

# MENTAL HEALTH: QUESTIONING OUR ASSUMPTIONS

whatever man called it, that was its name  
faith shines through depression





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# state of mind

# Editorial



Laurence Crutchlow is CMF Associate Head of Student Ministries and a GP in London

'No health without mental health' is a commonly heard campaigning cry. An average GP's surgery involves a great deal of mental health work, and problems of this nature are widely seen in the emergency department as well. There has been a great deal of media focus on mental health in recent months, along with promises of new funding and services within the NHS.

Such positivity about mental health hasn't always been the case. One grand round I attended as a student began with a rather obscure immunology case, which commanded rapt attention from a large audience. As the professor who was to present next was introduced, a sizeable number of the audience walked out! Why would this be, when he was much better known nationally than the immunologist? The problem was the subject matter. The second talk was on psychiatry, and the professor came from the large and famous psychiatric hospital situated directly across the road, about fifty yards from the front gate. Yet despite geographical proximity, the two hospitals seemed to have very little in common to us as students, a view clearly shared by many of the doctors at the grand round that day.

Whether by intention or not, disorders of the mind have always seemed to have lower status in western medicine. The reductionist, scientific method that serves us well much of the time when dealing with physical illness is not always well suited to presentations which don't necessarily relate to an organic pathology. The very business of naming mental illnesses and drawing the line between 'normality' and 'disease' can in itself appear arbitrary, though careful thought may lead us to similar questions around many 'physical' diagnoses.

The Christian student will be well aware that those with mental illness are often among the most vulnerable we meet. Simply taking these problems seriously, and according them the same energy that is given to 'physical' medicine demonstrates that both body and mind are part of God's creation, worthy of equal study and care. Working alongside patients sometimes forgotten by modern medicine reminds us that God values them equally.

Later in our careers, we'll see more and more that mental health care is time-consuming, and that whatever money is spent by the NHS, there will always be a need for non-medical agencies to be involved, whether this is in practical support of patients, or in reducing loneliness. In these complex areas, we hope the expertise of CMF members can help local churches, both in understanding and in practical ways.

And of course, we mustn't forget our own mental health. Much media publicity has focused on younger people, and CMF has published members' stories in *Nucleus* in the past.<sup>1,2</sup> Problems can arise later in a career, with a GP member discussing such difficulties on Premier radio recently.<sup>3</sup>

We hope that this edition of *Nucleus* will help you explore this highly topical area through God's eyes. ▀

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# faith shines through depression

Stephen Critchlow considers low mood in Christians





**Stephen Critchlow** is a retired consultant psychiatrist and author in Northern Ireland

**S**ome Christian teaching has given the impression that if you are depressed then the problem must be spiritual: you must have sinned or failed in some way in your Christian walk. Unfortunately, this can lead to feelings of guilt which can compound the underlying depression. Depression often leads a person to spend much time by themselves resulting in isolation. This kind of teaching can lead to avoidance of church and Christian friendships, resulting in further isolation.

Jesus always sought to be inclusive. He was frequently moved with compassion when facing human need. Stigma is still a huge problem in mental illness. We can seek to overcome this by being welcoming and compassionate as Christ demonstrated.

## what is clinical depression?

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  
(DSM IV Classification)<sup>1</sup>

Depression, as above, is not uncommon and between two and three percent of the population suffer from depression like this at any one time.

There is good evidence that those who practise their religious faith tend, as a group, to have less depression than those who do not. This comes out strongly from the work of Professor Patricia Casey.<sup>2</sup>

## depression in the Bible

The Bible is very real about personal experience. We see people's struggles as well as their joys and successes. In their low times, we may not necessarily say that they suffered from clinical depression (through lack of sufficient evidence) but it certainly seems likely. Who were these people?

## Job

Job was one of the leaders of his city who sat at the gate giving judgement.<sup>3</sup> However, there came a fateful day when in quick succession he lost everything. All his herds of animals and then all of his children were suddenly taken from him. His wife responded by turning against him. His health was broken. He sat on the ground scratching his itching skin with a piece of broken pottery. We read:

“May the day of my birth perish” (Job 3:3) and

“Why is light given to those in misery...who long for death that does not come?” (Job 3:20-21)

Job wants to die and wishes he had never been born. Job had lost so much that was precious to him and could not understand the reason why. In my experience, many people with severe depression have been through similar losses which they may not understand. In Job's situation, despite no material change in his circumstances and despite the poor advice of his friends, his faith shines through when he exclaims, “I know that my redeemer lives!” (Job 19:25). In difficulties that we may not understand our faith can still triumph. In the end Job receives back double for all that he had lost.<sup>4</sup>

## Jeremiah

The prophet Jeremiah had the onerous task of warning the people for the final time to turn from their wicked ways or else risk deportation to Babylon. Jeremiah became extremely unpopular and he and his message were widely rejected. The prophets, the priests, the king and the court and even his own family turned against him. During this experience of overwhelming rejection he cries out:

'Cursed be the day I was born!' (Jeremiah 20:14)

Yet in the midst of the storm of rejection, we read of a deep and tender relationship growing between Jeremiah and his God. For example, the Lord says to him, "'I will make you a wall to this people...they will fight against you, but will not overcome you, for I am with you to rescue and save you' declares the Lord.' (Jeremiah 15:20)

Like Jeremiah, many people today experience major rejection in their lives but what does Jesus promise?

'In this world you will have trouble. But take heart! I have overcome the world.' (John 16:33)

'And surely I am with you always, to the very end of the age.' (Matthew 28:20)

## Elijah & David

Similarly recorded in the Old Testament, we read about Elijah who had an episode of severe low mood, which may well have been related to near total exhaustion.<sup>5</sup> Also, in Psalms 6, 32 and 38 we read of many features of depression experienced by King David. Psalm 32 relates this to a sin issue in David's life. We should be aware that physical factors (Elijah) and sin issues (David) can be related to depression.

**depression amongst Christian leaders.** Leadership brings additional responsibility and the possibility of increased isolation. The mantle of Christian leadership may bring attack and persecution, adding to the risks of depression.

## Judson

Adoniram Judson was one of the first 'modern' missionaries who went to Burma (known today as Myanmar) in 1813. During his time there, he became profoundly depressed. It is not difficult, however, to track some of the factors that lay behind this. During war in the country, he was severely mistreated and imprisoned. He then had to leave his wife and child behind to try and help in the aftermath of the conflict. In his absence, sadly both his wife and child died. He could not forgive himself for not being with his wife and child when they had needed him most. He tried to bury his grief in his work of Bible translation, but this did not help. Instead his grief became worse. He retreated into the jungle where he dug a grave and walked around it for several days in a suicidal state. He could not feel God's presence with him. However, his fellow missionaries prayed constantly for him and he gradually recovered. Following recovery, whilst previously he had preached to little effect, now thousands embraced the Christian message.

## Spurgeon

The story of the depression endured by the famous preacher Charles Haddon Spurgeon is quite well known. He himself had considerable insight into some of the related factors.<sup>6</sup>

## what may we conclude from studying these 'case histories'?

- First, there are many different factors which may lead to depression. People are very different and a commitment to understand each individual is vital.
- Second, God remained very close to these people and brought them through.
- Third, God showed himself to be gentle and loving, treating each person with respect and dignity.
- Fourth, prayer by fellow Christians proved to be very important.
- Fifth, we might also say, as we observe these historical cases, that we wish that certain effective treatments had been available.



Modern treatments such as antidepressants, cognitive behaviour therapy (CBT) and even electro-convulsive therapy (ECT) could have been helpful in both reducing suffering and the length of their depressive episodes.

## how can we advise and help a person with depression?

### medical assessment is necessary

This helps to identify possible underlying factors (including physical factors) and enables the severity of the depression to be gauged and permits the formulation of a treatment plan.

### support & help for the depressed individual

We can try to encourage the depressed person to take regular meals, a normal sleep pattern, and remain socially involved. We should be compassionate and caring and seek to remain involved with the person. We can pray with them or for them as appropriate and encourage Christian fellowship.

What other ways can we help? Accurate information about good local resources can be very valuable. Booklets on all aspects of mental health are freely downloadable from the Royal College of Psychiatrists' website.<sup>7</sup>

Some churches, with help and advice, have started drop-in centres which can offer friendship, structure, support and practical help.

### seminars for the general public

Over the last few years I have been conducting seminars on mental health issues for the general public. I have, for example, given a series of three or four talks over a weekend, or as a weekly series, generally concentrating on the topics of depression, anxiety, suicide and addictions. With each topic, I like to give an overview followed by spiritual and biblical input for those who wish to remain to hear this (usually at least 80%). Many of these have not had a strong Christian connection and it has been a joy to point people towards the Lord.<sup>8</sup>

More details of this, including the talks themselves, are on my website: [www.stephencritchlowmentalhealth.com](http://www.stephencritchlowmentalhealth.com), along with synopses of the talks and other issues are covered in my recent book: *Mindful of the Light: practical help and spiritual hope for mental health*.<sup>9</sup> ▀

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# addiction: closer to home than you think

Alex Bunn asks searching questions about substances





Alex Bunn is CMF Associate Head of Student Ministries and a GP in London

## what is addiction?

'Can you control your drinking?' a colleague innocently asked a circle of doctors, at the bar at 5pm, followed by: 'and why do you think you need to control it?'

The issue of control is at the heart of addiction. I will look at psychoactive substances in this article, but the same principles apply to any activity that controls us, such as gambling, social media, pornography, eating habits or shopping.

The psychiatric manual DSM5 defines substance misuse according to four features that signal addiction: impaired control, the impact on relationships, predictable harms, and pharmacological indicators (tolerance and withdrawal).<sup>1</sup> Useful questions include:

- Do you want to cut back or stop?
- Do you spend a great deal of your time obtaining, taking, or recovering from your use?
- Do you experience strong desires or cravings to use?
- Do you continue to use even though you suspect, or even know, that it creates or worsens interpersonal or social problems? Or problems with your mind and body?
- Do you find that you need to use more than in the past in order to achieve the same desired effect?

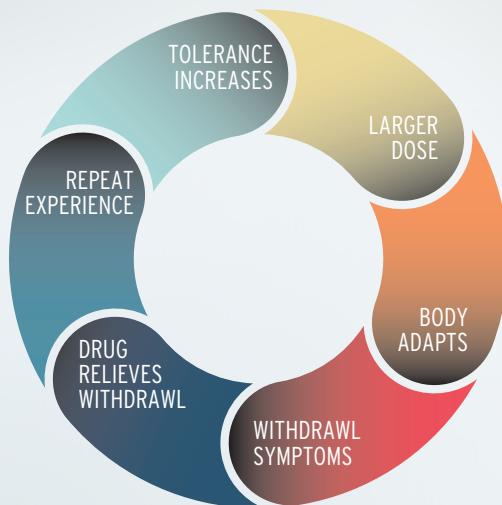
## why do people take drugs?

These questions may ring alarm bells for some of us. So what reasons do we give for our addictive behaviours? Most people use caffeine or nicotine as a stimulant and alcohol as a social lubricant. Some use riskier drugs out of boredom. Hallucinogens are often used for a mind-expanding, even transcendent experience. Others are simply pleasure-seeking, although invariably there are diminishing returns to quick 'fixes'. People who are dependent use chemicals to treat withdrawal

symptoms, and many users are trying to regulate mood or fill an emotional, even spiritual void.

*'I have absolutely no pleasure in the stimulants in which I sometimes so madly indulge. It has not been in the pursuit of pleasure that I have periled life and reputation and reason. It has been the desperate attempt to escape from torturing memories, from a sense of insupportable loneliness and a dread of some strange impending doom.'*

Edgar Allan Poe



For most of us, heavy drugs like crack, smack or spice are not very tempting. But in the wrong context, they might be. For instance, half of the American soldiers fighting in the Vietnam War tried heroin, and two-thirds cannabis, with half becoming addicted. Yet 99% escaped addiction on returning home.<sup>2</sup> How can we explain this?

Broadly speaking, there have been three schools of thought about what causes addiction. Historically, society tended to blame the addict as weak-willed or self-indulgent. As doctors came to understand the pharmacology of addictive drugs, experts stressed their ability to 'hijack' the brain's reward circuits. For instance, patients taking



L-Dopa for Parkinson's are at greater risk of addictions.<sup>3</sup> More recently, an influential experiment suggested that the social environment is a major factor. In the 1950s, rats were given the choice of drinking sugar water or opiate water. Often the rats preferred the chemical hook to food, and died due to self-neglect. This fitted with the doctrine that drugs are inherently evil, a view which drove the global 'War on Drugs'. But in the 1980s researchers used a different setup called 'Ratpark', in which rats were given larger and more stimulating cages to explore. The rats had other rats to socialise and mate with. This time the rats rejected the morphine, even if they had previously been addicted.<sup>4</sup> The conclusion: it's not the chemical hook that causes addiction, so much as 'the cage you are in'. If someone feels trapped in life's 'proverbial cage', they will be much more vulnerable than if their world feels like an adventure playground with deep social connections to others. For instance, the harrowing experience of warfare in the Vietnamese jungle provoked far more addiction than life back home with the family. Whilst humans are not caged rats, researchers saw parallels with life in poor housing, especially for

those with difficult family relationships and limited employment prospects.<sup>5</sup> It's a powerful, new narrative that challenges the demonisation of those living with addiction.

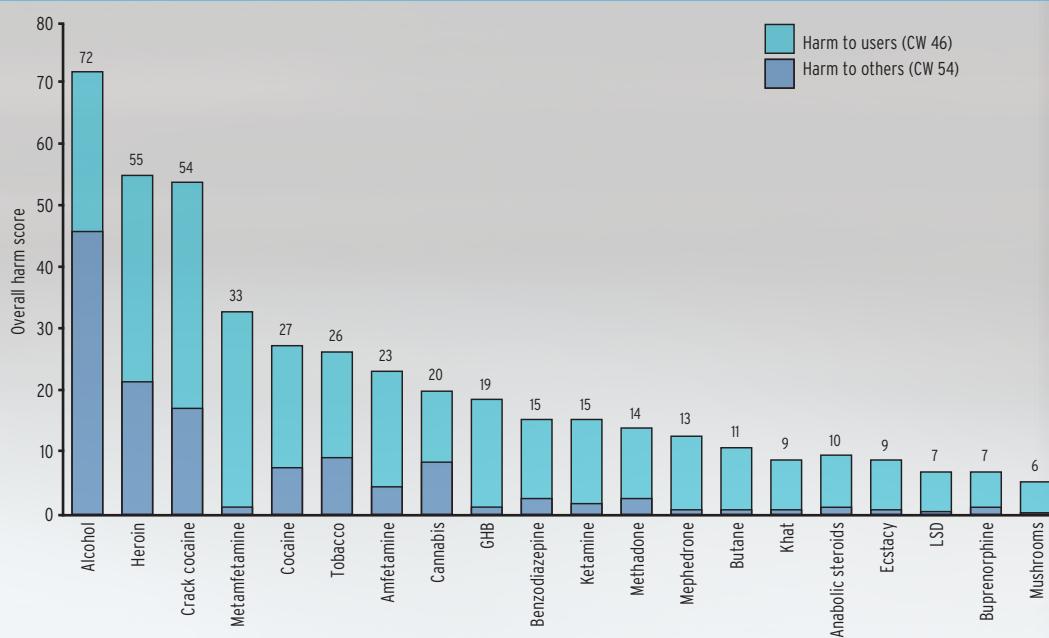
### theories of drug addiction:

- **Degeneracy:** addiction is personal weakness
- **Pharmacology:** some chemicals are dangerously addictive
- **Vulnerability:** adverse life experiences predispose to addiction

### assessing drug harms

All societies have used psychoactive drugs of some sort. But perceptions about the latest drug are constantly changing as harms emerge. For example, Pope Leo XIII endorsed cocaine wine before it became the milder Coca-Cola.<sup>6</sup> Queen Victoria's physician recommended cannabis, and probably prescribed it to her.<sup>7</sup> Sigmund Freud had a blind spot for his tobacco addiction that ultimately killed him. Troops in WWI were sent amphetamines and Harrods gift packs containing heroin.<sup>8</sup>

Social prejudices also shape how we view drugs. When at Eton, it is alleged that a future Prime



Minister was found with cannabis, and was merely given a hundred lines of Latin as punishment.<sup>9</sup> But a black person caught in possession of drugs is six times more likely to be arrested, and eleven times more likely to be imprisoned.<sup>10</sup> Cocaine use for bankers is tolerated as a way to boost assertiveness and unwind, whereas the cheaper crack cocaine is associated with social deprivation and vice.

As well as class and race, we need to be aware of how the media and corporate interests can bias us. A friend of mine was found dead in the bath by his children. It was a devastating shock. Which drug comes to mind? Cocaine? Ecstasy? Heroin? In fact, it was alcohol, the drug that causes more harm than any other.

Up to 35% of all A&E attendances are alcohol related.<sup>11</sup> Liver disease has surpassed lung cancer as the leading cause of years of working life lost, and is set to overtake ischaemic heart disease within three years.<sup>12</sup> Alcohol is implicated in 40% of violent crime and 50% of child protection cases.<sup>13</sup> The total cost of alcohol harm is up to £52 billion annually.<sup>14</sup> The drinks industry would have you believe otherwise, with their 'drink aware' message.

But 60% of their profits come from problem drinkers.<sup>15</sup> No wonder they were linked to a campaign to highlight the risks of ecstasy, when this cheaper drug threatened their profits.<sup>16</sup>

What about other drugs? The Advisory Committee on the Misuse of Drugs scored drugs for the harm they cause (see graph).<sup>17</sup> It's important to recognise not just the impact on physical and mental health, but the collateral damage to family life, the economy and crime, both at home and abroad. For instance, even when cocaine is taken 'recreationally', its trade causes an epidemic of knife crime and gang warfare.<sup>18</sup>

Finally, medics need to recognise our complicity with the growing problem of dependence forming medications (benzodiazepines, pregabalin, opioids and hypnotics) affecting 9% of the population.<sup>19</sup> It's a shocking fact that prescription drugs are involved in the majority of overdoses.<sup>20</sup> Are we the pushers now?

## a biblical overview

Look in a Bible concordance and you won't find crack or spice. But the Bible does mention at least five psychoactive substances, including gall (which

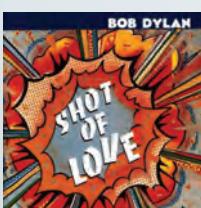
may have been hemlock or an opiate),<sup>21</sup> mandrake, wormwood and myrrh. But alcohol tops the list with 250 references, and is a helpful worked example.

In everyday life, wine was seen as a gift that refreshes and 'gladdens the heart',<sup>22</sup> and eases distress.<sup>23</sup> There was probably some value to lightly fermented drinks where clean water was hard to come by. Wine was also seen as a sign of God's blessing<sup>24</sup> but the 'grapes of wrath' were a metaphor of God's judgment.

There are numerous warnings about excess drinking<sup>25</sup> and the dangers of addiction.<sup>26</sup> Specifically, hazardous drinking impairs judgment and causes disinhibition.<sup>27</sup> Drinking can lead us to forget God's good laws,<sup>28</sup> and entangle us in actions we may regret.<sup>29</sup> Scripture was millennia ahead of modern medicine in recognising the link between alcohol and violence,<sup>30</sup> and morning drinking as a significant red flag.<sup>31</sup> Scripture outlines some woes for 'drinking heroes and champions',<sup>32</sup> including a vivid description of a hangover.<sup>33</sup> And there are disastrous stories of misuse in the lives of Noah, Lot, King Xerxes, Herod, and an appalling ruse by David to spike a friend's drink.<sup>34</sup>

One of the commonest reasons for taking drugs or an addictive activity is that it regulates mood, or numbs some inner pain.

Jesus' example here is extraordinary. He knew how to celebrate, and was accused of enjoying a party too much.<sup>35</sup> But on the cross, Jesus needed to remain alert to finish the task of liberating us from sin and death. So he refused the emotional and spiritual anaesthetic that was offered him in 'gall wine'.<sup>36</sup> We too, need to remember that we are in a spiritual battle, and must remain alert.<sup>37</sup>



which Bob Dylan rated as better than any drug.)

Instead of getting drunk on wine that distorts and deadens the senses, we are encouraged to be filled with the Holy Spirit,<sup>40</sup> who wakes us up to reality and heightens our senses.

*'I'll handle it, quit it. Just one more time, then that's it.'* Kelly Clarkson, Addicted

value your freedom. don't surrender it

*"I have the right to do anything," you say – but not everything is beneficial. "I have the right to do anything" – but not everything is constructive. No one should seek their own good, but the good of others.'*<sup>41</sup>

What does this mean personally? First, we can be thankful for the huge freedom the Christian has been given; we are no longer under the Old Covenant. God is for us, and not out to scold us. Even though our freedom in the New Covenant is substantial, Paul reminds us not everything is a *beneficial* use of our time and energy. How are we going to cherish and best use our freedom? Instead of retreating into escapism, the gospel invites us to join God in building a better world. The gospel turns us inside out, and helps us seek the good of others.

Second, God liberated us from slavery to sin and death,<sup>42</sup> so let's not surrender that hard won freedom! He has gifted us self-control as a work of the Spirit, to keep us from being enslaved or mastered again.<sup>43</sup> When temptation does come, we have God's word that now we really are free to say no:

*'God is faithful; he will not let you be tempted beyond what you can bear. But when you are tempted, he will also provide a way out so that you can endure it' (1 Corinthians 10:13)*

Often, I am in a substance misuse clinic, imploring and coaxing a revolving door client not to let a chemical rule and ruin any more of their life. The poor dentition, the emaciation and the

track marks, all tell a tale of captivity and waste. I wonder if the Lord ever views my stubbornness over my cravings and idols in the same way. How much better that 'my heart and my flesh cry out for the living God'.<sup>44</sup> Dare we confess our weaknesses, where we are prone to become enslaved? The Alcoholics Anonymous method encourages a 'searching and fearless moral inventory of ourselves'.<sup>45</sup> It might be diagnostic and therapeutic to fast from things that we suspect are in danger of mastering us.<sup>46</sup>

## what can we do?

Why not visit an AA meeting or rehab centre?

It's a profound experience to hear testimonies of healing, and the humility of those who recognise their powerlessness.<sup>47</sup> Many will not have an explicit faith, but some will thank a 'greater power'.

<sup>48</sup> Once in clinic I nipped out of the consulting room, but my patient stopped me: 'I wouldn't leave your

## Questions for reflection

- Which chemicals do I use? Do I use them to escape?
- Am I addicted to something I should fast from?
- How can my church engage with addictions?

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# whatever man called it, that was its name

Josué Reichow considers the meaning of naming in psychiatry



**O**ne of the central teachings of the Bible, especially emphasised in the letters of Paul, is the principle of *the lordship of Christ over all of life*. This principle received special attention by Christians fighting back against the modern secular dualism that divided spheres of reality between *sacred* and *profane*. This dogma proclaimed that faith should be lived exclusively as a private matter, leaving the public space as a neutral, scientific and rational sphere. From Kuyper to Schaeffer the idea that faith has to do with all dimensions of reality and life has challenged us to

seek integration of our faith with our activity in the world. So, we are called to develop a Christian world view.

While for some, this idea might sound very familiar, the practice of integration is a very hard task. For instance, what would that mean, for the Christian psychiatrist? How should we integrate faith with the field of psychiatry, in a way that honours the lordship of Christ? Writing as a non-medical, my aim is to provide a framework for Christian medics to look at these questions, both to stir discussion, and lead to a transformative *praxis*



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(practice). An exploration of the meanings of the creation mandate of *naming* will form a framework for understanding what the nature of reality is, with application to psychiatric practice, a challenge to medics to reform their medical imagination in order to develop a Christian psychiatric imagination.

**reality comes into existence through a creative act of speech, through a spoken word that creates and orders creation**

### the naming mandate

We read in the creation narratives that 'in the beginning was the Word' (John 1:1), that when he created, 'God said...' (Genesis 1:3). Although, the meaning of 'the Word' in John is much larger, being connected to the divine *logos*, to the Son himself, it is clear that *reality* comes into existence through a creative act of speech, through a spoken word that creates and orders creation. In the same way, the Creator speaks man into being, creating him, according to the Genesis account, in his image and likeness. Therefore, man is *imago Dei* (in the image of God). Our anthropology – who we are – is derivative, which means that there is an external source to our identity. That is why the knowledge of God and the knowledge of the self, walk hand-in-hand; we need the revelation of God's word to shape our understanding of ourselves.

As *imago Dei* we reflect the Creator's attributes: in our rationality, emotions, relationality, moral capacity, and patterns of work and rest. However, another attribute is seen in our mandate to name things: '*Now the LORD God had formed out of the ground all the wild animals and all the birds in the sky. He brought them to the man to see what he would name them; and whatever the man called each*

*living creature, that was its name.'* (Genesis 2:19).

Even today biologists are still naming organisms. Every time a new one is discovered is up to us to *name it*. For instance, in 2008, in a popular diving site in Indonesia, a new species was found. Biologists named it *psychedelic frogfish*.<sup>1</sup> This is so not only within the biological realm; God gave us the mandate of *naming* reality. How can *naming* be defined though? Besides, what does it say about reality?

The attribute of naming expresses our calling as co-creators, as those that the Creator put in charge of the garden, to develop culture, and multiply. Naming could be defined as a *creative discernment*. It involves working with the given, but going beyond it. Only God creates *ex-nihilo* (out of nothing). We don't have this capacity. However, it doesn't mean we cannot create. We do and should create and through naming things, things come into existence and in this way we reflect God. Reality is *facts plus meaning*. It is both objective and subjective. *Whatever the man called it that was its name*. The subjective perception and choice create something which we inhabit, from a political system to a particular way of naming a pathological behaviour.

### naming is a battle for meaning and ultimately for reality

Naming is a way of being in the world. It feeds our imagination, both with words and images, giving meaning to reality and impacting everything we do. Think of the example of idolatry in Psalm 115. We are told that those who create idols *will become like them*. We do become what we imagine, because our imagination provides the categories through which we understand ourselves and reality. So, naming is a battle for meaning and ultimately for reality.

It is fundamental for us as Christians to understand that every single cultural artefact created by us, including tools, concepts, epistemologies, methods and techniques, is value laden and carries a worldview with it. That is the reason why the task of integration is so hard. In order to integrate our faith with medicine we cannot simply accept the tools of a particular science. For instance, thinking Christianly may require more than simply applying the accepted diagnostic criteria of psychiatry uncritically, and then applying what is thought of as a Christian answer. Most of the time using the correct terminology shapes the debate, and getting the naming right is a vital first step.

### naming in psychiatry

Working with the apparatus produced in the modern world, it is necessary to develop Christian wisdom to discern how to navigate the concept and method of naming. Every single concept created by science is based on assumptions about what reality ultimately is – an *ontology* (beliefs about the nature of things). Applying that to the field of medicine, how can we identify psychiatric practices that might be completely based on a secular *ontology*? What do their categories look like? Are they big enough to capture the human condition? Can a Christian psychiatrist use these categories without compromising a Christian view of reality? I think these questions are big challenges for medical students who wish to integrate their faith with everything they do.

An example of naming reality within medical practice is the Diagnostic and Statistical Manual of Mental Disorders (DSM). It is crucial for psychiatrists to realise that naming is a battle for meaning, as we are called to describe and create. The methods and tools produced by the DSM are important and must be studied carefully. Nevertheless, we cannot forget that they are value-laden and carry a world view that in many cases distorts and reduces reality, in some way undermining human flourishing.

Every time a field of knowledge makes exclusive claims (based on its own assumptions) to explain one or more aspects of the human experience and reality, there is a risk of reductionism. Put in other words, when a field colonises another field, reality shrinks to fit within those categories. Think about a biologist who explains morality only in biological terms, or a historian who reduces the religious aspect of life to a mere sociological phenomenon. A similar risk can occur with medicine: the medicalisation of everything. If everything comes down to a ‘mental health problem’, for instance, how can we conceive human freedom? Is there such a thing, at all?

### the need for a Christian imagination in psychiatry

If we lose the grasp of larger realities, reality will also be narrowed once we inhabit what we imagine. If within our horizon there is only an *immanent frame* (the here and now), as Charles Taylor puts it, categories such as *sin* and *evil* will make no sense. Besides, if these categories only make sense on Sunday and are not part of the picture in the clinic on Monday, we are already secularised, functional atheists.

So, there is a challenge posed for Christians working within this medical field. How can we develop a non-reductionist psychiatric practice that unfolds the task of naming in relationship with its Creator? I believe there is a need for a *Christian psychiatric imagination* to be developed. Remember, we inhabit our imagination. But our imagination derives from the categories we use to name the created order. If we are in rebellion against the Creator, we will name his creation very differently than if we are submitting our imagination to the Creator’s revealed will and purposes. Psychiatrists have to remember that *whatever man called it that was its name*, without forgetting, however, that in the beginning was the Word.

Alex Bunn reflects on how Reichow's article can be applied to clinical practice

## 'naming' in clinical psychiatry

**S**o 'naming', creating definitions and classifications is a basic human activity mandated by God. How might medical language illuminate or distort our view of people?

### how do you know?

There are two main schools of thought about knowledge. At one end, there is *positivism* which relies on hard sciences to 'read' a reality that exists independently of us. For instance, astronomers used telescopes to discover the laws of gravity. On the other end, there is *social constructivism* which states that truth is always socially constructed, and embedded in the local culture. We impose an order on the world, such as when men decided that a constellation resembled a lion, and called it Leo.

The naming of physical conditions is largely positivist. A diagnosis of TB likely represents an infection with a physical entity that can be visualised. The success of treatments like antibiotics gives biomedical classifications huge status. But in psychiatry, it is not so easy to 'read' the mental events and pathology of someone's inner world. So our definitions rely more on the imagination. We describe phenomena that cluster together, and decide whether they need attention because they cause distress or dysfunction. If so,

we give them the label of a mental disorder.

Medicalising thoughts and behaviour has pros and cons. It can be very reassuring to know that your negative experiences are shared, and that certain treatments worked for others. For instance, a young woman was diagnosed with Autistic Spectrum Disorder and was immensely relieved. She was not just 'odd'; the diagnosis gave her access to professional help and specialist education. A diagnosis may also legitimately excuse someone from thoughts and behaviours beyond their immediate control. Somebody with schizophrenia is unlikely to intend paranoia or delusional thinking.

However, no naming is neutral, as it expresses a culture and a worldview. Historically, some labels have reflected prejudices, or been misused by political regimes. Sadly, many societies including Christian ones have used labels like 'witch' to persecute those on the margins of society. The diagnosis of 'drapetomania' was invented by an American physician to describe the inconvenient habit of a slave in disobeying their masters by running away.<sup>1</sup> The Soviet Union deemed unauthorised beliefs (political dissent and faith) a mental illness, 'political intoxication', in need of compulsory treatment.<sup>2</sup>

## over-medicalisation, materialism and personal responsibility

More recently, the number of conditions in the DSM has swelled from 14 to 250, perhaps partially driven by the need for a diagnosis to access insurance funding in the US. Some cite false epidemics of ADHD, hypomania, and childhood bipolar disorder as a result. But has this mapping of every aberrant thought led to the over-medicalisation of human experience? DSM5 no longer excludes the diagnosis of depression following recent bereavement. Does this lead to the medicalisation of entirely appropriate grief? Is an elderly man with hoarding disorder best understood as sick or just self-protective? Mild cognitive impairment is a new entry, but where do we draw the line between naturally declining memory, and a pathological dementia?<sup>3</sup>

Another tendency of western medicine is to reduce humans to the merely material. For instance, when does sadness become depression? The serotonin hypothesis collapses melancholy to a chemical imbalance,<sup>4</sup> which may distract us from the higher level causes that need addressing, such as abuse suffered in childhood or heavy drinking used to forget it. The pharmaceutical industry<sup>5</sup> has an interest in maintaining a simplistic account, and doctors can be tempted to collude by prescribing rather than listening.

A final area of tension is our approach to certain behaviours that would previously have been viewed as sinful, needing repentance. Now they are more likely to be classed as disorders, needing treatment. A variety of acts, from terrorism to gambling and sexual harassment, have been reported this way.<sup>6</sup> I remember meeting a patient who had been convicted of grooming a minor online. He showed me letters he had written to his wife, asking why she hadn't spotted he was sick. He was convinced that his psychologist had told him 'the depression made me do it'. This is very unlikely, but illustrates how labels can suggest explanations for our actions.

## questions for reflection

- When might a psychiatric diagnosis be de-stigmatising?
- When might a psychiatric diagnosis undermine personal responsibility?
- To what extent might some psychiatric categories be in tension with a biblical account of human behaviour?

The concept of a personality disorder (PD) aims to provide a scientific approach to antisocial or dysfunctional behaviour. ICD10 defines a PD as 'severe disturbances in the personality and behavioural tendencies of the individual; not directly resulting from disease, damage, or other insult to the brain, or from another psychiatric disorder; usually involving several areas of the personality; nearly always associated with considerable personal distress and social disruption; and usually manifest since childhood or adolescence and continuing throughout adulthood.'<sup>7</sup> This classification recognises the impact of adverse childhood events on psychosocial development, and antisocial behaviour. But I have seen patients use the diagnosis of antisocial PD to justify violent behaviour or the need for addictive medications. Worse, I have heard doctors write such patients off as beyond redemption. It is worth reflecting deeply on the 'mad, bad or sad' debate.<sup>8</sup>

So let's be careful with the names we give people. ■

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# essentials: big questions

Bernard V Palmer asks why we are Christians



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*'I am the true vine... Neither can you bear fruit unless you remain in me.' (John 15:1,4)*

*'This is to my Father's glory, that you bear much fruit, showing yourselves to be my disciples.' (John 15:8)*



**C**atherine Booth, wife of the founder of the Salvation Army was giving a talk in an established church when she said, 'Is this all you do for God; you go to church?'

The vine in the Old Testament represents Israel.<sup>1</sup> In John 15, Jesus unhesitatingly puts himself at the centre of this picture. 'I am the true vine' is Jesus' claim that God's people are dependent on him. The significance of this staggering passage doesn't stop here; it emphasises that we are in Christ in order to produce fruit. This concept is repeated seven times in the first, eight verses – so presumably the Lord wants us to be very clear about this. But what exactly does he mean by, 'to bear fruit'?

There was a caring, conscientious GP who, when a young man, had been active in his medical school Christian Union. But now, in the 'real world', he realised that to suggest that others must take Jesus seriously could cause considerable tension and loss of popularity. 'I now have a responsible position in society', he argued, 'and I do not think it is my gift to point people to the Bible or to talk about the Lord. I major on the fruit of the Spirit, on love, joy, peace and patience instead.' He now appears as a very kind doctor, but is not recognisable as one of 'those who belong to Jesus Christ' (Galatians 5:24).

In John 15, there are several clues as to what Jesus really means by bearing fruit.

- It is not something within ourselves but an effect outside, 'I chose you and appointed you so that you might go and bear fruit – fruit that will last.' (John 15:16). The mission of the church is to 'make disciples of all nations' (Matthew 28:19).

■ 'This is to my Father's glory that you bear much fruit, showing yourselves to be my disciples.' (John 15:8) This verse seems to equate 'bearing fruit' with showing ourselves to be disciples.

We are meant to show our faith to others.

Jesus wants his followers to see him as the focus for the whole world and to make this obvious to others. Christians must show, both by the way they live and the way they speak, that they are devoted to Jesus. This, after all, is the purpose of his creation, 'to bring unity to all things in heaven and on earth under Christ' (Ephesians 1:10).

The last nine verses of John 15 make it abundantly clear that this is what Jesus means. Christians are not persecuted for being loving, or joyful or patient. It is an uncompromising allegiance to Jesus that many react against.

Verse 26 conclusively proves that this is what 'bearing fruit' (John 15:16) means in this context. We so desperately need the Holy Spirit to keep us living God's way, according to his truth. A major part of this is to testify openly to others about our Lord Jesus Christ.<sup>2</sup>

Why do so many Christian doctors drift away from their 'first love' (Revelation 2:4) – an open devotion to the Lord Jesus – into a socially acceptable, easy, sterile Christianity?

Let us all beware lest we fail to remain in Christ, not testifying about him, for God can easily discard doctors! ■

# *leadership*: lessons from a life well lived

John Greenall shares a personal example of his grandad and the giraffe





**John Greenall** is CMF National Field Director and a Paediatrician in Bedfordshire

**T**he wooden giraffe was my favourite. Hand-carved by one of my grandparents' friends in Cameroon, it joined my collection of carved animals that gathered on my shelf. By the age of twelve, these were not the only reminders of my grandparents' missionary life overseas. Stories of conversions and miraculous escapes imprinted themselves on my brain. I wanted to be like my grandad. I craved adventure, recognition and the knowledge I'd been useful to God.

But he died recently. I find myself reflecting on this, as I learnt as much about him at his funeral as I learnt when he was living. He didn't write books or blogs. He rarely preached. He was a quiet, salt-of-the-earth type who had no airs or graces. And yet from the tributes of friends and family, I learnt that this remarkable, quiet, humble man was a true leader. The fruit of his life is incredible – five children, 13 grandchildren and nine great-grandchildren (and counting – although no more additions to my family!). He was a missionary in later life to Papua New Guinea, Cameroon and Malawi. There are countless stories of faith, love and hope. So much could be said about him, but here are five leadership lessons he has taught me.

### he built

Born in Middlesbrough in 1931, grandad was committed to his family. My mum, one of his five children, remembers the night shifts and taxi driving to make ends meet. On his days off, he spent time with the children, played games and used his woodworking skills to make unique presents. Genesis 6 speaks of Noah finding favour with God. He was a man entrusted with building an ark, the type of which had never been seen before. He was entrusted with taking on board the animals God commanded and limiting the number of humans to his close family. Why was he trusted to do this? Because he 'was a righteous man, blameless among the people of his time, and he

walked faithfully with God...'<sup>1</sup> He had built his character on an earth that was 'corrupt in God's sight...and was full of violence.'<sup>2</sup> And he had built his family, teaching them to obey and follow him. The Apostle Paul picks up this theme when outlining the qualifications for elders and deacons,<sup>3</sup> the majority being based on character rather than gifting or competency.<sup>4</sup>

Leadership doesn't mean prominence, glory or fame. It doesn't spring from ambition or even gifting. Instead, it requires men and women open to God who allow him to build their characters, and if given to them, their families in the middle of a depraved and wicked generation. Such people will be entrusted with spiritual leadership in God's economy.

my grandad was a mild-mannered gentleman; he never seemed to raise his voice; he sat quietly and spoke gently. And yet behind this lay a steely passion

### he was obedient

They say that sport can turn the mildest of folk into a frenzy. My grandad was a mild-mannered gentleman; he never seemed to raise his voice; he sat quietly and spoke gently. And yet behind this lay a steely passion. Trips to the old Ayresome Park to watch his beloved Middlesbrough Football Club would leave his youngest son, my uncle, rather shocked as he saw the referee receive clear and vocal 'advice' from my grandad. But his passion didn't stop at Middlesbrough FC. He wanted to please Jesus, and his passion for his name meant he was willing to be radically obedient, at every stage of life.

Aged 49, my grandparents sensed God asking them to fill in for a missionary couple in Papua New Guinea for a year. When the church leadership



considered this, someone asked, 'If we felt you should not go, what would you do?' Grandad thought for a moment and then replied, 'We'd go anyway'.

They took their youngest daughter (aged 16) and she gained much from the experience. They later went and worked with a German mission in Cameroon, West Africa. Using his experience as a clinical nurse teacher in the UK, he and grandma developed a much-needed health centre among the villages of the Ejagham people in the rainforest near the Nigerian border. They would later move to Malawi, working with a South African Bible School, giving basic Bible teaching to village church leaders who had neither the money nor literacy to go to Bible School.

if as a leader, I can show interest  
in people's lives and bring them to my  
Heavenly Father in prayer, that will  
be a life well lived

They had a mortgage on a house, so had to sell it to help finance the trip. A kind friend told them they would come back with nowhere to go. Grandad told him that God is a good employer and was well able to provide a house when needed. Fifteen years later, my grandparents came back to UK and a house of their own. They knew it was a miracle.

As you read this, you might feel that you can be introverted, quiet, and perhaps go almost unnoticed. Whatever our personality and gifting, we can know a steely passion for the glory of Christ as his servants,<sup>5</sup> bound to him with a determination to make his name known and a willingness to go anywhere and do anything for him.

### he prayed

Sometimes a full paragraph is required to make a point, but this one requires very little. Quite simply, he prayed. Letters, cards, phone calls – all would assure me of his and my grandma's prayers. Paul models this life of prayer so well, praying for those he was leading to have hope,<sup>6</sup> peace and unity,<sup>7</sup>

to be filled with spiritual power,<sup>8</sup> and for righteousness and purity.<sup>9</sup> If as a leader, I can show interest in people's lives and bring them to my Heavenly Father in prayer, that will be a life well lived.

### he meant what he said

Living in Malawi was not without danger. Travelling to Zomba, the former colonial capital of Malawi to hold a seminar one Saturday morning, a driver coming the other way warned my grandad's team to stop because of a pitched battle between the army and the Young Pioneers (the paramilitary group of the Malawi Congress Party) further up the road. But my grandad drove on. He was followed at speed along bumpy back roads until he arrived at his destination and met the convenor of the seminar. Grandad said, 'We promised we'd be here by 9am, and here we are'.

As well as being a man of his word, when he spoke, he was worth listening to. At home, whether it was the special 'one-on-one' times or when he had to tell them off, his children really cared about, and took notice of what grandad said. Abroad, he watched, listened, and spoke out when he saw something was wrong or unjust. In his later life, his quiet words of encouragement and wisdom were valued by church leaders and members of all ages. Even his Parkinson's didn't stop those quiet, well-chosen words!

The words of leaders can be constructive or destructive. We have power to build up or tear down. We can keep our word or break it. Let's be those whose 'yes' means 'yes'<sup>10</sup> and who choose our words wisely to speak truth into situations and lives around us.<sup>11</sup>

### he kept going to the end

Parkinson's is a nasty disease and watching my grandad suffer was hard. It wasn't so much the physical symptoms, but the mental and emotional ones. He would often be very low in mood. He would sometimes voice his feelings of helplessness. He got frustrated at being so limited. But what was

incredible was seeing the way God worked through him right to the very end. His gentleness, kindness and love impacted on people, even my children.

One of them took to praying for him every night for months that he would look forward to the day when he would be dancing in heaven. He lived out the truth that 'from life's first cry to final breath, Jesus commands my destiny'.<sup>12</sup> And he reminded me that should I lose many of my abilities or roles in life, that whilst I still have breath there is work to be done.

Leaders go all the way to the very end because they know the ultimate goal awaits them. The Apostle Paul's words in 2 Corinthians 4:16-18 call to mind my grandad who knew his God and therefore did not '*...lose heart. Though outwardly we are wasting away, yet inwardly we are being renewed day by day. For our light and momentary troubles are achieving for us an eternal glory that far outweighs them all. So, we fix our eyes not on what is seen, but on what is unseen, since what is seen is temporary, but what is unseen is eternal.*'

The wooden giraffe is still on my shelf. And my grandfather's genes and passion live on in me. But it's no longer a thirst for adventure, recognition or significance. No. It's a thirst to be a humble servant-leader who builds his character and family with a passion born from eyes fixed on Christ, that drives me to radical obedience; who yearns to be a man of prayer, speaking truth in love and who keeps going to the very end. ▀

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# *be prepared*: psychiatry as a medical student

Claire Wilson looks at effective engagement with mental illness as a Christian





Claire Wilson is a psychiatry trainee in London and CMF psychiatry link

**A**s a medical student, you will encounter mental ill-health across the specialities through which you rotate. As a future doctor, you will continue to encounter it in the patients for whom you care. Indeed, it will almost certainly feature in many other aspects of your life: fellow students, friends, family, church members, even you, could all be affected. How can you best prepare yourself to engage with psychiatry now, as a medical student?

As a psychiatrist, I have reflected back on my years as a medical student to provide a practical framework to help you navigate some of the challenges and unique opportunities that may present themselves to you in the face of mental illness. I will focus on two broad themes: How does psychiatry sit within our world view as Christians? And, as a Christian, how can I effectively engage with those with mental illness?

I will cover a number of different issues that are important to be thinking about as one develops into a Christian doctor, so resources are suggested for further reading.

### how does psychiatry sit within our world view as Christians?

From your earliest exposure to psychiatry, you will be encouraged to think about (and structure exam answers around!) psychopathology from a 'biopsychosocial' perspective, considering the biological, psychological and social explanations for an individual's condition. Begin thinking now about the spiritual dimension. Regardless of whether or not the individual is a Christian, there will often be a spiritual aspect to the aetiology of their presentation, which can also influence how they respond to mental illness. This may not yet have been explored by health staff but is a central aspect of holistic history taking.

## resources

### further reading on mental illness and Christianity

- *The Problem of Pain* by CS Lewis
- *Mad, Bad or Sad?* edited by M Dominic Beer and Nigel D Pocock (reviewed in this edition of *Nucleus* - page 41)
- CMF files 32: Human suffering
- CMF files 53: Depression and cognitive behavioural therapy
- CMF files 58: Is Christian faith delusion?
- CMF files 64: Mindfulness

All CMF files are available at:

[cmf.org.uk/resources/publications/cmf-files](http://cmf.org.uk/resources/publications/cmf-files)

### mental illness as a form of suffering

Mental illness is one of many examples of suffering that we see in our world. The creation story in Genesis helps us begin to make sense of suffering, though we may never during this life fully understand suffering, especially when we are in the midst of it. In Genesis, we are told that God created the world and that it was 'very good'.<sup>1</sup> We then learn of how, through man's disobedience, sin and suffering entered the world<sup>2</sup> and separated us from God.

The Bible is full of examples of profound struggling. The classic example is that of Job, who lost everything that was important to him in his life, even the support of his friends and family. Job appears to experience symptoms of depression. However, we also learn of how Job reached a point at which he had a renewed sense of faith and reliance on God through this experience. Indeed, in Hebrews 12, we are reminded that 'No discipline seems pleasant at the time, but painful. Later on, however, it produces a harvest of righteousness and peace for those who have been trained by it' (Hebrews 12:11). In my experience, this is far easier (although still extremely challenging) to reconcile at a theoretical level than when faced with individual or (worse) personal suffering. Yet the

## taking a spiritual history

### opening questions

**Ideas:** 'Do you have a faith that helps you when you are struggling?' 'Do you have a faith that helps you at times like these?' 'What gives you hope?' 'What keeps you going in difficult times?' 'What gives you meaning or purpose in your life?'

### spiritual past

- Establish their world view.
- Has this changed during their life? Any threats to spirituality in the past? eg any major losses or mistreatment? How has this affected them?

### spiritual present

- If not done already, elicit what their current beliefs are.
- Do they feel valued and that their beliefs are respected? Are they able to share their ideas openly? Do they feel that there may be a spiritual element to their current problem?
- Would they like support?

### spiritual future

- Explore hopes and fears about the future. Are they worried about death and dying?

### next steps

- What support, if any, would they like? Who do they confide in?
- What is available? Explore ideas with them eg within their faith community, family or friends; voluntary organisations; with faith-based counselling and hospital chaplains.

examples of healing performed by Jesus remind us that God will in time deliver us from our state of suffering and will use that to reveal his glory.<sup>3</sup>

**mental illness as the work of Satan**  
We also read in the New Testament of Jesus casting out demons.<sup>4</sup> While demonic possession may occasionally play a part in a patient's presentation,

we should also remember the other parts of our biopsychosocial formulation; for example there is good evidence for the role of biological influences on a number of psychiatric conditions. There may also be less direct ways in which Satan may play a role in somebody's mental illness; for example, through temptation or spiritual attack people may sometimes make life choices that lead to a decline in their mental health or cause them to misuse substances.

Often, we may not fully understand what has caused a person to become mentally unwell. Uncertainty is a challenge that we face in many areas of life as Christians, so too in medicine. Yet God knows. Isaiah 55:8-9 says: "For my thoughts are not your thoughts, neither are your ways my ways", declares the Lord. "As the heavens are higher than the earth, so are my ways higher than your ways and my thoughts than your thoughts".

### as a Christian, how can I effectively engage with those with mental illness?

By reflecting on our own views of mental illness we can better engage with those experiencing it. Reflection can also help us offer hope of an eternity free of pain and suffering, and a restored relationship with our Heavenly Father through Christ's death on the cross.

### spiritual history taking

Only when we know where a patient has come from, can we truly understand them in the present and have a sense of where we might lead them. This is the essence of history taking in any speciality and a spiritual history is at the core of it. I'm pleased to say that, in my experience, I've met few psychiatrists who are opposed to the principle. A single question such as 'do you have a faith that helps you when you are struggling?' can suffice or it can open doors to sharing your own faith sensitively. Remember, you will never have more time with patients than you do now as a medical student.

## what does the GMC say about taking a spiritual history in 'Good Medical Practice'?

'Adequately assess the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views and values.'

'It may therefore be appropriate to ask a patient about their personal beliefs. However, you must not put pressure on a patient to discuss or justify their beliefs, or the absence of them.'<sup>5</sup>

As a Christian medical student, what an opportunity you have to offer something unique and life-changing to those facing the fear and despair of mental illness. You have the gospel! You have good news!

CMF's Saline Solution course looks at how we can share the Gospel sensitively and with regard to GMC Guidelines.

## it's okay not to be able to help everybody all the time

Despite this, it is important to maintain perspective of oneself as working for God but not being God. God encourages us to rest.<sup>6</sup> As Christians our primary identity should be as a child of God and not as a doctor. You cannot hope to know all, cure all, heal all, so when it is challenged remember your primary identity. Psychiatry is famous for 'not curing people'. In fact, most of medicine is like that; chronicity is the mainstay these days, but lives can be improved nonetheless. That's okay. On a similar note, in the same way as you cannot hope to reach the whole world with the gospel, you cannot expect to have illuminating conversations with every patient. I stress this as it is easy to become absorbed in kingdom building activity and to forget to rest; establish habits of rest now as a medical student and seek to maintain them as you enter the world of work.

Know also that the patients you will like the least are often the ones you feel as though you can help the least. I am thinking particularly of patients with

## resources

### Further reading on working with those with mental illness

- *Mindful of the Light* by Stephen Critchlow. Provides helpful ways of explaining mental illness to patients.
- *Tackling Mental Illness Together* by Alan Thomas.

### Explores the church's role in supporting those with mental illness.

- Mind and Soul Foundation ([www.mindandsoulfoundation.org](http://www.mindandsoulfoundation.org))

### Links to more resources and services.

- Royal College of Psychiatrists Spirituality and Psychiatry Special Interest Group ([bit.ly/2y0gCj5](http://bit.ly/2y0gCj5))

personality disorder (although there are plenty of management options for these patients), encountered mostly in psychiatry but when you will likely encounter at various points in your medical journey. It is okay not to like all of your patients. Have the self-insight to note when you feel negatively towards a patient and you will be in possession of a degree of self-awareness that eludes most doctors. However, remember as a Christian, that you can pray for patients with whom you have had contact at the beginning or end of the working day.

## conclusion

In conclusion, encounters with those suffering with mental illness, whether it be on your psychiatry rotation or outside it, present a number of challenges but also some unique opportunities to us as Christians. It is important to be prepared for these encounters as a medical student, but also throughout your working life as a doctor. ■

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# *distinctives*: addiction in pregnancy

Eilidh Urquhart describes lessons from a student project

**E**dinburgh is famous for its iconic skyline, the festival and its important place in Scottish history. However, in the city also famous for *Trainspotting*, you don't have to journey far to come face-to-face with the harsh reality that faces many of its residents.

A 25 minute bus journey from where I lived as a student, takes you from one of the wealthiest areas

in Scotland to one of the most deprived and yet most of Edinburgh's middle class population are unaware of the deprivation and poverty that is on their doorstep. These areas have higher rates of crime, lower life expectancy, poorer health and are less educated. There are also much higher rates of drug misuse and dependency.<sup>1</sup> Life here is chaotic and breaking the cycle of poverty is difficult.



Eilidh Urquhart is a junior doctor in Scotland

It was amongst this population that I found myself, in my fourth year of medicine, undertaking a project looking into drug addiction in pregnancy. Although this was primarily a research project, I found that the people I met and things I learnt really challenged me: around 1 in 80 women in Edinburgh between the ages of 15 and 69 have an illicit drug problem.<sup>2</sup>

I joined the PrePrepare team, an integrated pregnancy and parenting support team established in 2006 to reduce maternal drug use, improve pregnancy and neonatal outcomes and protect children from harm. They work primarily with pregnant drug users. These women are amongst the most chaotic and regularly do not attend appointments or engage with services. The team aim to break the cycle of poverty and addiction. They run parenting classes, provide financial advice and educate on the harms of drug use, all in a supportive and blame-free environment.

The aim of this study was to determine whether women with benzodiazepine dependence were receiving a gradual dose reduction of long acting benzodiazepines in accordance with guidelines.<sup>3</sup> It also aimed to explore the barriers to reducing drug use. I found that diazepam prescriptions were not being reduced in accordance with guidelines but that there were many barriers to doing so. These barriers included chaotic lifestyles, complex family relationships, the use of drugs as a coping mechanism and lack of education. Reducing the prescription couldn't be done without tackling some of these issues, and keeping the patients engaged. All the women felt they benefited from PrePrepare's work and I was struck by the commitment of the staff to working relentlessly to bring about change in these women's lives.

Addiction is a very powerful vice. It has a psychological and physical grip on people and completely controls their lives. This often results in manipulative drug-seeking behaviour as people

look to get the next fix. Perhaps understandably this doesn't endear them to others. However, we can often fail to see past the addiction to the person.

I spoke to women about their lives, their families and how they started using drugs. Many attributed the start of their drug use to 'getting in with the wrong crowd.' However, around half of the women I interviewed disclosed experiencing significant childhood trauma, including childhood abuse, exposure to parental domestic violence, parental addiction and family members in prison. There is strong evidence that exposure to violence as a child increases behavioural problems in children and leads to domestic violence in their own relationships as adults.<sup>4</sup> Childhood trauma also increases the likelihood of drug addiction, earlier drug use, depression and suicidal intention, all of which negatively impact parenting ability.<sup>5</sup>

In my study, two-thirds of the women were in abusive relationships. Two-thirds of their partners had previous convictions or prison sentences. To cope with their unstable home environment, many women turned to drugs such as diazepam, methamphetamines and heroin. These women were now bringing children into the same environment that they themselves had been brought up in.

All the children in the study were put onto the child protection register before birth – 60% of babies went straight into care; the remaining 40% went home with their families with input from social work and other services. Over three-quarters of these women already had other children in care. Sadly, many of these babies were born with neonatal abstinence syndrome which can have long term effects.<sup>6,7</sup> The separation of a mother from her child is always painful but particularly so when these women are left with a sense of shame and failure in their role as parents.

These mothers were hurting deeply. One woman cried throughout the interview because all she

wanted was her children back home. She desperately wanted to stop taking drugs and be free from the control her drug dependence had on her.

Through these conversations, I began to understand the depths of pain and suffering that many of these mothers had experienced and been exposed to throughout their lives. When you begin to realise this and share in someone's pain, you see a hurting and broken woman trapped in a situation that she grew up in, instead of the addict who brought it upon herself.

Drug users are amongst the most stigmatised in our society, particularly in healthcare settings. This stigma is often left unchallenged because of an underlying belief that the addicts are to blame for their addiction. I'm sure we have all heard the way that staff talk about 'the IVDU in bed four', or the scepticism surrounding requests for pain relief. It seems that the stigma is even greater towards drug-using pregnant women because the drug use harms both mother and baby. One woman told me she was refused analgesia during labour by staff who thought she was drug-seeking.

When we call a woman by a label such as 'the IVDU in bed four', we define them by that. This becomes her identity. As Christians, our identity is in Christ and we believe that all human beings are created in God's image - this is our call to treat everybody equally. The Bible tells us that we are all broken and sinful and in need of grace.<sup>8</sup> The Bible also tells us to love one another as ourselves.<sup>9</sup>

This is not an instruction to love the people that we like or the people that are easy to love, but an

instruction to love each and every person that we meet. Loving someone who is addicted to drugs is often difficult, but these are people who need love the most. Jesus loved people that no one else did and who were despised by society, such as the tax collectors, prostitutes and criminals.<sup>10,11</sup>

As Christians, we are called to be more like Jesus and to love those who society ignores or neglects. Working in the NHS we see many people who fall into that category, which includes people with addictions. As Christian healthcare professionals, we should be on the front line in challenging attitudes and stigmas towards some of the most vulnerable people in society. We are called to reach out to these people, to believe that their lives can be different and to show them a glimpse of a love that they have never experienced, pointing them to the Father who loves them more than we ever could.

What does it look like to show love to a drug user? Don't be afraid to talk about their drug use; it shouldn't be a taboo subject. Let them tell their story. Be interested in them and their lives without judgement.

The biggest lesson I learnt through this project was not to give up on people in seemingly hopeless situations. I met people who had stopped using drugs after years of addiction and who were slowly breaking the cycle of poverty that they had been trapped in with help from healthcare and social workers. We can't always predict how lives can change, but God can transform lives no matter the situation. ▀

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# local groups: medical schools

**Laurence Crutchlow looks at new medical schools**



**Laurence Crutchlow** is CMF Associate Head of Student Ministries and a GP in London

**C**hanges to the UK and Ireland's medical school map aren't new. If you visit the CMF student office, and sit on the sofa recently installed by Rachel, our Head of Student Ministries, you will be looking directly at a large wooden shield decorated with twelve smaller shields, one for each of the London medical schools at the time of production. Although some of the sporting rivalries remain, mergers have seen that number reduced to five larger institutions over the past 30 years.

The first formal UK medical school was established in Edinburgh in 1726, but there are records of apprenticeship style training at St Bartholomew's Hospital in London dating back to 1123. Ireland was ahead of the UK in this regard, with a medical school starting at Trinity College, Dublin in 1711. The last significant expansion of medical training in the UK was in the early 2000s when Brighton, Keele, Warwick, HYMS and Norwich medical schools all opened. There are now active CMF groups in all these schools.

Further expansion is ongoing, with new schools at Buckingham, Aston (in Birmingham), University of Central Lancashire and Anglia Ruskin (ARU) already taking students. Courses in Canterbury, Lincoln, Sunderland and Edge Hill Universities have also been approved by Health Education England, as well as expansions at existing schools.<sup>1</sup>

While there may be questions about exactly where the new students will undertake clinical placements, CMF's main aim is to establish groups on each of these campuses. We will do this through our already strong links with UCCF and aim to meet medical students via CUs initially, offering support from the office and making links with local doctors.

As well as praying for the new schools, please put us in touch with anyone you know who is starting at, or on one of the new courses, or anyone you should find yourself sharing a clinical placement with. ▀



**E**ssex's first medical school has opened its doors this September to its first intake. The 100 students pioneering the new faculty join the established school of nursing and the CMF group already present there. Given the geographically widespread nature of the ARU students, membership of the Christian Union is small, but is supported by local churches and the university associate pastor in putting on welcome and evangelistic events for the new students. The hope is that having a new cohort based onsite will give more of a base for ministry on campus. We look forward to welcoming students into the CU and hopefully CMF. We have already had a great time linking with the new student nurses and medics at the fresher's fair and sharing some CMF resources.

## Points for prayer

- The continued growth of CMF groups within ARU and new students to pair with the current members at the university.
- For new and current members to develop links with the Christian Union, and to find support and a home at local churches.
- For the many overseas students joining us in Chelmsford, that they would know the comfort and security of Jesus, even whilst so far from home. ▀

**James Howitt** is CMF Associate Staffworker in Essex

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**A**bortion 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 guidance to doctors challenging. Despite some reviews showing that abortion is linked to various adverse mental health outcomes, other reviews say there is no link, failing even to acknowledge controversy in the field, while yet others say social mores are the cause of any mental harm.

One problem with even some of the best known and most widely cited research studies is 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).<sup>1</sup>

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.<sup>2</sup> 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



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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.<sup>3</sup>

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<sup>4</sup> and Pedersen in Norway.<sup>5</sup>

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.<sup>6</sup> Coleman has produced findings suggesting a clear link between abortion and adverse mental health effects.<sup>7</sup> 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.*'<sup>8</sup>

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. ▀

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# *my trip to...* the ICMDA World Congress 2018

I had the privilege and unforgettable experience of attending the 16<sup>th</sup> World Congress of the International Christian Medical and Dental Association (ICMDA) from 21-26 August 2018. The Congress occurs once every four years (like the Olympics). It is a gathering of doctors, dentists and medical and dental students who are passionate about mission and seeing God's kingdom come through their work and studies.

This year it was held on the outskirts of the bustling city of Hyderabad, hosted by the Christian Medical Association of India (CMAI) with the Evangelical Medical Fellowship of India (EMFI – India's equivalent of CMF). The theme of the conference was 'Reflect, Repent, Renew: In the footsteps of the Great Servant Leader'.

On arrival at the lush Leonia International Centre for Exhibitions & Conventions, we were greeted with a warm Indian welcome, *namastes* galore, tea, coffee, kiwi juice (!) a badge and a goodie bag (importantly containing a free ICMDA pen and notebook).

There were 847 people from 84 countries in attendance, with strong UK representation (24) including staff from CMF HQ, with some leading sessions throughout the congress. As well as accommodation for all the delegates, the huge grounds included swimming pools, a spa, a cinema and even an international go-karting track (which many of us, especially CMF National Field Director John Greenall, thoroughly enjoyed racing on).

## programme

The week was split in two, with the first three days being for students and junior graduates and the second part for everyone. Of course, some older doctors and dentists found their way into the first part and I think the excellent teaching was still relevant for them. There were also some optional pre-congress seminars, including Saline Solution



and Whole Person Medicine, which catered to those who had arrived early.

The structure of each day was similar to that of CMF conferences with a mix of main talks and seminars (or 'breakout' sessions) interspersed with coffee breaks, buffet lunch and dinner. The students' and juniors' conference kicked off with a wonderful spread of Indian and other world foods for lunch. Following that, music was very ably led by two bands, Shiloh Worship Band (from Christian Medical College, Vellore) and Sounds of the Nations; the contemporary worship got us all up singing and dancing.

Main speakers for the students' and juniors' conference were Dr Daniel Ho, an engineer and General Secretary of the National Evangelical Fellowship of Malaysia and Dr Helen Sigua, a GP and managing director of a clinic in the Philippines. Daniel engaged us with his sense of humour as he spoke in very practical terms on how we can bear the hallmarks of a covenanted and distinct people, rallying us to pursue our calling of being a light to the nations. I was especially challenged by his anecdotes on how he shared the gospel with anyone and everyone he met (in a taxi, on the plane, in public toilets...) even in the face of persecution. Helen spoke on how we can influence our workplaces and campuses through servant leadership, using her own personal experience as an example. We had a Q&A session with both speakers, where pertinent questions such as 'What



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do you think about women in leadership?' were asked. There was also time for small group reflection and discussion in our regional groups.

The breakout sessions covered wide ranging topics such as leadership, mission, practicalities of setting up a community project, mental health, palliative care, hyper-connectivity, world views, and cults and corruption. There were also parallel workshops which ran across two breakout slots. It was hard to choose what to attend, as we were spoilt for choice!

For the main congress, we moved to a bigger hall, set up with decorated tables and chairs, much like a huge wedding reception! The congress included an inspirational series of talks from Dr Rajkumar Ramchandran and Rev Charles Price with plenary sessions by Dr David Stevens, Dr Daleep Mukarji and our very own Dr Peter Saunders speaking on medical ethics. Charles Price from Canada gave an exposition on Isaiah 42:5-7 (the theme passage for the conference) and Jeremiah 31:33-34 across three talks, taking us through the three phases of the New Covenant: a new redemption, a new relationship and a new righteousness through which the character of God can be expressed in us. Indian engineer-turned-evangelist Rajkumar's Scripture-filled talks complemented these as he spoke on how to take the fragrance of Christ with you and how to share the salvation message with others. Every speaker

was presented with a certificate of thanks, with a tree planted for every certificate issued.

Besides the impactful talks, beautiful worship and scrumptious food, another highlight for me was International Night. The organisers decided that one was not enough – so we had two truly amazing international nights, one at the students' and juniors' conference and another equally exceptional night at the main congress. The all-singing, all-dancing evenings of fun (with a bit of stand-up comedy thrown in for good measure) were a showcase of talent from all over the world, complete with many different styles of traditional dress. Writing about it really doesn't do it justice, but some videos on social media give a small glimpse of what we enjoyed. The UK crew even managed to get the whole world ceilidh dancing, following our 'Strip-the-Willow' demonstration with our Head of Students Ministries Rachel Owusu-Ankomah calling out instructions.

I thoroughly enjoyed my time at ICMDA World Congress, meeting missionaries, NGO directors, student leaders and receiving encouragement from many more inspiring people from all around the world. Worshipping alongside over 800 like-minded people from 84 different countries is an experience that will forever stay with me. Some were saying, 'Is this what heaven will be like?', I do not know, but even if it was just a small foretaste, we have a lot to look forward to!

Your next chance to attend an ICMDA World Congress yourself is in 2022, in Arusha, Tanzania (at the foot of Mount Kilimanjaro). Start saving! Details should become available via the ICMDA website ([www.icmda.net](http://www.icmda.net)) where you can also find details about other ICMDA events. I would like to thank CMF UK for giving me a generous bursary towards the cost of attending this amazing conference. ▀

# *crossing cultures*: international experiences

Stuart Fergusson & Jessica Cooper explore experience in the context of UK medical careers

## Stuart writes...

In previous times, a decision to use your medical skills in low-resource environments inevitably meant committing months, if not years of your life in locations far removed from home, where communication would take weeks. With modern travel and communication technologies, it is now practical to invest time abroad for much shorter periods of time, or even while physically based at home. Gaining international experience in the context of a UK medical career is increasingly being recognised as a valid, valuable option for postgraduate career development and is a practical possibility for most doctors. Amongst other motivations, doctors and medical students use international experience as an opportunity to experience other cultures and healthcare systems, learn and grow personally and professionally, serve disadvantaged populations and to explore future career options. Christian doctors will also view cross-cultural medical service as an opportunity to express their faith, through practical care, health system development and sometimes through evangelistic effort alongside medical work.

International medical experience can be obtained using various mechanisms at different career stages:

- **Elective placements:** (undergraduates);
- **Between training stages:** ie after Foundation Training, after Core Training (we would recommend that you do not delay the Foundation Training after graduation);
- **Out-of-programme opportunities during training:** note this needs to be agreed well in advance (6-12 months before) with your training programme;
- **During leave:** eg Mercy Ships short placement;
- **Following completion of specialty training:** before competing for permanent jobs, during leave, on sabbatical, or as a permanent move.

International medical experience can be gained in a variety of ways, often but not exclusively on



a voluntary basis. The UK's All-Party Parliamentary Group on Global Health have described the diversity of approaches to medical volunteering:<sup>1</sup>

- **Coordinated or uncoordinated:** most volunteering happens informally although some long-term institutional partnerships support a rolling programme of visits.
- **Short-term or long-term placements:** for reasons of sustainable impact, many organisations focus on longer-term placements, but successful partnerships often use short-term trips in the context of a longer-term institutional relationship.
- **Grant funded or self-funded**
- **Capacity-building or gap filling:** gap-filling, such as in short service provision trips, has been the more traditional model of global health engagement and remains widespread, but there is now further development of projects that aim to leave behind a more sustainable impact.
- **'Lunch-break' or in-country volunteering:** many workers assist in capacity-building while based in the UK, through remote project support, mentoring, and fundraising.

As highlighted in a recent report by the Royal College of Physicians and Surgeons of Glasgow, international medical experience is of clear value to the development of a UK medical career, and to the UK health service.<sup>2</sup> As well as exposure to a volume and variety of clinical experience – often unattainable in UK training roles – these experiences commonly stimulate unparalleled personal development. We regard our international experiences as a key highlight in our careers so far and encourage you to explore options for yourself! ■



**Stuart J Fergusson** is a surgical trainee in Scotland who has volunteered in Africa, and co-authored a major report on the value of international volunteering<sup>1</sup>



**Jessica Cooper** is a GP on the Scottish island of Islay and has spent a total of three years in a church-affiliated Zambian hospital

## Jessica writes...

I am a GP working on the beautiful Scottish island of Islay. Prior to my appointment here, I spent three of the preceding five years working in St Francis Hospital, in the rural eastern province of Zambia. St Francis Hospital is church-affiliated and has a long-standing partnership with the Borders General Hospital in Scotland. The first year that I worked at St Francis Hospital was on an 'Out of Programme Experience' (Oope) year, taken between my second and third years of GP training, facilitated by the Deanery, drawing on the existing partnership relationship.

Taking time out to volunteer completely transformed my thinking on what medicine really is about, changed my career ambitions, and matured me as a person and as a clinician. The opportunity I was given to take time out and come back to my GPST3 year gave me a chance to explore a different way of practising medicine, and in doing so, I found a passion and a joy in being a doctor that has remained since. Notably, during my GPST3 year my trainer was pleased to find me a more confident clinician, having previously been consistently under-confident, a difficulty commented on in every assessment I had undertaken throughout training.

By the end of the GPST3 year, I had decided that this was the beginning of something new for me, and so after completing GP training I looked to spend some time abroad. After completing a diploma at Liverpool School of Tropical Medicine, I returned to St Francis Hospital with lots of ideas and potential projects to tackle at the hospital that I knew, cared for and had already invested in. On my arrival the local staff seemed grateful for my return; volunteers are often not seen again. I found that by continuing to invest in this place that I was beginning to call home, trust was built quickly and easily with my colleagues and more change was possible, and hopefully achieved more sustainably,



through teaching and mentoring.

I have now returned to practice in the UK with new skills that I am putting to use as a rural GP, where a wider skill set is demanded. I have a more mature understanding of what medicine can and can't achieve, and a clearer understanding of what patients need in their doctor, whatever the setting. Patients want a doctor who is thorough and clinically able, honest and practical. Sometimes doctors need to be brave and able to stand up for what a patient needs, but also able to care for them when medicine is not the answer. Also, to an NHS under intense resource pressure, doctors with a practical understanding and experience of apportioning scant resources in a low-income setting are a significant asset. ■

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# counterparts : Papua New Guinea

Erick Mange describes his home, and his experience on CMF's Developing Health Course



**G**reetings to you all in the name of our Lord and Saviour Jesus Christ, and 'the love of God and the fellowship of the Holy Spirit be with you all.' (2 Corinthians 13:14)

I am from a small town called Lalibu in the Southern Highlands Province of Papua New Guinea (PNG). I have just completed my two years of residency training after five years of medical studies at the University of Papua New Guinea School of Medicine and Health Sciences at Port Moresby.

I was so delighted to have travelled to the United Kingdom (UK), especially to London to attend the Developing Health Course (DHC) at the London School of Theology from 8–20 July this year. I had travelled right across Asia and Europe which was so tiring but worth it. My sincere gratitude and appreciation to the Christian Medical and Dental Fellowship in Australia (CMDFA) through HealthServe for being my prime sponsor to attend the course.

I was raised in a Christian Catholic family and was observant and faithful to the Catholic faith. However, I did not well understand my need for

Jesus Christ until I was old enough to think for myself at the age of 13, when I accepted Christ as my Lord and Saviour during a youth camp. Since then, I never regretted the decision because I have seen the goodness of Christ in my life, not because of my success in becoming a doctor, but because of the victory I have in Christ Jesus as my strength in my infirmities and calamities.

I became involved in the International Christian Medical and Dental Association (ICMDA) in 2014 when I was a fourth year student. We help Christian medical students at the campus to realise the opportunity that we have as healthcare professionals, dealing with people's lives in a different way that encompasses their physical, emotional and spiritual well-being (whole-person medicine). However, I must say that there are seemingly vast challenges before me. Our desires for the world seem to be more than desiring to know God and establishing an intimate relationship with him. Hence my prayer daily is to grow less in my lustful desires and more into my relationship with God and what he wants me to do with my life.

Attending DHC was something I never thought



Erick Mange is a doctor in Papua New Guinea

## medicine in Papua New Guinea

PNG is very diverse in culture and tradition, with more than 800 different languages. Located just north of Australia, it shares a land border with Irian Jaya (also known as Papua or West Papua), the eastern part of Indonesia. It is a tropical country with vast diverse biodiversity and unique customs intertwined with the environment.

Medicine was previously based on various local belief systems. The cause of disease was attributed to curses, spells and or wrongdoings, including negative emotions as well as breaches of traditional laws. There was little or no knowledge about micro-organisms.

Traditional medicinal healers knew the varieties of herbs used for different diseases, and focused on spirits and supernatural things which were specifically attributed to cause of the disease. Knowledge of traditional medicine is passed on from generation to generation through practical acquisition and verbal explanation.

In herbal medicine, those renowned traditional healers selected the particular herb based on history taking and then prepared a broth or mixture for the patient to drink or apply on wounds. They often chanted whilst or after preparing the mixture prior to the patient taking/applying it. Sometimes they use typical garden foods as medicine but prepare it differently with chanted words.

Other traditional healing methods include pig killings in a sacred place associated with identifying the cause, eating cooked pig blood mixed with herbs, and using a spear to project through the roof of a grass house usually at night and then doing troubleshooting by asking nature to lift the spear if the cause of the disease is mentioned. These practices are mostly seen in the highlands region where I originate.

Practices in coastal areas encompass similar though more diverse beliefs, including rituals such as *wudu* practices. They depend mostly on the sea for medicines, as well as power to cure diseases. Even today, the practice is renowned and people resort to it as part of primary care prior to seeking medical assistance.

During my residency in Port Moresby, I have seen evidence of sorcery or *wudu* practice, not only in primary care, but also when patients in hospital do not improve as expected. Payment to traditional healers used to be in valuable items but nowadays, huge sums of money prior are given prior to them receiving their treatment. Herbal practices remain widely accepted in PNG whereas the rituals practiced in the highlands are now becoming less important and uncommon. ■

about, until Ben Reardon (the ICMDA Oceania student representative) for informed me of the course, and Professor Bill William Hague helped facilitate financial support. I met not only British nationals but people from Africa, Asia and Europe who share the passion of serving God as missionaries. The engagement during the meals, the discussions during the workshops and sessions, and the devotions were magnificent and superb. I learned about preparations needed when

considering a short or long-term mission, challenges and difficulties faced encountered by the missionaries depending on the cultural context, and the need for discipleship.

Attending the DHC has changed my perception of mission in a positive way and I am really challenged by this question 'Am I willing to become a missionary doctor?' This would mean that I must die to myself (sin) and live in Christ to do his work as he has commissioned us to do. ■

# *a day in the life:* perinatal psychiatry

Dr Abigail Crutchlow talks about her speciality

**P**erinatal psychiatry is a relatively new specialty, which has gained new funding and media interest over recent months. Women with existing mental health problems are at increased risk of suffering a relapse during their pregnancy or the first year of their baby's life.<sup>1</sup> Those who become unwell, either for the first time or due to a pre-existing diagnosis, require prompt and specialist treatment.<sup>2</sup> Without this, there is a significant negative impact on the woman's safety and well-being and her baby's intellectual and emotional development. Perinatal psychiatrists work holistically with women and their families, in a specialty at an exciting stage in terms of service development and research.

Perinatal psychiatry does not discriminate. Women of all ages and backgrounds may experience mental ill-health while pregnant or in the postnatal period. For some, this may be the first time that they have had contact with mental health services, while others may be well-known to an existing psychiatric team. In both cases, timely and individualised care and intervention is crucial in helping a woman and her family understand what is happening and to help navigate the vast array of different professionals and agencies (such as midwifery, health visiting and social services). This is especially important given that this is an extremely vulnerable and emotional time for the family, with high stakes if things go wrong.

Perinatal psychiatrists hold in mind three factors: the mother, the infant and the mother-infant relationship. My approach changed compared with other areas of psychiatry in which I had worked. Appointments are longer and contact more frequent, with relationships and communication at the heart of the job. There is strong team involvement, with reflection, co-working and sharing ideas actively encouraged.

The combination of close involvement in patients' lives, coupled with real opportunities to

make a clinical difference to vulnerable patients, make this a job where God's care is visibly and daily expressed for those who are struggling.

Interested students may be able to spend time with perinatal psychiatric teams during medical school. Perinatal psychiatrists do general adult psychiatric training, which is a six-year programme after the Foundation years. A higher specialist training post in perinatal psychiatry, or some sessions as a newly qualified consultant, would be helpful for those keen to pursue this work.

## case example:

I met 'A', a woman in her 30s, just prior to the birth of her second child. She'd suffered an episode of postpartum psychosis after the birth of her first child, meaning that the risk of postpartum psychosis following this delivery was substantially increased (from one to two per 1,000 with no previous history to around one in two).

She became unwell and required admission to hospital. However, my prior involvement meant that there was a clear plan, including how to recognise deterioration, and guidance around medication. As a result, her admission was brief (around 72 hours), as she began medication quickly and robust community follow-up was put in place. This approach helped maintain family relationships and reduced the time she was apart from her husband and children, as well as minimising the time she was actively unwell. 'A' recovered well with no evident long-term effects on her bond with either her children or her husband. ■

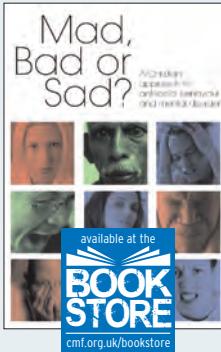
**Dr Abigail Crutchlow** is a perinatal psychiatrist in Surrey

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# Bereft

book: *Mad, Bad or Sad?*



## Mad, Bad or Sad? A Christian approach to antisocial behaviour and mental disorder

edited by M Dominic Beer  
& Nigel D Pocock

248pp, CMF 2006  
ISBN: 9780906747353  
Paperback £7.00

**Chris Damant** is a GPST2 in London

**S**hould psychopaths be punished for the crimes they commit? Is it sinful to be angry or self-centred even if provoked by crushing anxiety? And is it ever the case that sinful behaviour can cause mental illness?

It would be hard to get through your psychiatry rotation without being bothered by these questions. These issues affect all areas of life including family and friends at church who may be experiencing mental illness – and perhaps you do too? Is it bad to be mad or sad? And does bad (sin) make you mad or sad?

The relationship status between mad, bad and sad is best described as 'complicated'. Fortunately, help is at hand. *Mad, Bad or Sad?* leads us through the tricky theological questions. It is very practical, covering not only the role of prayer and how best to raise children but also discusses exorcisms and how to respond to paedophiles.

The book is a collection of essays written by various authors (psychiatrists and theologians), but manages to avoid the disjointed feel this could easily create. The introduction explores mental illness and faith, before a fascinating chapter on mental illness in childhood. This is looked at as a combination of many different causes, with a detailed discussion of the nature-nurture debate. Some intriguing diagrams highlight how family dynamics change and spiral out of control when faced with parental or child mental illness.

The chapter helped me to gain greater compassion for all involved. The primary responsibility for raising children remains with the parents, but there is also a significant role for wider society,

including the church. We need to reflect on how we can best help families in an enabling and non-judgmental way.

The next topic discusses how we treat psychopaths, and how we would care for a repentant paedophile who wanted to join our church. There are no simple answers here, but lots of useful suggestions. The most impressive idea is the Christ-like attitude towards offenders where they are still to be held responsible for their actions (to varying degrees) yet not 'written off'.

The remaining chapters look at substance abuse, Christian counselling and demon possession.

It's a medium length book and easily read by those with a medical background, so clearly all these topics are only introductions. But I know it's a book that I will keep coming back to in the future. These are all deeply controversial areas where societal pressures and new psychological theories seem to be increasingly at odds with Christian principles. That's why I so appreciate this paperback; because it is unashamedly committed to the Bible but represents secular research seriously and fairly.

Grappling with these questions is well worth doing, not only to get through your psychiatry rotation, but also to apply to your personal life and when dealing with these issues in your church. The Lord is building his kingdom and we are to serve those in need having compassion for them. There is no quick fix, but this book will help you do this a bit better. ■

# Reviews

## book reviews

### Mindful of the Light: Practical help and spiritual hope for mental health

*Dr Stephen Critchlow*

232pp, Instant Apostle  
ISBN: 9781909728448

Paperback £8.99, Kindle Edition £5.99

**Zack Millar** is a medical student in Cambridge

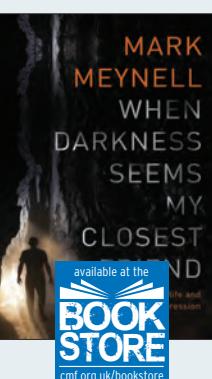


### When Darkness Seems My Closest Friend

*Mark Meynell*

218pp, Inter-Varsity Press  
ISBN 9781783596508 2018,  
Paperback £9.99

**Sarah Wright** is a core medical trainee in Wales, and a former CMF Deep:ER volunteer



### Mad or God? Jesus the healthiest mind of all

*Pablo Martinez & Andrew Sims*

pp208, Inter-Varsity Press  
ISBN 9781783596058  
Paperback £9.99

**Paula Busuulwa** is a junior doctor in London



Whether you struggle with mental illness yourself or treat those who do, you will meet healthcare professionals who view faith with disdain and religious leaders who label mental illness as spiritual failure. Arguing against them is Stephen Critchlow, a very experienced Christian psychiatrist, with his book *Mindful of the Light*.

Odd-numbered chapters present a basic clinical perspective on mental illness and are written to be accessible to the church leader or interested layman without any medical training. Critchlow

'Everything went without a hitch. Until my mind seemed to fall apart.' Mark Meynell explores his journey through depression and reflects on the challenges and joys that this has brought him. He faces a problem – how do you navigate mental illness when you're in full-time Christian ministry?

Through personal accounts and stories, Meynell guides the reader through his journey, and invites the reader to gain insight into difficulties he has faced. Using various analogies to describe depression, including 'the cave', he allows readers

Martinez and Sims do an excellent job at dissecting the personality and mental health of Jesus Christ in their new book *Mad or God?*<sup>1</sup> I appreciated their approach to the trilemma presented by CS Lewis,<sup>2</sup> which argued that what Jesus said and claimed to be was either true, a lie, or to be discredited due to mental illness. The last option is the focus of this text.

The use of examples demonstrating the various manifestations of mental illness were particularly helpful. One such example is that of a man named Peter,<sup>3</sup> who demonstrated evidence of stress and

describes the disease processes at work and provides insights and practical advice for those in contact with mental illness: helpful ammunition against the religious guilt often heaped on top of psychiatric problems.

The even-numbered chapters then consider the spiritual aspects of mental health and will prove enriching and encouraging to student and consultant alike. Firmly rooted in Scripture and bursting with love and compassion for those battling with mental health, Critchlow suggests ways to approach mental illness from a Christian

perspective, both in medical treatment and in a pastoral role. Looking for a reason to work faith into the social history? Wondering how best to support your struggling friend? How to keep going yourself? These chapters will be of wonderful help to you.

Short enough that it needn't be relegated to the summer holidays, *Mindful of the Light* gave me welcome relief from OSCE revision last June and would be an excellent addition to your bookshelf. But I will let Critchlow close: 'It is by the power of the Holy Spirit... that we can endure our trials and come through them without bitterness or hardness.' ▀

to understand more about what it is to live and serve with mental illness. For those who live with mental illness he guides them towards hope in a God of restoration and declares 'Jesus is not ashamed to know me, even me!' (p92). He provides strategies for living in the darkness and isolation of mental illness and teaches friends and families how to care for their loved one in the 'cave'. This easy reading book allows the reader to be lost in the story, while challenging mainstream responses to those struggling with depression.

This engaging book is also informative, and full

of hope and encouragement. The stories and descriptions resonated deeply, and I valued the practical advice and resources listed. If you're looking for a book to help you understand a loved one who is struggling with their own mental health, or struggling yourself, there is plenty of encouragement. I would highly recommend this book to everyone as an excellent description of what the journey through mental illness looks and feels like. ▀

anxiety after returning from war. Jesus was also exposed to significant stress which culminated in an excruciatingly painful death, yet never demonstrated evidence of mental instability. Other similar analogies permeate the rest of the book which not only support the overarching aim of the paperback, but also make it accessible to a lay audience.

The authors' experience in the field also adds credibility and weight to their arguments, which supports its use in discussions with non-believers. I would caution, however, that a basic

understanding of the Christian faith would be helpful in gaining the most from this book.

For those interested in mental illness or looking for a book to recommend to those enquiring about the Christian faith, *Mad or God?* has something to suit all. ▀



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# Breviloquy

## tv review: 13 Reasons Why

**13** *Reasons Why* topped Jumpshot's analysis of most-watched original shows on Netflix in the US when released in 2017.<sup>1</sup> The series chronicles the final year of the life of Hannah Baker, a high school senior, who takes her own life. She leaves behind 13 cassette tapes to be passed around her peers after she dies. Each episode covers one tape, which focuses on one person, and Hannah's view of their role in her suicide.

Popular also in the UK, the show was cited as a key topic of teenage discussion by the local youth counselling service at a GP training day I attended recently. Though critics responses were very positive, a broader range of reactions were seen in the Christian and medical spheres.

Some Christians advocated outright avoidance of this series,<sup>2</sup> while others were more balanced.<sup>3</sup> A respected journal linked the show to an increase in online searches for suicide in the days following the series' release.<sup>4</sup> The article noted that World Health Organization guidelines on suicide suggest warning messages and helpline numbers should be shown with such material, none of which were present initially.

I found the tragic story quite believable and barring the odd trans-Atlantic difference largely consistent with what I see in general practice in London.

### How might we respond to this series?

■ **Be aware of such programmes.** Some Christians may not like them, but they are watched by many of those we look after. If we have watched, we will engage better with teenage patients sharing similar problems who've also seen it, although those for whom on screen depictions of suicide, sexual assault or substance misuse will cause problems would be



better to avoid this series.

■ **Question it.** Some truths are depicted. The tapes suggest that no single issue triggered Hannah's suicide. Lots of things built up over a year.

But a well-executed series can lead us unquestioningly to accept its underlying ideas. Does Hannah really have the deep insight into events suggested by her tapes? Has she really got her revenge on those who were involved, now that she has died and left the recordings? Even

if she was wronged, did it really justify all her actions? The second series questions these things, but still left a sense that Hannah had taken control by ending her own life. Is that really ever the case?

■ **Learn.** The setting resonates with many teenagers: oblivious school authorities; large parts of life with apparently little involvement of parents; the focus on here and now and God conspicuous by his absence (aside from a brief, rather stereotyped priest in series two). The contrast to our lives may be stark for some, but series like this are often popular just because they reflect reality to a degree.

*13 Reasons Why* undoubtedly has artistic merit. Even though the underlying message and some of the content may concern us, questioning and thoughtful viewing will help us understand the background behind some of the patients who present to us. ■

**Laurence Crutchlow** is CMF Associate Head of Student Ministries and a GP in London

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# HEROES + HERETICS

Rachel Owusu-Ankomah talks about confronting concern and championing change

## HERO + HERETIC 24: MENTAL HEALTH HEROES

**W**hat contributions have Christians made to mental health? For so much of history, those with mental health issues have often been poorly treated: chained like animals and locked in cages. Tragic stories of ostracisation and stigma scar our history books. Things have changed, but there is still much to do.

The Seventh Earl of Shaftesbury, Anthony Ashley-Cooper (1801-1885) is often considered one of the most important figures in 19th century British psychiatry for his political work reforming the mental health laws of his era. Interestingly though, this is probably not what he is best known for.<sup>1</sup>

He was a devout, evangelical Christian and this faith can be traced back to the kindness and witness of a maid, Maria Millis and his sisters. They were a stark contrast to his parents' absenteeism and lack of affection. Millis showed him a model of Christian love that formed much of the basis of his social activism and philanthropy.<sup>2</sup> He felt called to 'devote whatever advantages he might have bestowed...in the cause of the weak, the helpless, both man and beast and those who had none to help him'. He lived up to this gaining the nickname 'the poor man's Earl' among his parliamentary colleagues.<sup>3</sup>

In 1844, he brought forward a motion asking Queen Victoria to take into consideration the report



Anthony Ashley-Cooper, 7th Earl of Shaftesbury

of the Metropolitan Commissioners of Lunacy, of which he was a contributor. He ended his motion with these powerful words that echo the justice of Proverbs 31,<sup>4</sup> the human dignity of Psalm 139<sup>5</sup> and highlight the driving force behind much of what he did. 'These unhappy persons are outcasts from all the social and domestic affections of private life... Their condition appeals to our highest sympathies. Majestic, though in ruin... the motion is made on behalf of the most helpless,

if not the most afflicted, portion of the human race'.<sup>6</sup>

The Earl of Shaftesbury was thoroughly committed to seeing improvement in provision for and care of those with mental health issues. He was consistently advocating for their rights, arguing for early treatment and praising non-restraint. Although bringing several acts to Parliament from 1845 to 1862, his work did not go unchallenged. This led to personal doubts and anxieties. He worried that the 'labour, the toils, the anxieties, the prayers of more than fifty years....in one moment [could be] brought to naught'.<sup>7</sup>

For our next hero, Rev Dr Chad Varah (1911-2007), one moment would have a profound effect on his life. In 1935, he took his first funeral – a 13 year-old girl who had committed suicide. She thought she had contracted a sexually transmitted disease and was destined to die a slow, painful and shameful death.

The sad reality is that she had in fact started her period. On that day, Varah committed himself to helping people like her overcome the isolation and ignorance that had led to this tragedy.

Although Varah had some unorthodox views on reincarnation and pornography, he stuck to his graveside vow. Greater London in the 1950s, typically saw three suicides take place a day. This appeared to him to be a great need not be being met by healthcare professionals and social workers. He was initially reluctant to fill this need and worried how he would support his young family if he did. In his autobiography he wrote:

"There ought to be an emergency number for suicidal people,"

I thought. Then I said to God, "Be reasonable! Don't look at me... I'm possibly the busiest person in the Church of England... It'd need to be a priest with one of those city churches with no parishioners". Shortly afterwards, he was offered the rectorship at St Stephen Walbrook in London – just such a church.<sup>8</sup>

In 1953, he set up a phone in the crypt of the church with the number MAN 9000 (MAN for Mansion House where the church was based) with the aim of 'befriend[ing] the suicidal and despairing'. This organisation was named the Samaritans. The first phone used can still be seen on display in the church today. It was the first 24-hour helpline in the world. Since then the organisation has grown significantly. The Samaritans have over 20,000 volunteers at 201 branches across the UK and Ireland who answer a call, email or text every six seconds.<sup>9</sup> Varah said: 'Little girl, I didn't know you, but you have changed the rest of my life for good.'<sup>10</sup>

Another force for change is our third hero, Dr Kaaren Mathias, who at this year's ICMDA World Congress was awarded the ICMDA 'Right to Dignity



Rev Dr Chad Varah



Dr Kaaren Mathias (centre)

and Health Award'. She is the director of Project Burans based in the rural northern Indian district of Uttarakhand. Dr Mathias thought she was going to India to work in child and maternal health, but much like Shaftesbury and Varah she saw the desperate abandonment of people with psycho-social disability and mental health problems and felt called to action.

Mental health disorders account for 11.8% of healthcare needs in India, yet mental health services are allocated less than 1% of the national health budget. Uttarakhand has one specialist psychiatric hospital and seven government psychiatrists for a population of more than 10,000,000. One in 100 people with

depression in Uttarakhand seek help from mental health services. Most treatment decisions are medication; almost none access counselling or talking therapy services.<sup>11</sup>

Burans was set up in 2014 with the aim of 'working with communities to improve mental health care'. The project is led by the Emmanuel Health Association (EHA) who work 'in the name and spirit of Jesus Christ so as to manifest him through word and deed'.<sup>12,13</sup>

Dr Mathias is a New Zealander (though born in India to missionary parents) with a background as a public health physician. None of her 18-person team are mental health specialists, but they employ a diverse range of strategies to engage community members with issues of mental health.

In just three years, Project Burans has identified more than 650 people with psycho-social disabilities and brought them for mental health treatment. They have formed multiple support groups for people with psycho-social disabilities and their caregivers. They have begun resilience groups for girls at government

schools and for girls who have dropped out of school. Community health and development workers from 50 Christian NGOs and over 800 government community health workers in mental health have been trained. They have provided leadership and training for over 400 church leaders and workers.

Their website is full of success stories, including people like Savita who had been struggling with depression for six months. She had been unable to cook food, wash clothes or even leave the house. A local community worker from Burans started visiting her weekly, listening to Savita and providing counselling. She was taken to her local doctor where she was started on anti-depressants. All these interventions transformed her life. She now receives guests to her house with a big smile and has resumed her responsibilities at home and beyond.<sup>14</sup>

Dr Mathias reports that there is still much to do, particularly around the areas of suicide and alcoholism, but her faith gives her hope and persistence to keep going. She writes: 'Grace is everywhere in the reign of God. Knowing that each person we work with (even the seemingly unbudging officials) are made in the image of God is something that is easy to overlook...When Jesus meets and talks with the woman from Samaria at the well, he takes time to talk to and encourage someone on the edges of her community – and then says "if you knew the gift of God..." I feel that so often we have a very limited and narrow understanding of God's work and the ways God brings welcome to each person.'

As these three heroes have exemplified, all too often, we can see the immense need for healing and ultimately salvation through Jesus and the opposition to that, and despair. I leave you with Shaftesbury's Christmas 1851 diary entry: 'What gained for the cause of our blessed Master? Whatever little, if any, has been achieved, it has been by God's own grace. To Him then be all the glory! ... Few can know the troubles I have endured ? the sorrow of mind, the weariness of body; the labour I have undergone by day and by night; the public and private conflicts; the prayers I have offered, and the tears I have shed. Here, however, is my consolation,

## lessons from mental health heroes

- The opposition to Christianity and the fight for justice can be overwhelming. This is God's work that he graciously allows us to be part of and he will supply our needs as we serve him.
- All too often, big impact projects start off as small, simple ideas. What simple ideas do you have that use your skills, gifts and opportunities to honour God?
- There is immense need for healing and ultimately salvation through Jesus in this world. Where is God calling you to serve him and build his kingdom?

that, amidst frailties and sins, trespasses and shortcomings, I have had one single object perpetually before me. It was God's grace that gave me the thought; God's grace that has sustained me hitherto, to have, in truth, but one end, the advancement of his ever-blessed name, and the temporal and eternal welfare of all mankind...*Sursum corda* [lift your heart].<sup>15</sup>

As you read this, perhaps God is calling you to be the next mental health hero, calling you to meet some unmet need in the UK or abroad. Remember, 'we are God's handiwork, created in Christ Jesus to do good works, which God prepared in advance for us to do.'<sup>16</sup> ■

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