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spotlight

for today's Christian nurses & midwives

- self-care for the carer
- loss, hope & healing: a personal testimony
- recovery for all

spotlight
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editorial

This edition of *Spotlight* is on mental health. It seems all of us, or people close to us, are affected at some stage of our lives by poor mental health. As nurses, we may be particularly vulnerable to depression or burnout due to both our personality types and the highly demanding nature of our jobs. You can read more about this in my article *self-care for the carers*.

Kathryn, a student in Scotland, makes mental illness real and personal as she bravely writes about her own battle with depression and anxiety.

Other contributors to this edition include Esther Chevassut, who in her article *stress: friend or foe?* expounds how and why stress affects us so much. Rachel Denno, a final year dual student of adult and mental health (MH) nursing, suggests how the holistic 'recovery' approach (which focuses on hope, agency, opportunity and self-care) can be applied to general nursing and to our own faith journey. Philippa Taylor, CMF Head of Public Policy, assesses the effect of abortion on mental health.

The Mental Health Foundation recently focused on the need for relationships to help improve mental health. They tell us that we urgently need a greater focus on the quality of our relationships to prevent and help alleviate mental health breakdowns. We need to understand just how fundamental relationships are to our health and well-being. We cannot flourish as individuals and communities without them. In fact, they are as vital as better-established lifestyle factors, such as eating well, exercising more and not smoking.

As Christians, we recognise this need for relationship as being fundamental. God created us for relationship, as evidenced from his early words about mankind in Genesis 2:18 'It is not good for man to be alone.'

We reflect the Trinity (Genesis 1:26). In his book, *The Good God*, Michael Reeves writes: '*The very nature of the triune God is to be effusive, and bountiful; the Father rejoices to have another beside him... As the Father, Son and Spirit have always known fellowship with each other, so we in the image of God are made for fellowship*.'[1]

No wonder poor relationships and lack of fellowship can adversely affect mental health.

As we give out in our workplace, our families, and our communities, let's remember to carve out some time for our own health and well-being; in Paul's words from Hebrews 10:25, 'let us not give up meeting together.'

If it would help you to meet with other Christian nurses and midwives in your area, those who truly understand what challenges you face, please consider joining a local CMF group if you're not already connected.

Email *nurses@cmf.org.uk* and I can let you know where your nearest group is. If there isn't yet a group near enough to you, we can explore starting one. But let's work at finding faithful friendships, those we can share with, pray with and be encouraged by.

Pippiatt

1. Reeves M. *The Good God: Enjoying Father, Son and Spirit*. Milton Keynes: Paternoster, 2012

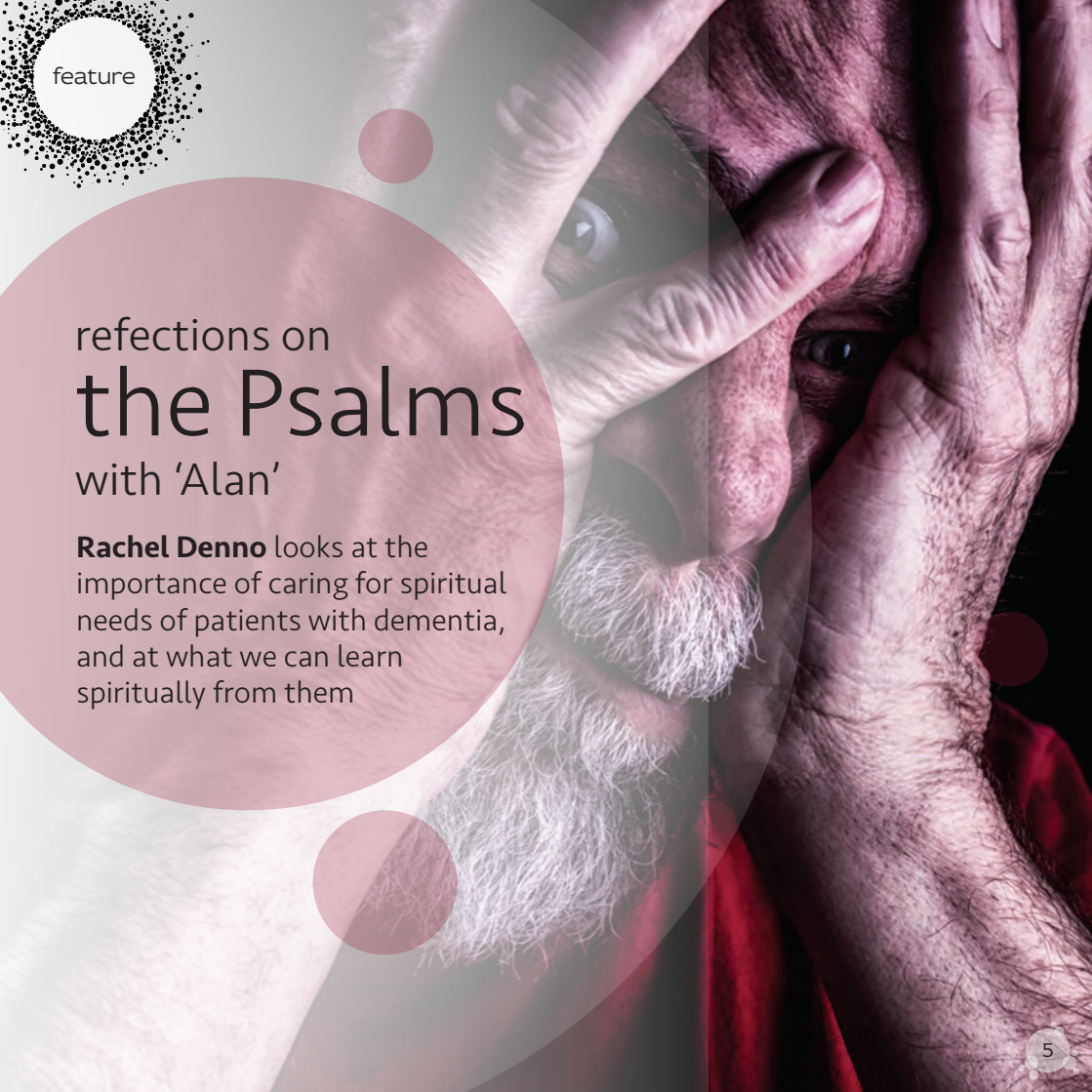
Pippa Peppiatt, CMF Head of Nursing
Pippa trained as a nurse. She has planted a church for students with her husband, set up a charity for street kids in Uganda, and has been a Friends International Student Worker.

PS. Are you a budding writer who would be keen to write for *Spotlight* in the future?

If so, our *nurses writers' day* might be good training for you. It's held at our London office on 16 March 2019. If you're interested in being considered for this, please email me at *pippa@cmf.org.uk*

New! CMF Prayer Diary

If you want to be kept up-to-date with prayer needs for CMF and others working in healthcare, please subscribe to the *CMF Prayer Diary* by emailing *prayer@cmf.org.uk*



refections on the Psalms with ‘Alan’

Rachel Denno looks at the importance of caring for spiritual needs of patients with dementia, and at what we can learn spiritually from them

Recently, I have been reminded afresh that in unexpected environments and using unexpected teachers God reveals himself and his will to us.

Earlier this year, I was on a placement in an older persons' mental health unit on a secure ward for patients with acute presentation of organic disorders.This manifested itself as caring for many patients with dementia. Many patients were sexually disinhibited and struggled to control their aggression both physically and verbally, often becoming violent towards staff and other patients. On several occasions I left shifts with scratches, bruises and bite marks as well as offers of dates, and on more than one occasion, marriage. Often, working on this ward felt like entering an alternative reality; hilarious and tragic in equal measures.

Most patients would stay on the ward for at least two months, so it was nice to have some continuity with the patient group, something I had not experienced much of before.
My previous placements had been in acute admissions where patient turnover was high. The ward provided an opportunity to really get to know the patients and their ways. I hesitate to write I was 'building up relationships with the patients', as the nature of the psychiatric conditions would somewhat necessitate a redefinition of the meaning of the phrase, due to the challenges patients with dementia have in forming new relationships. However, cognitive impairment and memory loss by no means discount meaningful interaction; furthermore there's value in repeated meaningful interactions over the course of time.

One patient, Alan had about 25 minutes of lucidity each afternoon, otherwise he would sit very still on his own with his eyes closed, mouth firmly shut and limbs rigid for most of the day. Occasionally, he would be more passively disengaged rather than this active state of isolation. At sundown, he would become agitated and distressed, slamming his body against windows and a door in an attempt to leave.

One evening as I was assisting him to bed, he opened his eyes and said 'Stop. Pray.'So I knelt down with him and he led me as we said the Lord's Prayer together. This is not a completely novel experience in older person's care; routines such as repeating set prayers are often comforting and habitual for many. After praying, Alan then began to hum a familiar tune so I sang along to 'Just As I Am.' The next day his wife visited so I shared with her what had happened, she smiled knowingly and told

me she would bring in a *Songs of Fellowship* book. I soon learned that Alan's favourite song was 'Just As I Am', and despite a plethora of song choices provided by the *Songs of Fellowship* book, we nearly exclusively sang his one favourite.

Alan's wife seemed greatly reassured that there was a Christian involved in Alan's care. She commented that despite informing the nurses on admission that Alan was a practicing Christian, little spiritual support had been offered. In practice, I have generally noticed that despite being a routine part of admission paperwork in clinical settings, the 'religion' question is routinely omitted by nurses. If information has been provided, it is often overlooked. As a student nurse, I have frequently found going back to admission paperwork to check that the 'religion' box is completed is an effective way of starting conversations with patients and staff alike.

In her book, *Dancing with Dementia*,[1] Christine Bryden (an Australian civil servant who was diagnosed with Early Onset Alzheimer's when she was 46-years-old) writes about spirituality in dementia care. She stresses the role we have as healthcare professionals in guarding and encouraging our brothers and sisters in their faith within the context of memory loss. She writes:

'*As I lose an identity in the world around me, which is so anxious to define me by what I do and say, rather than who I am, I can seek an identity by simply being me, a person created in the image of God. My spiritual self is reflected in the divine and given meaning as a transcendent being.*

'As I travel towards a dissolution of my self, my personality, my very 'essence', my relationship with God needs increasing support from you, my other in the body of Christ. Don't abandon me at any stage, for the Holy Spirit connects us, it links our souls, our spirits – not our minds or brains. I need you to minister to me, to sing with me, pray with me, to be my memory for me.'

Initially, I (foolishly) was thankful to God for the opportunity to serve Alan and his wife in supporting him in his spiritual care, carrying his faith with him to encourage and remind him of his identity as an adopted child of God in the midst of an identity stealing disease. The thankfulness wasn't foolish, but my assumption of role as exclusively a caregiver and Alan as exclusively a care-receiver in our interactions was. 'Interaction' is a reciprocal action after all. I sought to capture Alan's lucid moments each day; spending time together reading, praying and singing.

There are over
850,000
PEOPLE
LIVING WITH
DEMENTIA
in the UK today

'As I travel towards a dissolution of my self, my personality, my very 'essence', my relationship with God needs increasing support from you, my other in the body of Christ.'

38%
of the population have a
CLOSE RELATIVE
or FRIEND with
DEMENTIA

Source: Alzheimer's Research Dementia Statistics Hub
www.dementiastatistics.org

However, as time went on, I realised that in fact Alan was serving and encouraging me in my faith so much more than I felt I was doing so for him.

How marvellous that as we seek to minister to others, God uses those in our care to minister to us too! The first time I placed a blue Gideon's hospital Bible in front of Alan, he opened it and turned to Psalm 90. I smiled to myself as I was studying the book of Numbers at the time and had recently read Psalm 90, as this psalm is a prayer of Moses. As a 'man of God', Moses taught the Israelites how to pray and gave them words in this psalm to use to turn to God in prayer. The verse below highlights that in the light of eternity, our days on earth are neither insignificant nor desultory.

The figure is set to reach
1 MILLION by 2025
2 MILLION by 2050

'Teach us to number our days, that we may gain a heart of wisdom. Relent, Lord! How long will it be?

Have compassion on your servants. Satisfy us in the morning with your unfailing love, that we may sing for joy and be glad all our days.' [2]

In God's sovereignty, our days are numbered; numbered in a beautiful, life-giving and meaningful divine order. Surrounded by the noise, carnage and confusion of the ward, where it seemed so easy to question God's purpose in preserving disorientated and distressed bodies, God used Alan to guide a re-orientation of my heart: he reminded me that all the days of someone's life are known to God.

I thank God that in the midst of confusion and upheaval, he is constant and unchanging. Despite facing an unknown future, Alan faithfully lived out Psalm 145, sharing his faith with another generation, enabling us to meditate on God's wonderful works together.

'Great is the LORD and most worthy of praise; his greatness no one can fathom. One generation commends your works to another; they will tell of your mighty acts. They speak of the glorious splendor of your majesty – and I will meditate on your wonderful works.' [3]

Rachel Denno is a final year, dual field adult and mental health nursing student

1. Bryden C. *Dancing with Dementia*. London: Jessica Kingsley Publishers, 2005
2. Psalm 90:12-14
3. Psalm 145:3-5

abortion & mental health

Philippa Taylor looks at the research, the myths and the reality of how abortion affects the mental health of women

Abortion continues to be a major political, cultural and spiritual battleground, and the question of whether abortion is linked to mental health problems in women has long been a part of this debate.

Assessing the effect of abortion on mental health is complex and controversial, and findings are frequently conflicting. Even though studies may show an association or link between the exposure variable, abortion, and a health effect, the way that studies are designed mean that we cannot always be certain that the exposure definitely causes the health effect. It is simply not possible to conduct a randomised controlled trial assigning some women to an abortion group and others to a birth group.

Yet it is essential to do the research. Nearly 200,000 abortions are carried out in Britain each year, so even minor psychological effects on a few women will affect large numbers in total. Moreover, around 98% of abortions are carried out in the UK under Ground C of the Abortion Act 1967 – that it is better for a woman's mental health to have an abortion than to continue with an unwanted pregnancy. Any challenge to this premise would effectively suggest that most abortions are not justified under the Act.

Reviews of the psychological effects of abortion have arrived at disparate conclusions, which makes the provision of clinical guidance challenging. Despite some reviews showing that abortion is linked to various adverse mental health outcomes, other reviews say there is no link, failing to even acknowledge controversy in the field, while yet others say social mores are the cause of any mental harm.

Some of the problems with even the best known and most widely cited research studies include choosing what groups to compare with women who have an abortion (Women who have had a miscarriage? Given birth? Women who have never been pregnant? With an intended pregnancy or not?) because there is no direct equivalence. Then there is selection bias (many studies have high drop-out rates and low recruitment rates) because those who are least likely to participate will be those most affected by the abortion. And many studies simply fail to follow up women long enough after the initial study (often women cope well initially, but years later reappraise the abortion negatively). [1]

One of the most comprehensive reviews into

the mental health outcomes of abortion, carried out in the UK in 2011, found that having an *unwanted pregnancy* is associated with an increased risk of mental health problems.[2] However, they found that the rates of mental health problems for women with an unwanted pregnancy were the same, *whether they had an abortion or gave birth*. In other words, abortion made no difference to the outcome.

However, the review also found that women who have mental health problems *before* an abortion are at greater risk of mental health problems afterwards. They also found that several other factors such as stressful life events, pressure from a partner to have an abortion, a negative attitude towards abortions in general and a negative emotional reaction immediately following an abortion, may also have a negative impact on mental health.

The results of this review were re-examined by Prof David Fergusson, who confirmed that although some studies conclude that abortion has neutral effects on mental health, *no study* has reported that exposure to abortion *reduces* mental health risks (which should theoretically nullify the use of Ground C for abortions). His own research reports small to moderate *increases* in risks of some mental health problems post-abortion.[3]

A growing body of evidence suggests that women may be at an increased risk of mental health disorders, notably major depression, substance misuse and suicidality, following abortion, even with no previous history of problems. Researchers not associated with vested interest groups have published this growing scientific evidence. They include Fergusson in New Zealand[4,5] and Pedersen in Norway.[6]

Researchers who are known to be more 'pro-life' have also published extensively in academic journals on this topic for many years. See for example Sullins, Reardon, Rue and Coleman.[7] Coleman has produced findings suggesting a clear link between abortion and adverse mental health effects.[8] Her findings are striking: nearly 10% of *all* mental health problems are directly attributable to abortion, and women with an abortion history experience nearly double the risk of mental health problems when compared with women who have not had an abortion. Even compared to women delivering an unintended pregnancy, she found that post-abortion women still have a 55% increased risk of mental health problems.

Coleman's work has strengths and weaknesses. It was published in the *British Journal of Psychiatry*, passing extensive scrutiny, and is a meta-analysis of 22 published studies, with nearly 900,000 participants. However, it has several methodological weaknesses that have been criticised by researchers who have come to different conclusions. Yet Fergusson, who has described himself as a pro-choice atheist, defends Coleman and concurs with her overall finding: '*There is a clear statistical footprint suggesting elevated risks of mental health problems amongst women having abortions*.'[9]

Women have been told that abortion is an emotion-free, quick and safe process requiring a simple operation or a couple of pills. They are entitled to be told that it is more significant than this and that there are associated risks. Many women who present for abortion are ambivalent – a known risk factor for later adverse effects – so it is imperative that health professionals provide all relevant information for their decision-making.

At the very least, they should be told that there is a lack of academic studies showing any benefits from abortion – despite the fact that so many are carried out on the presumption that abortion reduces mental health risks.

Philippa Taylor is CMF Head of Public Policy

This article was originally printed in the autumn 2018 edition of Nucleus*, the CMF students' magazine.*

1. More information on some of the best-known studies, their findings and limitations, can be found in Pike G. Abortion and Women's Health. *SPUC* 2017 *bit.ly/2EL2DOs*
2. Induced Abortion and Mental Health: A systematic review of the evidence — full report and consultation table with responses. *Academy of Medical Royal Colleges*. December 2011
3. Fergusson D, Horwood L & Boden J. Does abortion reduce the mental health risks of unwanted or unintended pregnancy? A re-appraisal of the evidence. *Australian and New Zealand Journal of Psychiatry* 2013;47:1204-1205 *bit.ly/W5FPm5*
4. Fergusson D, Horwood L & Boden J. Reactions to abortion and subsequent mental health. *British Journal of Psychiatry* 2009;195(5):420-6 *bit.ly/1tWeTCM*
5. Fergusson, D, Horwood, L & Boden J. Abortion and mental health disorders: Evidence from a 30-year longitudinal study. *British Journal of Psychiatry* 2008;193:444-51
6. Pedersen W. Abortion and depression: A population-based longitudinal study of young women. *Scandinavian Journal of Public Health* 2008;36(4):424-8. *bit.ly/2NcT2ZV*
7. For references to these, and other researchers, see Pike G. *Art cit*.
8. Coleman PK. Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009. *British Journal of Psychiatry* 2011; 199:180-86
9. Saunders P. David Fergusson wades in to defend Coleman over abortion mental health link. *National Right to Life News* 20 October 2011. *bit.ly/2CQszg7*

stress: friend or foe?

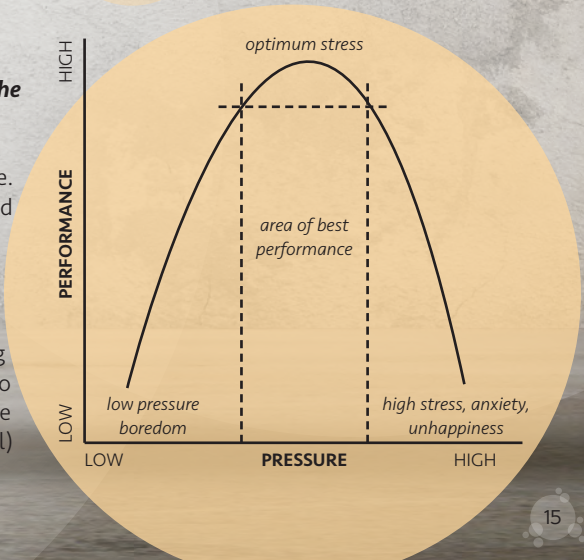
Esther Chevassut looks at how we manage stress in a way that makes it an ally rather than an enemy

In 2017, *Nursing Standard* reported 10% of nurses in England who take sick leave do so because of anxiety, stress or depression.[1] In a 2016 investigation into the impact of perceived stress and ability to cope, 92% of nurses reported moderate-very high stress levels, with more than 60% having inadequate sleep, an unhealthy diet and no regular exercise.[2] RCN Scotland Director, Theresa Fyffe stated that rising patient demand, coupled with the highest yet nurse vacancy rate are taking its toll. '*Nurses are working longer than their contracted hours and through their breaks. All this means that nurses are burning out because of stress.*'[3]

is it possible to survive the battleground of stress that seems to invariably come with the career of nursing?

Stress is a word tossed around us all the time. Our society appears to promote busyness and in many workplaces there is an underlying culture of competitive overworking. The *Oxford English Dictionary* defines stress as 'a state of mental or emotional strain or tension resulting from adverse or demanding circumstances'.[4] Burnout is perhaps harder to define but is understood by many as the state of exhaustion (emotional, mental or physical) from prolonged stress. It is a debilitating manifestation of 'tipping over the edge'. It is important for us to be aware of our own vulnerability in this area.

Experiments into stress show that our performance is directly correlated to the motivational demand put on us; i.e. we do not perform when there is little or no reason to. Thus 'stress', or motivational demand, is not in itself a bad thing. As pressure on us increases, so does our performance – as seen in elite athletes who attain personal bests when competing, which are unlikely to be achieved in training.



This can be illustrated by the 'Stress Responsive Curve' created by Robert Yerkes and John Dodson in 1908 and discussed in *Zeal Without Burnout* by Christopher Ash.[5] Stress hormones stimulate, energise and activate us — but these stress responses are designed for short bursts (the fight or flight response) and must be balanced by periods of rest and recovery. The pressure-performance curve has a limit at our optimum stress level; after this point, if pressure continues to build past the point at which we can cope, performance falls. Extended periods of high stress levels deplete our reserves and push us towards the 'tipping point', after which we are vulnerable to burnout. This tipping point is individual for each of us and as we recognise ourselves nearing it, we must be aware of our need to stop, step back, re-evaluate and rest.

what do we see in ourselves when we are beginning to burn out?

When stress begins to have a negative effect, this may manifest in irritability, reactive or defensive behaviour, short temperedness, feeling overloaded and an inability to cope. A stressed or exhausted limbic system produces a higher volume of irrational or frightening thoughts adding to anxiety. We often lose insight and feel exhausted or emotional. In turn, it also diminishes our ability to deal with stress.

As energy depletes, this stress response can develop into burnout and present as tearfulness, exhaustion, demotivation, inability to concentrate and perform, depression and time off sick. For nurses, this state can also be called 'compassion fatigue'.

why does working in healthcare put you at risk of burning out?

- **High pressure environment**; high expectations and frequent high emotions
- **Responsibility for people**: seeing directly the effect of your actions and decisions
- **Long, irregular working hours** making a healthy lifestyle challenging
- **Stretched resources, increased workload and understaffing**
- **Constant noise, unpredictability and interruption to tasks**
- **Emotional situations such as death and dying**
- **Challenging characters and conflicts** – amongst colleagues, patients and relatives, who are likely dealing with stress themselves and can take it out on you!

Perhaps we can conclude that working in healthcare often means working in a high stress environment and operating near to our peak ability with high energy demand for extended periods of time. We need to be self-aware to protect ourselves and to ensure we have appropriate amounts of rest and recuperation before we run out of reserves and forget why we wanted to care for people in the first place.

so how can we recognise these burnout symptoms before it's too late?

We need to know ourselves and let those who know us well help us recognise our symptoms. We are wired uniquely and each susceptible to burnout differently. It is wise to be deliberate in setting healthy habits (rest, exercise and sleep) to learn to manage our stress. To some extent our relationship with God shapes how we manage stress, but experiencing stress and burnout is certainly not spiritual weakness. We are all vulnerable to it, and different elements will be at play individually in each of us. We are not made to function in isolation but in community. In a world of social media, it's easy to have many Facebook friends but few deep friendships. It's valuable to be deliberate and to invest in a few close, accountable friends with whom we can share burdens and support.

Remember, there is hope. We can cast all our burdens on God[6] who showers us in his love and grace!

Esther Chevassut is a staff nurse and a CMF Associate Staff Worker for nurses and midwives on the southcoast.

1. Jones-Berry S, Munn F. Exclusive: One in ten nurse sick days down to stress or depression. *Nursing Standard* 27 September 2017 *bit.ly/2P71J47*
2. Jordan TR, Khubchandani J, Wiblishauser M. The Impact of Perceived Stress and Coping Adequacy on the Health of Nurses: A Pilot Investigation. *Nursing research and practice* 2016: 5843256. *bit.ly/2ShgX8I*
3. Jones-Berry S, Munn F. *Art cit*.
4. Definition of stress. *English Oxford Living Dictionaries*. *bit.ly/2IQQN8O*
5. Ash C. Zeal *Without Burnout: Seven keys to lifelong ministry of sustainable sacrifice.* Epsom: The Good Book Company, 2016
6. 1 Peter 5:7

self-care for the carer

Pippa Peppiatt looks at the importance of taking care of ourselves as health professionals and at some practical and spiritual tools that help us to do so

First, let's blow a myth. Christians can and do get depressed and they can and do suffer from mental health conditions. Many great Christians, including Martin Luther, Charles Spurgeon, John Newton and Mother Theresa battled bouts of depression and/or anxiety. If you are or have struggled with mental illness, you're in good company!

Moreover, Christian healthcare workers seem particularly vulnerable to burnout. This vulnerability stems from three seemingly good things: character, commitment and the Christian climate. Let me explain:

character

Most nurses and midwives have caring and giving personalities. We are usually capable and motivated people with very full lives and a strong sense of responsibility. The demands are not just at work but often in our families and our churches too. Part of the problem is that we are often other people centred and often bad at self-care. We're so busy giving out and serving others (frequently while under pressure) that we rarely stop, to take stock and to care for ourselves.

commitment

There's a sense as a Christian that we are to live a life of service and embrace suffering like Christ did. We follow a Saviour whose obedience led to crucifixion, so it would be wrong to want a stress-free life, wouldn't it? Aren't we supposed to 'go the extra mile' at work and always be the last one to leave the ward at the end of a nursing shift? But, as we read below, God has made our bodies to need rest and time to refuel, so we require ongoing wisdom as to when it's right to sacrificially serve and when it's right to say 'no'.

Christian climate

Then there's the stigma of admitting to mental illness. Will Van de Hart, Pastoral Chaplain at Holy Trinity Brompton church in London calls the lack of conversation and acceptance of mental health issues in the church 'the elephant in the pew'.[1]

In society, there is a climate of shame and silence over mental illness (though this is beginning to improve) but the stigma is compounded for Christians if we believe that by suffering from mental illness we have offended God or are expressing a lack of faith.

what is clinical depression? [2]

These are the common features of clinical depression that one would look for in seeking to establish a diagnosis:

Two weeks or more experiencing symptoms 1 or 2, plus at least four of the other symptoms (3-9) for most or all of the time.

1. Feeling low and down nearly all the time
2. No interests or pleasure in anything
3. Unable to sleep properly
4. Loss of weight (sometimes gain in weight)
5. Agitated or very slowed down
6. No energy, tired all the time
7. Feeling worthless or guilty
8. Unable to concentrate
9. Recurrent thoughts of death or suicide

As Christian healthcare professionals, all of us must take responsibility for creating a culture that is rich in God's grace. A culture where we patiently walk alongside each other and support each other without judgment. A culture where we remember that we live in the 'now' and the 'not yet' of God's restorative kingdom. Our journey this side of heaven as a Christian nurse or midwife may be up and down. But with fellowship, prayer, biblical wisdom, practical help and support, and when needed, medical help, things will improve.

Many of us may not have clinical depression, but we may suffer from stress, anxiety or depression for shorter periods, often in response to specific stress factors or chronic workplace challenges. Even though much of this is a normal human response, God wants us to flourish in life and in the vocation to which he has called us. We will better serve others in the long-term if we look after and are kinder to ourselves. So, *how can we improve our mental health and well-being?*

Will van de Hart likens the way our bodies operate to that of an engine. Every engine is dependent upon oil, air, fuel and its battery. [3]

1. get enough rest

The oil of the mind is the neurotransmitter serotonin which typically depletes in times of high stress and exhaustion. I mentioned earlier the self-giving nature of most Christians called to healthcare, who feel the added compulsion to give sacrificially when they read words like the apostle Paul's in Romans 12:1 '*Therefore, I urge you, brothers and sisters, in view of God's mercy, to offer your bodies as a living sacrifice, holy and pleasing to God...*'

However, there's a difference between godly sacrifice and needless burnout. A 'living sacrifice' might be better expressed as a 'sustainable sacrifice' – the sort of self-giving that enables us to go on day-by-day for the long run while having wisdom to prioritise rest.

Replenishment often comes in times of rest and contentment. Where possible, try to keep a regular sleep pattern and enhance falling to sleep by planning for a 'non-screen unwind' period before bed.

2. give yourself a break

Air keeps the engine cool. We need clear air to gain perspective and clarity. When did you last have a holiday, or some time off just for yourself? Even Jesus, at the height of his healing ministry, would *regularly* take time off by himself to go and pray (Luke 5:16). Sabbath rest is ordained by God as essential to our well-being. We all need time, as Rob Parsons puts it, for 'kicking the leaves' – time for quiet reflection and with no other purpose than being able to unwind.[4] Try and find activities or friendships that are life-giving to you and then make sure you intentionally include time for these. You are important enough to invest in yourself!

3. good physical & spiritual food

Fuel represents good food for the body and good spiritual nourishment for the soul. God has made us holistic beings, and so how we care for our body and spirit also affects

We will better serve others in the long-term if we look after and are kinder to ourselves.

our minds. Exercise and healthy food helps us recharge, boosts our immune system and helps us keep well – all reducing stress levels. I realise it's hard to sometimes drink enough, never mind eat on a busy shift! But remember that your ongoing health is important, so grab that cup of tea or cereal bar when opportunity arises and don't feel guilty!

As Christians, we have an additional resource (fuel) to call on – the Lord Jesus Christ. Pray before, during and after a long shift, giving to God the pressures and anxieties of your work and ask for the Holy Spirit's help to show love and care to your patients and colleagues. Invite God's presence into all you do; refocus on what really matters; not just on the immediate pressures you face and ask him to help you cope with the load.

4. get connected with other Christians and with God

To recharge our battery, it helps to stay in fellowship with others. The tendency when depressed is to withdraw from others and hibernate in isolation, but it's exactly at this time

that we need other's support and encouragement. Even if you have just one or two trusted friends who you can talk to when you're struggling, they can keep an eye out, pray or simply hang out with you. Foster precious relationships in the good times, so they are there ready at any low points.

Let's be honest, we don't always feel plugged into God and the power of the Holy Spirit. But even if we feel rubbish, it's crucial to keep up our personal times with the Lord, turning to him daily whether we feel him close or not. The truth is, he is with us however we feel, his love and his Spirit will seep through our tired hearts and minds and bring comfort and resourcing, so we can keep serving.

When I'm feeling low, I love turning to the Psalms where King David and the other psalmists really knew the release of a good lament to God! Psalms 74, 80 and 90 are favourites of mine for this, and help turn suffering and pain into intercession. I equally meditate on the Lord's words of hope and encouragement from Scripture (e.g. God is our refuge and strength, an ever-present help in trouble (Psalm 46:1,3) or '*Do not fear, for I am with you; do not be dismayed, for I am your God. I will strengthen you and help you; I will uphold you with my righteous right hand*' (Isaiah 41:10)).

Carving out time to spend in prayer and in Scripture with Jesus will help bring healing, restoration and encouragement to our frazzled minds and spirits.

Serving others as nurses and midwives is a privilege and it's good to be diligent in our caring. But let's be mindful of our own limitations and our need for God. The mystery is that God puts his treasure in us, weak and fragile vessels that easily crack, so that the glory might go to him. [5]

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loss, hope & healing

Kathryn Coalter writes about her own battle with depression and anxiety as a nursing student

I celebrated my 21st birthday the way I think most people dream of. Friends travelled from near and far to be with me on the occasion. My boyfriend at my side, we shared cake and stories and celebrated in my beautiful countryside home. By the same day the following year, I was two suicide attempts in. Alone, I spent the day trying to keep my breath and not let myself give in to attempt number three.

As you can guess, a lot had changed in that year: I lost my boyfriend, some best friends, my self-esteem and my career as a nurse. The cord through it all — developing anxiety and depression.

Although I was a nursing student, I rarely thought about my own health. On the occasions when I did, seldom was my mental health the focus. I had written an essay on mental health, spent six weeks working in psychiatry and seen depression amongst my friends. I thought I knew the signs of illness. I thought I knew how to deal with it.

After five months of tiredness shifting into exhaustion and my desire to do anything relentlessly decreasing, I yielded to the well-intended advice to attend counselling. For someone who loves helping others, being helped felt like hell.

I hated those first months of counselling. Yet, finally having someone who genuinely wanted to listen to me made me feel that actually, maybe, I deserve to be listened to. So, I finally started speaking out. I finally spoke about my anger I felt from being hurt by others and of harmful experiences I encountered as a child and in doing so, they became a reality that I finally had to face.

I had kept my feelings from these experiences so deep inside, that when they finally came out they came as a tsunami wave.

The rest of that year, I was largely consumed with anger. Anger towards what others had done to me. Anger towards the rejection I experienced when I asked for help. Anger towards services and healthcare professionals who seemed to do very little good. Along came the panic attacks that kept me from going out and most things I considered good. I began cutting myself, desperate to find a source of relief, yet it quickly transpired that it was always short-lived.

Now 23, I'm spending my life doing the scariest thing I have ever done: learning to love myself. I'm learning what it looks like to

give my body what it needs. I'm learning that eating well, resting and developing an exercise routine that works for me are holy and sacred things. It has been a steep and unsteady learning curve, and one that I am so graciously overjoyed to be walking with Jesus.

I now often joke that my mental breakdown was the best thing to happen to me because in this process I have learned so much. And so, if you associate with my journey, I want to share some of the lessons I would tell my 21-year-old self. I hope that this advice respects and supports you. And I want to say to you, if you love Jesus and love others walking through this difficult journey and have no clue what to do, then I hope that my words equip and challenge you, and that my experience gives you even a glimpse of an insight into what your loved one is going through.

advice to 21-year-old me

1. **people may give you bad advice**
   I acknowledge the irony, but I feel that this is the most fitting point to begin with. Your illness can be so stressful to those around you if they don't know how to cope or what do to. Therefore, people who love you may give you terrible advice based on their own bias. Yet, for better or worse, no one knows your body like you do. So please listen to it.

   Sleep if you need to sleep, exercise if you can, stay away from public spaces if you feel you need to. Take medication if it helps,but talk to your doctor about stopping it if you feel like it's doing more harm than good. See a therapist if it helps, leave it if it doesn't. It is so important that you start listening to what your body is saying, not what others are.

2. **fight the pressure to be healthy**
   Stop making excuses for your health and accept the fact that right now you are not well. Your illness does not need to have a physical manifestation to be legitimate. It is okay that you are not well. Repeat it with me: 'it is okay that I am not well.' You are not defined by an illness. You are not a failure because of what you can or cannot do. Your worth is not decreased by a diagnosis!

3. **know who you are**
   If you are a follower of Jesus, you are complete in him. He loves you, thinks you are to die for (literally) and rejoices over you with singing (Zephaniah 3:17). He calls you a masterpiece (Ephesians 2:10) , knows

you deeply and has a beautiful plan for you (Jeremiah 29:11). None of this changes because of the pain you have experienced. None of this changes because you never felt loved. None of this changes because people reject or leave you. Your Creator still has the best and final word.

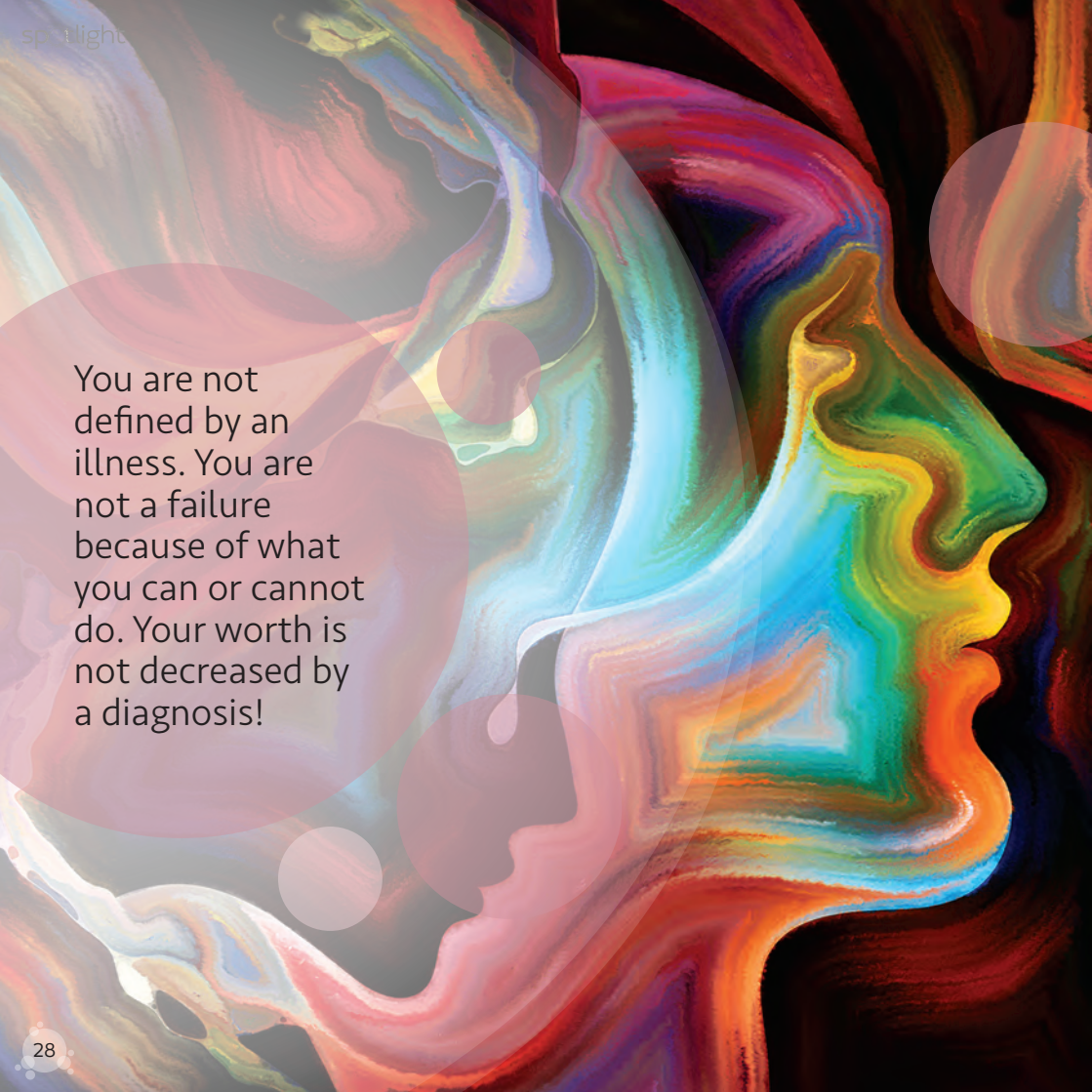
4. **ignore the lies and learn to fight**
   Mental illness is not just a chemical imbalance in your brain and it is definitely not a consequence of sin. It is not caused by distance with God or a lack of faith and does not become worse during a full moon! I hope you're laughing right now but believe me – they've all been heard. And I'll let you in to a secret – the Devil does not want you to be well. He wants you to lose all trust in Jesus and humans and frankly, make your life a living hell.

   That is why you need to fight every day. You need to read up and work out why it is you are ill, and what you can do about it. You need to do all you can to look after your body and learn how to reach out for help. You need to thank others when they support you and call them out when they verbalise thoughts and fears about your illness that are not true!

advice for friends, Christian carers and the church

5. **you are called to love, not to risk-manage or fix**
   Now is one of those beautifully golden times that you get to step up, show up and get your hands dirty by loving. Accept the fact that your relationship may seem one-sided for now and as best as you can keep giving. I know it will be messy. I know you may doubt yourself and feel like you don't know what to do. But there is only one thing you can do: love. Anything else is unhelpful. I find that a good way to test if you are loving is to think about the words you are using: Are you using words such as 'should' or 'ought'? (For example, 'You ought to stop self-harming'; 'You should see a counsellor'.) These words are never congruent with grace.

   Are your questions focused on who they are and where they are at, or are you trying to place them where you want them to be? Compare 'are you still taking medicine?' with 'how do you feel today?'. If you're only walking with them to feel like you've done your duty and to praise yourself for a job well done, it may be best now to walk away.



You are not defined by an illness. You are not a failure because of what you can or cannot do. Your worth is not decreased by a diagnosis!

6. **love in boundaries**
   Don't tell them you are always there for them unless you really mean it. Don't say they can call at any time if you know you can't or won't pick up the phone. Not only is it extremely harmful, but you will likely lose their friendship by killing their trust. If your loved one asks you for help in a certain way and if you can't, that's okay. It may initially hurt them, but their life is not your responsibility and you are not their keeper. You need to honestly weigh up how you can and can't help them. Maybe you know that you can't help them with their grocery shopping, but that you can drive them to appointments. Maybe you know that you can't meet them for coffee every week, but you can always pick up the phone. If you're feeling overwhelmed or confused by the gravity of their illness, why not ask them how you can help. They probably know best what they need.

   And I plead with you, do not let their illness excuse bad behaviour. If your loved one is being unkind, unhelpful or unfair, call them out on it – don't make their illness an excuse. We need to keep our behaviour in check just as much, when our minds are turbulent.

7. **love through prayer**
   Although you are brilliant, you are human and therefore flawed and limited in what you can do. Yet you are powerful with God on your side. So, invite him into this. Not only does he deeply care, he loves your friend intimately and he has the power to make them well. So, gather by their side in prayer. Rejoice with him in the good days and weep with him in the bad. Encourage yourself and your loved one by reaching out to him.

This article can only ever scratch the surface of what it is like to be mentally ill – even if I could give you a full account of my story, experiences are so broad and varied, even if the diagnoses are the same. For those of you walking through this, and for those walking alongside you, I'll leave you with one thing that in the murk and confusion always rang true. God never once left me alone in this. He was listening in my dark days when I prayed for an end to it all; he was with me in the disappointment when faith-filled prayers of healing seemed not to be heard and he rejoiced in the good days with victories so important although seemingly miniscule. You are not, and will never be alone in this. You may doubt, but your Father is always good.

Kathryn is a former student nurse who, after a break to recuperate, is now studying for a degree in health and social care.

recovery for all

Rachel Deno looks at a whole person approach to mental health and how it echoes God's spiritual recovery plan for us

In the same year as the NHS was formed, the World Health Organization (WHO) defined health as 'a complete state of physical, mental and social well-being, not merely the absence of disease or infirmity'. [1]

This definition pioneered, within modern healthcare, a recognition of holistic health and the rounded, multifaceted nature of human well-being. Yet, it still stipulated a need for a medical cure (dictating a need for an 'absence of disease'). Despite recognising 'holism', it allowed healthcare to remain illness-focused.

Historically, psychiatric care took this illness-focused approach and asserted 'cure' as the gold standard, often at the cost of very unpleasant side-effects, social isolation and near-punitive therapies. It wasn't until the late 1980s when Pat Deegan, amongst others, began to promote an alternative approach to be taken in the delivery of care to those struggling with mental illness. This seminal work became the conceptual basis of what we now know as the recovery approach; the model of care, all mental health services are encouraged to embrace today. [2]

the recovery approach

There is no single definition of the concept of recovery for people with mental health problems. Recovery may be considered a journey of well-being. Deegan describes recovery as 'a process. It is a way of life. It is an attitude and a way of approaching the day's challenges'. [3] The recovery approach is established on three main principles: hope, agency and opportunity. [4] It encourages healthcare staff to look at those in their care holistically, seeking to improve quality of life through social inclusion, as well as promoting community connectedness and community living.

Hope is foundational to recovery and probably impossible without it. [5] This hope is the belief that it is possible for someone to regain a meaningful life, despite serious mental illness.

Agency focuses on the individual taking responsibility for, and control over, their own care. The recovery approach emphasises that, whilst individuals may not have full control over their symptoms, they can have a sense of control over their lives. [6] Recognising the expertise of both the patient and the practitioner, it promotes collaborative working to establish goals based on what 'being well' means to the individual.

Opportunities for social inclusion; supporting people in the roles they already have (such as family member, student, in their work) as well as gaining new experiences and developing new skills is key to recovery. Together, they seek ways to facilitate patients to take part in mainstream activities and opportunities along with everyone else.

One of the constant burdens of working in the healthcare profession is the recognition that although you may have treated a patient's primary presenting complaint, you cannot rescue them from all the difficulty and pain they are experiencing at that time.

Furthermore, we cannot rescue people from the consequences of their actions, or what we may perceive as unwise decisions. Clinical competence rarely feels sufficient when we are faced with the suffering we see daily filling our wards and caseloads. In its nature, the recovery approach acknowledges that we will not be able to 'cure' all pain, but through partnership with the patient they can find meaning and hope within life's struggles. The recovery approach addresses the individual as a whole person, taking into consideration the stage they are at in life and their place in community.

From the very beginning of nursing training we are taught about holistic care. The NMC stipulates that it is a standard of competence for all fields of nursing that nurses should practice in a holistic manner.[7] The phrase 'holistic care' litters policy and guidance documents and is considered paramount in the delivery of high quality patient-centred care. As a final year, dual field adult and mental health nursing student, I have been able to experience a wide variety of practice areas in both medical and psychiatric worlds during my training. Increasingly, I see great value in applying the recovery approach when planning and delivering care in both fields.

Obviously, we should not apply the recovery approach in a reductionist sense when transferring to the physical healthcare setting. When we can alleviate pain and suffering from injury or disease, we should! However, seeing patients through the lens of the recovery approach enables us to see them as so much more than an illness.

God's model of care

As a believer, the recovery approach reminds me of God's model of care towards his children. Faith, like recovery, has long been compared to a journey. This metaphor not

only reminds us that we are travelling somewhere, but that the journey itself is a process during which we will be refined as we move towards our destination. God's love gives us hope, agency and opportunity.

In Jesus's death and resurrection, we have the greatest hope of all; a hope that if our trust is in Jesus as our Lord and Saviour, we are free from the power of sin over us. We can look forward with hope to an eternity with God; confident that we will be made new and will be free from all physical, mental and spiritual suffering. We will be free to enjoy Jesus fully and will see him face-to-face.

Patient agency focuses on the contribution that patients can make to their own care. Through collaborative work, the recovery approach seeks to challenge and change the mindset that a patient is defined by addiction or mental illness and that their life is controlled by its symptoms and limitations. Similarly, we as Christians need not live as if sin continues to control our lives. In Romans, Paul addresses just this point, stating 'we should no longer be slaves to sin' (Romans 6:6). Through Jesus's redemptive blood, we are saved from the eternal penalty of our sin, but not spared the everyday presence and potential of sin.

As such, we are not 'cured' of sin in this life. Until the new creation we will still experience present symptoms of sin: separation and suffering. Sin, like addiction and mental illness, is a persistent enemy we must battle daily. Much of this battle is a change of mindset. Let us pray, as Paul did, that we will be transformed by the renewing of our minds to live lives worshipping God and not idols. [8] Saving grace is where our relationship with God begins, but salvation is not where his grace ends. In our lifelong sanctification God calls us to *continue on under his grace* rather than move on from it. [9]

How marvellous, that when we come to know Jesus we are adopted [10] into his ever-growing, international family. As part of the body of Christ, we are each given a role to play and through the power of the Spirit we are equipped with gifts to serve God and his church. [11] Each of us are commissioned to share Jesus's love and the good news of salvation with those around us. [12]

Working in healthcare, we are given opportunities daily to share Jesus's love to those in our care. Often it may not be possible for us to speak openly about faith, but we do have the opportunity to pray for all those we meet. We know prayer is powerful.

the journey itself is a process during which we will be refined as we move towards our destination.

I encourage you to pray for as many patients as you can. These prayers don't have to be long, complicated or noticeable to those around you. But I do encourage you to pray; you may be the only person who has ever prayed for them.

conclusion

Let us pray not just for our patients, but also for our colleagues, family and friends who may similarly have an ongoing struggle with poor mental health with no 'quick fix' cure. Pray that they would know fresh hope, agency and opportunity, both in earthly and spiritual terms.

What a hope we have in Jesus; what a dignity that we are given the choice to live for him each day and what a privilege to have the opportunity to share the good news with those around us. That is essential to true 'holistic care'.

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