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MENTAL HEALTH II

Jesus and
Dementia

Self-Sacrifice
and Sexuality

More Than Pain

Culturing
Mental Health

Hooked and Hoodwinked

November 2024 – Mental Health II

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EDITORIAL: Mental Health II – Dr Catherine Hollier

Articles that span the breadth of life.

From Luke's Journal Nov 2024 | Vol.29 No.3 | Mental Health II



In the Hunter region of NSW, we gather annually as Christian health professionals to pray for our region, for each other and for our patients. It is always an inspiring and encouraging time of worship and prayer, as well as an opportunity to network with our Christian peers in health.

Two hours of praying flies by. Since its inception in 2016, without fail, one of the segments is praying for mental health issues. Anyone who works in health is aware of the tsunami of symptoms relating to mental distress. At Luke's Journal, as we gathered articles in 2023 for the Mental Health I issue, we were likewise overwhelmed with a plethora of topics and writers. This Mental Health II issue holds many thoughtful and encouraging articles that span the breadth of life.

Our cover art is by counsellor, Joel Kelsey, a complex trauma survivor. Art and poetry are therapeutic in processing trauma, where narrative often fails us. Jonathan Browning shares an excerpt from his book "Do You See Me?" and leads us in a reflective meditation on Scripture as an example of walking alongside others in pain, turning back to the Jewish tradition of lament. Dr Michael Burke expresses a different perspective on lament, looking at the groaning of creation in caring for our environment. In Israelite history, blessing and flourishing was tied to the fruit of the land. Today, our health is also affected by our connection to nature.

As we look at the span of human flourishing, we see that all aspects of our life timeline are affected by mental health. I was intrigued to see how Andrew Orenstein would address the newly emerging diagnosis of Pathological Demand Avoidance – how much do we adjust the world for those who suffer, and how do we build resilience? Dr Andrew Wilkinson explored the double-edged sword of screen use in *Hooked and Hoodwinked*, particularly in regard to our childhood and adolescent populations. For those in the juvenile justice system, Sarah Rizkallah writes passionately about our unique opportunity to support young people, embracing their full stories and helping them reframe their narratives as complex, multi-layered beings created in the image of a complex and loving God. Monica Cook wrote a thoughtful article on the rarely discussed subject of *Self-Sacrifice and Sexuality*, and explores how our teaching on theology may enable spiritual abuse. This is particularly helpful for those in the church who are subject to domestic violence. In all stages of modern life, loneliness is not good for our state of mind, and Jackson He reviews the theology and beneficial effects of *Friendship*. Finally, on approaching the end of life, Ben Boland, a chaplain in a residential aged care facility, presents an *ABC for Christian Healthcare Professionals Caring for Those with Dementia*, the leading cause of death for women in Australia since 2016.

This issue also offers practical help for a number of common symptoms. Anne Ward presents a suggested formulation for chronic somatic conditions that respond effectively to a biopsychosocial approach. Professor Kuruvilla George makes suggestions for how we can create a church culture that decreases the likelihood of suicide. Jeremy Ward gives us a scaffold for addressing anger from a Biblical counselling perspective, and Georgie Hoddle reports on how the Saline Process addresses spiritual assessment in mental health.

For those who care for others, both in health and pastorally, Dr Lidia Lae explores how culture impacts our mental health, and Dr Sunny Phillip presents a course for walking alongside others who have experienced emotional trauma. Dr Eleasa Sieh reviews Steve Midgeley and Helen Thorne's book on "Mental Health and your Church" (for lay people in pastoral care in the local church), whilst Tanya Tufanova reflects theologically on what we can learn from Matthew Perry's autobiography. In the midst of so much demand, it can be easy to be overwhelmed by the need and to neglect caring for ourselves and leaning into God in total dependence. Dr Paul Mercer gives a timely reminder of the importance of holidays,

particularly as healthcare professionals who are often under pressure to work to the limits of our capabilities. We trust that you will enjoy reading this issue, and be encouraged and supported in caring for others with a broad range of mental health issues.

Streams through the Desert



Joel Kelsey

Joel Kelsey is a counsellor and complex trauma survivor who attends Grace Evangelical Church in Newcastle, NSW. Joel's soft pastel artwork "Streams through the Desert" speaks to the nourishment and healing that comes from the God-given and God-anchored faith community in the journey of healing from Complex Trauma.



Dr Catherine Hollier

Dr Catherine Hollier is a part-time GP who loves to encourage Christian healthcare professionals to integrate faith in practice. Sharing the wisdom and thought of many through the wide reach of Luke's Journal is a great privilege and joy. She is very much looking forward to her 7-yearly sabbatical in 2026!

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Screen Addictions: Hooked and Hoodwinked – Dr Andrew Wilkinson

The full impact of screen use can be very unsettling

From Luke's Journal Nov 2024 | Vol.29 No.3 | Mental Health II



Image Cottonbro, Pexels

Being a father of four young kids and a child clinical psychologist is a difficult assignment some days. I am grateful to be married to a very understanding wife who arguably has the harder assignment of taking care of the children when I'm not there!

Working in child psychology tends to make people curious about the work we do. It's not uncommon for me to get asked, 'How do you deal with it?' usually based on an assumption that the rigours of hearing of physical abuse, sexual abuse and neglect must get too much. I get it. It's probably what someone expects we do all day: talk about the heavy stuff and carry the baggage home. Conversations and help in that space for kids is important but often less frequent than many realise. In psychology, we call these the 'Big T' traumas, usually one-off events that are highly distressing and disruptive.

In reality, I find my day-to-day job is mostly helping young people with what we call 'little t' trauma. 'Little t' traumas are things like a breakup, parental separation, conflict with parents, getting bullied, being rejected by friends, etc.. They are typically ongoing or chronic issues that cause distress. 'Little t' traumas can cause more emotional harm than the 'big T' traumas like physical or sexual abuse if not well managed.

What is striking is that while we are aware of 'little t' traumas, it can be so very easy to miss what I believe is the number one coping mechanism young people and adults use today for 'little t' trauma – recreational screen time. We know little about the full impact of screen use, but what we do know is very unsettling. We now know that the average teenager spends about **7 hours of leisure time per day on screens**, (excluding educational time on screens). Since the smartphone was introduced, the average teenager is receiving **192 notifications per day**. Honestly, this is one of my biggest concerns as a clinician and as a father. What is this doing to their faith, their brains, relationships and health? On a personal level, what is this doing to me?

The gospel speaks to the whole of life, and I certainly think it speaks volumes in giving us principles on how to approach such a weighty topic.

I can think of two mistakes we can easily make, where we need gospel-based principles to help us approach this issue:

1. Turning good things into the ultimate thing

1 Corinthians 6:12 speaks to the importance of not being mastered by anything. It goes on in verse 20 to say that because we were bought at a price, we are to glorify God with our bodies. In other words, it implies we can be mastered by 'things' and this can either be to the glory of God, or for our own personal desires that can become idols. Tim Keller talks about how it can be very easy for the 'good' things we enjoy to become the 'ultimate' things because our hearts are idol factories.

It is no surprise that screens are extremely addictive, now more so than ever before. Of course, it's not the screen itself that is addictive but the content behind it which can become the idol. Are we making an idol of influence? Easily achieved

online; we've all heard of 'influencers.' Or what about power? It's not difficult to try and project an image of strength or security through statements on career progress or acquired assets. How about acceptance? Many try to find that in comments and likes on a post.

Romans 12:2 tells us to "not be conformed to this world but be transformed by the renewal of your mind." Mastering our mind means submitting to the will of God and worshipping Him as the King, not our whims or desires.

2. Disconnecting from the world rather than learning to live in the world

In the book *Parenting*, Paul Tripp gives the example of how monasteries believed that by separating from the world they could become more 'pure'. However, this eventually became their Achilles heel because they ultimately forgot that sin is 'in us' not just 'out there' So, when approaching management of screen use we need to be wise and not write off all technology, thinking we are sacrificially protecting ourselves and our children. It is a parenting trap, as Tripp points out, for us to believe our calling is to **enforce the law** when in fact God has chosen for us to **restore awe**.

We want to see obedience and good choices made by our children from a genuine heart change to love others. Of course, we need to consider their age and capacity to make wise decisions. The younger the child, the more limited their capacity to make good decisions, so this may mean setting limits to what they can see for their own protection. Limits or correction should always be paired with teaching on 'why' we make that choice. As children become teenagers, more open dialogue is required and trust needs to be given so they can learn to make both wise decisions and mistakes while we still hold influence as parents.

Games and social media aren't a completely new invention, which begs the question – **Why is this such a prolific problem now?**

Social media and gaming platforms have seen some massive shifts in development over the past two decades. Social media came in around 1999 via MSN Messenger and in the early 2000's with Myspace and Facebook. It wasn't really until 2009 and 2010 that some brand-new innovations began to increase uptake of online products. This included:

- Facebook's launch of the 'like' button and Twitter's launch of the 'retweet' button
- Push notifications
- Infinite scroll
- Invention of the front facing camera
- Social element became far more integrated; ability to communicate with distant friends and coordinate leadership of teams of players to advance a game
- Emphasis on skill and online ranking through short fast paced rounds
- Many games stopped creating a definitive end point to the game but allowed continual character development

These developments have all been designed or invented to capture a child or adult's attention for as long as possible. It simply works. It is now estimated that with access to the smartphone, children and teenagers are spending an additional 2-3 hours per day on screen-based activities than before life with a smartphone. Pew Research from 2022 found that one third of teens say they are on social media sites 'almost constantly.' The rate of social media 'super users' (meaning more than 40+ hours per week) grew substantially between 2013 and 2015 in particular.

Social Media Super-Users (40+ Hours per Week)

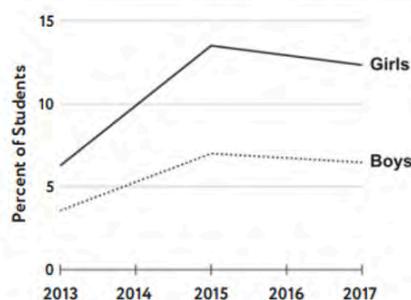


Figure 6.3. Percent of U.S. students (8th, 10th, and 12th grade) who reported spending 40 or more hours a week on social media. (Source: Monitoring the Future.)²⁸

What is also concerning is that the level of clinical depression reported amongst teenage boys and girls significantly elevates the longer they spend on social media sites. In fact, close to 40% of girls who use social media more than 5 hours a day reported they were clinically depressed. Compare this with girls who only use social media 1 hour per day where the rate of depression is around 15%. Correlation between poor mental health and social media use has existed for some time,

but causal factors have more recently become clearer. I don't have time to explain that here but the author of *The Anxious Generation*, Jonathan Haidt, goes further and explains, please see the link <https://www.afterbabel.com/p/social-media-mental-illness-epidemic>.

Depression by Level of Social Media Use, U.K.

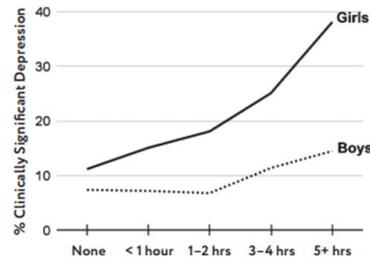


Figure 6.2. Percent of U.K. teens depressed as a function of hours per weekday on social media. Teens who are heavy users of social media are more depressed than light users and nonusers, and this is especially true for girls. (Source: Millennium Cohort Study.)¹¹

So, what makes social media and gaming so addictive? On top of rapid technological developments, behavioural engineers that work at some of these cashed up and powerful companies have worked out ways to get us 'hooked' without us even realising it's happening. These short term, dopamine-driven feedback loops target us in our weakest moments. Using artificial intelligence (AI) enhanced algorithms, social media applications input a set of instructions that predict exactly what you want to look at and manufacture it to keep you on as long as possible, using past information about your usage and what gets you 'hooked'. AI is so savvy now that it can also detect when someone is losing interest in a game, then adjust the response of the program to incentivise them to stay longer.

One way the feedback loop is created in games and social media is using the 'hook model.' It is essentially based on classic behaviourism principles to shape behaviour. It begins with a trigger, is followed by an action that gets a 'variable reward' and finally rewarded by an investment by the user. Once the cycle is established, it is easy for the process to be repeated again and again.

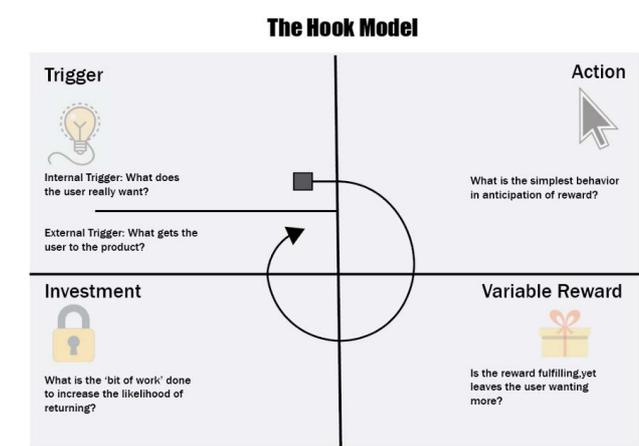
For example, consider a 12-year-old girl struggling to work out a difficult concept for a maths exam. She has access to a smartphone and Instagram account and decides to put a post up as a distraction. Then, she receives a notification about her post;

Step 1: It interrupts her study and effectively acts as the *trigger* or 'on ramp' back to her Instagram account.

Step 2: She then moves to the *action* phase and brings up her post on Instagram. This then leads to her anticipating the reward of a like or positive comment about her post. She checks the post.

Step 3: This leads to a *variable reward*, that is, sometimes she gets a reward (such as best friend liking the post) or perhaps she doesn't. She doesn't realise that not getting the reward she wants each time only increases her anticipation of wanting the reward next time she checks the app or post.

Step 4: Because she has *invested* so much time in her profile with photos and stories there is no longer a need for a trigger with a notification; she only needs to be distracted, finding study difficult, and her own thoughts prompt her to get her phone out again to check the latest change on her account.



So, when choosing how to engage wisely with social media and gaming, here are some suggestions:

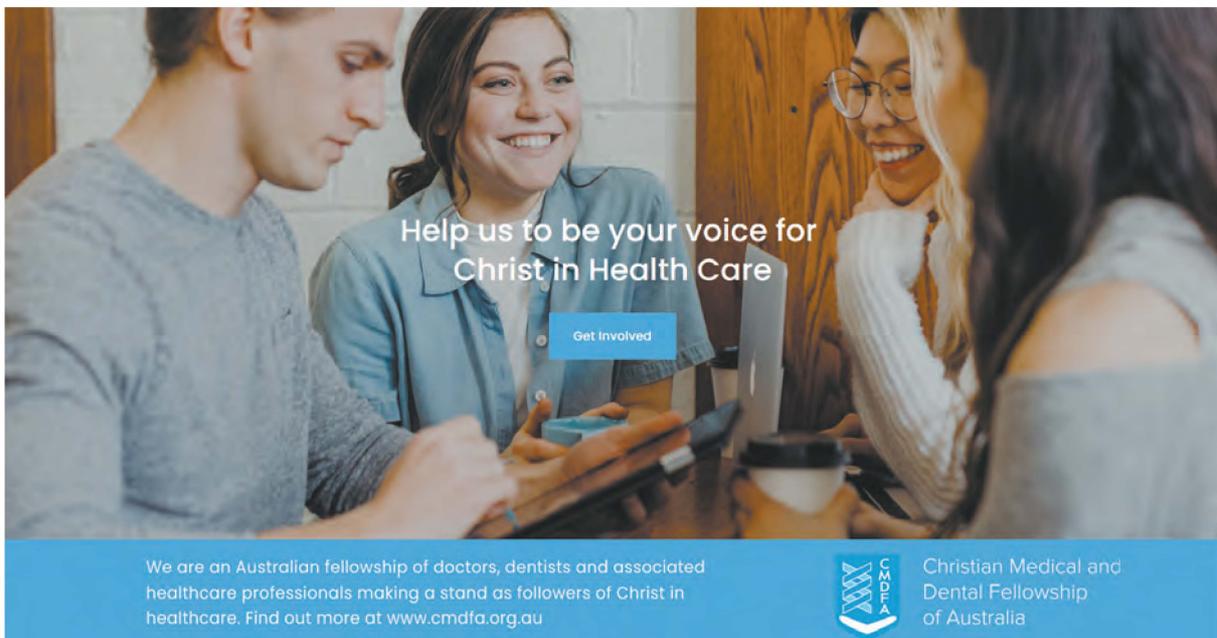
- **Makes screens an 'invited guest' not a 'permanent resident.'** Don't let technology be the Kramer from Seinfeld, the intruder who doesn't know when to leave! If you can't master it then learn to manage it; set some rules, change the way you can access it, find a better hobby and be accountable to someone.
- **Stop and think – Are you using screens out of habit or with a purpose in mind?**
- **Keep screens away from mealtimes.** Food, friendship and family go together, not screens and food. Stuck for ideas with what to talk about at dinner? How about asking about someone to pray for, something to be thankful for or something you want to say sorry for.
- **Avoid screen use in the bedroom where possible.** This is particularly important for children. Habits built like screen use in their bedrooms can lead to kids and teens disappearing and engaging with the online world rather than being present in the real world.
- **Role model well.** If you are a parent and you are home with the kids, minimise how much time you spend on screens around them. Spend time outside or find other activities inside that promote social interaction, enjoyment and learning together.
- **When you do use screens, use them with others where possible.** Parents that enjoy using screens with kids can help model positive behaviours, like how to manage emotions when something doesn't go your way in a game, or learning limits in how long to spend playing or watching something.
- **Don't be afraid to speak to a ministry worker or seek professional help if it's a problem you don't think you can manage alone.**

It becomes all too easy for us to be mastered, being enticed by our own desires for control, acceptance and influence. It's as old as Adam and Eve that we can believe the lie that the good life is found in going our own way, controlling what we choose and how we want to live. Gaming and social media addiction wires us to believe we can have what we want but it is an illusion. As Christians, Paul calls us to action in Philippians 4:8 saying, "*Finally brethren, whatever is true, whatever is honourable, whatever is right, whatever is pure, whatever is lovely, whatever is of good repute, if there is any excellence and if anything, worth of praise, dwell on these things.*" We can choose to submit to this honourable calling by enjoying gaming and social media, but choosing to make sure it is not where we gain our worth, identity or ultimate enjoyment. That was only made to be found in our Creator.



Dr Andrew Wilkinson

Dr Andrew Wilkinson is a husband, father of four children and a Clinical Psychologist. He and his wife, Alex, operate a child psychology practice in which the vision is to connect and engage with families in growing skills and wisdom for life. He is also a Director with a local preschool co-operative. He has been working as a psychologist for fifteen years and is motivated by Christ's example to see light overcome darkness.



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Pathological Demand Avoidance: Conceptualisations and Controversies – Andrew Orenstein

Challenging our understanding of neurodevelopmental conditions

From Luke's Journal Nov 2024 | Vol.29 No.3 | Mental Health II



Image Gabby K, Pexels

Pathological Demand Avoidance (PDA) is a controversial profile that has gained increasing attention in recent years, particularly within the autism community. This article explores various aspects of PDA, including its history, different theoretical frameworks for understanding it, geographical differences in its recognition, some treatment implications and the controversies surrounding it.

History

The concept of Pathological Demand Avoidance was first introduced by Elizabeth Newson in the 1980s. Newson, a developmental psychologist at the University of Nottingham, observed a group of children who displayed a distinct set of behaviours that did not fit neatly into pre-existing diagnostic categories. These children showed a need to avoid or resist everyday demands and expectations, often using social strategies to do so.

Newson and her colleagues published their initial findings in a 2003 paper, describing PDA as a pervasive developmental disorder distinct from, but related to, autism (Newson et al., 2003). They characterised PDA by several key features:

1. An obsessive resistance to everyday demands
2. Use of social strategies to avoid demands
3. Surface sociability, but lack of social identity, pride, or shame
4. Lability of mood and impulsivity
5. Comfortable in role play and pretend
6. Language delay, often with a good degree of catch-up
7. Obsessive behaviour
8. Neurological involvement (e.g., clumsiness, physical awkwardness)

Since Newson's initial description, PDA has been a subject of ongoing research and debate within the autism and broader psychological communities. There is no agreed upon framework for understanding PDA. The most common are outlined below.

Anxiety Framework

The most widely accepted framework for understanding PDA is rooted in anxiety. This perspective suggests that the extreme avoidance behaviours characteristic of PDA are driven by an overwhelming anxiety response to demands or expectations. The anxiety then leads to avoidance behaviours. The anxiety is often related to a fear of failure, uncertainty or a loss of perceived control. Newson et al. suggest that individuals with PDA often show a remarkable interest in and ability to engage in role-play as a coping mechanism in order to deal with the anxiety provoking stimuli. Researchers like Elizabeth O’Nions and Francesca Happé have contributed significantly to this understanding, suggesting that PDA might be best conceptualized as an anxiety-driven need for control (O’Nions et al., 2016).

Trauma Framework

More recently, some professionals have begun to explore PDA through a trauma-informed lens. This perspective suggests that PDA-like behaviors could be understood as responses to trauma or chronic stress (Miller, 2021). In this framework, extreme avoidance behaviours can be seen as coping strategies developed in response to overwhelming stimuli. Social strategies employed by individuals with PDA could be adaptive responses learned to navigate challenging environments. The ongoing emotional dysregulation may then be related to traumatic experiences and/or chronic stress. This trauma could be subtle (i.e. deemed as not traumatic by other individuals), cumulative, related to misunderstandings, sensory overload or other challenges associated with being neurodevelopmentally atypical. This approach often results in a more compassionate understanding of and intervention to PDA behaviours, viewing them as adaptive responses to traumatic stimuli rather than wilful disobedience.



Image M Nilov, Pexels

Polyvagal Framework

Some professionals have begun to apply polyvagal theory, developed by Stephen Porges, to understanding PDA. This theory provides a neurophysiological framework for understanding how the autonomic nervous system responds to perceptions of safety, danger, and life threat (Porges, 2007). In the context of PDA, demand avoidance can be conceptualised as a response to perceived threats. The social strategies employed by individuals may be attempts to engage the social system in order to mitigate perceived threats. The shutdown behaviours or emotional dysregulation can be understood as a dorsal vagal response when other strategies fail, often appearing as attempts to flee or to demonstrate dominance as reptilian brain responses. This approach to PDA always comes with a warning about a behaviourist approach to PDA as they can increase rather than decrease the perception of threat, and a consistent finding among PDA researchers observe that behaviourist approaches tend not to be effective.

This framework is still in its early stages of application to PDA and requires further research and validation, which is true of all polyvagal theories.

Geographical Differences

The recognition and understanding of PDA vary significantly across different countries. In the United Kingdom, PDA is widely recognised and discussed, with the National Autistic Society acknowledging it as a profile within the autism spectrum (National Autistic Society, 2024). Many UK clinicians consider PDA in their assessments and diagnoses, and a significant portion of PDA research originates from UK-based researchers. Many schools and educational psychologists in the UK recognise PDA and adapt their strategies accordingly.

In contrast, PDA is less widely recognised in Australia compared to the UK. Major autism organisations in Australia do not officially recognise PDA as a distinct profile, and most clinicians do not routinely assess for or diagnose it. There is limited

Australian-based research that is specifically focused on PDA, and schools and educational psychologists generally do not incorporate PDA-specific strategies in their approach to autism support.

The United States shows even less recognition of PDA than in Australia. Major autism organisations in the US do not officially recognise PDA, and most clinicians are unfamiliar with the term or concept. There is very limited US-based research on PDA, and it is not typically included in professional training programs for psychologists, psychiatrists, or special educators.

These geographical differences highlight the ongoing debate about the validity and utility of PDA as a distinct profile or diagnosis (Green et al., 2018). They also underscore the need for more international collaboration and research to better understand and address the needs of individuals who may fit the PDA profile.

Controversies

PDA remains a controversial topic within the autism and broader psychological communities. This is because there is ongoing discussion about whether PDA is a distinct syndrome, a profile within autism, or a collection of symptoms that may occur across various symptoms or because of aspects of the family system (Egan et al., 2019). There is a lack of large-scale, controlled studies into the concept (Woods, 2019). However, that is likely to change in the near-medium future. There are many concerns amongst some professionals about the potential for misdiagnosing trauma or other responses as PDA.

My own observation is that there are also debates about the most appropriate way to treat PDA, which can be influenced by the social and political views or the personal experiences of the PDA experts, who are more often than not based in the social media world. My experience is that most interventions on social media are overwhelmingly about changing a child's environment so that they are not exposed to anxiety-provoking stimuli.



Image M Nilov, Pexels

Treatment Implications

The conceptualisation of PDA can have a significant impact on the recommended treatment goals and methods for individuals with PDA. If one conceptualises PDA as an anxiety response, then it might be reasonable to recommend an exposure type of therapy. If it were a trauma conceptualisation, then a trauma informed approach that used a safe attachment and regulatory strategies might be the prescribed treatment. Alternatively, if a polyvagal conceptualisation was utilised then something akin to the PACE model (playfulness, acceptance, curiosity and empathy) from Dan Hughes might be recommended.

Furthermore, there are philosophical differences amongst psychologists and other treating professionals when it comes to recommending treatments. Often, when working with people who are suffering, and especially children, there comes a dilemma where one needs to consider whether to change the world for the child or the child for the world. The growth in the appreciation of the neurodivergence and affirming practices has brought a corresponding growth in 'change the world for the child' approaches for treating PDA especially. However, in the long-term there is a possibility that the 'change the world for the child' treatments might inadvertently support the avoidance of stressful stimuli. Too much avoidance of stressful stimuli may result in an anxiety disorder (or may be a simple definition of an anxiety disorder) and ultimately might lead to more harm to the child. This is, however, still a controversial matter without consensus amongst treating professionals.

All treating professionals would agree that the creation of safety within a good attachment system is critical to the treatment of PDA (and all mental health issues). Once safety is established, it can often be beneficial to explore what a child is capable of in the 'scared but safe' zone. In my opinion, this is where there will be disagreement amongst professionals. Some will be comfortable with exploring the 'scared but safe' zone and others would be less comfortable, preferring to make extensive changes to the environment in order to accommodate the distressed child. In the 'scared but safe' zone, within a good attachment, recommended strategies include but are not limited to; using humour, role plays, indirect praise, maintaining a flexible approach, avoidance of power struggles, wondering out loud, offering choices, and treating anger as communication (Carlisle, 2011).

PDA and Christianity

This is an interesting issue to consider from a Christian perspective. As Christians, we are called to discipline children well. Proverbs 22:15 says "Folly is bound up in the heart of a child, but the rod of discipline will drive it far away." This might be a relevant verse in that perceiving threats when there are no actual threats might be conceived of as folly. The appropriate response is discipline so that the folly is driven away. However, stories abound of parents who have used overly harsh discipline in the name of Christianity and have damaged children. There are verses that warn against harsh discipline like Eph 6:4 ("*Fathers, do not exasperate your children; instead, bring them up in the training and instruction of the Lord.*") and Col 3:21 ("*Fathers, do not embitter your children, or they will become discouraged.*"). The Bible reveals God's loving and merciful character in passages such as Ex. 34:6-7, Ps. 103:8-13, John 3:16, 1 John 4:8, Jer. 31:3, and Zeph. 3:17, which collectively portray a merciful, gracious, and faithful God.

There is a lot of space in Christianity for nuanced arguments emphasising different ways of conceptualising PDA and justifying various treatment options. Some might place emphasis on discipline, whilst others may focus on mercy and kindness. What is not justifiable in Christianity or psychology is overly harsh approaches to children. What is also hard to justify from a Christian perspective is making endless adjustments to a child's environment so that they are never exposed to anxiety provoking stimuli. It is neither true nor kind to inadvertently reinforce to a child that perception of their environment is threatening when the threats are not necessarily in keeping with reality. Between these two extremes lies the space for wisely intervening in order to help children thrive. The verses mentioned seem to suggest that a Christian doctor or psychologist should view a child with PDA in the same way they would any other child – that each needs kindness, mercy and wise direction from an adult that cares about them. The research in regards to PDA can add some more educated directions in helpfully intervening with children displaying PDA.

Conclusion

Pathological Demand Avoidance presents a complex and multifaceted profile that continues to challenge our understanding of neurodevelopmental conditions. While controversies persist, the various frameworks for understanding PDA – from anxiety-based to trauma-informed and polyvagal perspectives – offer some valuable insights that may inform more effective support strategies. The Christian perspective can provide a helpful approach in that it can balance warmth, kindness and mercy with helping children with PDA develop their ability to match their emotions to the real world with more consistency.



Andrew Orenstein

Andrew Orenstein has been working as a clinical psychologist for around 17 years. He has experience working with severe mental health issues like suicidality, psychosis, and trauma based mental health issues. He enjoys working with people experiencing depression, anxiety, emotional dysregulation (especially angry boys), behavioural issues and with those who struggle with being resilient. Andrew loves the outdoors and spending time with his family, especially adventuring on bike or foot in the Australian bush.

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Self-Sacrifice and Sexuality

– Monica Cook

How teachings on self-sacrifice can enable spaces of spiritual and sexual abuse

From Luke's Journal Nov 2024 | Vol.29 No.3 | Mental Health II



Image Caroline Veronez, Pexels

The Problem

As reports of domestic abuse, sexual abuse and broken marriages across churches continue to rise¹, I hear people baffled by how this could possibly be. Don't we live in a relatively safe country, with good education, rising equality between men and women and with our churches teaching love, kindness and compassion?

It has been suggested that these statistics are the result of continuing stigma around divorce, gender inequality (elevating the male voice in teaching and leadership) and a misunderstanding around the nature of forgiveness². However, as a sexologist, I suspect there is another misunderstood theological theme that is contributing to these mortifying statistics. Let's talk about self-sacrifice.

It was just this past weekend that I listened to a minister preach on the following verses '*Do nothing out of selfish ambition or vain conceit. Rather, in humility value others above yourselves, not looking to your own interests but each of you to the interests of the others.*' (Philippians 2:3-4) The overwhelming message was to value others above yourselves – even if it came at a cost in the form of time, money or health (which it probably would). The reasoning was that Jesus too made himself nothing, valuing us to the point of sacrificing his own body on a cross and we needed to follow him in this way (Philippians 2:5-8). It was backed up by the verse "*Follow God's example, therefore as dearly loved children and walk in the way of love just as Christ loved us and gave himself up for us as a fragrant offering and sacrifice to God*" (Ephesians 5:2).

The application of this message when I checked in with people after the service was the following: when you give yourself up for others it is a sacrifice to God, so when faced with other people's needs (which of course we always are), don't be selfish in thinking about yours and serve, serve, serve (even if it hurts) because that's the Christian way of shining God's love into the world.

While it has always been a familiar concept to me and in theory, a beautiful one, I quietly wondered how this sort of teaching protected people from burnout and resentment. How did it prevent Christians from being taken advantage of and how were Christians equipped to challenge various forms of abuse with this narrative in the background?

The more I reflected on it, the more I realised, with shock, that it was also this very concept that was leading to sexual devastation in many of my client's lives. I'd seen how so many married women had laid down their lives, their bodies and sexual preferences, enduring pain and discomfort for the sake of their marriage and in the context of being a sacrificial wife and mother. I'd seen how many men had unknowingly (and perhaps even knowingly) stepped into an entitlement framing around sex using sacrifice-laden Bible verses to support their position and make demands sexually.

Courtney Reissig writes about this self-sacrifice through the lens of motherhood, although this sentiment is often echoed in my clinical rooms multiple times over with regards to sexual intercourse in marriage. She writes, "[Motherhood] is a call

to death...fulfilment is found in following the way of the cross, in laying down your life so that another may live." She goes on to say, "But now I'm in the thick of it, most days I resent the sacrifice. I don't like the service required of me. I know it's better to give than to receive. I believe Jesus' words about losing my life in order to find it. But it really all feels like death most days."³

My question is, whether it be for a child or in the context of having sex with a spouse, is this kind of self-sacrifice, death-like existence and resentment how God wants his people to experience intimacy, or is there a better way? Moreover, it is no wonder that so many women are enduring abusive relationships because they feel like it's precisely this death-like existence that validates their role as a 'good Christian' wife.

(As a side note, I also see many ministers facing burnout as a result of similar teachings. The irony is that this often leads them to 'need' sex more urgently as a means of self-soothing or maintaining a corner that is just for them in the face of losing the rest of themselves to their congregation's needs. This places additional pressure on the act of sex, leading them to become more entitled and frustrated, and sometimes turning to pornography as an easy solution).



Image Weber, Pexels

Theology of self-sacrifice unhelpfully applied to sexuality

As one might imagine, the outcome of thinking about self-sacrifice in this way is far from edifying and can so easily lead to sexual dysfunction, relational tension, abusive dynamics and significant mental health issues. The thought process often goes something like this:

1. Sex (and specifically intercourse) is a good thing designed originally by God for marriage that we need to engage in regularly.
2. Her body belongs to him (*1 Corinthians 7:4*) so if he needs more sex (which culture and many Christian books constantly insinuate) then she should be a dutiful wife and provide it for him.
3. Love inevitably means some level of self-sacrifice and cost so it is right for her to abandon her own 'selfish' sexual preferences (particularly when it is to avoid intercourse) and instead withstand pain/discomfort for the sake of the other. Like Jesus she dies to 'self' and participates in an extreme act of service and generosity. She has given up her body for love (like Christ).
4. Withholding sex from her partner would result in a higher chance of Satan tempting him so it is a sacrifice of utmost importance (*1 Corinthians 7:5*).
5. If she isn't feeling any sort of joy in this giving process like Paul and Jesus (and instead feeling resentment, fatigue or anger), it is a result of her sin and selfishness. *Hebrews 12:2* tells us, "For the joy set before him he endured the cross."

Shame

By the time these women arrive in my clinic they are often struggling under six layers of shame, leading them to hide from God, their partner, and even from themselves, with significant repercussions to their faith, self esteem and relationship:

1. The **shame of inadequacy**—not feeling enough sexually for her husband because she is not enjoying sex as he does, nor as he would like her to.
2. The **shame of missing out** on what the world describes as a wonderful part of being human. Many women feel so alone in their struggle.
3. The **shame of denying her own body's needs** and preferences—the space has become traumatic, unsafe and therefore extremely triggering. It is a choice between honouring her husband's body or her own. Vaginismus and chronic illness is an all too common manifestation of this trauma.
4. The **shame of not feeling anything other than pure joy** in the process—she believes her misery is indicative of spiritual immaturity and sin.
5. The **shame of secretly despising her partner**—there is resentment and bitterness toward her partner for pursuing sex and seemingly enjoying it at her expense.
6. The **shame of dishonesty**—pretending to enjoy it or being impartial towards it when she secretly wishes that she could never have sex again.

By continually engaging in intercourse with such deep shame means there is retraumatisation, which after many years develops into an avoidance pattern and a felt sense of grief and hopelessness for the couple.

How this approach does not support healthy sexuality or theology

Apart from these negative consequences, the thought process above at first glance can seem like a fair interpretation. However, there are many aspects to these concepts that undermine the psychology of healthy sexuality and the way it was originally designed.

1. **Desiring and being desired is a fundamental part of what makes sex so wonderful** (God himself 'desires' his people and you see this throughout the Old Testament). Changing the act of sex into a legalistic act that says 'this is just what we should do regularly, now that we are married' changes the whole dynamic. It also means that the act of sex can be weaponised where one partner is telling the other what they need to be feeling/doing to ensure this ritualised practice takes place and is not one based on desire and free will.

2. This first perspective also reduces the act of sex down to penetrative intercourse – limiting what is possible and putting performance pressure on the couple to reach this goal every time. This is challenging, particularly if pain is part of the experience (which it often is when there is no arousal, and sex has become more of a chore). The verse, "*Let her breasts fill you at all times with delight*" (Proverbs 5:19) is interesting in that it **emphasises rejoicing in a sexual behaviour that isn't intercourse**.

3. While the Bible talks about one's body belonging to the other – it is a **vision of mutuality**, one that communicates the concept that 'what affects you affects me because we are one'. In a context where men were primarily interested in their own pleasure – this verse was radical in correctly focusing their attention on their partner's experience and not designed to enable any sort of abusive behaviour.

• Mutuality is a fundamental theological concept with Ephesians 5:2 highlighting a **vision for marriage that involves mutual submission**. In Song of Songs we see two lovers taking turns in speaking and acting sexually with one another.



Image Jay Willink, Pexels

When one partner relinquishes their ability to access pleasure and simply serves – it robs the other partner of being able to give. Interestingly, this dynamic can be driven more by the woman than the man partly because it's easier to hide behind a husband's sexual need and service this, than to be vulnerable enough to explore one's own sexuality which has often been suppressed for years. There can also be safety in being the martyr in the relationship and not taking an equal share of responsibility for this relational space.

4. While one may think they are ticking the box as they service their partner as a chore – what they don't realise is that it undermines the very heart and purpose of intimacy which is **to know and be deeply known** (Adam 'knew' Eve his wife... Genesis 4:1). By servicing him in this way she is making herself unknowable. It also moves the dynamic to a patient/carer dynamic (which is not at all erotic). No partner wants to be 'endured' sexually, nor will they be able to truly experience/ receive pleasure knowing the other is not also receiving.

5. Where there should be **no fear in love** (1 John 4:18) – this sexual act is mobilised out of fear – fear of a husband cheating on them if they don't give them the sex they 'need'. It also reinforces the unhelpful idea that it is a woman's role to manage a man's 'out of control' sexuality, which is reminiscent of the purity culture idea. It removes personal accountability for the man's own sexual desires and reduces a woman's sexuality to being about managing a man's sexual desires.

6. Interestingly many women seem to find a sense of value/worth in serving others (which can in itself be an idol) leading to toxic resentment when they are not appreciated or valued as they deserve. In other words they blindly step into other people's desires in what could only be described as perpetual people-pleasing for self-validation. This is different to **true other-person-centred service**.

7. The biblical command to self-sacrifice in a relational context is specifically directed at men. They are asked to sacrifice as Christ did – to lay down self (and selfish desires) for the sake of their wife (Ephesians 5:25). So if the **self-sacrifice concept** were to land anywhere it would be squarely at the feet of **men to let go of their desire or entitlement to having sex in a particular way** and be open to new ways of engaging sexually.

A healthier way forward

I am convinced that God never designed sex or intimacy to be this way. So how are we to correctly understand this concept of self sacrifice, given that there are indeed many verses in the Bible that call us to prioritise serving others and God before ourselves?

The first step is in understanding that we are freed from being slaves to sin (centring around self) with a new identity as God's children where we now centre our lives around Him (*Galatians 5:13-14*). When we do this we receive unconditional love, authentic belonging, acceptance and appreciation which means we can walk away from trying to attain this in the world. We no longer have to prove ourselves to the world by what we do, or how we please or what we have. We are free to drop the chase for self glory (letting go of rights, privileges, pleasures, possessions, expectations and well formed plans that serve to bring us glory) and can just, *"Be still and know that he is God" (Psalm 46:10)*.



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It's from this place of freedom and strength, peace, gratitude and abundance that we can love and serve others wholeheartedly and in a way that is detached from 'should' or fear of the other's response. Instead, the motivation to do this comes from God and a thankfulness in what He has done first for us (*1 John 4:19*), and not in response to a 'tit for tat' attitude, or a need to people please.

This concept resists the idea of 'duty' or 'obligation' and encourages us to freely and actively step into our own God-given desires and agency to decide and manage what service for God looks like. It resists saying 'yes' to whatever lands at our feet. It's why Paul says that he is *free and belongs to no one* – yet has *made himself a slave (1 Corinthians 9:19)*. Freedom and agency comes first – and then there is choice in how he loves and serves the other. This concept is reinforced again and again, encouraging Christians to use their freedom to serve one another in love (*Galatians 5:13-14*).

Using this principle in the sexual space looks like embracing a personal sexual agency for the purpose of serving your partner; freely desiring and not being moved to be sexual out of a sense of duty or pressure. It involves slowing down and co-creating a sexual space for both people which may or may not involve intercourse. It involves a focus on receiving pleasure (which can feel 'selfish' or 'indulgent' to someone used to servicing). The purpose of course is not to stay only focused on self – but to allow that 'self' to be known by another, which is at the core of what intimacy is about.



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To women specifically, I want to say that your engagement sexually isn't about laying down your own desires, hopes and purposes – to become less of yourselves and just pick up your husband's desires like a passive vessel. In fact, I believe God wants you to step into who you were created to be with your unique arousal patterns and desires. In Song of Songs, you see a woman boldly desiring and initiating, communicating her wants and what she loves about her partner – she leads and is led in pleasure – she is not disconnected from the beauty of her body but reminds herself of it; she lets in her partner's

admiration and opens herself up to engage in sensuality using her five senses. She brings herself to him with her desires and from that agency serves and loves him as well. The mutuality is tangible even as they even take turns speaking.

To men, that sacrificial service looks like laying down preferences for how you'd ideally like sex to be – in the hope of pursuing a vision that is something both of you can get excited about. This may also mean investing time and resources into making it work and being curious about your wife's sexuality – sometimes letting go of short-term pleasure for long term gains.

In summary, I'm appealing to those married couples that have unknowingly colluded around these concepts of self-sacrifice – where there is a subtle abusive dynamic involving sexual entitlement from the man and a servitude response for the woman leading to misery within their sexual space.

I believe the teaching around self-sacrifice (as a guiding principle in life exemplified by Christ) is being misunderstood at its core level in the sexual realm. Where self-sacrifice is about repeatedly denying and hiding oneself sexually with an overemphasis of caring for others at the expense of self, it opens people up to a deep shame that leads to dysfunction and relationship breakdown. Looking to the Bible for answers we see that we are called to lay down selfish (earthly) desires to pick up a new identity in Christ, where we no longer revolve around self in the static and demanding dance of self-interest, where our needs trump everything. Instead, we are called to look to God for our needs – freed of needing validation from the world – and free to love and serve each other in an authentic way. In a sexual space, this involves embracing sexual agency – coupled with mutuality and a concern for the other person's pleasure as much as your own – allowing both the joy of giving and receiving, fostering true intimacy in relationships.



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Jesus and Dementia – Rev Ben Boland

Outlining a Christian theology of dementia

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This article outlines a Christian theology of dementia and how this theology should underpin Christian health professionals' engagement with people living with dementia. We will begin by briefly defining both dementia and a Christian theology of dementia, before focusing on praxis and communication, and finally listing an Alphabet of Dementia care for Christian Health professionals.

Understanding Dementia

Dementia is a medical term so we need to start with the medical understanding of dementia. First used in its modern meaning by Philippe Pinel in 1797, dementia is an umbrella term for a range of diseases which impact the brain (of which the most common is Alzheimer's dementia). Please note that the definition refers to 'brain' and not 'memory' as, contrary to popular belief, dementia affects much more than memory and people can live with multiple kinds of dementia.

Dementia is progressive and terminal, indeed it is the biggest killer of women in Australia today.¹ There is much diversity of dementia with a range of clinical presentations throughout the population. With the complexities of the disease and all the ongoing new research, we can be thankful that there are great resources about dementia available. I recommend browsing the Dementia Australia website² as a beginning and enrolling in the UTAS 'Understanding Dementia' MOOC³ (which is online and free for Australian citizens). These resources will equip you to understand the basics of the biomedical aspects of dementia, and thus better inform your practice as health practitioners.

A Theology of Dementia

While medicine defines the term 'dementia', a key question for Christian health care professionals remains: What does the Bible teach about dementia? Perhaps the two key questions in this context are:

- What is a human?
- How should we treat humans?

These questions are significant in our 'hyper-cognitive' culture where cognition is tied to personhood – 'I think therefore I am' (Descartes). This is not merely a theoretical concern, but a practical one as Australian Ethicist Peter Singer argues that dementia removes a person from being a human and makes euthanasia appropriate.

Scripture, by contrast, teaches that our cognition is a blessing from God, but does not impact our value before God or how we are treated by our fellow humans. Specifically, the doctrine of the Imago Dei, teaches that all humans are created in God's image. So, Imago Dei means people, all people, are of immutable and incredible value. While all creation is a product of God's word and the value and treatment of animals is significant, the value and the treatment of humans is in a different category as made us in His own likeness.

Therefore, the basic tenets of a Christian theology of dementia are:

1. People living with dementia are PEOPLE made in GOD's image!
2. Christians are called to LOVE PEOPLE.



Image Hannah Barata, Pexels

How can Christian medical professionals effectively love people living with dementia?

So, what are the implications of the Biblical doctrine of personhood for people working in health care?

This is both incredibly simple (we need to love people living with dementia) and complex (how can we demonstrate this love for them?). Here are some great resources:

- *Second Forgetting; Remembering the power of the Gospel during Alzheimer's disease* by Mast (a Christian medical doctor).
- *Ministry with the Forgotten: Dementia through the Spiritual Lens* by Carder.
- *Keeping Love Alive as the Memories Fade; the 5 Love Languages and the Alzheimer's Journey* by Barr, Edward and Shaw.

However, people and particularly medical professionals are busy. So, the following section addresses the critical topic of communication. I have also provided an ABC of dementia care for Christian medical professionals at the end of this article.

Communication

Communication is a foundational aspect of enabling a person living with dementia to receive and understand love. Dementia-friendly communication is, like other communication, a matter of what is 'heard' being much more important than what is 'said'. I use inverted commas since communication is largely mediated by the five senses, which in turn are processed in the brain – and dementia affects the brain. So, I strongly recommend downloading the short and free "Dementia and Sensory Challenge: Dementia can be more than a memory" booklet which was written by people living with dementia.⁴ I also highly recommend engaging with Tera Snow, a world expert in dementia communication who has produced YouTube videos, courses and books.⁵

My advice in terms of dementia communication for health professionals is:

- Rushed communication is rarely effective. This is particularly true in the midst of dementia, not simply because dementia can slow a person's ability to understand and reply, but because a sense of limited time also increases people's stress and can leave them feeling unloved.
- Speaking slowly, clearly and using pauses, not to mention body language (e.g. smiling, open body posture and orientating yourself to be at eye level) are all incredibly important in terms of dementia communication. Additionally, using curiosity and confirming a person's understanding is critical.



Image Olly, Pexels

- Time and space impact communication. For example, communication in a ward amidst the bustle of sensory inputs makes it hard for most people to focus. A quiet room, with comfortable chairs, or walking together is often more effective. Communicating with a person living with dementia is generally going to take longer than with a person without cognitive challenges – so consider booking a longer consultation. Finally, many people living with dementia are ‘better’ in the mornings and or may struggle with ‘sundowning’,⁶ so consider this timing in planning your visits with them, and be aware of this effect.
- Generally speaking, short concrete sentences are more powerful than long abstract ones. Also, remember the power of narrative. It was not accidental that much of Jesus’ communication involved stories to convey his messages.
- A particular challenge for health professionals is the twin traps of being patronising, or overly complex. Just as giving an answer about faith would rarely involve the phrase ‘penal substitutionary atonement’, please endeavour to translate medical jargon and to communicate in a way the person understands. Of course, this translation needs to be individualised to the person.
- People living with dementia and other serious health conditions, can and often do, experience and express strong and distressing emotions. Additionally, the disinhibition often seen in dementia may result in these strong emotions being expressed during a consultation, which can be potentially distressing for the health professional. Dealing with a patient’s strong emotions can at times be difficult, and in such situations, the ability to apply emotional first aid is important. It may be advantageous for health professionals to undertake some special training⁷ in this area, as this is often missing in undergraduate courses. Referral to other allied health colleagues is also wise.
- Consider appropriate touch. Touch brings risk of abuse and allegation of abuse, but it is also universally recognised that people need touch. A clinician’s touch is often crucial for diagnosis and treatment, but touch is also important as a way of expressing love. Again, all touch should be appropriate and consensual.

I am sure most, if not all this, is not new information. My hope is that it provides both a refresher and increases your confidence in interacting with people living with dementia, and with their loved ones.

ABC of Dementia care for Christian medical professionals

Analgesia – Living with dementia does not make a person immune from pain. Indeed, a common challenge is that people living with moderate to advanced dementia may struggle to verbally articulate their pain. Body language and the question of whether a person would be likely to be experiencing pain are critical to effective pain management.

Baulking – Dementia is not a popular area of healthcare, but people living with dementia are our neighbours and we are called to love them, not baulk at providing them with healthcare. We need health professionals who are going to specialise in geriatrics and dementia care, and for everyone involved in healthcare to understand how to help people living with dementia.

Consent – People living with dementia are people and thus consent is critical. Therefore, every effort should be made to inform the person and seek their consent. The level of consent will vary with the invasiveness of the interaction. For example, extending your hand for a handshake is asking for consent to a handshake and does not require a formal consent document, but open heart surgery does! If the person is unable to give consent, consent protocols identical to those of anyone else who is unable to consent should be followed. This may mean suggesting an Enduring Power of Attorney attend medical appointments so that simple procedures can be performed on the spot (e.g. freezing warts, dental fillings and vaccinations).

Detection – Diagnosing dementia, particularly in the early stages is challenging. People often present their best to medical staff, and fear of a dementia diagnosis means they may avoid raising it with medical personnel. Diagnosis is important, as early treatment can delay progression, provide support and appropriate services, but also for the ability to give consent. This may require significant time to be involved, express their wishes and plan for their care as the disease progresses.

Elder Abuse – Not everyone who is elderly will develop dementia, since people can develop dementia at any age. However, the biggest risk factor for dementia is older age. Additionally, dementia is a significant risk factor for elder abuse. Medical professionals need to be actively aware of Elder Abuse and their mandatory reporting responsibilities.⁸

Faith – Dementia is not a spiritual disease. Sadly, I have heard Christians link dementia to spirituality: ‘Dementia is a symptom of the demonic or lack of faith’. Lifestyle factors can increase the chances of a person developing dementia CTE (Chronic Traumatic Encephalopathy), which used to be called pugilistic⁹ dementia is related to repeated head trauma. Korsakoff Dementia is linked with excessive alcohol, and Vascular Dementia is linked to poor cardiovascular health. Dementia is generally, like cancer, primarily caused by living in a world broken by the fall.

Grief – People living with dementia grieve and grief is good. Scripture records God grieving, Jesus wept when Lazarus died and the lament Psalms are full of grief. The challenge is not grief but how we grieve and how we love others in the midst of their grief – the short answer being – ‘weep with those who weep’. This includes not just the person living with dementia but also their loved ones.

Hospital – For most people being in hospital is distressing because of the health risks (e.g. infection) and because it’s a scary and unfamiliar space. This is particularly true for people living with dementia, many of whom find a break from routine traumatic. Therefore, a decision to send a person living with dementia to hospital should consider their medical need for hospital alongside the risks of moving them from a familiar environment.

Isolation – In the opening to this article I described dementia as an umbrella term for a disease of the brain – which is the accepted medical definition. However, an alternate definition is that dementia is a disease of social isolation, where society abandons the person living with dementia.¹⁰ Christians have a particular responsibility to love and not neglect their neighbours.

Jesus – We all need Jesus! People living with dementia often come into relationship with Him, as conversion is not primarily a cognitive process. I will be addressing conversion and spiritual care of people living with dementia more fully in an upcoming issue of Luke’s Journal. However, if you want to learn more now, I recommend *Coming to Christ in Dementia* by Mark Wormell.

Knowledge – Loving people living with dementia means growing our general knowledge about dementia, and also growing in our understanding of the individual who is living with dementia.

Language – Words are powerful, and medical professionals’ words carry additional weight. The language used around dementia (and growing older) in our society is often profoundly damaging, as it positions a person living with dementia as a lesser or even non-existent person. “Mum died twice”, “mindless empty shell” and “adventure before dementia” are demeaning. Another common word we need to remove from our vocabulary is ‘demented’ as this equates the disease with the person, we would rightly not describe someone with cancer as ‘cancered’ or ‘cancerous’. Even the word dementia with its perceived stigma is being challenged nowadays.²

Mental health – The prevalence of mental health conditions for people living with dementia is terrifying.¹¹ In particular, depression and anxiety are incredibly common and treatable so there is a massive space for health professionals to explore associated mental health conditions (these can even mimic dementia symptoms).

Naughty – Too often I hear medical personnel describe a person who is living with dementia as ‘naughty’. Yes, people living with dementia are people and therefore sinners, just like their medical professionals! However, often when I hear ‘naughty’ in the context of people living with dementia they are talking about challenging ‘behaviours’.¹² These are instead symptoms of their disease or unmet needs being expressed.



Image Gustavo Fring, Pexels

Oral health – Dementia is linked to a number of serious oral health issues.¹ We need dental practitioners, speech pathologists and dietitians willing to take time and patience to support those living with dementia to receive good oral care.

Palliative – with early diagnosis and treatments some dementias can be slowed. However, dementia is currently incurable and terminal. Therefore treatment should be palliative, in that they should focus on quality of life not cure.

Questions – As with the provision of any health care, asking questions is critical, not simply in terms of diagnosis and review of treatment, but in the use of person-centred questions such as, “What does Ben want?” and “Why is Ben....?”

Risperidone – The use and misuse of chemical restraint deserves a full article in itself. Basically, giving anyone any medication needs to be done carefully weighing indications, risks and benefits. Medication use, efficacy and side effects should be reviewed frequently, with the aim to use the lowest effective dose possible.

Sexuality – Biblical sexuality should be expressed within a marriage, and often people treat sexual activity by people living with dementia as aberrant or ‘dirty’. God created sex as a good part of His creation, and its pleasure is described in the Old Testament book The Song of Solomon. Loss of inhibition is a symptom of some dementias and families will need support around the distress that can be caused by this as well.

Time – People living with dementia need time, relationally and medically. Rushed communication with a person living with moderate or advanced dementia and/or with their carer is likely to be ineffective. Practically, this may mean booking longer appointments and deliberately speaking more slowly or re-explaining certain concepts and checking that they have been understood.

Urinary Tract Infections (UTIs) – A number of symptoms of dementia are also symptoms of other issues (e.g. UTIs, dehydration and depression). It is critical to rule out and treat delirium-inducing illnesses in people who are living with dementia.

VAD – Voluntary Assisted Dying is now legal in much of Australia and is a major challenge for many Christian health care professionals. Greater minds than mine have written extensively on this topic. As a chaplain, I simply want to encourage Christians in healthcare not to abandon people who have made decisions we disagree with and to continue to provide care within the carer’s moral boundaries. It is also important to prioritise your own self-care in situations that you might find distressing or challenging.¹³

Wisdom – Living with dementia does not make a person aspiritual, and spiritual care must not be abusive. This requires wisdom, particularly with competing ethical considerations. This will be explored in more detail in an upcoming issue of Luke’s Journal.

X-rays – There is a temptation for medical staff and families to seek tests, scans and procedures to establish concrete diagnoses for a range of issues. It is important that this desire is weighed against the benefits of diagnosis, particularly if it will not impact the course of treatment.

You – We are blessed to live in a time of ground-breaking medicines, machines and medical treatment. However, to steal Roger Ailes line, “You Are the Message”. Yes, people want the medical treatment you give but they want it from a person, from another human being who, like them, bears God’s image. Relationship and rapport are important aspects of effective healthcare.

Z – While ‘Z’ is the end of the dementia care alphabet, it is not the end of life. Much of this article has focused on the challenges and traumas of life with dementia. Yet, perhaps the most important message of “The ABC of Dementia for Medical Professionals” is that dementia is not the end. As Christians, we rightly know that, despite dementia being

medically incurable, eternity with Jesus is our ultimate hope. Nevertheless, Christians are promised God's love, indwelling and eternal hope in the now.

Now I know my ABCs. Next time won't you keep loving me?

The concepts described within this Dementia Alphabet may not be new, but I do hope they encourage you to continue loving those living with dementia.



Rev Ben Boland

Rev Ben Boland (BSc Hon, MDiv, Grad Dip – Ageing and Pastoral Care) has had the privilege of serving as an older person's chaplain for over fifteen years. He also serves as an advocate about Gospel ministry with older people and people living with dementia: writing, speaking on radio, podcasts and at conferences. Ben is a visiting lecturer at Brisbane School of Theology, Mary Andrews College, and coauthor of two books (Jesus Loves Me and Joy to the World) which share the Easter and Christmas accounts with people living with moderate to advanced dementia. Ben's next book about Christian ministry with older people and people living with dementia Priceless People will be published by Christian Focus Publications in July 2024.

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- 13 A great concise new resource on self-care is "Caregiving: Taking care of yourself while caring for someone else" by Debbie Barr

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On Holidays – Dr Paul Mercer

The mantra, ‘work-life-balance’ is very fuzzy at the edges

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The first part of this paper was initially published under the title, “Holiday-Deficient Doctors” in the Queensland AMA magazine, Dr Q, Autumn 2024.

PART ONE

I have to confess, my medical career has been holiday deficient. I am not saying I don’t like getting away, relaxing, and enjoying a refreshing change from work. Rather, I sheepishly put up my hand and say the words, “I should have taken more holidays.” The mantra, ‘work-life-balance’ is very fuzzy at the edges. Apart from a good dose of ‘workaholism’, yes, I love my job.

I am interested in reflecting here on why doctors are often on the wrong side of a sensible holiday ledger. There is some published literature encouraging adequate holidays:

Workforce retention¹ In the promised land of amazing technology, work demands never seem to fade. This is particularly true in rural and remote areas, but very few contexts seem exempt from seemingly insatiable demands. Locum services and other schemes can provide the backup needed, but cost, available workforce, and professional goodwill just don’t add up much of the time. The acute and chronic nature of this reality keeps the fire of ‘burnout’ going. Taking appropriate leave helps retain our workforce.²

Presenteeism³ This word captures the phenomenon of doctors struggling on with an ever-present sense of duty, even when we are sick or exhausted. While ‘responsibility’ is a shrinking violet across the board, somehow doctors not only role model responsibility, but take it to another level. It can be viewed as a structural blind spot for administrators and politicians and so doesn’t factor into workforce planning. Genuine productivity declines rapidly because of the personal consequences of presenteeism. Mature practice should guide us all to take adequate, timely leave for our wellbeing and productive professional service. Regular exercise, regular good-quality sleep, and modest alcohol use are associated useful interventions. Loss of these capacities should be a red flag for a holiday.

Job satisfaction The MABEL⁴ longitudinal study identifies that most of us have good job satisfaction. Correlations include a good support network, a patientbase who have realistic awareness of their medical needs, and few hurdles for holiday leave time out. These characteristics span all sectors of the profession. Losing job satisfaction is a red flag for needing a holiday.⁵

Access to General Practice care It has long been recognised that doctors need their own General Practitioner (GP).⁶ Reliance on self-assessment and self-prescribing is fraught with danger. The external set of eyes and ears of a seasoned GP can help semi burnt out doctors understand that a holiday is imperative. Access is not always easy. GP booking schedules are tight and not all are prepared to serve a colleague. Doctor’s Health in Queensland (dhq.org.au) can be contacted for advice around ‘docs for docs’ locations near you. The DHQ helpline is covered by trained, experienced GPs who can provide confidential crisis support. This service depends on all doctors establishing their own GP links.

Doctors as patients A flipside to access to care is the willingness of all doctors to enter into a partnership with a colleague for our own health's sake. None of us like to fail, yet it is a fallacy to imagine our roles exempt us from health challenges. We have fears, we bleed, we lose confidence in our capacities. Exaggerated pride and an inflated sense of resilience can distort our perceived need for the genuine refreshment of a holiday.⁷

Structural barriers There are times when the systems within which we work become obstacles to holiday leave. Our administrators, our medical leaders, our political bureaucrats and decision makers need to be vigilant to the needs of the health workforce for leave, and the wellbeing of a holiday. Holiday rosters need to be responsive, team-orientated instruments to empower their workforce. Poor structural decisions can aggravate demands on a medical workforce in ways that cut across good leave rhythms. In the medical context, working more than fifty hours/week is linked to suicidality.⁸

"All work and no play" is an aphorism that makes intuitive sense. Holiday deficiency is never a good measurement for a healthy medical workforce.

PART TWO

The idea of a holiday doesn't seem to translate readily into a Biblical world reality. This may be a little surprising, considering the creation story in Genesis records God as 'resting' on the seventh day. Indeed, the value of timeout and leisure can be seen when we also discover God 'strolling' in the garden with Adam and Eve in the 'cool of the day'. We catch a sense of mutual value in this garden glory perambulation for God and his image bearers.

But pleasurable leisure is soon brought crashing to the ground as sin enters the narrative. So in time, God calls a 'wandering Aramean' to build a people He will choose to bless.

One of the blessings now is the gift of 'sabbath'. Sabbath connects the God who rests with the value of rest for humanity. We receive the blessing of the Sabbath through the Ten Commandments. The account of Sabbath-keeping in Exodus links this practice to the role model of rest set by God. It was a day to enjoy the natural creation; to set aside business and focus on the worship of God. In the book of Deuteronomy, we find Moses sketching out God's hope – God's vision for Israel on the brink of the Promised Land. In this new context, there needs to be a Sabbath reset; now social justice, justice in the memory of delivery from slavery, and the memory of four hundred holiday-less years is to characterise Sabbath.

Every human person is "created in God's image". Every human being is given the dignity and respect of Sabbath in Moses' reimagining. Rest, leisure, and relief from the burden of work is a human right imagined and spelt out here. Israel was to be the torch-bearer for 'holiday' in the world.

The tragedy of evil, self-interest, and anxiety-driven wealth creation threatens the dignity of the Sabbath.

The prophets repeatedly call out self-interest, and speak against flagrant violations of Sabbath. Isaiah issues a Sabbath clarion call in chapter 58, verses 1 to 15. His passion for Sabbath and justice flows like a river: "*On your fast day [the perverse twisting of Sabbath rest into a day of fasting to display so-called holiness], you do whatever you want, and oppress your workers. You quarrel and brawl...*" and then, "*Isn't this the fast I choose; releasing wicked restraints... Isn't it sharing your bread with the hungry and bringing the homeless poor into your house...*".

The prophet Amos also focuses on the process of Sabbath injustice, "*I will tear down the Winter house as well as the Summer house... says the Lord*" (Amos 3:15). Sabbath is community-connected holiday and worship time.

Jesus continues to run the prophetic Sabbath race. He is scathing of religion which oppresses people, and calls it out: "*The Sabbath was created for humans,*" (Mark 2:27). As the one who brings in God's Kingdom, who is the Lord of the Sabbath, Jesus not only binds the strong-man of anti-Sabbath, but offers the pastoral hope of God with us (Emmanuel). "*Come to me, all you who are struggling hard and carrying heavy loads, and I will give you rest,*" (Matthew 12:28). In the gospels, we find Jesus not only reasserting the safe dignity of Sabbath, but He also models this for His discipleship class. When ministry is busy, He takes time out to meditate and pray (Mark 1:35-37; 6:45-46). He took his disciples to the beach holiday city of Tyre (7:24) and then embarked on a two-to-three week hike with them (7:31). The Saviour of the world needed time out as much as anyone.

The writer of Hebrews reflects on the idea of rest. A gentle warning is issued: "*Since the promise of rest is still open, let's be careful so that none of you will appear to miss it.*" (4:1). The writer recognises that Sabbath blessing is a gift that keeps on giving, so encouragement flows like this: "*Keep loving each other like a family. Don't neglect to open up your homes to guests (we could add, "especially holiday-makers") because by doing this, some have been hosts to angels without knowing it.*" (Hebrews 13:1).

The narrative arc of the Bible lands in what we could describe as 'eternal' Sabbath: a forever holiday of dignity and worship of God. We hear the promise in Revelation 21:3-4; "Look, God's dwelling is here with humankind. He will dwell with them, and they will be His peoples. God Himself will be with them as their God. He will wipe away every tear from their eyes. Death will be no more. There will be no mourning, crying or pain anymore, for the former things have passed away."

My case for taking holidays comes from the metanarrative of the Bible. The contemporary research I have cited, is a modern echo of Scripture.

"To travel is to feed the mind, humanise the soul, and rub off the rust of circumstances... who would not travel at a penny a mile?" These words penned in 1854 by Thomas Cook carry the 'rest' of holidays. Thomas was born in a small town called Melbourn in the UK and later established himself in the city of Leicester. From a young age, he exhibited not only an entrepreneurial spirit but also lived by his evangelical Baptist faith in the Victorian era where the average person worked six days a week. Cook committed six years of his young adult life as a village evangelist. He retained a lifelong passion for preaching.



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The excesses of alcohol misuse in English community life confirmed Cook as a teetotaler, and in 1841 he arranged a special train trip and outing to a temperance league event. He supplied food and a band to entertain. Cook built on this experience and by 1855 was arranging package tours to Europe; and later, in 1969, a trip to Egypt and Palestine. These later trips became very popular. In 1872, Cook was emboldened to create a 222 day around-the-world package tour. Cook's holiday packages enabled low-income families to travel and also provided a safe context for single women to enjoy a holiday. As a Christian, Cook embraced a Christian vision of rest and holiday. In his imagination, these tours offered evangelical possibilities for 'gossiping the gospel'.

While Cook experienced both personal and family suffering, he never let the dream die, working with his son to develop the company's 'portfolio'. The slogan, "Don't just book it... Thomas Cook it," was associated with the global business identity until 2019 when it was sold under financial duress. Along the way, profits from the business were returned to the community in the form of low-cost housing for needy people. A trust continues to manage these Sabbath justice-oriented facilities.

A good holiday gathers many of the concerns I have shared in this paper. In 2024, we need to factor in climate change and new social justice consequences of holiday choices. While Sabbath informs push-back against the relentless rush of modern life, some in our day are trapped in restless holiday consumerism, where 'bucket lists' replace the true rest of God. I am writing from the trenches of the modern rat race. Isn't it time for change? Let us renew an embrace of the holiness of time, as we plan our next holiday!



Dr Paul Mercer

Dr Paul Mercer is a GP at the end of a full General Practice career that has involved both chronic disease care, the full range of General Practice, and teaching. He confesses that he hasn't taken enough holidays along the way. Paul seeks to continue to grow in his understanding of the interface between work and faith, and facilitates an event called Theology on Tap in Brisbane each month. He has also had a strong commitment and interest in doctors' health over his career.

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More Than Pain – Anne Ward

A Biopsychosocial Approach to Case Formulation in Persistent Somatic Symptom Disorders

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Introduction

In a seminal paper, Naviaux¹ noted the significant rise in chronic illness over the past 70 years, which, despite advances in medical technology, presents significant ongoing challenges to the medical community. Naviaux observed that, compared to acute illness, chronic illness is characterised by recurrent, multi-system abnormality and failure in completing the healing cycle of intervention, treatment response and recovery. Heterogeneity in illness trajectories, symptom presentation and biological markers are the norm. This creates layers of complexity for researchers and practitioners in understanding and defining illness aetiologies and developing treatment pathways. Whilst specialisation has facilitated advances in the knowledge and treatment of acute illness, the need for more integrated, interdisciplinary approaches to understanding and treating chronic illness has become increasingly apparent in recent years.

The client's experience of their illness journey can deeply impact their quality of life across multiple fronts. A person's innate desire for healing is energised by their sense of agency, creating psychological pathways of hope in seeking a cure. This means being willing to trust and act on medical advice. However, medical visits across different specialties, ambiguous diagnoses, disappointments and setbacks from treatments falling short of expectations, can all take an emotional toll. Loss of normality in social, physical and occupational functioning, isolation and social withdrawal can lead to loss of purpose and meaning. This can impact a person at an existential, or spiritual level, such that their sense of identity is affected. Psychiatric comorbidity, particularly depression, is a common feature of chronic illness, regardless of a person's faith.

Persistent Somatic Symptoms (PSS)

This paper focuses on a particular range of conditions characterised by common symptoms associated with persistent pain. This includes:

- **post-illness syndromes** (e.g. viral/microorganism infection, chemical and mould exposure) that fall under diagnostic umbrellas of myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS), Lyme disease and long-covid, and
- **functional somatic syndromes** (also known as disorders of gut-brain interaction) characterised by persistent pain and/or other somatic symptoms, e.g. irritable bowel syndrome (IBS), urological, chronic pelvic pain syndrome, functional neurological disorders, fibromyalgia and temporomandibular pain.

Whilst symptoms may be localised to specific organs or tissue, biomarkers do not necessarily inform aetiology. Furthermore, the association between symptoms, cause and biomarkers can progressively weaken as the condition progresses.² Conditions are aggravated by stress and characterised by inflammation, with potential wide-ranging effects on executive functioning (cognition, concentration, memory), sleep (circadian dysregulation), and vitality (metabolic function

and energy/ATP regulation), all of which contribute to subjective symptom burden. For example, ME/CFS is characterised by a hypo-metabolic state associated with energy/ATP dysfunction and symptoms of post-exertional malaise.^{3,4}

Diagnostic systems such as the ICD-11 and DSM-5 classify illness according to distinct diagnostic boundaries (e.g. somatic, functional, mental). However, the commonality of physical and psychiatric symptoms across persistent somatic disorders has exposed the limitations of traditional classification approaches.

Advances in translational research across the fields of neurobiology, cognitive and affective neuroscience have facilitated the development of a more concrete and systems understanding of underlying pathologies and mechanisms of action. Consistent with the biopsychosocial framework, this knowledge brings with it opportunities for developing clearer, trans-diagnostic approaches to case formulation and treatment planning. Central sensitisation (CS) has been adopted as an umbrella term that recognises many of the common features.⁵ This paper explores the notion that CS may be a neurophysiological process that embodies a) dysfunctional mechanisms at play, and b) the generalisation effect of conditioned learning.

The biopsychosocial model provides a useful organising framework for the purposes of explaining the illness trajectory, and distinguishing the respective event-related and process-related factors that underpin and maintain symptoms and distress. Whereas past events can't be changed, process-related factors represent the mechanisms of action that maintain the underlying dysfunction. If treatment interventions can target these more effectively, treatment may impact beyond providing symptom relief to effecting more sustainable change. This paper will focus on three areas:

a. Event-related factors:

(i) environment and experience – the relationship between early life adversity, trauma and stress vulnerability

b. Process-related factors:

(i) mind-body communication and interoceptive dysregulation

(ii) memory, learning and behaviour

Event-Related Factors

Environment, Experience and Stress Vulnerability

There is widespread recognition that adverse childhood experiences create vulnerability to stress and inflammatory effects associated with later onset of physical and mental illness. A systematic review involving 85 studies across various countries found a significant association between adverse childhood experiences and the reporting of chronic pain conditions in adulthood.⁶ This appears to affect women more than men. For example, women with a history of abuse are four times more likely to experience chronic pelvic pain in adulthood.⁷ Reports of abuse by close others are seven times greater in patients with interstitial cystitis than those with acute cystitis.⁸ Seng⁹ proposed that oxytocin alterations due to attachment dysregulation may contribute to maladaptive coping responses, manifesting as emotional dysregulation, impaired memory processing (including dissociation), somatisation and chronic smooth muscle dysregulation (a prominent feature of chronic pelvic pain, urinary pain and IBS).

Allostasis

Allostasis refers to self-modulatory neuroendocrine, autonomic, metabolic changes that enable bodily functions to adjust to environmental demands and maintain stability in the context of extreme or protracted stress.^{10,11} This involves alteration of the operational parameters of biological systems via the hypothalamic-pituitary-adrenal (HPA) axis as the brain (Central Nervous System) evaluates and responds to environmental threats. Allostatic load refers to the wear and tear the body experiences in attempting to adapt to prolonged stress.

Research on the impact of adversity and psychosocial stressors such as loneliness, loss and uncertainty has established clear illness pathways whereby chronic stress and prolonged sympathetic nervous system activation produce an inflammatory response that alters gene expression, with an associated negative impact on immune system function and health. Social genomics researchers have coined the term Conserved Transcriptional Response to Adversity (CTRA) to describe the neuro-adaptive conditioning of the immune system toward a more pro-inflammatory stance.¹² Chronic stress in childhood can result in compromised early safety learning, whereby a state of vigilance and arousal becomes experienced as 'normal' and is undetected as a stress response in adulthood.

Dysregulation of the stress response produces cognitive, affective and behavioural responses marked by rigidity. These represent forms of maladaptive neuromodulation or conditioned learning, manifesting in common symptom patterns across a range of central pain syndromes. This 'maladaptation' can lead to secondary outcomes whereby biological markers of oxidative stress (inflammation) are manifested in various physiological systems (endocrine, gastrointestinal and enteric nervous systems).

Psychosocial stress is recognised as a major risk factor for somatic disease, due to the 'wear and tear' associated with prolonged physiological activity. CTRA may therefore represent a cellular 'biological signature' that is communicated physiologically, psychologically and behaviourally as a learned script, characterised by an unconscious sense of threat and generalised sense of 'unsafety'. Chemical and sensory signals are communicated to the brain via interoception (see below for further information). However, it is up to the mind to do the sense-making (emotion-cognition) that shapes the 'meta-narrative' about what illness and pain mean and how they are to be faced.

Process-Related Factors

Whilst event-related factors as described above play a significant role in creating vulnerability to stress-related illness, interventions need to target the mechanisms that are maintaining the symptom experience. Over recent decades a significant body of research has been focused on understanding the psychophysiological processes that underlie persistent pain conditions. Generalised unsafety has been conceptualised as an implicit conditioned response, whereby the sympathetic nervous system reverts to a default, non-conscious "ON" state which becomes normalised over time.¹³ This is explored further below.

Mind-Body Communication: Interoceptive Dysregulation

The brain is responsible for the conscious perception of sensory stimuli (e.g. pain, hunger, thirst, temperature). Interoception refers to internal signalling pathways that allow the brain (via the insular cortex) to interpret physiological signals ascending from the body and to form mental representations of the state of the body. Interoception enables the brain to modulate (downward signalling) the biological, neuroendocrine and metabolic processes involved in the regulation of homeostasis. It is fundamental to internal and external threat detection and the activation of the stress response (sympathetic nervous system pathway).

The mental representations have been described as comprising three main sub-processes:

- a) signal detection (e.g. heartbeat, pain),
- b) self-evaluation (subjective perception of the level of sensitivity) and
- c) meta-cognitive interpretation of what the signal means.

Interoceptive accuracy refers to the relationship between perceived and actual interoceptive signals.¹⁴

The functional effects of chronic inflammation have been found to increase neural activation of the cortical regions involved in interoception (insula, amygdala, anterior cingulate cortex).¹⁵ Interoceptive dysregulation has been found to be associated with a range of cognitive, emotional and behavioural responses, including amplified visceral sensitivity and increased perception of the pain threshold, anxiety, perseverative cognitions, social withdrawal, fatigue, lethargy and anhedonia. The reported perception of pain may therefore represent the subjective sense of symptom burden and not necessarily the level of severity of the condition. This requires sensitivity on the part of clinicians when exploring the patient's symptom experience, to differentiate between their pain and suffering, respectively.

Interoceptive dysregulation is implicated in a range of chronic pain conditions such as fibromyalgia, IBS, chronic pelvic pain, interstitial cystitis, ME/CFS and is associated with a higher risk of psychiatric comorbidity.¹⁶ Resting Heart Rate Variability (HRV) is regarded as an indicator of autonomic imbalance, particularly reduced parasympathetic activity. Resting HRV has been found to be a predictor of emotional instability, particularly positive affect.¹⁷ A meta-analysis covering 58 studies found lower reported HRV indices in patients with fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome compared to healthy individuals.¹⁸ Resting HRV may be a reliable biomarker of interoceptive dysregulation, potentially useful as a psychophysical assessment measure.

Learning, Memory and Behaviour

Memory stores the learning from previous experiences and serves as a reference for making predictions about the future. The "Better Safe than Sorry Strategy"¹⁹ has been used to describe the conditioning of the fear response, as characterised by an implicit, generalised assumption of unsafety, which in turn activates external and internal hypervigilance and an avoidant default coping response. It proposes that the chronic stress response is a psychophysiological default state determined by automatic (bottom-up) processes that shape how safety is perceived and construed. The implications are

that the stress response is largely unconscious, i.e. perceived safety is the outcome of the brain's prediction. Psychological processes, such as perseverative cognition, strengthen the negative attribution bias, generating anticipatory anxiety at a conscious and unconscious level (e.g. disturbed or unrestful sleep).

Conditioned fear learning involves a self-reinforcing cycle of faulty interoceptive processing that is stored in long-term autobiographical memory. Faulty interoceptive processing leads to the sensitisation of pain memories, which are associated with abstract, non-contextualised mental representations. Sensory signals activate automatic fear-based responses. This prevents new learning and acts as a barrier to recovery. Interoceptive errors involve the following information processing deficits:

1. Working memory: perseverative cognition experienced as worry, rumination and reinforcing internal attention bias.
2. Abstract construal of sensory input which is generalised into one symptom report
3. Input from somatic and affective states is not well distinguished and contextualised, making the person feel more vulnerable.
4. Threat assessment: cognitive inflexibility associated with low discrimination between danger and safety cues.
5. Generalised, non-contextualised pain 'scripts' are stored in long-term autobiographical memory. They contain implicit, self-limiting attributions (e.g. defectiveness, helplessness, failure) that reinforce loss of agency and lead to long-term negative side effects.

Generalisation is associated with a top-down command and control response via downward modulation of neural pathways in the central autonomic network (CAN), which creates the subjective experience of behavioural control over adverse events, with associated changes in motor-response programmes (e.g. avoidant coping).²⁰ This leads to enduring neuroplastic changes in the prefrontal cortex and compromised functional connectivity to ascending neural networks. As noted above, the Generalized Unsafety Theory of Stress proposes that prolonged stress responses are due to generalised and largely unconsciously perceived unsafety. As such, the perception of stress is determined by subjective internal experience and isn't necessarily dependent on the presence of external stressors. This has implications for treatment planning.

Psychological Assessment and Case Formulation

Pain has a social and emotional context which contains the personalised narrative of a person's symptom experience, including their beliefs (explicit and implicit) about the illness. These factors influence the individual's subjective state of weariness, sense of personal efficacy, level of ambivalence, expectations about treatment and potential for active engagement. In considering these factors, medical assessment may need to consider whether psychological treatment is warranted as part of early intervention. Psychological assessment should seek to understand the biopsychosocial context, with the goal of developing a joint understanding between the client and clinician that provides an explanatory model of the presenting problems and points to a way forward.

Psychological self-report assessments of depression and anxiety (e.g. DASS42) may not be sufficiently sensitive to cases where psychological distress is manifested as a somatic experience, as is the case in many persistent pain syndromes. The Patient Health Questionnaire (PHQ-15)²¹ and The Central Sensitisation Inventory (CSI)²² are examples of screening instruments that can provide a more informed understanding of psychological and somatic manifestations of stress.

Case formulation is an organic, iterative process that will benefit from an integrated, interdisciplinary approach between medical practitioners, psychologists and other allied health clinicians. Given the practical challenges involved, this may be optimised by informative written communication, and case conferencing where necessary.

Figure 1 below provides an example of the type of template that may be useful in psychological case conceptualisation. It seeks to map the biopsychosocial components of the client's illness experience, the functional consequences and the associated psychological mechanisms that form the basis of treatment planning.

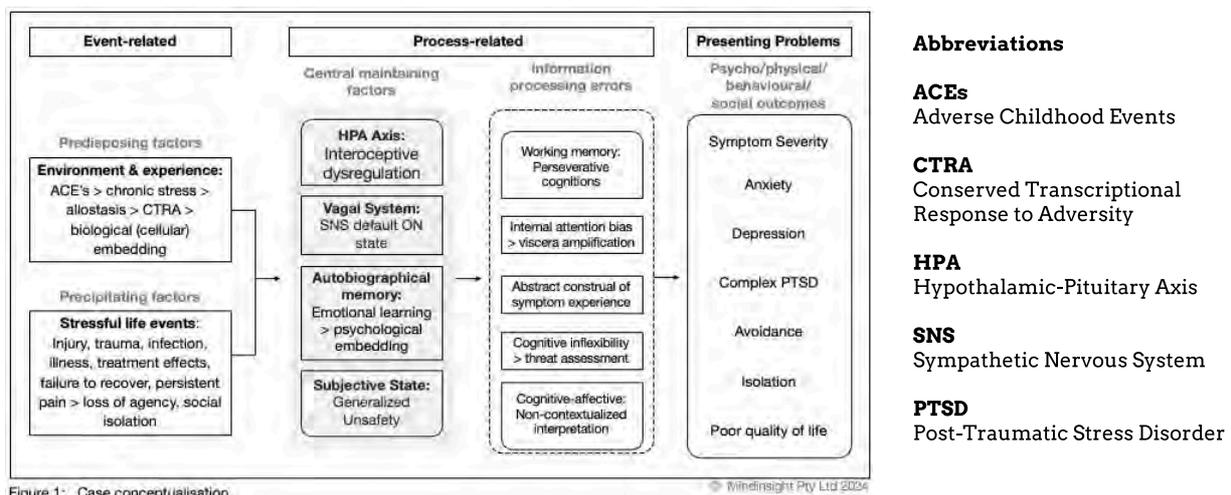


Figure 1: Case conceptualisation

Treatment Considerations

Treatment options fall into four broad categories:

- a) pharmacological treatments and other medical interventions,
- b) psychological treatments,
- c) nutritional strategies that focus on improving the gut biome and reducing inflammation, and
- d) other specific complementary treatments targeted towards reducing symptoms of ME/CFS, long-covid, mould toxicity, IBS, pelvic floor pain, etc.

The focus of this paper is on psychological treatment, with particular emphasis on a) the implicit nature of key maintaining mechanisms, as discussed above, and b) the relevance of heterogeneous, idiopathic factors that are an inevitable feature of the complexity of these disorders.

Treatment approaches that rely on top-down conscious mental processes may be insufficient in effecting change if the key maintaining mechanisms, as portrayed above, are a result of conditioned learning, stored in implicit dysfunctional memory and therefore outside conscious processing. Treatment modalities such as eye movement desensitisation reprocessing (EMDR)²³ and clinical hypnosis²⁴ are aimed at targeting top-down mechanisms as well as modulating autonomic nervous system (ANS) activity and the neural circuits (thalamic-amygdala-hippocampal) involved in memory formation and consolidation.

A recent clinical update on non-pharmacological approaches for inflammatory bowel disease, observed that patients who benefit most from cognitive behavioural therapy demonstrate psychological flexibility, which enables them to draw insights about how their thoughts and emotional states influence their experience of pain and level of suffering.²⁵ It was noted that patients with more visceral hypersensitivity find greater benefit from hypnotherapy, providing treatment is with a qualified clinician.

A person's mentalisation or reflective functioning skills may be a factor that informs treatment planning. Successful mentalising involves being able to maintain in conscious awareness the range of mental experiences (thoughts, emotions, memories) to make sense of one's internal state, thereby creating a sense of internal coherence and agency.²⁶ Stress, trauma and dissociation impede mentalisation. If prior safety learning has led to emotional numbing and avoidance this may need to be addressed as part of psychological treatment.

The above considerations reflect the inherent complexity of transdiagnostic research in addressing the multivariate factors that are a prominent feature of persistent somatic symptom disorders. SOMACROSS is an example of an interdisciplinary research initiative focused on this objective.²⁷ Whilst this research continues, clinicians must manage the challenge of remaining up to date with research whilst using clinical judgement to make informed decisions regarding treatment. There are a range of psychological modalities, with demonstrated small to medium effect sizes that may be utilised in the management of persistent somatic symptom disorders^{2,24}.

The following is an outline of broad treatment goals that may form part of an integrated treatment approach, oriented toward 're-learning safety', by working at the level of mechanisms of action, as portrayed in Figure 1 above.

Event-related:

- Desensitise and reprocess trauma-related memories to reintegrate dysfunctionally stored emotional, somatosensory and cognitive associations with adverse experiences.

Process-related:

- Focus on factors that promote the (unconscious) perception of safety rather than on situational stressors.
- Relearn 'internal safety' by modulating parasympathetic nervous system (PNS) activation.
- Improve reflective functioning and emotional regulation skills, expanding the time window for perceptual awareness of interoceptive signals and associated interpretation of cognitive-affective mental states.
- Improve threat detection and accuracy of perceived safety.
- Incorporate imaginal and behavioural activation strategies to create 'safety experiences' from everyday experience (social connection, body fitness, environment/nature).
- Reinforce and consolidate generalisation of safety learning and associated functioning across broad life domains.

Spirituality

For Christians, spiritual issues can often sit in the background. Mention was made earlier of the impact of chronic illness on identity, purpose and relationships. This can extend to spirituality. For some people, their relationship with God can provide a source of solace and strength. For others, depression can create a sense of disconnection from God, and/or a sense of failure (e.g. self-perceptions about lack of faith, lack of effort in evangelising), which may inhibit prayer and connection with other Christians. Social situations can be anxiety provoking. Well-meaning questions from others about the illness, treatment and recovery can be confronting, especially when there are no straightforward answers. For some, this invokes a sense of failure, shame and loneliness. Clinicians who are informed regarding these sensitive issues can provide an important source of validation in recognising the physical, emotional and social demands of the illness. Mutual understanding builds rapport and epistemic trust, which, regardless of the person's faith, can create a sense of 'being known'.

Concluding Comments

This paper has sought to provide an overview of current developments in research and clinical practice that demonstrate how a biopsychosocial, transdiagnostic approach may assist in managing the inherent complexity of persistent somatic symptom disorders. Of relevance is the need to distinguish between event and process-related factors that form part of the illness trajectory, and which enable mapping of the mechanisms of action that hold potential for effective change via multi-disciplinary treatment approaches. Sensitivity and understanding of the spiritual impact of the illness can provide a further source of encouragement for people navigating a difficult life journey.



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Friendship and Loneliness – Jackson He

How Christ and the Gospel transform them

From Luke's Journal Nov 2024 | Vol.29 No.3 | Mental Health II



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In an age where forming connections is easier and more convenient than ever, one could have envisioned a revolution in both the quantity and quality of our relationships. On the contrary, we find ourselves in a time where loneliness seems to be on the rise. Badcock et al.¹ (2022) defined loneliness as “a subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more, or more satisfying, social relationships.” In other words, a deep yearning for connection that remains unfulfilled, even in times when we are socially connected.

The *Household, Income and Labour Dynamics in Australia (HILDA) Survey*,² which follows the lives of 17,000 Australians annually, reveals a troubling statistic. An increasing trend in the feeling of loneliness in young people since 2012. In 2009, the loneliest age group was those 65 and older, twelve years later, in 2021, 15-24-year-olds had become the loneliest group.³ Although there has been some improvements with regards to overall decrease in loneliness in the later years of the pandemic, surveys completed in December 2023 indicate that approximately 1 in 4 (26.1%) Australians still experience persistent loneliness, with 41.1% of young people aged 18-24 years making up the highest risk group.⁴

Alarmed at growing trends of loneliness, public health authorities in recent years, are increasingly recognising persistent loneliness as a public health issue through its direct and indirect influence on mental and physical health, as well as its association with higher mortality risk.^{5,6} One study even considers lack of social relationships a mortality risk comparable to light smoking (15 cigarettes/day) and alcohol consumption (6 drinks/day), and suggest it poses a greater risk to mortality than obesity and hypertension.⁷

In this article, I aim to paint a picture about the modern state of loneliness and its impact on the lives of those around us. I am by no means an expert or even deeply knowledgeable in this field. However, though a layman, the experiences of both my peers and myself do modestly resonate with this description of the current state and trends of relationships.

Among the various types of relationships, I want to focus on the most common and deeply interwoven – yet no less significant – form of relationship: Friendship. Friendship is described as a state of enduring affection, esteem, intimacy, and trust between two people (Britannica). In many ways, it can be characterised as the foundation for all forms of companionship. As such, friendship plays a crucial role in shaping our experience of connection, and is one of the primary drivers of loneliness when absent.

“To the Ancients, Friendship seemed the happiest and most fully human of all loves; the crown of life and the school of virtue. The modern world, in comparison, ignores it.” C. S. Lewis

Why is friendship and relationship so critical?

We all understand the importance of friendship and relationship, but have we ever stopped to consider what is so wonderful about friendship? We go to reasons like building connections with people who have shared values and interests, gaining new perspectives and insights, and fostering a sense of belonging. All good and important aspects indeed. However, let us delve deeper, beginning with the book of Genesis:

Gen 2:18 "The Lord God said, "It is not good for the man to be alone..."

We were not made to be alone, in fact it was "not good". Connection and relationship is valuable and essential for humanity. When these needs are unmet, this leads to the unravelling of our physical, mental and spiritual health and, more critically, the core elements of our identity.

Companionship – being known, loved and to matter – is foundational to our being. It fulfils a deep existential and spiritual need (thirst – John 4). As beings made in the image of a Triune God who has always existed in loving community as Father, Son and Holy Spirit, we are inherently designed for relationship with each other and, ultimately, relationship with our God (Gen 1:27, Col 1:16).

A Biblical view of the current state of friendship?

However, this did not last. Mankind chose to reject their partnership with God and instead run and separate from Him (Gen 3:6-9). Alienated from the God who loved and cared for us, we became enemies through our persistent rejection of Him (Col 1:21). This fracture in the vertical relationship with our Creator did not come without cost to the horizontal relationship with each other. While there are some who work at times for the wellbeing of others, the prevailing tendency is to prioritise our own interests above all else – profits over people, ambitions over peace, our comfort over the suffering of others.

Titus 3:3 "At one time we too were foolish, disobedient, deceived and enslaved by all kinds of passions and pleasures. We lived in malice and envy, being hated and hating one another."

Here we have a picture of human relationships marred by moral foolishness, disobedience and deceit – where the pursuit and satisfaction of our passions and pleasures takes precedence. As a result, our lives often become filled with bitterness, envy and even hatred towards one another. While some may view this an extreme outlook on ourselves, when we take a step back, can we honestly describe humanity in any other way when we look at the broader picture?

"Yet we all struggle with a heart condition rooted in fear, mistrust, selfishness, contempt, impatience, envy, powerlessness, past wounds, all of which ultimately culminated in sin."

In our friendships and relationships, we naturally seek love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness, self-control, (Gal 5:22-23) as well as equity and justice. Yet we all struggle with a heart condition rooted in fear, mistrust, selfishness, contempt, impatience, envy, powerlessness, past wounds, all of which ultimately culminated in sin. This not only strains our relationships with others but also damages our relationships with ourselves, the world and ultimately, with God. And for those who unfortunately grapple with poor mental health, these negative attributes can be magnified to such an extent that they hinder the ability to maintain healthy connections with others.

In a world marred by selfishness and brokenness, how can true friendship exist? Who can bear the cost and weight of all the injury?

How does the Cross transform our relationship with God?

"The Son of Man came eating and drinking, and they say, 'Here is a glutton and a drunkard, a friend of tax collectors and sinners..." Matt 11:19

Here we see a God who was not distant from us, that while we were still His enemies chose to step into the darkness out of love. A God who made the first and ultimate move to repair the broken relationship we have with him (Rom 5:8-10). God did this by laying down His own life. Jesus not only reconciled us to God, but transformed our relationship from one of mere creator and creature, or master and servant, to that of dear friend (John 15:15). Through this act He established friendship by grace – a gift He willingly gave, setting the greatest example of friendship:

"My command is this: Love each other as I have loved you. Greater love has no one than this: to lay down one's life for one's friends." John 15:12-13

On the cross, Jesus' grace opens the door for outsiders, for those who are different for any reason. He sought out the marginalised to make peace with those who were far, hostile and estranged. We are no longer alone. Through His Spirit, we have access to God, becoming fellow citizens with all of God's people and joining in one heavenly family (Eph 2:13-19). This friendship, relationship and fellowship will last into eternity, never fading despite the trials and hardships we go through (Ps 77).

"Love is patient, love is kind. It does not envy, it does not boast, it is not proud. It does not dishonour others, it is not self-seeking, it is not easily angered, it keeps no record of wrongs. Love does not delight in evil but rejoices with the truth. It always protects, always trusts, always hopes, always perseveres." 1 Cor 13:4-7:

Having been forgiven and reconciled, He calls His people to do to each other what has been done to us (Matt 7:12). By following His example, we can extend that same grace to our fellow neighbours and love others as Christ has loved us. While there is much to explore in 1 Corinthians 13:4-7, I would like to highlight that love *“keeps no record of wrongs”*. In any relationship, we will encounter hurt and betrayal from each other, and when it comes from those who are the closest to us, it is especially hard. While it may not always come quickly in the moment, we can reflect on the foundation of our fellowship with God – the forgiveness that we have received. This makes it possible to be compassionate to one another, not holding on to the other’s guilt as ammunition, but giving the gift of forgiveness just as Christ did (Eph 4:32, Matt 6:12, 14-15). May we, who have been brought near and transformed by the blood of Christ, love others and draw them near as well (Phm 1:16), offering them true friendship modelled and centred around Jesus.

What is Christ-centred friendship?

At the centre of our entire lives is Christ, the one who came, died and rose for our good and for God’s glory. Therefore, Christ ought to be at the centre of every aspect of our lives, and friendship is no exception. So how do we ensure Christ remains at the heart of all our friendships?

“Let the message of Christ dwell among you richly as you teach and admonish one another with all wisdom through psalms, hymns, and songs from the Spirit, singing to God with gratitude in your hearts.” Colossians 3:16

Keep the life-changing good news of the gospel at the centre of all our friendships and relationships – good news for everyone! Despite all our differences – whether cultural, political, social, etc – it is the gospel of Christ that unites us (Gal 3:26-28). His example and sacrifice enable us to love others, even when it comes at a cost, because He bore our suffering, guilt and shame (Is 53:4, Heb 13:12-13). He brings peace to those whose hearts are distant from each other, offering forgiveness, reconciliation and transformation on so many levels, that everyone may become a friend.

“And let us consider how we may spur one another on towards love and good deeds, not giving up meeting together, as some are in the habit of doing, but encouraging one another and all the more as you see the Day approaching.” Hebrews 10:24-25

Let us make every effort to gather together in order that we may encourage and remind each other with the message of Christ, motivating one another towards love and good deeds to all we encounter. And ultimately, to the end and goal of all relationships: to glorify God and reach eternity together in Christ. For our friends who do not yet know Christ, may they experience the love and light of Christ through our deeds and glorify God when He returns (Matt 5:16, 1 Pet 2:12).

Summary

We were made for relationship and friendship, with others and with God. However, these relationships have been marred by sin, which ultimately leaves us disconnected and lonely. When our relational needs are unmet, it adversely impacts our physical, mental and spiritual well-being.

“This is love: not that we loved God, but that he loved us and sent his Son as an atoning sacrifice for our sins.” 1 John 4:10

Despite our brokenness, God first loved us and desired to reconcile our relationship with Himself through Jesus Christ’s sacrifice on the cross. Through His act of selfless love, He transforms our relationships to be friends of God and brings peace between each other. Therefore, let us make every effort to have Christ at the centre of all of our friendships and relationships, encouraging one another towards love, good deeds and eternity, ultimately glorifying God together. May we extend this love that Christ has shown us to each other, whether they be far or near.

Afterword – words of comfort for the lonely:

Thank you for making it this far. I pray these words have been helpful to you. This message is especially for those who are struggling with loneliness. Loneliness is hard. While it is an experience many go through at various points in life – perhaps more than once – it is never easy (having been in this position myself). If it is any comfort, please know that many can relate to what you are going through, and my encouragement to you is to reach out.

I totally understand that it takes immense courage and vulnerability to share this part of yourself with others. While I cannot promise you that everyone will always respond warmly, there are many – especially those who truly follow Christ – who will not turn away a neighbour in need. But I can promise you that God will not reject you, even in your vulnerability (Ps 51:17). Therefore, bring your struggles before Him in prayer and petition (Phil 4:6). Keep your eyes open for how He may answer these prayers, both conventionally and (perhaps more likely) unconventionally.

"Keep your eyes open for how He may answer these prayers, both conventionally and (perhaps more likely) unconventionally."

Perhaps the greatest comfort I can offer is that we have a God who is not detached from our troubles, hardships or suffering. He genuinely feels and understands our pain (Heb 4:15). Jesus Himself suffered rejection from His own people (John 1:10-11), abandonment by His closest friends (Mark 14:50, Matt 26:56), and the pain, humiliation and shame of the Cross (Matt 26:67, 27:26, 27:35). He willingly entered into human suffering in order to transform it, and ultimately bring the solution through the Cross.

So, I invite you to know and be known by Jesus. In Him, you can find a peace and comfort that surpasses anything this world can offer.



Jackson He

Jackson He is a final year PhD student at Monash University in Victoria investigating novel treatments for different types of cancers. He enjoys serving God at his local church and on campus and has a keen interest in how science points people to the Cross.

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A Christian Perspective on Suicide: PART 2 –Professor Kuruvilla George

Some ways that we as a faith community can respond

From Luke's Journal Nov 2024 | Vol.29 No.3 | Mental Health II



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A Christian Perspective on Suicide, Part 1 (2023) mentioned some of the theological perspectives pertaining to suicide and gave examples of suicides and contemplation of suicide mentioned in the Bible.

We reflected on these fundamental questions:

- 1. What is your perspective of suicide?**
- 2. Is suicide sin?**
- 3. What do you think of Christians who come to the point of being suicidal?**
- 4. What does the Bible say about suicide?**

This article suggests some ways that we as a faith community can respond.

Story of Mary

Mary is a 20-year-old young woman who accepted the Lord as her Saviour a few months ago due to the testimony and friendship of Amy who is a committed Christian. Both women have had traumatic backgrounds with a history of sexual abuse as children. Amy is a Christian and a regular churchgoer with a good network of Christian friends and support. She has been working with a support group for sexual abuse victims and that is how she got to know and developed a friendship with Mary. Mary has been finding it very difficult to get past the memories and trauma of her sexual abuse. She is suffering from post-traumatic stress disorder (PTSD) and has flashbacks. She has attempted self-harm and suicide several times in the past, but not after becoming a Christian. However, after coming in contact with the individual who used to abuse her, all her memories and trauma resurfaced and she sadly took an overdose of her antidepressant medication, which led to her death.

Story of Thomas

Thomas is an 86-year-old gentleman who is living on his own. His wife passed away a year ago after suffering from cancer for several years. Thomas was the main carer, though they had family who came to assist when they were able. Thomas is also suffering from arthritis which causes a lot of pain and discomfort. Though a committed Christian whose faith has been very important for him in the ups and downs of his life, he became very depressed following his wife's passing. He began to have psychotic symptoms with delusions that he is a bad person who has committed an unforgivable sin because he did not pray enough for his wife's healing. Thomas also began to hear voices telling him that he would be better off dead so that he can be with his wife in heaven. He sadly took his life by sitting in his car with a tube attached to the car exhaust.

Do you think that there were further supports or interventions as individuals or as a faith community that could have assisted Mary and Thomas? We may not be able to prevent suicide in all cases but there are always things we can do better as a faith community.

Factors contributing to the prevention of suicide

Suicide is an age-old problem and over the years, all kinds of strategies have been tried all over the world to reduce the rates. The sad fact is that there has been limited success. Suicide rates have unfortunately been increasing in many parts of the world and this is due, in large part, to the social, economic, cultural and religious changes taking place in the world.

“Suicide rates have unfortunately been increasing in many parts of the world and this is due, in large part, to the social, economic, cultural and religious changes taking place in the world.”

Emile Durkheim, the famous nineteenth century sociologist, made an exhaustive study of the various causes of suicide. In his book *Le Suicide*¹, he concludes that social causes play a crucial role in influencing suicide, and that the strength of suicidal tendency within societies is in direct proportion to its degree of social cohesion. His findings suggest that where social solidarity is strong, suicide will be an uncommon event. This explains the finding that religious adherence is associated with low suicide rates, a finding which still holds true today. Conversely, the finding that when social cohesion breaks down, as in times of economic stress, suicide rates rise. This view equates with the findings that rising unemployment, the breakdown of the family unit, the decline of religion and the collapse of community structures also lead to increased suicide rates.

There are several things we know* that might prevent or reduce the rates of suicide:

- **Family support** and especially the availability of a supportive partner is important as a preventative factor. We know that families with a history of disputes and domestic violence are a major factor in suicides. Also known is the fact that the loss of a loving partner can be a trigger for some to consider suicide.
- **Community support** is equally an important factor, especially the availability of good supportive friends, social groups including church, cell/prayer groups, etc.
- The importance of faith in preventing suicides can be controversial, but we know that **someone with a strong faith** is less likely to commit suicide. There might be times of physical and mental stress when one may think that life is not worth living anymore, but ultimately a strong faith can act as a preventive factor.
- Learning **coping strategies** for stress and trauma. As long as we live in this fallen world, we are not immune from experiencing stress and trauma, but those who have learned strategies and are able to put them into practice in times of stress and trauma are better able to cope without having to feel suicidal.
- Those who have a **purpose and hope for living** are much better protected from suicide than those who do not have such a purpose and hope in life.
- The importance of a good self-image cannot be negated as an important factor. Having a **healthy self-image**, knowing who we are in Christ, and that we are loved and accepted unconditionally by our heavenly Father is an important factor.
- It is important as a preventative factor to **be able to discuss and engage openly about suicide and thoughts of self-harm**. It is healthier to be able to do this than be in a situation where it is a taboo subject.

“As Christians, we must be agents of hope. I firmly believe that as long as there is breath, there is hope: There is hope for the right medication to be found to ease the depression. There is hope that the right therapist will be found to help find a way through the psychological distress. There is hope for God’s light to shine through the deepest despair. But if we aren’t talking about these things, hope becomes nearly impossible to find. Do not be afraid to ask someone you believe to be at risk whether they are indeed thinking about suicide. You will not be increasing the likelihood of suicide by asking the question.”² (Rachael A. Keefe).

Role of the Church or Faith Community

Here are a few things that we can do as individuals and as a faith community:

1. Educate yourself and your congregation on mental illness and suicide.
2. Know the resources that are available in your local area or easily accessible to your faith community. Where possible, make them available to your faith community.
3. Have a Mental Health Awareness Sunday at least once a year in your church or faith community.
4. Encourage conversations and sharing about mental health issues, including suicidality and self-harm.
5. Encourage prayer requests about mental health issues, suicidality and self-harm.
6. Offer support and care to anyone struggling with mental illness, suicidality or self-harm. Encourage the faith community to be involved in caring and responding to mental health crises the same way that the community would respond to physical health crises.
7. Provide leadership in breaking stigma around suicide and mental illness.

Quotes from Christians about suicide

- *“Suicide is a tragedy and a loss, and never to be encouraged or seen by Christians as a positive good.”* Warren Kinghorn.
- *“Some suicidal people in crisis say fear of hell has kept them from killing themselves”* S.R. Blauner.
- *“Telling people that suicide condemns them to hell may not keep them from the act, because the hell they are experiencing may be worse than any eternal hell they fear.”* Karen Mason.
- *“Many Christians, if they were really honest, would talk of times of depression and desperation with thoughts of death and dying.”* Kuruvilla George.
- *“The bottom line is that the Bible says nothing about God’s response to suicide, so all our theologies are conjecture.”* Rachel A. Keefe.
- *“Even Christians can, and do, take their own lives.”* Lloyd and Gwen Carr.
- *“Central to all ethical deliberation is the question, ‘Can we be open to a more humane, compassionate response without giving the impression that suicide is acceptable for anyone under any circumstance?’”* James T Clemons.
- *“As Christians, we should worry less about whether Christians who have killed themselves go to heaven, and worry more about how we can help people like that find hope in living.”* Lewis Smedes.
- *“Nothing will be able to separate us from the love of God in Christ Jesus our Lord” (Romans 8:38,39).*

In conclusion, my hope is that these short articles on suicide have helped us reflect further about this tragic issue and created a desire to consider responses as a faith community.



Professor Kuruvilla George

Professor Kuruvilla George (KG) retired in 2020 as Clinical Director of Aged Person’s Mental Health and ElectroConvulsive Therapy (ECT) for Eastern Health, Victoria. KG was also a Clinical Professor at Deakin University and Clinical Associate Professor at Monash University. He served as the deputy chief psychiatrist for the state of Victoria from 2002 to 2012. KG currently serves as the honorary associate director of the Centre for Theology and Psychology at the Melbourne School of Theology.

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“Do You See Me?” A Reflective Exercise – Jonathan Browning

A reminder that we partner with God in this work

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Image Mikhail Evstafiev

The practice of meditating on the Scriptures is a powerful reminder that we partner with God in this work, and that God is well practised in the art of ‘seeing’.

In Genesis 16, the angel of the Lord was certainly able to bring these qualities together. Take a moment to read through Genesis 16 slowly. After reading it a couple of times, try to imagine what it would have been like to be Hagar. What would the story of Hagar’s life be? The trials, fears and hopes that perhaps she never felt safe enough to voice... or maybe she never found anyone who would listen or who she felt would care.

Her story might go something like this

Unnamed in my own household; servant, foreigner, second class, second rate.

A story of exclusion;

quite simply a pawn in the purposes and plans of my mistress.

Taken or given it matters not;

inconsequential, mistreated, discarded;

not entirely innocent, mind you; and finally forced to flee

mine is a story without a future.

Or so it would seem.

My story is also one of encounter.

Addressed by name and drawn into a conversation that promises that I too am part of a much greater future than I could ever envisage.

My son will know freedom.

I call him the God who sees me and I know he looks after me.

(Hagar – Genesis 16)

The practice of prayer

As well as anchoring ourselves in the Scriptures, an integral part of being a co-worker who wrestles alongside is the practice of prayer, believing that not only is God up to something in a person's life, but is also at work in their lives for their healing. Prayer is the wrestle. More often than not it is the silent response of the heart to the story we are witnessing.

In a mental health context I have found that sometimes (actually a lot of the time) I do not have the words for an adequate response. The story is too heartbreaking and to give voice to the deep and complex emotions that surge within me is too difficult.

George Herbert (1593-1633) described prayer as "the soul in paraphrase" in his poem Prayer (I). For me, the most authentic responses are true to this inner wrestle. It is not the kind of prayer that is polite or couched in pious niceties but rather is raw, angry, disappointed, confused and desperately wanting to find hope in the midst of all that is going on. This kind of prayer I keep to myself, silently whispering to God with my questioning, my frustration and my not wanting to give up on the belief that God is still to be found here and has something to say.

"This kind of prayer I keep to myself, silently whispering to God with my questioning, my frustration and my not wanting to give up on the belief that God is still to be found here and has something to say."

The practice of lament is a powerful expression of this form of prayer. In her book, *Bearing the Unbearable* (2015), Deborah van Deusen Hunsinger describes lament as "faith's alternative to despair". Lament is protest and frustration that holds onto self-respect and self-worth when shame abounds; it is stubborn and persistent, holding onto the faintest of hopes when hopelessness is all too real; it can be a verbose tirade or an anguished cry; it wrestles with loss and uncertainty while desperately maintaining a posture of trust in the God who promises to save.

I have often used this photo of Vedran Smailović in groups to introduce the theme of finding our way again when we feel lost. It is a familiar experience of feeling disorientated by the struggles of life and living with mental health challenges. It also begins to open up the idea of how we might be able to find a way forward.

The discussions usually draw upon the despair and destruction that are immediately apparent. It takes centre stage, as it often does in their own lives as well. But then we start to talk about Vedran Smailović,¹ the cellist who is playing in the rubble, and discussing what on earth he is up to here. Grieving, protest, honouring that which is lost, providing hope, giving voice where others have not yet been able to find their own.

The conversation is rich and thoughtful as we begin to explore what we each might be able to do in our own circumstances of rubble and confusion. I call it prayer, but for those in the group it is often simply a meaningful and thought-filled conversation...



Jonathan Browning

Jonathan Browning operates a small counselling and pastoral supervision practice in Sydney, Australia, and also works in adolescent mental health care as a high school counsellor. His interest in mental health came from his years working in a private psychiatric hospital. His recent book, *Do You See Me*, is a reflection on those years and seeks to explore a narrative approach to listening and pastoral ministry.

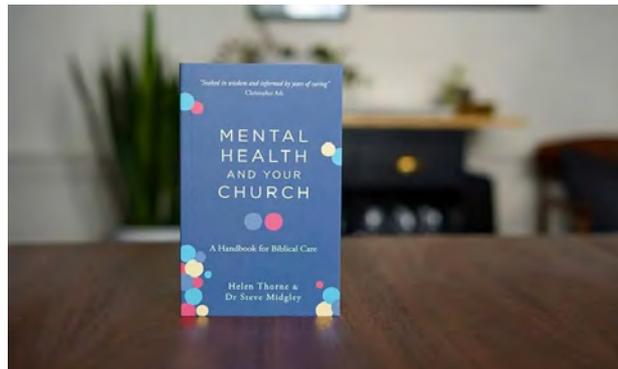
Reference

1. The Cellist of Sarajevo – copyright Mikhail Evstafiev. Licensed under CC BY-SA 3.0

Book Review: Mental Health and Your Church by Steve Midgeley and Helen Thorne

Reviewed by Dr Eleasa Sieh

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Initially I set out to write a book review of Steve Midgeley and Helen Thorne's book "Mental Health and Your Church" but as I began to write, I immediately thought of how this was being lived out in my own local church and, personally, in my community group. This is my hope for this review, that it is a handbook that can be applied in your own local church.

I had the opportunity to hear directly from Steve Midgeley when he visited Australia when invited by Biblical Counselling Australia¹ to lead workshops and discussions around this book. As in the book, he opened with a quick sketch of the global picture of mental illness: 1 in 8 people worldwide are affected by mental illness, and 1 in 5 people in Australia are affected by mental illness in the past 12 months.² In view of such a global reality, he first asks: What do people in your church believe? Is mental illness a spiritual issue where the solution is repentance and faith, or is it purely a biological and brain issue where the solution is medication.

A helpful feature of this book is the use of case studies which are composites of real people in the authors' churches. Here is where I want to introduce M – a lady in her early 50s who was working as a general practitioner (GP) at the practice where I was working. A compassionate curiosity drew me towards M, learning that she couldn't drive because of the strength of the analgesia she was on for chronic pain. Her pathway to being recognised as a vocationally-registered GP had become sidetracked by a head injury; then followed the diagnosis and treatment for breast cancer; whilst also being entangled by untrustworthy family members; and the financial strain of costly specialist reviews and treatments.

When I meet a person like this in my GP clinic, I have a bio-psycho-social-cultural-spiritual approach to helping them as an individual. But there is a richness that being part of a local church allows, in inviting someone like M to be cared for in that community. In the opening chapter, the authors put forth a vision of a church with the following metaphors: a **family** of brothers and sisters, a **body** whose members suffer and rejoice alongside its other members, a **flock** cared for by their Shepherd King, a **place** where all can use their gifts, a **fellowship** of shared resources, a supportive **community** and **congregation** with gentle boundaries in place for the good of all, and a countercultural **gathering**.

In the first section of the book, Thorne and Midgeley invite us to consider that:

- We are part of the continuum of our church family's experiences – thus, the "us and them" attitude that can be so easy to adopt as a healthcare professional is unhelpful, and I would argue unbiblical.
- Thus, we can find points of connection with everyone with mental illness, and we can offer help, starting with the gift of time and attention.
- Finally, there can be a helpful shift in thinking of psychiatric illness as being alien to us by considering that God speaks powerfully and repeatedly to address us in the frailty of our fallen state and has deep compassion for us. Thus we can speak God's words to others.

The next chapter provides a helpful and simple Biblical model of a person: that a person is both embodied and embedded. An important point I want to highlight is that the current bio-psycho-social-cultural model of the person has "a strange

omission of the heart". Biblical counsellors will also be aware that the human's heart is active and is always responding as a moral agent, to choose between right and wrong, good and ill – and as such, wisdom calls for boundaries. This section also includes helpful summaries of current treatments including medication and talking therapies, within a Christian worldview

The second section, titled "What can we do?", asks us to consider two perspectives that are simultaneously true:

Doing nothing is not an option; but that doing everything isn't an option either. At the workshop I participated in, Steve encouraged us to brainstorm barriers that prevent the local church from engaging well with those struggling with their mental health. This list included:

- A conceptual divide between spiritual and psychological needs, reflected in the statement "It's not the church's business"
- This is for the pastors and experts, not the layperson
- Lack of skills
- Lack of leadership for pastoral care
- That the church program is too full already, and it is too time-consuming
- Fear of doing harm
- Mental illness remains a stigma and taboo area to step into

Midgeley calls for the local church to have the following ambitions in pastoral care:

- to be eager, not reluctant;
- compassionate, not critical;
- Gospel-shaped, not worldly;
- wise, and not reckless.

To that end, he calls the church to do the following:

1. **Raise awareness in the church** of the lived experiences of people within their own congregation, not just for the sake of awareness, but so that what they are experiencing is within the bounds of normal human experience, they are not alone, and that there is hope and help in God and others.
2. **Relate to others, and do so wisely**, remembering that *trust builds slowly*, but also to help sufferers relate to God, encouraging them to turn to God in the midst of difficulty. Different ways include: praise, lament, intercession for self and others, Bible-reading and corporate worship.
3. **Remember who God is, as taught theology can differ from functional theology** which are defined in the book as "beliefs that drive their actual behaviour". Here he addresses the problem of spiritual abuse and being careful to prayerfully consult a trauma specialist and ask the person how best the church can help. The authors encourage us to prepare Bible studies with these experiences in mind by considering such questions as: How do they see God? How did this view of God develop? What would make it safe for them to consider changing their views? Are there realistic expectations of change?
4. **Refine**, by which the authors mean **refining what change can look like**. Helpfully they point out the balance between not expecting any change in an entrenched mental illness, to trusting that God is able to do immeasurably more than we can imagine, without an "*over-realised eschatology*" of promising complete transformation on this side of eternity before Christ returns.
5. **Resource its members practically**, including holding information nights with invited speakers who have experience in treating mental illness.

With my friend M, the way in which individuals in our community group have heard her story, allowed her to cry, organised a roster for her to be picked up for weekly community groups, and if possible, attend church, has been nothing short of God's answers to my unspoken and spoken prayers when I first met her. Through M, our community group has also been equipped with more awareness to the mix of troubles that are often found together: neglectful parents, trauma, complex chronic illness, and poverty throughout which God remains sovereign and gracious to save. Also, through M's own spiritual search for truth, she brings her questions where *taught theology* conflicts with her *functional theology* into our Bible study. This often led us into messy places of "Why?" that could not be answered neatly. As a result, I have seen our community group members grow in wrestling with their own understanding of the character of God and their own suffering, and developing patience as a result of her transparency and sincerity when asking questions.

The authors Steve and Helen also address confidentiality, stigma, and feeling out of our depth when encountering chronic complexity in the lives of those we meet in our local churches. I will only speak of confidentiality as this gets complex very quickly in the church context, particularly in the area of sharing prayer requests. I was grateful to read the authors' advice to speak directly to the person about how they want their information shared – in M's case, initially, she was happy for details of her life to be shared amongst the females in the community group, as our community group has decided to split into female and male prayer groups after the study finishes. However, over the past eighteen months, M has expressed

wanting to allow the men's prayer group to know her struggles, enabling them to pray for her as well, with the implied assumption of trust in their confidentiality.

Having a team of brothers and sisters involved in a pastoral care team is wise (Prov 15:22) and it is important to think carefully about how information is shared within this team. Importantly, this leads to the related topic of safeguarding. It is important not to over promise confidentiality in instances where self-harm and suicidality are present. The topic of domestic abuse is not specifically addressed in this book, so I would refer you to other books on this vital topic.³

The final section goes into detail with case studies on anxiety, depression, addiction, psychosis and finally, and very importantly, caring for the carers.

To me, this book serves as a call to personally work to create a culture of safety to care for the vulnerable in the local flock by doing so as a community. It was an encouragement to involve all members of the flock in the life and ministries of the church, within their capacity. After attending Dr Midgeley's seminar, I was prompted to email the senior GP in my clinic, Dr Paul Mercer, for a list of local churches in the area that housed op shops or community pantries to whom I could refer patients.⁴ I was also delighted that our practice pharmacist found and ordered a handbook of local services for women in crisis, since the local church is just one place of help amongst many.

This book reminded me that the kingdom of God has upside-down values in contrast with our world's culture. The gospel is for the needy, and the constant trajectory of the way of Jesus is that weakness is the way of demonstrating the strength of Christ in us (2 Cor 12:7-10). I highly commend this book to everyone, because we are all part of a local expression of the body of Christ. Did you also know that one of the objects of the constitution of CMDFA is to pastorally care for our members?⁵

This book is a very helpful resource for each of us, serving its intended purpose as a concise manual of practical theology. It is grounded in sound pastoral theology, written by experienced pastoral care leaders who understand that we are all fellow strugglers in Christ.

Mental Health and Your Church: A Handbook for Biblical Care (A Ministry Guide to Mental Illness, Anxiety, Depression, Trauma and Addiction)

by **Steve Midgeley** and **Helen Thorne**

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Culturing Mental Health – Dr Lidia Lae

Understanding how culture impacts our mental health can make the difference between barely coping and truly thriving.

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Exploring Culture's Impact on Mental Health from a Christian Perspective

The very first culture to exist from a Christian perspective is within the Trinity. Within the harmonious relationship of God the Father, Son, and Holy Spirit, we find a 'Kingdom Culture' where love, joy, peace, harmony, unity, freedom and truth flourish.¹ God's intention has always been for us to enjoy this fellowship within 'Kingdom Culture'. However, in our fallen and globalised world, culture clashes are everywhere. I've counselled many people who report toxic work environments, abusive family dynamics, and struggles with adjusting to new cultures after moving abroad. Understanding how culture impacts our mental health can make the difference between barely coping and truly thriving.

The Cultural Lens on Mental Health

Mental health, a vital aspect of our overall well-being, is deeply influenced by the cultural contexts we navigate daily. Culture shapes our beliefs, behaviours, and attitudes toward mental health, affecting how we perceive and address these issues. From a Christian viewpoint, understanding the interplay between culture and mental health gives us unique insights into fostering holistic well-being.

Culture is the shared values, norms, meaning, and practices of a community or organisation.² Whether within our families, workplaces, nations, or urban and rural areas, each of these unique cultures significantly influences how we interpret our experiences and cope with life's challenges. For instance, in some profit-driven urban workplaces, there is often a neglect of workers' mental health, whereas in rural areas, workplaces may foster a strong work ethic and encourage connectedness within small farming communities. My own research showed cultural differences in the life stories of European-Australians and Singaporean Chinese,³ with Western cultures often emphasising individualism and self-reliance, leading to a personal approach to mental health. Conversely, many non-Western societies prioritise community and familial support, resulting in different influences in how mental health issues are addressed and perceived.

"Conversely, many non-Western societies prioritise community and familial support, resulting in different influences in how mental health issues are addressed and perceived."

Having recently returned from Timor Leste, where I was born, I witnessed firsthand how my brothers and I were raised not only by our parents but also by aunts, uncles, grandparents, and our small community in Baucau. This collective support during my formative years profoundly impacted my mental health, teaching me that my well-being is intertwined with harmonious relationships within my extended family and community. However, my children have grown up in Australia, influenced by more individualistic values. Within our own family, different generations embody dissimilar cultural values, which must be acknowledged and respected.

In many cultures, mental health stigmas persist, discouraging open discussions and seeking help.⁴ Misunderstandings and misconceptions about mental health can lead to shame and isolation.⁵ However, through the lens of Christianity, these cultural barriers can be challenged and redefined, promoting a more compassionate and supportive approach.

The Christian Perspective on Mental Health

Christianity offers a unique perspective on mental health, emphasising the intrinsic value and dignity of every individual. The Bible teaches that each person is created in the image of God (*Genesis 1:27*), affirming the inherent worth of everyone, regardless of their mental health status. This belief encourages a compassionate approach, countering cultural stigmas, and promoting acceptance and support.

Christian teachings also emphasise community and bearing one another's burdens (*Galatians 6:2*). This aligns with the collectivist cultural approach, highlighting the church's and community's role in supporting individuals facing mental health challenges. The church can serve as a sanctuary, providing spiritual, emotional and practical support to those in need.

Culturing Mental Health by Integrating Cultural Sensitivity and Christian Compassion

Addressing mental health from a Christian perspective involves integrating cultural sensitivity with Christian compassion to create a culture of mental health and well-being. This means recognising and respecting cultural differences while applying biblical principles and the Christian worldview to promote mental health.⁶ The Apostle Paul exemplified how to engage with the culture of this world respectfully in his classic speech to the Greeks in Athens (*Acts 17:10-34*). His example and the principles can be summarised in four key points:

- 1. Cultural Awareness:** Paul developed cultural awareness by being observant and knowledgeable about other cultures (*Acts 17:22-28*). Understanding the cultural background and experiences of individuals is crucial. This awareness helps in providing appropriate and effective support. In cultures where mental health is stigmatised, creating safe spaces for open discussions can encourage individuals to seek help without fear of judgement.
- 2. Biblical Counselling:** Paul exhorted believers to examine the scriptures daily (*Acts 17:11*). Christian counselling, grounded in biblical principles, offers a holistic approach to mental health. The Bible addresses spiritual, emotional and psychological aspects, providing comprehensive care. Incorporating cultural understanding into counselling with scriptural encouragement can enhance its effectiveness, making it more relevant and impactful.
- 3. Community Support:** Paul, Silas, and Timothy were supported by believers in Berea (*Acts 17:14-15*). The Christian community plays a pivotal role in promoting mental health. Churches can organise support groups, workshops and counselling services, fostering a supportive environment. Encouraging openness and empathy within the church can significantly impact individuals struggling with mental health issues.
- 4. Prayer and Spiritual Practices:** Paul wrote to the church in Thessalonica about the spiritual practices that promote mental health: "Rejoice always, pray without ceasing, give thanks in all circumstances; for this is the will of God in Christ Jesus for you." (1 Thessalonians 5:16-18). Integrating prayer, meditation and other spiritual practices into mental health care can provide comfort and strength. These practices, rooted in Christian faith, offer hope and resilience helping individuals navigate their mental health journeys.

Conclusion

Culture profoundly impacts our mental health, shaping our perceptions and responses to mental health challenges. From a Christian perspective, integrating cultural sensitivity with biblical principles offers a compassionate and holistic approach to mental health care. By embracing cultural diversity and applying Christian teachings, we can create supportive environments of 'Kingdom Culture' that promote mental well-being and reflect the love and compassion of Christ. This is what I mean by culturing mental health. Through this integration, we can address mental health challenges more effectively, fostering a community where every individual is valued and supported.



Dr. Lidia Lae

Dr Lidia Lae, PhD, is a writer, psychologist and speaker committed to empowering individuals and organisations to build healthier cultures for meaning contribution. She currently serves as the Director of To Learn Consulting and as a Key Facilitator at the Centre for Theology and Psychology. Lidia is finishing a book and regularly blogs at www.lidialae.com, exploring issues about 'Culture and Self'.

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Beyond the Headlines – Sarah Rizkallah

Understanding the complexity of youth crime

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News stories like this are pretty scary. They showcase the worst behaviours that youth around the world have to offer, making readers terrified of being an innocent victim of this “wave of violence”. The state of young people in Australian youth justice systems has become a topic that dominates our news headlines, is the subject of political discourse, and is a major talking point in the lives of some communities. In all the articles, all the backyard and watercooler discussions, there is an impending sense of helplessness dominated by the story of uncaring and chaotic youth driven towards anarchy... and there seems to be nothing anyone can do to stop it.

“It doesn’t matter anyway, I’m the bad twin so no one really cares...”

“Yeah, but like, it’s just what I do, I have to ...it’s like me now...”

“The only person who ever cared about me is dead. So why should I care now?”

“Wait, what do you mean, ‘Be a different kind of man?’”

“I can’t tell when I’m going to get angry... I can’t control myself”

Dialogue within a therapy room may be different to the watercooler talk, but it also has its similarities. These are all quotes from young people within the youth justice system. Self-perspectives like this are pretty disheartening. They showcase a sense of being lost, a lack of perceived options, and a deep loneliness that comes from people deliberately leaving you behind. *In all my conversations with affected youth (whether at a residential home, youth justice medical centre, or police watch house) there is an overarching sense of helplessness dominated by stories of being justifiably angry as they’ve been pre-judged by others, then abandoned and left with the inevitable punishment ... and there has been nothing they could do to stop it.*

As may be evident, I am presenting a comparative narrative here. Within the world of therapy, this is called a *parallel process*. That is, a phenomenon where the dynamics in a therapeutic relationship mirror those in another relationship. In this case, the relationship between the community and young offenders begins to mirror the relationship that young offenders have with the people from their past traumatic experiences. Unconscious mirroring of problematic patterns can make it difficult for us as therapists to maintain objectivity. It then increases both parties’ feelings of being overwhelmed, and consequently stalls progress all together.

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As medical practitioners, it is our job to hold these young people within a delicate dichotomy; one that recognises their actions, the consequences and need for accountability, but also sees them as kids, who are not just our patients, but God-loved, multi-layered individuals, each with their own unique story that underpins their criminogenic action. Although copious amounts of frameworks exist within the world of therapy, I have found Narrative Therapy to be particularly

helpful. This reminds me to see these young people in all their complexity, both good and bad, within the socio-politico-economic landscape in which they reside.

Complexity of Life Reflects our Complex God

To better understand complex matters, it can be helpful to begin with the source—God. A common question arises when initially comparing the Old and New Testaments: “How can this be the same God?” At first glance, the Old Testament seems to portray God as vengeful, strict, and loving, yet weary of giving second (or third, fourth etc.) chances. By contrast, the New Testament emphasises a God of love, mercy, and forgiveness. This apparent contradiction can be confusing. However, on deeper inspection, this is not a contradiction but rather a reflection of God’s unchanging, yet multifaceted, nature. God is consistent throughout the revelation in both Testaments, displaying both love and judgment in different ways. God is intricate and not confined to a single characteristic but rather embodies the fullness of both justice and love across all time despite the variety of situations described to us in the Scriptures.

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Being made in the image of God means that we, in many ways, reflect His complexity. We are not simple, straightforward creatures. Rather, we are intricate and multifaceted, with layers of personality, experience, and emotions. However, there is one crucial difference between us and God—our sin. This (not so) ‘special ingredient’ distorts our complexity, adding brokenness to every aspect of our being. Sin doesn’t strip away our complexity; instead, it seeps through each layer, distorting them with brokenness and this makes us even *more* difficult to understand. We are then not only complex in our God-like nature, but also fractured, with parts of our identity and story marred by sin.

The idea that sin permeates and distorts our complexity is a powerful one. It suggests that our brokenness is not something that can be easily fixed or ignored, it is a fundamental part of who we are. For young people in the Youth Justice system, this brokenness is often manifested in behaviours that society deems unacceptable or criminal. However, these behaviours are often symptoms of deeper issues—issues that are rooted in each complex and broken story.



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Complex approaches for complex people

The challenge for those working with these young people is to see beyond the behaviours and understand the underlying narratives. This requires acknowledging the complexity of their stories. One of the greatest dangers in working with any patient, regardless of setting, is the tendency to reduce them to a single story. In Narrative Therapy, a single story refers to a narrow or limited narrative that defines a person’s identity or experience based on a single aspect or event. It often involves viewing oneself or others through a singular, often negative, lens. Narrative Therapy challenges us to reject these single stories and instead embrace the full complexity of each person’s life. This therapeutic approach recognises that our lives are made up of multiple stories, and that the stories we choose to focus on can significantly impact our mental health and well-being.

One way we can combat unhelpful viewpoints in the public domain is by actively recognising the power of single stories; whether they are shown through media or even created by us as well-meaning professionals. We need to strive to sit amongst those with complex stories marred by sin, and listen without judgment, just as Jesus sat and ate meals with tax collectors. Jesus did this not because he ignored unlawful behaviours, and not because he condoned and supported selfish behaviours, but because he saw both sides of people clearly – their sin *and* their worth. As Christian medical practitioners, we need to approach our work ensuring that we actively balance these seemingly opposing truths; that the young person in front of us is both a vulnerable child who is loved by God, but is also the perpetrator of a violent crime. By doing this, we can work with the perpetrators of heinous sin with the grace of Jesus leading us.

Secondly, we can promote change by looking at ways to actively invest in a better future for these young people. Low socio-economic status, disability, effects of intergenerational trauma, and ongoing racism are everyday facts of life for young offenders. Our role as Christians is to not only hold out hope, but to reflect the hope we have in Jesus rather than reflecting the trauma that a sinful world produces. By actively investing in change, growth, and safety, we can stand apart and truly embody the hope we have in Jesus. This hope can bridge the gap between the devastation of this world, and the offer of forgiveness now and in the world to come.

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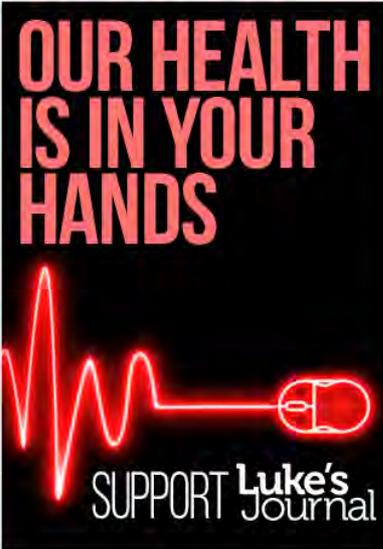
Finally, we need to ensure that we are aware that we have our own sin, our own bias and judgements, and that with God’s help we can put them aside to create a safe space for young people to share their stories. We need to work in smart ways to ensure that we are safe while doing this work, both spiritually protected from powers that want us to judge with fear and doubt alone; and safe physically from young people’s behaviours (which may have initially developed to keep them safe from harm, but now may lead to them hurting another). Talking openly with colleagues, supervisors, and leaders about what this looks like means that we can contribute over the long-term in complex areas while remaining safe ourselves.

The mental health challenges of young people in the Youth Justice system are complex and multifaceted, reflecting the brokenness and complexity inherent in all of us. As Christian medical practitioners, we have a unique opportunity to support these young people by embracing their full stories and helping them reframe their narratives. By doing so, we can offer them a path toward healing and wholeness, grounded in the understanding that they are more than the sum of their brokenness—they are complex, multi-layered beings created in the image of a complex and loving God.



Sarah Rizkallah

Sarah Rizkallah combines a passion for healthcare with a deep appreciation for the transformative teachings of Jesus. With a background in Clinical Psychology, and having worked across non-government organisations (NGO), public health community, hospital settings, and youth justice settings, Sarah explores the intersection of compassion, humility, and patient-centred care, drawing inspiration from both biblical wisdom and practical healthcare experience.



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ALIVE: Making Christ Known by Caring – Dr Sunny Philip

Emotional trauma is the church's most compelling challenge

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The poem above was written by C, a mother, wife, teacher, a believing Christian, and an active member of her church. Her childhood trauma is playing havoc with her mind. She says, "If it is not for the support of D, I would have ended it all." Both C and D have attended our ALIVE (Alive to God, Alive in the Community) training. One discovered the pain and hurt behind her masked life, the other practices what she learned during the training – "We are fellow travellers, not solution providers. A friend never gives up on a friend." (used with permission)

The Christian church, from its very beginning, proclaimed the good news of Jesus Christ by actively and creatively responding to the challenges of poverty and injustice; illiteracy and ignorance; disease and epidemics. Today, the greatest need of our world is dealing with emotional trauma. Domestic violence, sexual abuse, marital problems, prejudice and stigma, depression and suicide are everyday experiences in our world. Students in schools, patients in hospitals and clinics, the public at their workplaces, and worshippers at churches carry this hidden burden.

Some of us may know about these issues. But how many of our friends, church members and relatives suffer unnoticed and uncared for? It is not because we don't care but because we do not know how to care, or how to read the hidden messages they try to send our way.

Emotional trauma is the Christian church's most compelling challenge today. It is also our window of opportunity to make Christ known. The church is a caring community because the God of the Bible is a caring God. When we care we are not just responding to a need, but we are being transformed into the character of Jesus Christ.

Then, what we do in the name of Christ will become a spontaneous overflow of the character of the God who dwells within us – an extension and consequence of who we are in Christ. When we are empowered and directed by the God who lives within us, everything we do becomes service to God, and service to God becomes more than what we do. Then we will not look for who is deserving of our service and who is undeserving of God's pleasure. Instead, we become Christ-like in all our dealings.



"Tired of the masks I have to put on to face people...as one mask comes off, another is ready...wanting to be me but not able to..."
- ALIVE Training Participant.

ALIVE training

ALIVE training is Transform4Life's response to this predicament in our communities. It is designed to create awareness and provide basic skills to non-anxiously journey with a friend who may be going through some form of emotional trauma. Everyone deserves a caring friend. Caring is the church's response to a hurting world. We are called to be *alive* to God, *alive* in God's world.

- A Christian is a community builder not a spiritual consumer.
- Staying with people in their moments of need and journeying with them as they struggle with their pain and uncertainty are effective ways to make Christ known.
- The most effective realm to make Christ known is in our own spheres of influence.
- When the Christian community truly feels the pain of those in their spheres of influence, then they will know that there is a God who cares. "See how much he loved," said the world when Jesus wept with Martha and Mary at the tomb of their brother.
- Caring is more than crisis management. It is a process, a journey.
- Caring is staying with people in their moments of need and beyond. Friends never give up on friends.
- Caring friendships have healing power, but it does not replace or disregard professional therapy and care.

ALIVE Strategy

Move slowly, intentionally, and patiently. ALIVE is not solution-focused. We believe that when we do the right things the right way, we will get the right results. In Jesus's parable of the sower, even the seeds that fell on the good soil did not all produce the same result. We believe that as long as we sow the seeds of God's Kingdom, there will be a harvest.

ALIVE people are everywhere. They do not sit in offices or consulting rooms waiting for their clients to come to them. They are everywhere because they are mothers, fathers, brothers, sisters, friends and even strangers. Remember, the man who stayed with the victim in Jesus' story of the good Samaritan was a stranger and an outcast. He was also on a journey and possibly just as vulnerable. ALIVE is a training programme of Transform4Life, designed to empower the local church to connect with their communities with the purpose of making Christ known.

It was emphasised throughout the course that, "Our life is God's and not our own," and God wants us as individuals and community to be caring friend(s) to those around us who are in the grip of violence, abuse, victimisation, pain, fear, anger, anguish, trauma, etc. Before helping them to go to a professional caregiver, such victims under (sic) trauma need a friend who is prepared to walk along with them in their traumatic journey, (to) give support by being present with them, and giving (them) confidence to open up. Among all the topics, I single out one point which touched me as a parent and grandparent, and it is about transgenerational trauma which a person under trauma, may pass on to their next generations. It is a warning to all parents as well as prospective parents. - ALIVE Training Participant.

Transform4Life

Transform4Life exists to make Christ known by caring for those who are emotionally wounded. Our goal is to establish communities of trained caregivers who provide emotional care and relief to those in their spheres of influence. We are a group of people from the fields of education, health, pastoral care, psychology, and social work.

"We believe that the most effective way to make Christ known is by caring. We want to enable spiritual consumers to become community builders."

Our mission is to motivate, mobilise, train and support those who are committed to bringing healing and restoration in the name and spirit of Jesus Christ to those in their sphere of influence. We believe that the most effective way to make Christ known is by caring. We want to enable spiritual consumers to become community builders.

We have several training programmes ranging from short seminars and workshops to fully-fledged face-to-face and online certificate courses to suit the needs, abilities, and availability of the community. Currently, we have participants from sixteen countries. We conduct training in several languages in small groups of 25 to 30 people at a time. Currently, we work with local churches and Christian institutions in East Asia, India, Africa and Australia.

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A Biblical Counselling Approach to Anger

– Jeremy Ward

Scripture gives us a vision for becoming good and angry

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Recently, my wife, Hayley, had been in conversation with others from church where she feared she had been misunderstood. I was a bit surprised at how quickly I got angry in response. Not angry at my wife. It was more the thought of, "Why does everything have to be so hard?!"

This experience got me thinking about how often my anger is connected to my desire for ease and comfort.

Anger is often bad

Anger is often bad. Bad anger can be overt and explicit: a raised voice, clenched fists, physical intimidation and violence. Perhaps you've recently observed this in an incident of road rage, or harsh, damaging words you witnessed from a parent to a child, or the explosion of a customer at a store. Bad anger is driven by a desire to punish and attack what is considered wrong.

But bad anger can have subtle, less overt forms:

- being passive-aggressive ("I'm angry at you, but I'm not going to address it directly"),
- grumbling ("I'm not getting what I want in life"),
- having a victim lens ("I'm always being mistreated!"),
- being sensitive to the failures of others,
- or being highly critical or irritable.

We can map anger in relation to whether it is hot or cold. Hot anger is the explosive side of anger. It's like 'scorched earth' around the angry person. As a result they may feel isolated, alone, or unfairly judged while everyone else keeps a safe distance away.¹ Cold anger can be expressed as stonewalling, the 'silent treatment', withdrawing to punish ("You don't affect me!"). It can also express itself in calculated revenge.²

Anger is sometimes good

But anger is sometimes good. Consider our reactions to injustice: “How could she use you like that?!” “How could he just stand by and let that happen to you!”, “I’ve got to pursue justice. What happened was so wrong!” An advocate who stands up for someone wronged can express constructive anger – an anger that brings comfort to the victim and springs from love.

Our anger is usually a mix

Our anger is usually a mix of good and bad. Think back to the example I shared about the conversation with my wife. Allow me to share some further details. Hayley was having constructive conversations about music at church. There was some good in my reaction – it included, “This matters!” – concerns bigger than my preference were at play. The songs we sing have a significant shaping influence on us. Hayley has done some excellent thinking about the place of lament, songs reflecting various concerns shaped by Scripture. So there was some good in my strong reaction, “This is something worth fighting for!”

But there was also bad in my anger: impatience (“It’s not happening on my timeframe!”), a desire for my life to be easy (not messy and complicated) and a failure to acknowledge our good God, who wants to work good in us through the process of having these conversations.

In many instances, we find this mix of good and bad in our anger. But the Lord’s command for us is:

“Be angry and do not sin.” Ephesians 4:26: ESV

How do we get there? That’s what a biblical counselling approach to anger is aiming for. However, before we flesh that out, it’s worth clarifying what anger is.



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What is anger?

The core beneath the many faces of anger is, “I’m against that.”³ It’s saying, “That matters... and it’s not right.”⁴ It’s, “Active displeasure towards something that’s important enough to care about.”⁵

When I feel anger, three things happen:

1. I pinpoint something that I see as wrong;
2. I take a stance of disapproval; I’m unhappy about it;
3. I’m moved to take some action (or potential action).

For example, my son interrupts me while I’m writing an SMS on my phone.

1. Firstly, what do I see as wrong? The interruption (“I should have a moment of uninterrupted peace and quiet to finish my thought!”).
2. Secondly, how do I express a stance of disapproval? I’m against my son; I disapprove of his interruption (“He shouldn’t have done that!”).
3. Thirdly, what action am I moved to take? I lash out with critical words: “Can’t you see I’m in the middle of something?!”

These same three things play out whether the incident is an example of bad anger (as above) or good anger (for example, someone discloses abuse, and you respond by feeling anger towards the perpetrator).

Anger motivates us

But it's also worth pointing out that anger motivates us.⁶

Anger "protects what it loves".⁷ It works to right wrongs.⁸ We see this play out in good anger as people work towards justice, restoration, and healing. But we also see anger protecting what it loves with bad anger, as people react badly to interruptions, cut down others to defend their reputation or assert their power.

Anger isn't "content to sit idle."⁹ It's difficult to restrain with self-control.¹⁰ When people have no outlet for anger, people turn sour, it can lead to depression.¹¹

A friend of mine speaks of anger like a nuclear reactor. It's volatile and dangerous. It can also be harnessed for great good.

God's plan for our anger

Consider this example. A couple plans a special meal at home. The husband goes all out. But his wife is caught up in traffic and arrives home late. A big fight follows. It spoils the rest of their evening. Each is angry at the other, convinced that they have experienced real wrong. Their hopes for the evening are dashed.

How does God and his plan rearrange the hearts of this husband and wife?

Let's return to this example shortly.

Good and angry

God wants to make us "good and angry".¹² We follow a Saviour who was both angry (e.g. Mark 3:5) and without sin (Heb. 4:15). Jesus didn't just die to take away our sin, he "died to make us good"¹³ (e.g. Titus 2:14). That 'good' is that our lives are patterned after his. This includes our anger becoming good and clean like his anger.

Building on our definition of anger, we see that it involves making value judgements. What you get angry about reveals your heart, what you value, what you love.

We can go wrong in three ways.

- Firstly, **sometimes I value the wrong things**. For example, if I love power or control, I might use my words to belittle you: "You think you can challenge me? You're good for nothing! You ought to be ashamed of yourself!" What's the message? "You exist to do my will. Submit to me or face my wrath!"
- Secondly, **sometimes I value good things too much**. Consider the example of me sending an SMS and being interrupted: "You're disturbing my peace!" Peace and quiet can be a good thing. But it has become a demand in my heart if I'm willing to lash out at others who disturb it.
- Thirdly, **sometimes I don't care enough**. I'm apathetic, unmoved, and lack love. For example, my son comes home and tells me about his experience of bullying, but I'm not moved. What he needs from me is, "That was so cruel! I need to address this with Mr Robinson!"

Becoming like Jesus, the process of God changing our anger, involves being concerned about what God cares about. God is in the business of changing our desires. This means that God changes **what I want** (where the desire is wrong), he changes **how much I want** (where the desire is too much), and he changes **what I love** (increasing my love, so I care about things that I wasn't concerned about before).

C.S. Lewis gives us a helpful illustration about the goodness the Lord is working in us. He says it's like playing the piano. It's not about hitting any key at any time. But it's when we play the right key at the right time that we produce a beautiful tune. He gives the example of the mother instinct. There are times when advocating for your child will result in things being unfair for other children. On that occasion, the desire to advocate needs to be restrained. But there are other times when standing up for your child is necessary. Occasions where that desire is to be acted on.¹³ This is the beauty of what God's Spirit does in us. He shapes us to want the right thing, with the right intensity, at the right time.

The constructive displeasure of mercy

David Powlison has coined the phrase, “the constructive displeasure of mercy” to capture God’s own anger and the shape of our Christlike anger.¹⁴

What is it?

- Firstly, constructive means that it is going somewhere good. That means that it’s free of our self-centred concerns for getting our will, our way.
- Second, displeasure is that sense that what has happened is not good. Being unhappy about something. Taking a stand against it.
- Thirdly, mercy is that desire not to simply treat others as they deserve, but instead a determination to do what is good for them.

Powlison unpacks four key ways we express the constructive displeasure of mercy: (i) patience; (ii) forgiveness; (iii) charity (kindness); and (iv) constructive conflict. For our purposes, let’s zero in on patience and constructive conflict as we think about good anger.

1. Patience

Patience in Proverbs is closely related to anger. Where the NIV translates ‘patience’ the ESV often translates ‘slow to anger’. For example:

“Whoever is patient has great understanding, but one who is quick-tempered displays folly.” Proverbs 14:29 NIV11

We’re like God when we’re slow to anger. It means persevering in a relationship with someone when they still have a lot of growing to do. It means slowing down when something pushes our buttons. For example, taking a week to sit on a draft reply to a critical email rather than firing it off immediately.

2. Constructive Conflict

James 3:13-18 is a key passage on constructive conflict:

*“Who is wise and understanding among you? Let them show it by their good life, by deeds done in the humility that comes from wisdom. But if you harbour bitter envy and selfish ambition in your hearts, do not boast about it or deny the truth. Such ‘wisdom’ does not come down from heaven but is earthly, unspiritual, demonic. For where you have envy and selfish ambition, there you find disorder and every evil practice. But the wisdom that comes from heaven is first of all pure; then peace-loving, **considerate**, submissive, full of mercy and good fruit, impartial and sincere. Peacemakers who sow in peace reap a harvest of righteousness.”*

We read of the difference between ‘worldly wisdom’ and ‘heavenly wisdom’. In 3:17 the ESV translates ‘considerate’ (NIV11) as ‘open to reason’. It’s a posture saying, “I’m going to stay calm. I’ll hear you out.” “I’m not going to take it personally.” “I may disagree with much of what you say, but is there a grain of truth that I need to hear?” This openness can make a world of difference in a conflict.

Constructive conflict aims to make peace (3:18). It’s the difference between keeping the peace (‘peace-faking’) and peacemaking. It’s a willingness to have difficult conversations for the sake of establishing real peace (think ‘shalom’ in the Old Testament, a deep harmony in community). There’s a place for honesty, but it’s honesty and love together. We work hard to say things in a way that invites relationship, in a way that’s easier to hear rather than attacking.

God is the Judge

Good anger makes and leaves room for God’s judgement. It asks God to act and right wrongs. Anger tempts us to assert ourselves as the judge. Instead, we’re called to submit to the Lord. James says:

“There is only one Lawgiver and Judge, the one who is able to save and destroy. But you—who are you to judge your neighbour?” James 4:12 NIV11

We follow the pattern of the Psalms. We ask God to judge, expose evil, bring justice, right wrongs. Likewise, we’re told clearly by Paul:

“Do not take revenge, my dear friends, but leave room for God’s wrath, for it is written: “It is mine to avenge; I will repay,” says the Lord.” Romans 12:19 NIV11

Returning to the couple's conflict

How do these plans of God change the couple in conflict about their failed evening together?

- For the wife, she recalls that the Lord is her Shepherd, who gives her all that she needs. How does that reality change the way she engages in conflict? "I'm still right to challenge my husband for being unreasonable. But now I see that changes my tone—it's a loving correction, not an attack. Not everything depends on whether he hears me or not. It doesn't have to be resolved here and now. If I try, and he's not receptive, there will be other times to try again. Whether he hears me or not, the Lord is with me, and he will give me what I need most."
- For the husband, his eyes are opened to see that he wanted a good thing (in a special meal) but that something had got distorted in his heart. "It's become more about me and my expectations for our time together... I've been feeling hurt... I'm disappointed and feel like you don't appreciate me... But I was wrong to be so unreasonable and impatient when you were held up. Will you forgive me?"

How to help: a four-step process

In this final section of the article, we're going to consider a four-step process to help us deal with our anger and help those around us who struggle with anger. I'm borrowing this framework from Alastair Groves and Winston Smith. The four steps are: (i) identify; (ii) examine; (iii) evaluate; (iv) act.¹⁵

You can jump in and help others at any of these four steps. Your initial help might only be focussed on one of these steps.

Before we unpack the steps in detail, it's helpful to think about the change process in the Christian life. I often think of a scene in the movie, *The Matrix*. Neo is being shot at, rapid fire. We see everything in slow motion. The camera pans. Neo sees each bullet and is able to dodge and weave to avoid being shot. As we help others to change, we want to help them slow down and see things in a micro-moment that they've not seen before.

With anger, there's a particular blindness. An angry person is usually the last person to see that they have a problem.¹⁶ It's difficult to take the log out of their eye (Mt. 7:3–5). When someone says, "I have an issue with anger," it's huge!

Working with an angry person can take time. For an angry person given to twenty minutes of rage and ranting, change might start by reducing their rage to fifteen minutes. Growth is in learning to identify anger sooner. What we're aiming for is a growth in self-awareness where two paths emerge – early in the moment of anger. This is the freeze-frame, the micro-moment. We want them to see, "This is the path I typically choose. I don't have to pick that path. The Lord offers me a way of escape and this is what it looks like..."

1. Identifying anger

In identifying anger, we're asking, "**What's going on in me?**"

"Oh, I'm angry!"

How do we recognise anger? Anyone in attack mode. Physically, anger may be evident by rapid breathing, a flushed face, tense muscles, clenched fists, and one's whole body feels tight. Long-term anger may be expressed by hypertension, digestive issues and high blood pressure.

Think of common bad anger: a raised voice, harsh, critical words, broken items like smashed dishes, holes in walls, shattered phones. There's violence—where someone physically attacks another.

On the receiving end of anger one might have tears, respond in tense silence, anxious attempts to calm or with return attacks—"fighting fire with fire."

When you're the angry person, anger feels so right. Like the time I was cycling and a driver broke road rules to overtake me. In my anger, I was deluded in thinking he'd benefit from my heated words and shaking fist.

You can feel like everyone is out to get you. The world is full of idiots, people who treat you unfairly, incompetence.

Sometimes anger is expressed in less intense forms: frustration, irritation, grumbling and complaining. Each of these is anger—just in more or less intense forms.

2. Examining anger

Examining anger is turning the incident over in your mind. It's not aiming to conclude whether the anger is good or bad; it's gaining insight. What happened? Was there a trigger? We're asking, "**Why am I angry?**"

This step alone can help diffuse anger. Perhaps you have had a fight with your spouse about how to stack the dishwasher, and asking this question helps you to see how silly it is!

"What wrong am I perceiving?" Name the injustice that you feel; what you're attacking (or wanting to attack).

"What is the outcome of my anger?" Is my response helping others? Or damaging them?

Anger can hide behind escape: turning to alcohol or drugs or any way of checking out—like TV, social media, binge-eating. This kind of anger simmers beneath the surface until you're tipped over the edge. It becomes clear when there's a sudden explosion.

3. Evaluating anger

Now we're aiming to **assess whether our anger is good, bad, or a mix:**

- Was my response reasonable? Out of proportion?
- Am I taking a stand against something that matters? Am I upset about what God is upset about?
- Or is this more about not getting my way? Things not going according to my plan, my agenda, my kingdom?
- What was happening in my heart? Did desires for other things hijack my love for God?
- Have I caused damage to others and failed to love? Have I asked God to right what was wrong?
- Or have I been bent on vengeance, taking things into my hands?

Here's a healthy caution: if we conclude there was a real wrong, it can be wise to slow down our responses in order to make them right. Invite a wise friend in, ask for their input. Our anger may have something healthy to it, but we can still be prone to self-righteousness ("I'm right; you're wrong"), pettiness (maybe it's not a hill worth dying on?) or getting even ("I want to make them pay"). It's worth asking if we've understood things accurately.

Occasionally, we just misunderstand something. Did they really mean that? Does what I perceive of this person stack up with what I know about them? How do they usually treat others?

4. Acting on anger

How can I act constructively on my anger?

Slow down!

"... Everyone should be quick to listen, slow to speak and slow to become angry"
(James 1:19 NIV11)

We ask questions like: what steps can I take to love God and neighbour? Are there steps I can take to pursue truth and justice? Are there wrongs that I need to put right because of my own bad anger?

These four steps can be very helpful. But we follow them, engaging God throughout.¹⁷ We live before a personal God and we need His help!

We're asking for the ability to see ourselves clearly. For him to shed light on places where we've become blinkered, tunnel-visioned, unable to see him and others. For the help we need to put right any wrong we've done. For the Lord's forgiveness when we have responded with bad anger.

We're asking Him to see where He's forming good desires. What it means for us to express constructive anger.

We're asking Him to hear, act and rescue when our anger is in response to our suffering.

We each experience anger in a variety of forms. But Scripture gives us a vision for becoming good and angry. In the kinds of ways we've explored, anger can be redeemed and serve God's purposes in making us like Christ!



Jeremy Ward

Jeremy Ward works part-time as a biblical counsellor in his own practice (christiancounselling.sydney). He's passionate about joining the dots between the things God says and the stuff of life. Jeremy is married to Hayley and they have four children.

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Spiritual History Taking in Mental Health – Georgina Hoddle

Building courage and resilience through wise communication

From Luke's Journal Nov 2024 | Vol.29 No.3 | Mental Health II



Image Tima Miroshnichenko, Pexels

*This work was presented in part at the NCFI Congress, Malaga, Spain 2024
(After reading this article and completing the activities you can gain 1 hour of CPD)*

Introduction

This work was developed to assist nurses and other healthcare professionals to address the spiritual care needs of people with mental illness: Building courage and resilience through wise communication.

This presentation is the fruit of collaboration between the Hunter Mental Health Network (who are Christian Practitioners) during two Saline Process™ Tasters delivered in Newcastle in 2023. The Tasters were attended by almost 30 people from many areas of healthcare. Attendees included a mental health registered nurse, a psychiatrist, psychologists and counsellors as well as an occupational therapist and members of the church. One attendee was a non-Christian carer and active participant.

The standard set of 20 slides approved by IHS Global for a Saline Process™ Taster (SPT) were presented within the context of a workshop in which attendees were invited to discuss the content of the slides and participate in 4 activities.

Worksheets were prepared and approved by the Nurse's Christian Fellowship International (NCFI) Saline Process™ Coordinator. The fruit of these SPT workshops was the knowledge that the area of disability and mental health requires particular attention to the language and approach used when assessing the spiritual health of people with mental health issues.

In principle, what I will be illustrating here is the application of wise communication by drawing from the corpus that the Bible provides, using the ethical principles of permission, sensitivity and respect when dealing with vulnerable and underserved populations.¹⁻³

Background

Much experience and research has gone into developing an understanding of the complexity of interaction on a spiritual level with people who are affected by mental health issues.^{4,5}

My personal experience (2005 to 2023) with a person who was living with an acquired disability caused by mental illness (Type 1 bipolar disorder) has led me to study and evolve as a nurse educator and linguist, and resulted in the compilation of a case study.

This person (here I will call CS) was followed up for a period of six years. CS demonstrated courage as they became interested in the Saline Process™(IHS Global)³ in 2018. New skills gave me insight into the ethics of supporting clients, as well as my own mental health, ^{4,5} resulting in the development of my own resilience and awareness.

Activity 1: What is your context?

Think of a person whom you treat or support, to whom you can apply the language of wise communication.

Clients in Australia may present with a National Disability Insurance Scheme (NDIS) referral which could relate, for example, to bipolar disorder, schizophrenia, a history of trauma, substance abuse. Case facts could also include that they are homeless, unable to attend to psychosocial needs or have a diagnosis of psychosis, with auditory hallucinations and perceptual difficulties (delusions).

Table 1. Facsimile of template used for discussion in the 2023 SPT Workshops

*Client's journey	Case facts	Related activity	Discussion focus
e.g. ANXIETY Pt presents to MH clinic, referred by GP. Are they reactive? Establish boundaries Emotional regulation required	Draw from an authentic case (remains anonymous).	Supportive action in taking a spiritual history; building a support network. E.g. Apply national Guidelines; develop a sense of reassurance, do not be judgemental; build trust	Type of mental health issue; be cautious. requires experience; Delicate. Consult the literature.

*Client, patient, resident or friend could be used throughout this article. For ease of reading, client will be used throughout.

Activity 2: Timeline your case study

Indicate the weeks/months/years of ongoing spiritual care.

Table 2. Case Study Timeline:

2018	Introduced CS to the Saline Process™ with permission, by answering CS's questions
2019	Discussed teaching and training activities with CS (intense that year!)
2020	CS Commenced Zoom prayer meetings with HealthServe Australia
2021	Implementation of holistic person-centred care. Application of active listening
2022	CS developed prayerful networks. Answered open-ended questions about Biblical topics
2023	Continued to pray in the name of Jesus. CS passed on to eternity

Activity 3: What key words and phrases apply to your context?

When thinking about the client with mental health issues to whom you have been able to apply the human right of spiritual care, which words or phrases from the list (Table 3) could be used appropriately in the context of your case study? (Remember to maintain confidentiality).

Table 3. Key Words and Phrases

ACCOUNTABLE	DYSREGULATION	REACTIVE
ACQUIRED DISABILITY	EMOTIONAL	RECOVERY ORIENTED
ANGER	ETHICS	RESILIENT
ANXIETY	HOPELESSNESS	SUPPORTIVE ACTIONS
ASSESSMENT	HOSTILITY	UNDERSERVED
COURAGE	MISTRUST	UNDERVALUED
DISCONNECTION	PERSONAL RESPONSIBILITY	VULNERABLE

Activity 4: In your experience what is essential:

1. To obtain before you assess a client?
2. To demonstrate towards your client?
3. In your treatment of them?
4. What emotions can be observed ?
5. What is the most difficult spiritual barrier to overcome?

**Some suggested answers can be found at the end of this article, compare them to your own.

Spiritual history taking as a supportive action

Taking a spiritual history could involve discussing the client’s upbringing and education (and if/when these were disrupted). It could also include past trauma as well as past and current treatment. Ask open-ended questions in order to build trust and rapport.^{6,7} Discern if their spiritual life is natural or esoteric, new age, non-existent, hocus pocus or a more established religion or faith.

Supportive actions include effective implementation of the recovery approach as well as strategies and narrative threads,⁸ e.g. talking about nature could lead to a discussion on the Fibonacci sequence, spirituality and the attributes of God as per <https://christianperspective.net>



Example: The Fibonacci sequence found in the nautilus shell is astounding mathematically and can be seen as a map for spiritual growth. We start in the centre, where we begin to understand that our actions have reactions; gaining knowledge of where we are disconnected and learning how to move on helps us to spiral out (of our old self); we must challenge ourselves in situations to grow.

Spiritual Assessment Tools

These assessment tools are useful in both acute and long term care settings. They gather and evaluate relevant data pertinent to the client’s situation and bio-psycho-social-spiritual and religious health. The most effective questions to use are open-ended and encourage the client to speak freely in a safe environment. Spiritual assessment is not just the domain of chaplains. Doctors and nurses can integrate spiritual history-taking within the context of holistic person-centred care.

Table 4. Spiritual Assessment Tools

FACT	the facts, feelings, family/ friends, and faith ⁹
FICA	Faith and Belief; Importance; Community of Faith; Address in Care ¹⁰
HOPE	Sources of Hope; Organized Religion; Personal Spirituality and Practices; Effects on Medical Care and End-of-Life Issues. ¹¹
Open – Invite	Open the Door to Conversation; Invite Discussion of Spiritual Needs. ⁵

Quotes from the spiritual assessment of persons with mental health issues.³

Emotional barriers in these vulnerable people could involve anger, fear, anxiety, hostility and frustration. These emotions often cause dysregulation. The client may not want to press on with the idea as they may already feel overwhelmed and may look at these emotions in a negative light. There could be mistrust and disconnection with low self esteem (“Why should Jesus care about me?”). They could also be embarrassed or lonely (“Jesus can’t give me connection”), or angry (“If He cares, why doesn’t He help me?”). The client may have suffered trauma; negative health, faith, relationship or life experiences; as well as past injustices (“Pain is causing all my problems!”).

Identifying and overcoming intellectual barriers may be affected by a client’s low cognitive ability¹, and meeting these challenges would only come after establishing emotional safety. Often a client in crisis is worried primarily about ‘survival’ and meeting basic needs. They may lack self-identity (what it is to be human), who they are in relation to others; or have difficulty identifying their boundaries as a person. There are also cultural considerations.

After overcoming emotional and intellectual barriers, clients then enter the end stages of change. Volitional choices come into focus as they decide whether to accept and commit to treatment or therapy in line with their values and desires. This needs to be conducted in a safe environment.

The ethics of spiritual care^{7,8}

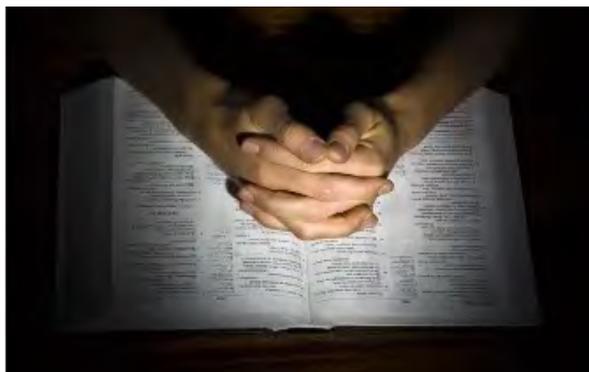
Ethical behaviour or responsibility is doing the right thing for the client. Ignoring responsibilities makes clients suffer. Healthcare workers can be held accountable for these behaviours. Examples of unethical behaviour include fraud and neglect, including neglecting to address spiritual care if the client requests and consents to it. An in depth course with training on the ethics of and tools for spiritual history-taking by Christian healthcare workers is available via The Saline Process™ Witness Training.¹²

Table 5. Principles of nursing ethics, spirituality and the Bible

Moral Principles ⁷	Bible references
Beneficence	The Good Samaritan (Luke 10:25-37)
Non-maleficence	First, do no harm (Luke 10:29-37)
Autonomy	Free to do what is right (I Cor 6:12)
Justice	Jesus said, “And will not God bring about justice for his chosen ones?” (Luke 18:7-8)

Table 6. Biblical verses to allay anxiety (NLT)

The Lord nurses them when they are sick and restores them to health. Psalm 41:3
For God has not given us a spirit of fear, but of power, love and self-discipline (and of a sound mind. www.christianity.com) 2 Timothy 1:7
Don’t worry about anything; instead, pray about everything. Philippians 4:6
Seek first the Kingdom of God above all else, and live righteously, and He will give you everything you need. Matthew 5:33



Conclusion

More studies on the language of wise communication for the support and care of people with mental health issues are required. This population can be fearful and guarded. There is still a lot of shame and stigma. Nurses and other healthcare workers are often ill-prepared to address client issues and need to be better equipped to overcome the barriers and challenges. Nurses can ethically address mental health communications but need to be educated to do so.^{6,7}

Doctors need to support nurses by providing consistency of assessments and documentation of required psychosocial interventions and health promotion.¹¹ One of the main advantages of nurse-led mental health treatment is the ability to provide a holistic and person-centred approach to care.¹³ However, nurses themselves encounter psychological distress and burnout (a major health issue facing healthcare staff over recent years) and require support from employers, policy makers and management to ensure their mental health is maintained.¹⁴

****Suggested answers for Activity 4**

1. Consent/permission.
2. Sensitivity and respect
3. Safety
4. Anger, frustration, irritation, judgement, fear
5. Emotional dysregulation



Georgie Hoddle

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Lamentation for a Groaning Creation

– Dr Michael Burke

A challenge to respond biblically to the harm done to God's creation

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Many today are troubled by the stress of harm to God's creation, both for the current day and the future. We have even created a new term, *eco-anxiety*, to describe this unease. Eco-anxiety is defined as extreme worry about current and future harm to the environment caused by human activity and climate change. We are now likely to live lives, for a time, in an era of creation harm.

This article seeks to act as a Christian resource to comfort and reassure us as we continue to journey with God, both as individuals and as a community.

Our God has entrusted to us a beautiful world. The created world is repeatedly declared good (Gen 1: 4,10,12,18, 21, 25, 31). People are created in the very image of God (Gen 1:26-27), and the pinnacle of creation is the Sabbath (Gen 2:2-3) – a time to reflect, rest and enjoy the presence of God in His creation.

We were called to work in the garden and keep it (Gen 2:15). All of this is recorded in the two creation accounts of Genesis 1 and 2. Sadly, Genesis 3 follows – and relationships with God, each other and God's creation are harmed.

"These people, like people of our generation, are at times splendid and creative, and at other times disappointing and destructive."

We can learn much about the nature of God through his natural revelation. We also learn much, in the biblical account, of the relationship between a loving, merciful and just God with His people, the Israelites, to whom He has promised much. These people, like people of our generation, are at times splendid and creative, and at other times disappointing and destructive.

God continued to journey with his people. He sent prophets. He sent his Son (John 3:16). God so loved the cosmos! The cosmos is a word for the whole of creation – the environment, the creatures, and people. To be healthy, all need to be healthy. This is presented in the Old Testament concept of *shalom* and modern secular One Health.

The Israelites were familiar with the concept of lament – to express sadness, grief, and regret. Biblical lament is, according to N.T. Wright;

"...grieving for the present situation yet acting in the hopeful assurance that God will deliver and redeem. Despair, in itself, is hopeless, a weeping for something that cannot be regained. But lament is characterised by hope."

When loss presents, lament is a response. We even have an Old Testament book named Lamentations. The Psalms capture the full range of human emotions. Old Testament scholars tell us that more than half of the psalms are laments.

The promise of 'land' is a strong theme throughout the Bible:

- Israel lamented their separation from the land of God's promise to Abraham.
- From the time of Jacob to Moses there was loss, sadness, and lament for four hundred years.
- With the exile in Babylon, there was a lamented separation of seventy years.

*By the rivers of Babylon, we sat and wept
when we remembered Zion. (Psalm 137:1)*

While the value of our real estate may be increasing, creation is groaning (Rom 8:22). For over two centuries, human activity in industrialisation has increased atmospheric carbon – initially silently, then with more and more disturbance and attention. The rate of biodiversity loss is alarming. The emerging story of microplastics further heightens eco-anxiety.

And so, we can lament for a time. Regretfully, this may be a significant time. The harm to creation requires healing and care for the world Jesus has made (John 1). Yet as Christians in East Africa say – “God is good, all the time. All the time God is good.” Yes, there is future hope – God has promised a renewed earth. This is our hope.



Image Topeasokere, Pexels

There is a challenge to respond biblically to the harm done to God's creation. A challenge brings an opportunity, and a response starts with a first step. Lament is positioned as a well-recognised biblical response to loss and separation. The Psalms and other Old Testament books provide us with a template of lamenting as a modelled response to the loss of the land of promise.

Our time of lament for a groaning creation may be seventy years, four hundred years or more. There are many ways to lament and to then respond. Let me share two!

1. The International Christian Medical and Dental Association (ICMDA) has several training tracks, which are short courses. Please join an upcoming ICMDA Creation Care and Health training track – <https://icmda.net/resources/trainingtracks/cch/>
2. For your church community, you may seek to encourage them to learn more about eco-churches. See <https://arocha.org/en/theology-churches/eco-church/>.

Shalom.



Dr Michael Burke

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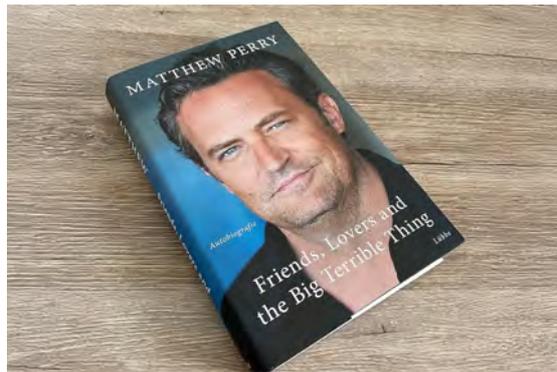
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BOOK REVIEW: Friends, Lovers, and the Big Terrible Thing by Matthew Perry

Reviewed by Tanya Tufanova

From Luke's Journal Nov 2024 | Vol.29 No.3 | Mental Health II



What Can We Learn From Matthew Perry?

A Tough Time

Gisella groans.

"I'm in Hell," she thinks, as she weeps into her pillow.

Tossing and turning, she clutches her stomach, rubbing it with her hands.

"So much pain," she moans. *"This life is Hell. This life is Hell."*

Worse Than This

Sadly, that's not an uncommon belief in this world. That, yes, Hell exists but not somewhere out there. Here. Right where we are. This life is Hell, and that's what Matthew Perry, a Hollywood actor on the sitcom TV show *Friends*, believed but it's not true. Although this world has many pains, trials, distresses and sorrows, there's another place completely different from here and it's much worse than this.

Matthew wrote this erroneous statement about Hell in his memoir *Friends, Lovers and The Big Terrible Thing*. He continues his error-filled thoughts on the spirit world throughout his book, mentioning God many times, and although he makes positive statements about God, it seems his general view of The Almighty is that God is mean and out to get him. He believes this because he has suffered feelings of abandonment ever since his parents split when he was only about nine months old, and he claims he has found that the only way he can find relief from these painful feelings, is to deaden them with drunkenness, illicit drugs and narcotic pain killers. He states that this self-medicating behaviour has grown into a life-long illness called addiction and this is further evidence that he's not one of God's favourites.

God Is Love

But is this way of thinking true? The Bible says God is love and that He longs to be a perfect father to all of us and that if we surrender to Him, He will be a father that never forsakes us. That doesn't sound like a mean God. That doesn't sound like a God who's out to get anyone, let alone Matthew Perry. The Bible also gives us abundant evidence that God has the power to heal and not only heal us but heal us of anything and everything. Not everyone gets healed this side of death. Some of us must wait until we enter Heaven but if we surrender our lives to Jesus, the Bible says every single one of us will find healing in Heaven. I wonder if Matthew Perry ever heard that. He may have because his book shows he has heard of the Bible account of Sodom and Gomorrah and John 8:7 which states, he who is without sin should cast the first stone, and hementions that at the age of fifteen, he went through a life event that brought him face to face with the reality of death, judgement, Heaven and Hell.

God Heals Those Who Surrender

Matthew doesn't state in his book who or where he heard these Christian concepts from, and he doesn't mention if his family gave him any Bible teaching or if he ever attended a Christian school, but he does say that he has sought help for his addiction in rehabs and sobriety-living homes. In fact, he says that he has spent seven million dollars trying to quit drinking, has attended six thousand AA meetings, rehab fifteen times, a mental institution at least once and attended therapy twice a week for thirty years. Christian groups often either own or operate health facilities, so perhaps he heard these Bible doctrines there. I know genuine Christian people who still struggle with cravings for nicotine, but I also know Christians who say that although addicted to alcohol and recreational or prescription drugs for years, upon conversion, God took those tastes away, in an instant, without any monetary payment, and they now live drug and alcohol free. Did Matthew ever hear of this phenomenon while seeking treatment? He doesn't say, but it sounds far cheaper and easier than what he did try over his lifetime.

Accept God For Who He Is

He gives a clue that he may have heard this kind of testimony when he mentions an experience he had in his kitchen while feeling discouraged about his addiction. He states he asked God to reveal himself to him and states he then saw God and felt warm and peaceful during that experience, but those feelings didn't last. But did Matthew really see God, and if so, why did the peaceful feelings he felt that night end? I'll hazard to say that although he may have seen his version of God, he did not see the one true God. I say this because Matthew mentions, earlier in his book, that he finds it problematic that the Christian God thought it perfectly fine to put His own Son on a cross. This suggests to me that God had already revealed himself to Matthew earlier in his life. God revealed himself to Matthew through the Gospel, but Matthew rejected Him, possibly because of his inability to see God as a loving, fatherly God that will never abandon him the way his earthly father did.

Repent of Your Sins

Matthew also calls his addiction an illness and blames it on his genes. I'm not qualified to know if genes and biology contribute to substance abuse, but I do know that the God of the Bible calls drunkenness a sin and commands us to confess it as such and to repent of it. 1 Corinthians 6:9-10 says, "Do not be deceived, no drunkard will enter the Kingdom of God". God is love, so God doesn't punish people in Hell because they're sick or have defective genes. God punishes people in Hell because they've sinned and rejected his offer of forgiveness, and the Bible says we love our sin. Although Matthew frequently states how difficult his addiction is and how much it has cost him, he occasionally states that he loves alcohol and the feelings narcotics give him. Whether genes affect alcohol addiction or not, Matthew states he has stolen, lied and broken the law in order to feed his substance addiction. That's definitely sin. Perhaps Matthew preferred these sins over confession and repentance of his addiction and the sins that fed it? We can't ask him anymore because he passed away in October 2023.

Take A Different Path

Matthew Perry says he has slept with many women, but he always told them upfront that these relationships were only physical and would never end in marriage. If any of those women had fallen pregnant, that means Matthew would have found himself in the same situation his father had all those years ago, where he left instead of staying, abandoning his child. Knowing how much pain that causes children, it makes you wonder why Matthew would follow in those footsteps.

So, what can we learn from Matthew Perry? We can learn that:

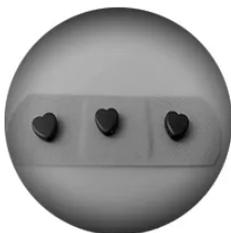
- Hell is real. It's far worse than here, and we should seek God's forgiveness, so we can avoid it.
- We can learn that we should be the best parents we can because, sometimes, how we live out those roles affects how our children see God in His role of father.
- We can learn not to follow the same path our parents took, if that path affected us in painful ways.
- We can learn that God is a God of love. He's not out to get anyone and heals everyone that surrenders their life to Him. The healing might not come in this life, but it does come for everyone who enters Heaven.
- We can learn that if God has already revealed himself to us, we should accept Him for who He is and confess our sins to Him, rather than making up our own version of Him and clinging to the sins that version of God permits.

But, overall, Matthew Perry's memoir gives health professionals a look at the mindset that lay behind at least one person's drug and alcohol addiction. It helps health carers see addiction from the other side, from the side of the patient, and for that reason, I highly recommend it.

Friends, Lovers, and the Big Terrible Thing by **Matthew Perry**

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Tanya Tufanova

Tanya Tufanova is a personal care worker who has worked at a hostel for people suffering with the effects of alcohol abuse. She enjoys sharing with others how valuable people with disabilities are and loves telling how God can forgive us of even the worst sins.

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