of Social Work comprise persons exhibiting symptoms of mental illness. Nevertheless, the cultural stigma causes a large percentage to deny their mental illness and refuse to seek or accept treatment. Geanacopoulos quoted a monograph recently published by Australia's Monash University: *"Ancient Greeks used the word 'stigma' to refer to a mark on the body of a person who should be avoided. Today, stigma refers to being different in some undesirable way. It is a sign of shame, disgrace or disapproval, of being shunned or rejected by others or even the entire community."* As a result, the fear of humiliation leads those with a mental illness and their family members to suffer in silence. Many say that the stigma they face is more painful, devastating and limiting than the illness itself.

Geanacopoulos framed the goal of this program as a first step towards enabling us to develop actions that will create in our Church what some towns and cities are calling, *"mental health stigma-free zones"* - places where all members of a community are regarded equally.

UNDERSTANDING MENTAL ILLNESS:

DEMETRIA DeLIA, Ph.D., LCSW, MA presented the segment on *"Understanding Mental Illness."* She is a Licensed Psychologist and Clinical Social Worker, a Supervisor at Family Services in Morristown, NJ and a private practitioner in psychoanalysis and psychotherapy.

Acknowledging that mental illness is a deeply complex issue that can be difficult to diagnose and even harder to treat, Dr. DeLia reported that it can be caused by a combination of factors including genes inherited from our ancestors, trauma, environmental or emotional experiences, and temperament.

She noted that recent research suggests that mental illness can begin in the womb if the pregnant mother is exposed to infections, toxic chemicals, stress levels, or natural disasters; however, because some fetuses and infants are better able to handle adverse experiences, not all traumatized children will develop mental illness.

Dr. DeLia observed that because some people translate emotional conflicts into physical symptoms, they deny psychological stressors and visit medical doctors in hope of a cure. Even symptoms of the severest disorders, such as schizophrenia, bipolar disorder, and major depression, are overlooked. She gave examples of the paranoid schizophrenic patient who withdraws from society being described as shy or introverted, and the depressed patient who is unable to get out of bed being accused of laziness.

Although a family's concern with appearances may cause them to suffer in silence, she urged families to look for early warning signs such as children who start fires or are cruel to animals. *"Early intervention is the best way to help recover from mental illness,"* she said.

Dr. DeLia discussed the relationship between mental illness and substance abuse, emphasizing that a pattern of avoiding the problem can lead to self-medicating with illegal drugs or illicitly obtained prescription drugs. She noted that such a response complicates the issue, as it adds a secondary diagnosis of substance abuse to the person's illness. Additionally, patients with minor emotional problems who may not be aware of potential risks often have psychotic breakdowns after using even milder drugs such as marijuana.

Dr. DeLia stated that medication compliance is often difficult, stressing that many patients stop taking prescribed drugs because of unpleasant side effects, while others stop when they begin to feel better, thinking they are "well". Because mentally ill persons are protected by law even if they have a history of self-destructive or violent behavior, they cannot be forced to take medication even when we know that their disordered thinking is causing them to refuse the drugs. She cited the example of the patient who refuses to take drugs to help alleviate compulsive hand washing using the excuse that the drug will make them forget to wash their hands; thus, they will be poisoned by germs.

Violent behaviors, including suicide, are highly correlated with abandonment by loved ones or lack of support. Dr. DeLia stated that Adam Lanza, who killed his mother and 26 others at Sandy Hook Elementary School, was abandoned by his father and brother. When his mother left him alone for the weekend, he snapped. While Dr. DeLia said we cannot know exactly what he was thinking or feeling when he acted out this horrendous spree, she noted that perhaps he thought his mother was never coming back either. His case is one of hundreds of documented histories with similar antecedents.

Dr. DeLia examined the issue of abandonment in infancy. She said that it is often an overlooked, serious risk factor for violence later in life. Separation from mother, incubators, a mother's illness, or a child's hospitalization which results in separation from the family often are experienced as abandonment by the child. An important fact is that babies experience emotions that have lasting effects, a characteristic that goes against the commonly held belief that babies do not remember what happens to them. She related the issue of abandonment to adopted children who spent the first months of life neglected in orphanages often overwhelming loving parents who cannot understand why their adopted child, who has been so loved and nurtured, can become violent.

The abandonment of new mothers is another factor that increases stressors in infants. We are horrified when we read of postpartum psychosis -- a psychotic disorder that results in infanticide. Postpartum depression is very common and is caused by the new mother's exhaustion, hormones, and adjustment to her new family. She pointed out the tradition in Greek culture of protecting the newborn and mother with a 40-day period of confinement. During this time, older women in the family take turns to care for the new mother with food, advice, and household help. This wonderful custom ends with the new mother and baby being blessed in Church where she is welcomed into society again. Unfortunately, as we become rooted in American society, Greeks tend to spread out, away from family, often leading to the loss of the 'protection' provided by living close to relatives. Dr. DeLia closed her presentation by stating that family stability can be a protective factor in our work towards helping those who suffer from mental illness.

IMPACT OF MENTAL ILLNESS ON THE FAMILY:

CHRISTINA KALLAS, ESQ. provided personal insight into "*The Impact of Mental Illness on the Family*". She has a private practice as an attorney and mediator, and is a former president of the New York Women's Bar Association. She continues to serve on its Advisory Council and on the Board of its Foundation. Over ten years ago, Ms. Kallas and her husband, Xenophon Theofall, became support group facilitators for the *Family Connections Program of the National Educational Alliance for Borderline Personality Disorder* (NEA BPD) after their daughter was diagnosed with the disease. (*The NEA BPD website can be accessed at www.borderlinepersonalitydisorder.com*)

Ms. Kallas spoke of parental feelings of overwhelming responsibility, exhaustion, frustration, anger, hurt, stress, chaotic family life, loyalty, loneliness, and tremendous concerns about what will happen to the child when the parents no longer can care for him or her. She spoke of guilt -- whether because of genetics or not knowing whether the mental illness stems from something the parent(s) did or did not do. She cautioned how some family members become enablers while others blame themselves or their spouse or their in-laws for their child's condition. As it is in the best interest of the child, she emphasized the need for both parents to be consistent and "in synch" regarding how to deal with their child.

She spoke of 'casseroles' v 'criticism' - pointing out that there is a clear distinction in our community's responses: families of those with a physical illness are likely to be supported and visited, while those whose children or other family members suffer from mental illness often encounter criticism and rejection.

One of her great points of emphasis was that a family's denial of mental illness is a grave mistake. Early acknowledgement that a family member is exhibiting symptoms of mental illness should be regarded as a loud call to seek professional evaluation and consultation, not only so that parents can seek help for their child but also for themselves. One such way parents can do so is through a family support group.

Referring to her experiences first as a participant in the NEA-BPD Family Connections program and subsequently as a facilitator, she said that family support groups help relatives understand, cope, and deal with their child's mental illness in a safe environment comprising others encountering similar issues. These groups are places to obtain accurate information about their relative's condition; they allow family members to speak about their feelings in a non-judgmental, non-critical setting, and are a resource for brainstorming about what has and hasn't worked among the other families in the group, e.g. what others have done when the child refuses to go to school, or comes home at 4:00 am and wants the parent to pay for her cab ride, or is involved in the justice system, whether jail, bankruptcy, or other lawsuits.

She noted that support groups help relatives evaluate and access appropriate resources including therapists, treatment programs, services, and public benefits. They help relatives improve their ability to communicate skillfully with mental health and medical professionals, with educators, and with extended family members who may or may not understand what the parents are experiencing.

Ms. Kallas urged the audience to focus on the person rather than the disease. She offered a touching and profound closing to her presentation:

"You may never know why your child is ill. You may feel guilt or intense grief, but you need to hunker down and get help. And you need to understand that there is no ritual in life that allows you to publicly mourn your lost dreams for your child".

SUPPORTING THE JOURNEY THROUGH FAITH & HOPE:

REV. PROTOPRESBYTER NICHOLAS G. ANCTIL, Proistamenos at Holy Trinity Greek Orthodox Church in New Rochelle, NY and President of the Archdiocesan Presbyters Council closed the formal portion of the program.

Fr. Anctil noted that in the past, much of our religious instruction came from our mothers and grandmothers who taught us what they had learned about illness -- both mental or physical -- from a perspective that somehow laid blame for the illnesses on the sins of the person; that perhaps even God Himself was imposing some kind of punishment as was done to Adam and Eve in the Garden as a result of their disobedience. Today, though, as most of our religious instruction is taught by our clergy and Church Schools, our perspective is that *God is love; God brings healing; God brings restitution -- not sickness, death and disease.* He stated that we often use the phrase "***the Church is a hospital***" -- a place of healing, a place for people to come and be restored and strengthened in their struggle to be God's people.

He indicated that the charge and Great Commission of our Lord to His disciples, and subsequently to us, was to go into the world and *“Baptize all nations in the name of the Father and the Son and the Holy Spirit, teach His commandments, and receive the promise that God will be with us to the close of the ages. Amen.”*

Following the calling of the twelve disciples, he said that Christ gave them *power* against unclean spirits, to cast them out, to heal the sick, cleanse the lepers, raise the dead, and even cast out devils.

In the days of Christ, Fr. Anctil said that we saw a correlation between sin and physical illness. He noted that among the 40 or so miracles that Christ performed in the New Testament, we hear from the Gospel of John in Chapter 9, *“and the disciples asked Jesus, saying, ‘Master, who did sin, this man, or his parents, that he was born blind?’ Jesus answered, ‘neither has this man sinned, nor his parents; but that the works of God be made manifest in him!’ ”* It is a case where Jesus is exercising not only His power to heal people with physical illnesses, but to reveal it through healing to show His true power as the Son of God.

Fr. Anctil said that several incidents in the New Testament showed recognition by Jesus Himself that demonic spirits existed. He noted the powerful miracle of Christ’s supremacy over demons through the healing of the Gerasene demoniac. In Matthew, Chapter 8 (Mark 5 and Luke 8) we hear; *“a man full of demons, who lived among the tombs met Him. He bowed before Jesus and shouted, ‘What have You to do with me, Jesus, Son of the Most High God? I adjure You by God, do not torment me.’ Jesus asked the demon what was his name. The demon answered, ‘My name is Legion for we are many.’ He begged Jesus not to send them back to the abyss, but into a herd of swine that was nearby. Jesus told the demons to leave the man and gave them permission to enter the swine. The unclean spirits came out and entered the swine, and the herd, numbering about 2000, rushed down the steep bank into the sea, and were drowned in the sea!”*

Remarking on the profound nature of this message, Fr. Anctil stated that Christ speaks with the demon inside this man. The demon acknowledges Christ as the Son of God. And finally, Christ has the power to rid this man of the demon or demons! A most powerful miracle of healing by Jesus!

In keeping with this train of thought, even well before the time of Christ, Greek physicians treated people for mental illness. The Church Fathers routinely refer to medical treatment of those with mental illness (*then called “insane”*) with no hint of disapproval. In one case, (*then called “lunacy”*) however, they insist that the cause is not physical, but demonic. Instances like these confirm that the Fathers of our Church generally believed that mental illness was distinct from demonic possession.

Fr. Anctil then asked the audience, *“So, where does this leave us?”* If we truly believe that the Church is a hospital, we must believe that we are body and soul, physical and mental beings. We believe in God yet we are tempted by the devil in our day-to-day struggle to live Godly lives. The Church acknowledges all that is inside of us, mentally, physically, and emotionally. God knows us, even the hairs on our heads are all numbered.

He noted that the Church deals with each of these human conditions with distinct remedies. On the topic of mental illness, he said that the role of the church is to dismiss the myth that this kind of illness is God’s vindictive revenge due to sin. He cautioned that we should not consider mental illness as a condition that can be cured by exorcism as was depicted in the movie, *THE EXORCIST*. Rather, he pointed out that our prayers of exorcism are those heard at our Baptism during the Catechesis. For those who are spiritually weak, it is the prayer of St. Kyprianos that is read over them.

Because we know that what is impossible with man is possible with God, Fr. Anctil stated that prayer especially needs to be administered according to the need. As such, our prayers should be for those suffering from the illness and for the strength and support of family and caregivers.

Fr. Anctil stated that our collective role should be one of acknowledgement, acceptance, prayer, compassion, and understanding. He said that our Church – and thus, each of us -- needs to be one that

shows love towards those with mental illness and to their family members who stand actively and quietly by their sides. The Church – and thus, each of us -- needs to assure families of those with mental illness that these afflictions should be treated exactly like physical illness and that secrecy only complicates our ability to offer assistance and support.

Fr. Anctil stated that because it is crucial, in this day and age, to support the caregivers of family members affected by mental illness, he proposed that Churches reach out to and partner with local therapists to ensure that their services are conducted with sensitivity to the characteristics unique to our community including our perspectives of religion, faith, and spirituality. He urged Philoptochos Chapters to sponsor and assist family support groups led by local mental health professionals to help families deal with their relatives' sensitive situations.

Regarding the role of our priests, he spoke of what is sometimes referred to as the *"theology of presence"* – that of just being there to offer one's presence and love. He affirmed that sometimes, a priest just needs to be present in the lives of those with mental illness and their families to offer prayer and support. He pointed out that these are crucial to a caregiver who oftentimes feels alone when dealing with day-to-day struggles.

He noted that although the Church offers prayers, Sacraments, and Holy Services to fortify and strengthen those with illness, we should not, in our spiritual innocence, believe that those things alone can be a cure! God has given us the knowledge and ability to diagnose and treat the many different forms of illnesses that affect us.

Concerning responses by our Church, Fr. Anctil said that he is gratified that many of our parishes are proactive in their duty to serve God's most precious -- parishes who put prayer into action by hosting special monthly liturgies on a Saturday or particular feast day for those afflicted with long-term illnesses, special needs, or disabilities. Stating that these services require added attention by the priest in the format of the liturgy, he referenced a parish near his own that calls this liturgy the *"Challenge Liturgy"* at which the church fills with families not regularly seen on a Sunday – families who come with their loved ones in wheelchairs and hospital beds; families who attend with loved ones with mental illness who cannot remain still or quiet during a regular Sunday liturgy.

Urging us to treat all of our brothers and sisters with love, kindness, and hope, regardless of their conditions, illnesses, differences, or challenges, Fr. Anctil closed his presentation with the following appeal: *"A beautiful synergy of God and persons working together will bring about the best situation of living a life of acceptance and understanding in dealing with God's most precious and final creation: human beings like you and me."*

CONCLUSION:

As the time allotted to this program only could provide an overview of the topic, detailed handouts were distributed to provide additional information and resources about mental illness, families, and Church responses. Copies of these handouts are available at www.Philoptochos.org/socialservices.

Q&A: Audience members were given index cards on which to write questions for the speakers. Given time constraints, most could not be responded to publicly at the forum. Shown below are the responses submitted by the panelists subsequent to the program.

**RESPONSES TO AUDIENCE QUESTIONS SUBMITTED
TO THE PANELISTS FOLLOWING THE PROGRAM**

RESPONDENTS

Panelists:

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PAULETTE GEANACOPOULOS, LMSW

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The responses shown below and references cited are for informational purposes only. They are not and should not be construed as medical or psychological advice or treatment. Readers should not rely on the information contained for diagnosing or treating any illness, condition, or disorder, and they should not be used to replace the specialized training and professional judgment of a health care or mental health care professional.

*As each situation is different, please consult with a physician or trained / licensed mental health professional about your specific circumstance(s) before making any decision regarding treatment of yourself or others. To locate local mental health professionals and service providers in or near your community, you may refer to the national databank of the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services that can be accessed at:
<http://findtreatment.samhsa.gov/MHTreatmentLocator/faces/quickSearch.jspx>.*

Neither the Greek Orthodox Ladies Philoptochos Society, Inc., nor the Greek Orthodox Archdiocese of America, nor the responders to the questions are responsible for how readers use the information.

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Q. Please describe bipolar disorder.

(DeLia): Bipolar Disorder is a mental illness that also is considered to be partly biological. It basically refers to episodes -- mood swings -- that go from depression to mania. In the depressed state, a person may have no energy or interest in participating in daily routines. In the manic state, the same person has too much energy, stays awake for long periods of time, has impulsive behavior, and often is unaware that the behavior is extreme.

(Geanacopoulos): The following is excerpted from <http://www.mayoclinic.org/diseases-conditions/bipolar-disorder/basics/definition/con-20027544> (Jan. 18, 2012)

Symptoms of Mania

- *Inflated self-esteem or grandiosity*
- *Decreased need for sleep (e.g., one feels rested after only 3 hours of sleep)*
- *More talkative than usual or pressure to keep talking*
- *Racing thoughts*
- *Attention is easily drawn to unimportant or irrelevant items*
- *Increase in goal-directed activity (either socially, at work or school, or sexually) or agitation*

- Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

Symptoms of Depression:

- Overeating or loss of appetite almost every day
- Insomnia or sleeping too much
- Feeling restless and unable to sit still
- Feeling guilty or unworthy
- Having low self-esteem or feeling down on yourself
- Difficulty concentrating
- Anxiety
- Increased use of alcohol
- Suicidal thoughts

Q What should we look for if we think someone is suffering from schizophrenia?

(DeLia): The symptoms of schizophrenia include

- Social withdrawal
- Hostility or suspiciousness
- Deterioration of personal hygiene
- Flat, expressionless gaze
- Inappropriate laughter or crying
- Odd or irrational statements or beliefs (delusions)
- Forgetful; unable to concentrate
- Extreme reaction to criticism
- Strange use of words or way of speaking
- Hearing voices or seeing things that aren't there (hallucinations)

(Geanacopoulos): The following is excerpted from <http://www.mayoclinic.org/diseases-conditions/schizophrenia/basics/definition/con-20021077> January 24, 2014

Schizophrenia is a severe brain disorder in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and extremely disordered thinking and behavior. Contrary to popular belief, schizophrenia isn't a split personality or multiple personality. The word "schizophrenia" does mean "split mind" but refers to a disruption of the usual balance of emotions and thinking. Schizophrenia is a chronic condition, requiring lifelong treatment. In men, schizophrenia symptoms typically start in the early to mid-20s. In women, symptoms typically begin in the late 20s. It is uncommon for children to be diagnosed with schizophrenia and rare for persons older than 45.

The symptoms of schizophrenia in adults are noted in Dr. DeLia's response. In teens, schizophrenia symptoms are similar, but the condition may be more difficult to recognize - in part because some of the early symptoms of schizophrenia in teenagers are common for typical development during teen years.

Symptoms of schizophrenia in teenagers include:

- Withdrawal from friends and family
- A drop in performance at school
- Trouble sleeping
- Irritability or depressed mood
- Lack of motivation

Compared with symptoms of schizophrenia in adults, teens may be:

- Less likely to have delusions
- More likely to have visual hallucinations

Q. Can a person be diagnosed with depression but actually have a medical condition?

(DeLia): Absolutely. Stroke victims, patients with heart disease, cancer, or a chronic illness such as multiple sclerosis often suffer from depression or anxiety. Support groups are very helpful.

Q. Tell us more about anxiety disorders. What about adults with anxiety disorder and / or depression – can they live a regular life? Can love and acceptance help a person to recover?

(DeLia): Love can help everything! So can prayer!

(Geanacopoulos): The following is excerpted from <http://www.mayoclinic.org/diseases-conditions/depression/expert-answers/depression-and-anxiety/faq-20057989> entitled, "Is it possible to have depression and anxiety at the same time?" By Daniel K. Hall-Flavin, M.D.

Depression and anxiety are different conditions, but they commonly occur together. They also have similar treatments. Feeling down or having the blues now and then is normal. And everyone feels anxious from time to time – it's a normal response to stressful situations. But severe or ongoing feelings of anxiety and depression can be a sign of an underlying mental health disorder. Anxiety may occur as a symptom of clinical (major) depression. It's also common to have depression that's triggered by an anxiety disorder, such as generalized anxiety disorder, panic disorder or separation anxiety disorder. Many people have a diagnosis of both an anxiety disorder and clinical depression. Symptoms of both conditions usually improve with psychological counseling (psychotherapy), medications, such as antidepressants, or a combination of the two. Lifestyle changes, such as improving sleep habits, using stress-reduction techniques, or getting regular exercise, also may help. If you have either condition, avoid alcohol and illegal drugs. They can make both conditions worse.

**Q. a) Does the primary care physician have the skill(s) to see/detect the signs of mental illness?
b) Is there a stigma because it's not considered a "disease"?
c) Is there a cure? (I apologize if this is a stupid question).**

(DeLia): There are no stupid questions! Much depends on the skill of the primary care physician and his/her relationship to the family. Some family doctors are excellent diagnosticians and see through physical symptoms that are covering emotional distress.

(Geanacopoulos): For help in understanding whether behaviors, feelings and thinking exhibited are symptoms of a mental illness, please refer to: <http://www.mayoclinic.org/healthy-living/adult-health/in-depth/mental-health/art-20044098> entitled, "How to Recognize if You or a Loved One Needs Help"

Q. How do you get someone into treatment?

(Kallas): They have to want to. If they do, you can assist with finding appropriate treatment.

Q. What do you do when your 30-year-old son refuses to get help after he's been diagnosed with bipolar disorder?

(DeLia): Without knowing details of the case it is difficult to answer. But I generally advise: Don't give up on him and keep trying to be supportive without enabling. "Dum spiro, spero = While I breathe, I hope."

(Kallas): Continue to love him. Find a way to take care of yourself, and to deal with your frustration, disappointment, and grief, either through the Church, or therapy, or in some other way. Meet parents similarly situated, through NAMI (National Alliance on Mental Illness) or another similar organization.

Q. How can you explain to a child who was negatively affected by a person with a mental illness not to be afraid of them?

(DeLia): Education is important. The answer would depend on the age of the child and what exactly happened. Without more details, commenting in general would not be appropriate.

(Kallas): I don't know that you can. And fear may be a healthy response to a mentally ill person who has hurt me, especially if that person is not in treatment. You could discuss this problem with a mental health professional who has expertise with both children and with the mental illness of the person who instilled the fear in the child.

Q. Can you give some quick tips for dealing with a 6-year-old child who is dealing with the death of her mother?

(DeLia): The child needs to know that a reliable, loving person will be there in mother's place. The caregiver needs to be emotionally available. If the caregiver is grieving the death of the mother, too, the child may not be receiving enough sustenance. The death of a parent is the worst trauma that can befall a child.

(Geanacopoulos): Many schools, social service organizations and hospitals offer age-appropriate bereavement groups for children and adolescents. Led by trained professionals, they help children mourn, deal with their grief and talk about their feelings through art therapy, puppets, an empty chair, etc. Children are encouraged to make a memory book about their parent (photos, anecdotes, etc.) or write a letter to the parent who passed away ("Dear Mom: I miss you.") As importantly, they help children acknowledge and deal with their anger over losing the parent and help them understand that the child is not to blame. Many help the child write a 'contract' to be signed by the remaining parent/ guardian including items such as, "I will take care of myself"; "I will stop smoking"; "I will never drink and drive"; "I will attend my daughter's soccer games at least once a week"; "I will be home for dinner", etc. Ask the 6-year-old child's teacher for a referral to such a group. Additional information about dealing with grief by children of various ages can be found at: <http://www.kidspace.org/uploadedFiles/grief%5B1%5D.pdf>. This document is entitled, A Time to Grieve, A Time to Grow and was developed by Kidspace: The National Center for Kids Overcoming Crisis.

Q. My mother was a hoarder and it contributed to her death. My younger sister suffers from the same mental illness and now is on the verge of homelessness because of it. What public agencies can be used to assist people with this "secret" (because they look and act normally) disease?

(DeLia): Community mental health agencies are available in urban cities. Many therapists who are part of HMO panels charge only a co-pay for services. Also in the New York Tri-State metropolitan area there are institutes that offer low-cost therapy to anyone who is in need or who does not have insurance. In Manhattan, the Center for Modern Psychoanalytic Studies has a low-fee clinic, as does the Academy of Clinical and Applied Psychoanalysis in Livingston, NJ. Don't let the word psychoanalysis scare you off. The methods used presently address the wide range of psychiatric conditions.

(Kallas): One problem with mental illness is that people may exhibit 'apparent competence' in one sphere and are unable to function in another, which is confusing to the people around them and makes it more difficult to help effectively. NAMI (National Alliance on Mental Illness) is a national organization; you might contact the local chapter and ask about services in your area. Most jurisdictions offer services to adults through "Adult Protective Services" (a/k/a Protective Services for Adults). "Google" that name to obtain contact information for the appropriate agency in your community. In NYC, if a tenant is being sued and does not appear to be competent, the Housing Court Judge might require the appointment of a guardian ad litem for the tenant, to help advise the client about his/her options. We also have advocacy organizations, e.g. Coalition for the Homeless and Advocates for Children of NY, and government agencies, such as the NYC Dept. of Homeless Services. The Urban Justice Center has a Mental Health Project.

Q My daughter was molested by her cousin at age 10. Help was there for her – therapy, etc. Now, we have discovered that she has been cutting, using drugs, etc. She has left home and we are distraught. Do we push her to come back home? (She does communicate with us). She says that she wants to prove herself to us. Or, do we let her alone?

(DeLia): Some general questions: Is the cousin still accepted in the family? Has there been genuine support from parents or has the attitude been -- "get over it already?" Have parents taken responsibility for not protecting the child? Even if the parents didn't know, molested children often feel rage at parents who didn't realize what was happening. Was the therapy long enough? Many factors are involved, including was this an isolated incident or did it continue for a long time?

(Kallas): Even when my daughter was screaming that she hated us, I never truly believed that she wanted us to leave her alone. I believe she did want to prove herself to us, which is a normal, healthy instinct for a growing child. You don't say how old she is now. If she is old enough to live outside of your home, you may not be able to "make her" come back without making things worse. What does your priest say? What does your therapist say? Do you have a social support system including parents of children like your daughter? What have they suggested? Does your daughter have a therapist? Could you have a joint session with your daughter's therapist? Again, prayer can work miracles.

Q. How do we approach and offer support and help to someone we suspect may be going through severe depression without offending or further hurting them?

(DeLia): A good approach in many cases is simply to stay connected without being intrusive. Reaching out with a friendly word is often the best way to start. Not offering advice is very important. Respecting a person's willingness to share certain feelings while not being willing to discuss other topics is essential. Although people with mental illness often withdraw or become isolated, don't let that behavior stop you from maintaining contact.

(Kallas): Gently and from a place of compassion. For example: "You look like you could use a friend; how are you doing?" Mental illness is isolating; if I can just relate to another person as a human being that might be a huge help to him / her. To see what I mean, try saying hello to a homeless person on the street, and see how some react when you actually look them in the eye and smile pleasantly, even just in passing.

Q. Although infancy through age three is considered to be the most profound in terms of trauma, could one or more of the panelists please discuss any insights into the rising number of incidents in PTSD particularly with regard to returning veterans over the last eleven years from Iraq and Afghanistan? Specifically, what is our Church doing to address this?

(DeLia): The latest research on PTSD focused on an important question: Why do some soldiers develop this condition while others do not, even though they may face similar circumstances? There are many factors that account for a person's ability to be resilient in response to trauma. The research discovered that a person's temperament and response to stimulation are factors. Most interesting in the findings is that a person traumatized during the first three years of life is more likely to suffer from PTSD if exposed to trauma as an adult.

(Fr. Anctil): Addressing the question of Post-Traumatic Stress Disorder from the Church's perspective is very interesting. Since it is considered a "new" disorder of types, we can't always go back to the Church Fathers and get a theological treatment to this question. One can surely say that the Church looks at us as whole individuals; body and soul. We can also say that those two elements need to work in harmony in order for a person to be whole and complete, and that when one of those elements is challenged by any disorder, that the body and soul are not working harmoniously, and therefore might even work against each other. Perhaps the soul is feeling the deepest of pains when a soldier returns home to his safe environment

after witnessing death and/or even inflicting death on another human being that is considered "the enemy" in war. So the memory of such events does not leave us easily.

It is important to know that the Church acts as a healing institution. It deals with both the healing of the body as well as the soul. In cases like these, the priest needs to be made aware of the fact that a soldier has returned into his parish. The priest needs to know and be able to spend time in listening to the person, then offering the healing elements of the Church, the Sacraments most especially, followed by a regimen of prayer and fasting that starts to strengthen the person's weaknesses by refueling the body and soul with Godly and spiritual nourishment.

Needless to say, however, that this disorder also needs medical attention. One cannot assume that treating such a disorder from only one aspect will be enough. Even though the body and the soul can be positively affected by the Church, one never knows what psychological remnants such visions of death and killing can leave the mind. So, one should assume that the Church plays a major role in dealing with (but not necessarily curing) this disorder. That being said; we also must recognize that the support of God and man, Church and medicine, must also be applied to offer the best chances of dealing with such stress disorders.

(Geanacopoulos): The following is excerpted from <http://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/basics/definition/con-20022540> (April 14, 2014):

Post-traumatic stress disorder (PTSD) is a mental health condition that is triggered by a terrifying event – either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.

Many people who go through traumatic events have difficulty adjusting and coping for a while, but they don't have PTSD – with time and good self-care, they usually get better. But if the symptoms get worse or last for months or even years and interfere with the person's functioning, s/he may have PTSD.

Getting effective treatment after PTSD symptoms develop can be critical to reduce symptoms and improve function. Post-traumatic stress disorder symptoms may start within three months of a traumatic event, but sometimes symptoms may not appear until years after the event. These symptoms cause significant problems in social or work situations and in relationships.

PTSD symptoms are generally grouped into four types: intrusive memories, avoidance, negative changes in thinking and mood, or changes in emotional reactions. Symptoms also may include avoidance of places or things reminiscent of what happened [some survivors of the September 11 attack on the World Trade Center avoid barbecues]; hypervigilance - fearing constant danger; social withdrawal; difficulty trusting; rage reaction, etc.

Q. If there is someone in our parish who exhibits mental illness (borderline personality disorder), how can the local Philoptochos best help them?

(DeLia): Help should be offered as to any parishioner who is in need of support and compassion.

(Kallas): If that person is open to accepting help, I would start by asking him/her, "How can we help?" Then I would assist in whatever way that person felt was helpful, if I could. Knowing how to help is difficult, as BPD presents in so many different ways, depending on so many factors (gender, age, other disorders present, capacity of the individual in various areas of his/her life). The one thing I usually found useful is to validate whatever I find valid. People with BPD (indeed, any mental illness) are often told they are imagining things or they should just 'get over it'. It can be a Godsend to validate such a person's reality. For example, if someone says he does not want to take his meds because they make him feel out of it, or sick, or gain weight, you might validate that reality by saying, "Of course, anyone would be reluctant to take medication with those side effects!" Compassionate listening, and validating whatever is valid, can be the beginning of trust which could lead, over time, to accepting help. Patience is essential; most people take time to trust others and having a mental illness doesn't change that dynamic.

(Geanacopoulos): The following is excerpted from: <http://www.mayoclinic.org/diseases-conditions/borderline-personality-disorder/basics/definition/con-20023204> (August 17, 2012)

Signs and Symptoms of borderline personality disorder include:

- Impulsive and risky behavior, such as risky driving, unsafe sex, gambling sprees or illegal drug use
- Awareness of destructive behavior, including self-injury, but sometimes feeling unable to change it
- Wide mood swings
- Short but intense episodes of anxiety or depression
- Inappropriate anger and antagonistic behavior, sometimes escalating into physical fights
- Difficulty controlling emotions or impulses
- Suicidal behavior
- Feeling misunderstood, neglected, alone, empty, or hopeless
- Fear of being alone
- Feelings of self-hate and self-loathing

Q. How can you get help when a child is 18 years old and starts to exhibit mental illness, or starts to not take their medications?

(DeLia): Often it is helpful if other family members consult a therapist. The child can be asked to join in family meetings with the therapist. In this way the child does not feel he is being singled out as the problem. He may accept that the family system is also involved.

(Kallas): I would contact my local NAMI affiliate (National Alliance on Mental Illness), and take the Family to Family course referenced in the materials we gave out at the panel discussion. Some of those family members will have been through similar challenges, and may be a source of referrals, and of suggestions. If your 18-year-old does not want to take meds, find out what is the reason. Ask gentle, compassionate questions, and listen; I always found that more effective than telling my adult daughter what to do. If the reasons make sense, help your child find alternative medications that have fewer side effects, or, if appropriate, help your child to negotiate with the doctor about the dosage, or the time of day when the medication is taken.

Q. What do you do if the “child” is over 18 years old?

(Kallas): You don't say exactly what your concern is. In New York State, a person over 18 years old can appoint a parent or another as a 'health care proxy', which enables the proxy to discuss treatment with the doctors, and to obtain information about the patient's status.

Q. How can someone help a long-distance family member get help when (a) they don't believe they are sick, and (b) the state they live in won't help unless they hurt themselves or someone else? (Similar question) If you believe a family member has a mental illness and you do not live nearby, how can you broach the subject without it being perceived as an “attack” on them? How can you be supportive?

(Kallas): Express your concern as the result of your lack of ease, rather than a result of your family member being 'wrong' or 'uncaring' or some other negative behavior. You can't make someone else get help. You might be more effective if you learn skills to help you to tolerate your own distress. You may have to lower your expectations of that other person. For me it was a great help to find other parents dealing with similar denial on the part of their adult children; addressing my own needs, partly by having those other parents validate my concern, helped me to stay grounded. Sometimes it helps to change directions. Suppose you have been saying to another person, “you are sick; you need help.” The next time your family member objects to getting help, what if you said, for example, “Yes, it is difficult to find good help,” or “yes, it is very expensive to go to therapy.” And just stop talking. If you unexpectedly agree with another person, it sometimes causes enough of a shock, so that it opens the other person up to a new way of looking at things. And, you can always pray for another person.

(DeLia): This is a very difficult problem. Unfortunately there are many people who are in desperate need of help but blame others for their misfortunes. I often say that the people who come to therapy are much healthier than those who don't because those who seek help are open to the idea that change is necessary, and they are willing to examine why they are suffering. People who are dragged to therapy by family members or the court systems are usually very resistant to help but certain techniques have been utilized to engage them in therapy.

Q What do you do when you try to help a family with mental illness and they start attacking you?

(DeLia): It would be important to know what help has been offered before commenting. Unfortunately, we often think we are being helpful, but may not be responding to the type of help the patient needs or wants.

(Kallas): You don't say whether the attacks are physical or emotional. If they are physical, I would protect myself, either by leaving the scene, or by calling 911. Mental illness is not an excuse for physical abuse. If the attacks are emotional, I would take care of myself. Depending upon my situation that might mean going for counseling myself, either with a mental health professional or a priest (or both). That might mean moving out, or requiring the other person to move out. That might mean going for mediation, which in N.Y.S. is available in all 62 counties, at no cost, through the Community Dispute Resolution Centers. In Manhattan and Brooklyn, that means the NY Peace Institute: 212-577-1740, or 718-834-6671.

Q How can you convince someone to stop enabling a family member who is mentally ill?

(Kallas): I'd have to have intimate knowledge of the circumstances. And even then, I'd be reluctant to judge what behavior is 'enabling' and what behavior is 'helping'. I don't feel qualified to make that judgment -- and it is a judgment. If the 'enabler' was seeking my opinion, I'd ask for help in understanding why s/he is doing what s/he is doing. After listening with openness and compassion, I would validate whatever I could about the difficulty of the 'enabler's' situation. For example, I might say something like: "It must feel awful to know that your family member is so ill!" "I can't imagine what it's like to feel as if you must do what you are doing or else s/he will (be homeless) (kill himself)." "You sound as if you are in so much pain; how can I help you?"

I would avoid giving advice about matters that I am not an expert in. Instead I would ask questions; again, in a compassionate, non-judgmental way: "What have you tried so far? How did that work?" "Have you sought help from a (mental health professional) (spiritual advisor)? What does your (spouse) (therapist) (priest) think about this?" I might also offer to help find a competent professional to help the family address the problem. If really pushed for advice, I would say what worked in our family. When we were not happy with how much we were supporting our daughter, we would come up with a plan to change the circumstances. I would try to consult with my spouse first. Then we presented the request for change in a loving way by saying, "We are uncomfortable doing this. We would like to find a way for you to get what you need in some other fashion." In other words, present it as, "We have a problem doing this under these circumstances," rather than, "You have a problem and you need to fix it now!" Our daughter is very bright; brainstorming with her to solve the problem often helped her to see it through our eyes, without our having to throw it in her face. Part of her shame, in fact, was how much she felt she needed to rely on us. It was often helpful to her to strategize about changing what made us unhappy. This approach isn't foolproof, but over time we were able to find many solutions to problems.

Q How does a family begin to find help?

(Kallas): We tried all of the following:

- We spoke with our Parish Priest and asked for his spiritual guidance*
- We spoke with our friends to find referrals to mental health professionals, for each of us and for our adult daughter.*
- We asked our health insurance provider for referrals to mental health professionals.*

- We found NAMI, which has many different types of resources for people with mental illness as well as family members. Through NAMI we found NEA-BPD, which is focused specifically on the primary disorder that our adult daughter has, borderline personality disorder. There are many such organizations: AA and Al-Anon, groups for people with eating disorders, ADHD, etc. Some of these communities are available online, and some in real time. At first we were careful about what we disclosed, as not all people we met in these communities were able or willing to help us. In our case, we attended many meetings hosted by NEA-BPD, met family members who faced similar challenges. They provided us with many types of help: referrals, social support, and education about where to obtain services. Eventually, we volunteered to lead the NEA-BPD family support groups referenced in the handout from the panel discussion, which we found very helpful. We were able to practice our coping skills in those groups, and obtained help and emotional support. Even when things were at their worst, and we couldn't help our own child, leading the groups was of tremendous benefit to us, since we felt as if we used the knowledge we had to help other families who were suffering.
- Last but not least, we prayed fervently

Q What was the most important thing you did to help your mentally ill relative?

(Kallas): Take care of myself. By doing so:

1. I modeled for her what being mentally healthy looked like;
2. I encouraged her to take care of herself, by showing her it was possible, even in the midst of chaos;
3. I increased the chances that I would be able to help her when and if she needed help, because I was more likely to be centered, strong, and healthy.

Q. Please explain the link between mental illness and addiction and our higher power.

(Related question) **How do you differentiate between symptoms of mental illness and those of substance abuse?**

(DeLia): They are intertwined. As I mentioned during my presentation, mental illness is often the underlying problem in addiction and addiction is often an attempt to relieve the pain of emotional distress. Other factors are often responsible, such as family traumas, parental divorce, or hostile environments. A person who becomes addicted to a substance or an activity has usually felt some lack of emotional nourishment in life. Faith has the benefit of knowing that God is always there for us with unconditional love which often is absent in our relationships with actual people.

(Geanacopoulos): The concept of Higher Power is suggested in 12-Step Programs. It is a spiritual concept of something greater than oneself, and it is left up to the individual to decide how s/he wishes to define it. There are no 'rules' except that this power has to be greater than the individual. 12-Step groups also exist for family members, friends, co-workers who are affected by someone's drinking or drugging, e.g. Al-Anon, Alateen, Families Anonymous.

Included below is an excerpt from the website of the National Alliance on Mental Illness website (NAMI) on the relationship between mental illness and substance abuse:

http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/By_Illness/Dual_Diagnosis_Substance_Abuse_and_Mental_Illness.htm

Dual Diagnosis: Substance Abuse and Mental Illness Dual diagnosis is a term used to describe people with mental illness who have coexisting problems with drugs and/or alcohol. The relationship between the two is complex, and the treatment of people with co-occurring substance abuse (or substance dependence) and mental illness is more complicated than the treatment of either condition alone. This is unfortunately a common situation – many people with mental illness have ongoing substance abuse problems, and many people who abuse drugs and alcohol also experience mental illness. Certain groups of people with mental illness (e.g., males, individuals of lower socioeconomic status, military veterans, and people with more general medical illnesses) are at increased risk of abusing drugs such as marijuana, opiates, cocaine and other stimulants, and alcohol. Recent scientific studies have suggested that nearly

one-third of people with all mental illnesses and approximately one-half of people with severe mental illnesses (including bipolar disorder and schizophrenia) also experience substance abuse. Conversely, more than one-third of all alcohol abusers and more than one-half of all drug abusers are also battling mental illness.

Relationship between substance use and mental illness: The relationship between mental illness and substance abuse or dependency is complex. These relationships are often as follows:

- *Drugs and alcohol can be a form of self-medication. In such cases, people with mental illness may have untreated – or incompletely treated – conditions (such as anxiety or depression) that may “feel less painful” when the person is high on drugs or alcohol. Unfortunately, while drugs and alcohol may feel good in the moment, abuse of these substances doesn’t treat the underlying condition and – almost without exception – makes it worse.*
- *Drugs and alcohol can worsen underlying mental illnesses. This can happen both during acute intoxication (e.g., a person with depression becomes suicidal in the context of drinking alcohol) and during withdrawal from a substance (e.g., a person with panic attacks experiences worsening symptoms during heroin withdrawal).*
- *Drugs and alcohol can cause a person without mental illness to experience the onset of symptoms for the first time. For example, a twenty-year-old college student who begins to hear threatening voices inside of his head and becomes paranoid that his chemistry professor is poisoning his food after smoking marijuana could represent a reaction to the drug (potentially called a “substance-induced psychosis”) or the first episode of psychosis for this individual.*

Abuse of drugs and alcohol always results in a worse prognosis for a person with mental illness. People who are actively using are less likely to follow through with the treatment plans they created with their treaters: they are less likely to adhere to their medication regimens and more likely to miss appointments which leads to more psychiatric hospitalizations and other adverse outcomes. Active users are also less likely to receive adequate medical care for similar reasons and are more likely to experience severe medical complications and early death. People with mental illness who abuse substances are also at increased risk of impulsive and potentially violent acts. Perhaps most concerning is that people who abuse drugs and alcohol are more likely both to attempt suicide and to die from their suicide attempts. Individuals with mental illness and active substance or alcohol abuse are less likely to achieve lasting sobriety. They may be more likely to experience severe complications of their substance abuse, to end up in legal trouble from their substance use, and to become physically dependent on their substance of choice.

Q. What is the best treatment for a drug addict? He was arrested for shoplifting, spent months in jail, received treatment. Great for two years. Started drinking again, on drugs, stopped meds, now homeless. Not receiving help. Diagnosed 25 years ago with clinical depression. Hospitalized, did not continue treatment. Now 46 years old.

(DeLia): This person has obviously struggled with depression and may have turned to drugs for relief. Without knowing the patient, it would be inappropriate to comment.

Q Ms. Kallas, you spoke about what we can do when we feel that this illness has affected our family or us personally. So, how can we turn this to help us identify a fellow parishioner who may be in need of this assistance, or even recognition that there is a problem? People hide what is going on.

(Kallas): Firstly, I need to be sure that my offer of help is both welcome and appropriate. Am I offering help because of my deep spiritual conviction that it is the right thing to do?

To identify someone in need of assistance, I would start by paying attention. I know how most of my fellow parishioners behave. I would look for behavioral changes. Is someone more quiet, or irritable, than usual? Has someone ‘dropped out’? These may be clues that there is a problem at home. If someone is not a regular parishioner, how does s/he present? Is there anything extreme about that person’s behavior? Does the individual engage easily with others at the coffee hour? Then I would assess what kind of help I can offer,

before I offer it: a non-judgmental ear to listen with? Transport to and from church or doctor's appointments? Help with housekeeping chores? Providing prepared meals? I need to be sure that I'm not offended if my offer is rejected, because others are not required to accept my help or advice. I can continue to offer help over time, so that the other person believes that I am sincere. Whatever the response to my offer, I can always offer private prayers on behalf of my fellow parishioner, with or without his or her knowledge, and whether or not at his request.

Q. I am a Philoptochos board / member. When are we helping as opposed to enabling?

(Kallas): I don't feel competent to decide where that line is in any other family. The last thing I want to do is make that judgment from outside the family, and add to the family burden by telling them what they are doing wrong.

If I am asked to give financial help, the procedures we have in place as Philoptochos are set up, in part, to encourage others to find long-term solutions to their problems, and not to become dependent upon us.

Q When should we call 9-1-1?

(DeLia): Call 9-1-1 immediately or go to the nearest emergency room if the person is a danger to him/herself or to others, or if property is being destroyed (throwing things, punching walls, etc.) and the threat of escalating violence seems imminent.

(Geanacopoulos): For informational purposes and as a preventative measure, post information in your church about the National Suicide Prevention Lifeline 1.800.273.TALK (8255). It operates 24 hours / day and 7 days / week and helps people in crisis, whether or not they are thinking about killing themselves. The caller is connected to a skilled, trained counselor at a crisis center in the Lifeline network closest to his / her location who will listen to the person's problems and tell them about local mental health services.

Q. What affect does nature v nurture have on an adoptive child?

(DeLia): This is a very important question. Adopted children, no matter even if they have been adopted at birth, often feel that they have been abandoned by their biological parents because they are defective. Sometimes no matter how loving the adoptive parents are, the child still acts rageful and rejecting. This is very hard for adoptive parents to accept and they often feel very hurt as they try to nurture and support.

Q. What can you say to personality development related to underlying "abandonment" of an adopted child? (Growth and adolescent, adult years).

(DeLia): Adopted children often feel they have been abandoned by their biological parents and carry the scars. Often the distress they feel does not erupt until adolescence or when they become parents themselves.

Q. Is there any hope for adoptive parents whose child is diagnosed with RAD - Reactive Attachment Disorder?

(DeLia): There are therapists who specialize in treatment of this disorder.

Q. What happens when parents do not treat their children equally, e.g. boys are better than girls?

(DeLia): Historically, in many cultures, boys are preferred. The reasons would be too numerous to include here but think of the pressure in England for the birth of male heirs and the infanticide of female infants in China. Girls often have low self-esteem if they get the message from their parents that they are second best. Fortunately many girls manage to become competitive to prove their inherent worth.

Q. ADD / ADHD and no early discipline. Are they related?

(DeLia): True diagnosis of ADD/ADHD is a neurological condition and is not related to lack of discipline. This diagnosis should be made cautiously since it is often given for children who are agitated. Agitation in children is often a sign of depression or a response to abuse or neglect.

(Geanacopoulos): More information on ADHD can be found at:

In children: <http://www.mayoclinic.org/diseases-conditions/adhd/basics/definition/con-20023647>

In adults: <http://www.mayoclinic.org/diseases-conditions/adult-adhd/basics/definition/con-20034552>

**Q. Is Asperger's Disease a mental illness?
(Related question) Is autism a form of mental illness?**

(DeLia): Asperger's is not a mental illness. It is a neurological disease. It is considered to be a high functioning form of Autistic Spectrum Disorder. Autism is a neurological disorder. The causes are mysterious and research has not yet understood what actually happens in the brain of children who develop Autism or Asperger's.

(Geanacopoulos): More information on autism spectrum disorders (ASD) can be found at:

*<http://www.mayoclinic.org/diseases-conditions/autism-spectrum-disorder/basics/definition/con-20021148>
January 18, 2012*

Q. Are people with mental illness possessed by demons?

(DeLia): No. Demonic people have abused them. Unfortunately demonic people have been victims themselves and they repeat the abuse against someone else. Patients suffering from Multiple Personality Disorder often appear to be possessed when they change into angry personalities. This is a condition known as dissociation. These unfortunate people have suffered horrific traumas at the hands of other people, often parents or family members.

Q. Can you please give me guidance to help me differentiate between mental illness caused by a true physiological reason and trauma from someone who is doing something from an evil spiritual root, or a combination of both? (Question submitted by an MD physician).

(DeLia): This is a philosophical question that requires an essay but I will try to respond briefly. Mental illness can be physiological (e.g. schizophrenia, some types of obsessive compulsive disorder, bipolar disorder). When we speak of "an evil spiritual root" I have found that what has been traditionally thought of as evil, is not the work of some defect in the person but rather that some evil has befallen the individual. For example, almost 95% of women who have become prostitutes have been sexually abused. Their behavior may seem evil but evil has been done to them.

Dorothy Otnow Lewis, a psychiatrist who interviewed prisoners on death row, discovered that 90% had had traumas from some kind of physical violence or accidents. My doctoral dissertation on serial killers pointed out that almost all of them were traumatized beginning in the womb and that abuse continued in infancy.

Q Do we still do exorcisms today? Are there any priests who do them?

(Fr. Anctil): In the Clergy Prayer Books of the Church (Euxolygia) Exorcism prayers still exist and are read by the clergyman when applicable. Exorcism Prayers are also read at each Baptism Service during the Catechesis Service prior to the actual Baptism.

We should also mention that the Church has a prayer against the "evil eye" which is often requested over or in lieu of the Exorcism prayers. The Exorcism prayers are a series of prayers in the Euxologio composed by St. Basil the Great, whereas the prayer composed to combat the "evil eye" was written by St. Cyprianos and is a single prayer read over people feeling that someone has "hexed" or cursed them, and in turn has resulted in a series of unfortunate circumstances.

So, in answering this question; yes; clergymen do read the Exorcism Prayers. Each clergyman needs to exercise great discernment before reading the Exorcism Prayers too freely. These prayers deal with serious subjects and should not be read without great care in examining the circumstances of his parishioner concerning the situation.

Q. Does the Church permit a funeral for someone who has committed suicide?

(Fr. Anctil): This question might first be looked at with the statement that is found in our Archdiocesan Yearbook:

"Suicide, the taking of one's own life, is self-murder and as such, a sin. More importantly, it may be evidence of a lack of faith in our loving, forgiving, sustaining God. If a person has committed suicide as a result of a belief that such an action is rationally or ethically defensible, the Orthodox Church denies that person a Church funeral, because such beliefs and actions separate a person from the community of faith. The Church shows compassion, however, on those who have taken their own life as a result of mental illness or severe emotional stress, when a condition of impaired rationality can be verified by a physician."

With that being stated, the Church is most often compassionate at such times. We should say that the Funeral Service is conducted not just for the deceased but also for the living members of the family, and that many of the hymns and readings are chanted to strengthen, nurture and educate those who are left behind concerning death and the after-life.

The Church also keeps the door open concerning funerals following suicide. If it can be shown that the suicide happened as a result of mental or emotional illness then, with Episcopal permission, a funeral will be granted. Each case needs to be individually examined.

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