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Journal of Family Research and Practice

Mental Health

Claudio Consuegra, DMin
Pamela Consuegra, PhD
Editors

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JOURNAL INFORMATION

The Journal of Family Research and Practice (JFRP) is an annual, peer reviewed publication of the Family Ministries Department of the North American Division of the Seventh-day Adventist Church. The journal is primarily intended for professionals, practitioners, pastors, and lay-people in the North American Division (Bermuda, Canada, Guam/Micronesia, and the United States). An electronic edition is available, anywhere at https://www.nadfamily.org/resources/journal/

Each volume is intended to be both academic and practical in nature, dealing with the day-to-day challenges that families face. The topics of each annual volume have been identified as key issues relevant to today's families.

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FOREWORD

According to the Centers for Disease Control and Prevention (CDC)[1], Mental illnesses are among the most common health conditions in the United States. The CDC indicates that more than 50% will be diagnosed with a mental illness or disorder at some point in their lifetime, one in five Americans will experience a mental illness in a given year, one in five children, either currently or at some point during their life, have had a seriously debilitating mental illness, and one in twenty-five Americans lives with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression.

In a report from Mental Health America (MHA)[2], the nation's leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all, in 2019 fifty million adults, or 19.86%, experienced a mental illness. More than half, or 27% of adults with mental illness, do not receive treatment. Sadly, 11.1% of Americans with mental illness are not insured, the second year in a row that this indicator increased since the passage of the Affordable Care Act (ACA). In addition, 4.58% of adult Americans report having serious thoughts of suicide, a number which has increased every year since 2011-2012. The National Institute of Mental Health (NIH)[3] states that in 2020 in the United States the number of adults who live with a mental illness is one in five, or 52.9 million.

Among young people, the report states that 15.08% of youth experienced a major depressive episode, and 60% of youth with depression do not receive any mental health treatment. Even in states with the greatest access, one of every three youth are going without treatment. To make matters worse, even among youth with severe depression who do receive some treatment, only 27% receive consistent care. To make matters worse, in states with the least access, only 12% receive consistent care.

We could cite many more statistics, all of which point to the rising cases of mental illness and the lack of appropriate access to treatment for many of these individuals. In this issue of the Journal of Family Research and Practice we tackle the topic of mental illness to provide information and practical ideas to help individuals and the families of those suffering from mental illness.

We're also very pleased that this is the first fully peer reviewed issue of the journal which takes it to another level of professionalism and a valuable outlet for researchers and those in academia. We are very pleased to present you with this issue of the journal and look forward to continuing to make it available both in print and free to view and download online on the North American Division Family Ministries website.

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Pamela Consuegra, PhD

Family Ministries Directors
North American Division
Seventh-day Adventist Church

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SELF-HARM: WARNING SIGNS, RISK FACTORS, AND PREVENTION

Rates of suicide and self-harm have been increasing in children and adolescents over the last 20 years (CDC, 2022). Suicidality and self-harm are preventable, treatable, and manageable. Parents and those who work with children, teens, and young adults are an important part in addressing this issue. This article reviews the current statistics of suicide and self-harm, role of trauma, risk-factors, causes, prevention, and treatment options. Practical tips and resources are included. The reader will better understand the phenomenon and know how self-harm and suicide can be prevented and treated.

After holding steady or decreasing for many years, from 2000-2018 suicides for those aged 10-24 have increased by 56% (CDC, 2022). Suicide is now the second leading cause of death for those aged 14-18 (Ivey-Stephenson, 2020). The pandemic increased this trend even more, especially for girls. Visits to emergency departments where a suicide attempt was suspected were 51% higher for girls in 2021 compared to the same period in 2019 (Yard, et al., 2021). Suicidal ideation is quite common, 1 out of 5 teens have thought about suicide (Ivey-Stephenson, et al., 2020).

Self-harm is another concern for this age group (a rate of about 17%) (Meuhlenkamp, Claes, Havertape, & Plener, 2012). This behavior includes cutting, burning, or scratching oneself. Teens have the highest rate of participating in this behavior. It is not a mental illness in and of itself, a way to get attention, or a suicide attempt but is a way to cope with emotional distress. It is a way to release emotional tension and can even become an addiction. It should be taken seriously though because self-harm indicates something is seriously wrong in that child/teen's life. They are 9 times more likely to attempt suicide (Chan, et al., 2018).

Causes

Research has identified some potential causes to these increases. Developmentally, adolescents have always been more impulsive and have less consideration of the future. This is due to less brain neuron activity in the pre-frontal cortex at that age, the part of the brain that oversees decision making. Brain development is not complete until the mid-20's. (Colver & Longwell, 2013).

Due to this brain limitation, teens and young adults are known to experiment with substances because they make a person feel good in the moment. Research has found that substance use/abuse is a major risk factor for self-harm and suicide (Singhal, Ross, Seminog, Hawton, & Goldacre, 2014). Part of the issue is that some substances lower inhibitions that would normally stop

someone from harming themselves or could increase their impulsive tendencies.

The invention of the smart phone in the 2010's is thought to have contributed significantly to increased mental instability. Smart phones and then the corresponding social media involvement have been linked to higher rates of depression, anxiety, isolation, and on-line bullying that can be directly linked to suicide deaths (Twenge, 2017).

Smart phones aren't the only the only negative development that happenedthat happened around that time. We also experienced the Great Recession that led to concerns about teens' economic future and ability to be independent. This gave rise to an increased pressure to succeed academically to get scholarships so they can avoid student loans. Teens observed their older siblings and parents struggle with paying off student loan debt so don't want to make the same mistakes (Davis, Baltazar, Trecartin, & VanderWaal, 2022).

As a response to these increased depression and anxiety rates, children and teens have been prescribed anti-depressant medications. Selective Serotonin Reuptake Inhibitors (SSRIs) are known to decrease these symptoms, but in some children, teens, and young adults there is a unique risk of suicidal thinking and self-harm (Nischal, Tripathi, Nischal, & Trivedi, 2012). Psychotic and manic episodes have been reported with SSRI usage in those with a tendency towards those symptoms (Bowers, McKay, & Mazure, 2003).

Role of Trauma

Trauma is a common experience in a sinful world. In the U.S. about half of youth have experienced at least one Adverse Childhood Experience by the age of 18, 20% have experience two (CDC, 2021). Adverse Childhood Experiences (ACEs) are ten different types of traumatic events that research has shown impacts physical and mental health throughout the person's life. The more ACEs one has experienced, the worse the outcomes. These take a negative physical and emotional toll (Feletti, Anda, Nordenberg, Edwards, Koss, & Marks, 1998). The book The Body Keeps the Score by Vessel Van der Kolk (2014), recounts the multiple ways trauma effects the brain and body which then has an impact on behavior.

Those who have experienced multiple smaller traumas or a few severe traumas when young experience the world differently. There is increased cortisol and norepinephrine responses to subsequent stressors (Bremner, 2006). Their brain is always prepared for the next danger which keeps their limbic system (includes the amygdala and hippocampus) easily activated to keep them safe. The limbic system is what quickly perceives danger, before the logic part of the brain (the pre-frontal cortex) has a chance to think about it. When in perceived danger, this type of brain activity is needed so we can fight it off or run away, but we aren't always in danger (Bremner, 2006).

When a person is stuck in this type of brain activity, it makes logical thinking more of a challenge. They are more likely to misunderstand other people's intentions, assuming the worst of others and themselves. As a result, it can be challenging to reason with those who have a significant trauma history especially when in emotional distress.

Risk Factors

Though self-harm and suicidality can happen to all youth, we do know that some

are more at risk than others. Youth who are involved in the juvenile justice or child welfare/foster system, who are LGBTQ+, or American Indian/Alaska Native need special attention in implementing the known protective factors (HHS, 2012). Girls are more likely to attempt, but boys are more likely to die by suicide (CDC, 2022). Boys are more likely to use lethal means (guns) in the suicide attempt that is more likely to be deadly than girl's preferred mode of suicide (overdose).

Other individual and family factors for increased risk of suicide include:

- One or more mental or substance abuse problems
- Impulsive behaviors
- Imprisonment, or going to jail
- Past suicide attempt
- Undesirable life events or recent losses, such as the death of a parent
- Family history of mental or substance abuse problems
- Family history of suicide
- Family violence, including physical, sexual, or verbal or emotional abuse
- Gun in the home
- Exposure to the suicidal behavior of others, such as from family or peers, in the news, or in fiction stories

Situational factors can also contribute to the problem, these include:

- Changes in their families, such as divorce or moving to a new town
- Changes in friendships
- End of an intimate relationship
- Problems in school
- Other losses

There are warning signs of suicidality to pay attention to:

- Changes in eating and sleeping habits
- Loss of interest in usual activities
- Withdrawal from friends and family members
- Acting-out behaviors and running away
- Alcohol and drug use
- Neglecting one's personal appearance
- Unnecessary risk-taking
- Obsession with death and dying
- More physical complaints often linked to emotional distress, such as stomachaches, headaches, and extreme tiredness (fatigue)
- Loss of interest in school or schoolwork
- Feeling bored
- Problems focusing
- Feeling he or she wants to die
- Lack of response to praise

Many of these warning signs are symptoms of depression also.

Another warning sign is making plans or efforts toward attempting suicide:

- Says "I want to kill myself," or "I'm going to commit suicide."
- Gives verbal hints, such as "I won't be a problem much longer," or "If anything happens to me, I want you to know …."
- Gives away favorite possessions or throws away important belongings
- Becomes suddenly cheerful after a period of depression
- May express weird thoughts

Writes 1 or more suicide notes (Johns Hopkins, n.d.)

Mental Illness

There are many mental illnesses that are associated with self-harm and suicidality. These include depression, bipolar disorder,

borderline personality disorder, anxiety disorders, eating disorders, schizophrenia, and substance/alcohol abuse (Singhal, Ross, Seminog, Hawton, & Goldacre, 2014). If a mental illness is suspected to be the underlying cause, it should be identified and treated by a mental health professional like any physical illness that is impacting functioning.

Prevention

These facts can cause emotional distress by just reading about them. Research has found ways to prevent youth from turning to self-harm to cope with emotional distress. The best way to address the adverse childhood experiences and their impact on health is for parents and caring adults to increase protective childhood experiences (PCEs). The more of these a child experiences, the less of an impact ACEs have. These include (Morris, Hays-Grudo, J., Zapata, et al., 2021):

- Caregivers who love them unconditionally,
- At least one best friend,
- Regular opportunities to help others,
- Involvement in organized sports groups,
- Active membership in a civic group or faith-based youth group,
- An engaging hobby,
- An adult other than a parent they can trust,
- A home that is clean and safe with enough food to eat,
- Clear routines and rules,
- And a school that provides sufficient resources and academic experiences to learn.

Not all these activities are necessary to prevent self-harm, but the more a child experiences these prevention efforts, especially if the child has a trauma history, the better their outcomes.

Treatment

Since prevention doesn't always happen or completely protect our youth, these symptoms can be treated and managed. There are several ways to approach them.

Increase the window of tolerance

Many who self-harm or have a significant trauma history have a limited window of tolerance (Siegel, 2012). They tend to be easily hyper- or hypo-aroused. Window of tolerance is the emotional space where we can handle life's ups and downs without affecting functioning. It helps to notice the early warning signs. For hyper-arousal one of the first signs is the feeling of not being able to calm down. Other symptoms are being overreactive, not being able to think clearly, and feeling emotionally distressed. This means the person's limbic system is over-active and needs to be calmed down so a person can think more rationally.

The techniques to bring a person out of hyper-arousal are: Using mindfulness, anchoring techniques, and breathing exercises. Some physical activity can help release any muscle tension. The best approach will vary by person but should be decided upon before the person gets hyper-aroused.

- When a person is hypo-aroused this means their brain and body are flooded with cortisol which can have the opposite effect of hyper-arousal. The body can only be hyper-aroused for so long before it reaches exhaustion. Noticing when the person is shutting down

is an early warning sign. Some later symptoms are feeling depressed, lethargic, numb, and unmotivated.

The techniques to bring a person out of hypo-arousal are like hyper-arousal: Using mindfulness, breathing exercises, and physical activity.

- Christian mindfulness

Mindfulness is often associated with eastern philosophy and Zen Buddhism. Mindfulness basically means being mindful of the present and your current surroundings. It helps to address the human tendency to become agitated over regrets of the past and/or fears of the future which can cause or exacerbate emotional distress. The goal is to become more self-aware in the present moment. This is done by paying attention to a person's thoughts, feelings, and sensations at that moment (Mindful, 2020). With the goal of not judging them as good or bad.

Research has found mindfulness to be very effective in decreasing self-harm (Yusainy & Lawrence, 2014), but Christians are often uncomfortable with the spiritual aspects. Eastern- oriented mindfulness is more self-focused, promotes a oneness with the universe, supports emptying the mind, and encourages escape from reality. Buddha did not invent mindfulness; it has long been part of Judeo-Christian beliefs. Like any good thing the Lord has given us, it can be misused. The main difference between Eastern mindfulness and Christian mindfulness is that one is horizontal (paying attention to self) and the other is vertical (connecting with the divine). We just need to approach it in a wise and Biblical way. The Bible has a lot to say on keeping a calm mind and focusing on our creator God and His goodness (Focus on the Family, 2019). The cited verses are from the New King James Version.

- Philippians 2:1-2 "Therefore if there is any consolation in Christ, if any comfort of love, if any fellowship of the Spirit, if any affection and mercy, fulfill my joy by being like-minded, having the same love, being of one accord, of one mind." Christians are called to be mindful and focused on the present.
- Thessalonians 5:17 "pray without ceasing," Prayer is a way for Christians to apply mindfulness on a regular basis.
- Psalm 48:9; Psalm 63:6 "We have thought, O God, on your loving kindness, in the midst of your temple." "When I remember you on my bed, I meditate on you in the night watches." Christians are to spend time focusing on God's goodness.
- Hebrews 12:2; Philippians 4:8 "looking unto Jesus, the author and finisher of our faith, who for the joy that was set before Him endure the cross, despising the shame, and has sat down at the right hand of the throne of God." "Finally, brethren, whatever things are true, whatever things are noble, whatever things are just, whatever things are pure, whatever things are lovely, whatever things are of good report, if there is any virtue and if there is anything praiseworthy-meditate on these things." We are to look to Jesus and think about admirable things.
- Matthew 6:25 "Therefore I say to you, do not worry about your life, what you will eat or what you will drink; nor about your body, what

you will put on. Is not life more than food and the body more than clothing?" Christians shouldn't spend time worrying about the future.

- Romans 12:2 "And do not be conformed to this world, but be transformed by the renewing of your mind, that you may prove what is that good and acceptable and perfect will of God." Being a Christian is to transform our thoughts to the ways of God.

There are several Christian mindfulness techniques that exist that can comfortably be used by Christians. A simple internet search will reveal many books, apps, and videos on Christian mindfulness. A great place to start is just to sit still in the presence of God, to focus your mind on Him (Perry, 2020). This can be done right after devotional times or after a good sermon. The goal is to give God time and space to work on your heart, to give you guidance instead of you trying to figure things out on your own. It can be challenging at first and many worry if they are doing it right. It is a skill that needs to be developed and practiced.

Anchoring Techniques

These techniques are a physical way to get the human mind into the present. To bring it back from a flashback or a desire to dissociate from a painful present. Sometimes the limbic system is so activated it is too difficult to intentionally focus the mind on anything. Anchoring techniques involve the senses to help a person come back to the present reality. When you are with someone who appears to be dissociating or if you are aware of the early signs of dissociating in yourself, ask, "What are,
5 things you can see
4 things you can feel (literally touch different textured objects)
3 things you can hear
2 things you can smell
1 thing you can taste." (Smith, 2018)

It may be difficult to remember the order. The main point is to use the body's senses to bring the mind back into the present and to distract and calm the limbic system from focusing on its perception of danger that isn't actually happening. A simple anchoring technique is just going outside in bare feet to connect with God's creation. It is a way to physically connect with something permanent and away from emotional distress.

Breath Work

When the limbic system is activated, our bodies are getting ready to either fight off or run away from danger. The heart rate increases to elevate oxygen levels so the body can run or have the muscle strength to fight. Other body systems that are impacted include: enlarged pupils in the eyes to improve vision, slows digestion so its energy is diverted to other areas of the body, relaxes airway muscles to improve oxygen delivery in the lungs (Cleveland Clinic, n.d.)

This reaction is sometimes necessary when we are in physical danger, but usually isn't needed in most "scary situations" especially if someone has a significant trauma history that is easily activated to protect a person from further trauma. Telling someone to "calm down" doesn't work when the rational part of the brain has taken a back seat to the emotional part of the brain that

is working with the body to physically defend itself.

The best way to tell the body that there is not going to be an inevitable attack is to slow down the heart rate. This is best done by slowing the breathing down. If there is less oxygen coming in, the heart can't keep up the higher rate. It can be uncomfortable to do this at first. Like mindfulness and anchoring, there are many different breathing techniques.

A simple technique is just to breathing in through the nose (this will automatically slow the oxygen rate compared to breathing in through the mouth) hold it for a few seconds and then breathing out through pursed lips twice if breathing in. It is best to focus on the breath coming from the diaphragm instead of the chest. Breathing from the diaphragm helps to fill the lungs more. A way to know if this is happening is to put one hand on the chest and one just below the belly button and notice which hand goes out when taking a breath. It can take 5 to 10 minutes before there is a noticeable decrease in anxiety. The earlier it is started, the quicker the body can relax.

For kids a favorite breathing technique is Pizza Breathing. This is done by pretending to hold a piece of pizza and smelling how good it is, but then it is too hot, so you must blow on it slowly to cool it down. This should be done a few times to notice a decrease in anxiety symptoms.

Breath work can be used to relax the muscle tension that comes with hyper-arousal. A way to do this is to do a quick body scan to notice any tightness. Then focus on that tension and feel it relax as the breath is slowly released. For a more complete relaxation experience, tighten and relax each muscle group starting with the toes and ending with the top of the head. A fun one for kids is to pretend to be a wet noodle to release any muscle tension.

These activities help to activate the parasympathetic nervous system which restores the body to a state of calm (McCorry, 2007). Sometimes the parasympathetic nervous can be too strong and the body stays in the hypo-arousal longer than needed to recover from the sympathetic nervous system activation. Breath work can also help the body to get out of hypo-arousal. Taking in a quick breath through the mouth can activate the sympathetic nervous system to give the body a boost of energy to face the day.

The Role of the Vagus Nerve

The vagus nerve system helps to counterbalance the fight or flight response by triggering a relaxation response. It is one of the cranial nerves that connect the brain to the body. It is in the neck and can be activated with the breath work mentioned above. There are additional techniques to stimulate the vagus nerve that slows heart rate (Horeis, 2020):

- Loud gargling with water
- Loud singing (if it is something that is typically enjoyed)
- Foot massage
- Cold water face immersion (forehead, eyes, and 2/3 of both cheeks)
- Laughter

Physical Activity

All humans benefit from a certain amount of physical activity. This is especially important in helping to decrease physical tension that develops from hyper-arousal and to bring a person out of hypo-arousal. Research has found that exercise can decrease depression and anxiety symptoms in some individuals (Netz, 2017). Walking is a

great place to start. It gives you fresh air and sunlight, regulates heart rate, gives a change of scenery, and the opportunity to connect with others that are seen on the walk or in walking along with others which helps with bonding. These combine to aid in improving a person's mood when distressed. Walking through a forest is ideal (Song, et al., 2018). If that is not possible, then a person should look for as much green (in plants & trees) and blue (in the sky) as possible.

Self-care Activities

When a person is struggling with self-harm and suicidality, they often are not taking good care of themselves. There are just certain things humans need to do in taking care of themselves that helps to prevent disease – physical or mental.

Diet – Eating a diet rich in whole grains, fruits, and vegetables (look for foods known to decrease inflammation), healthy fats, magnesium and folic acid, low fat protein, and high in fiber helps the nervous system to work more efficiently. Avoid sweets and highly processed foods that contribute to increase inflammation (Ljungberg, Bondza, Lethin, 2020). It is best to eat meals with others to improve interpersonal relationships and eat healthier.

- Social support – We are created to be social beings. Spending time with others helps with emotion regulation (Marroquin, 2011).
- Spirituality – People of faith can still suffer from mental illness. We often feel disconnected from God when under emotional distress. Having faith and hope in an all-powerful being can help us through difficult times, but religious struggle can worsen depression (Braam & Koenig, 2019). As mentioned earlier, prayer is a powerful way to unburden our worries.

Getting Help

All children and adolescents go through periods of emotional distress. The exercises mentioned above can help them manage the inevitable problems that happen in life. If symptoms last more than a few weeks or affects functioning it is time to get professional help. There are multiple professionals who can treat self-harm and suicidality (psychiatrists, psychologists, clinical social workers, and licensed professional counselors). Since a history of trauma is strongly associated with these symptoms, it is best to find a psychotherapist who is at least trauma informed and ideally trauma trained.

Psychotherapy

There are many different therapeutic modalities that are known to successfully treat these symptoms:

Cognitive Behavioral Therapy – Addresses cognitive distortions that trigger or exacerbate emotional distress (Beck, 2011). This includes behavioral techniques, some of them mentioned in this article.

Dialectical Behavioral Therapy invented by Marsha Linehan (1987) – includes the following elements:

- Mindfulness – described above
- Distress tolerance – learning how to get through a crisis without making the situation worse
- Emotion regulation – learning to identify goals, functions, and models of emotions and reducing emotional vulnerability to decrease the frequency of unwanted emotions and emotional suffering

- Interpersonal effectiveness – learning to maintain good relationships, self-respect, and communicate needs/wants in a healthy way
- Walking the path in the middle – learning to see things from different perspectives, validate, and avoid the power struggle

Internal Family Systems Therapy invented by Richard Schwartz (2020) works to identify a person's internal family system that plays different roles in helping a person cope with life's stresses. The approach assumes individuals possess a variety of "parts" who play these roles. The goal of this therapy helps the person identify these parts, better understand their roles, then work to find better ways to approach problems. It is thought there is a self-harm part that helps the body avoid excessive criticism (another part) and emotional distress (another part that holds wounds from childhood).

EMDR (Eye Movement Desensitization and Reprocessing) invented by Francine Shapiro (2016). A form of exposure therapy to help the brain heal from a past trauma that keeps triggering hyper-arousal.

There are many other forms of therapy; just make sure they are based on research, and fit a person's values. Many of these therapies can have a Christian element. Unfortunately, it is not always easy to access therapy due to time, transportation, and/or cost. Teletherapy is more available than before. There are apps that aid with the use of the many activities mentioned in this article.

Therapy is not quick; it can take weeks, months, and years for there to be significant improvement in symptoms, depending on the severity of the illness and amount of trauma, the ability of the therapist, the willingness of the client, and the techniques that are used. The relationship between the therapist and client is very important in addressing self-harm and suicidality so it is okay to do research ahead of time or change therapists if needed. Information about therapists, including if they use Christian therapy, should be able to be found on the internet.

Hospitalization

If there is any talk about feeling hopeless or not wanting to live and/or there is a plan to die, get help immediately. If you aren't sure if a person is suicidal, just ask "Are you thinking of hurting/killing yourself?" This does not plant the idea in his/her head, that idea is probably already there and is a relief when it is finally out in the open (National Institute of Mental Health, n.d.). To get immediate help, the child should be taken to the local emergency room where doctors will rule out any physical causes for the suicidality and then there will eventually be an evaluation by a psychiatrist or similar profession to determine the necessity of inpatient psychiatric care. If the individual is 18 or over and refuses to go, there are legal ways to compel a person to be taken to the emergency room for a psychiatric evaluation. The rules will vary from state to state or by country.

If it is believed the person is not in immediate danger, but a plan of suicide has been devised, access should be limited or eliminated, such as, removal of razor blades, firearms, and/or medication. In addition to protecting a person from the ability to harm themselves, a suicide safety plan should be designed.

Suicide Safety Plan

When there is chronic self-harm and/or the possibility of suicide, it helps to create a plan before the emotional distress, when a person can think more clearly. It should be put in writing and in a place that is easy to find. In addition, it should be done in consultation with a mental health professional or responsible adult who will also have a copy. Recommended information that should be in the plan includes (V.A., n.d):

1. Hopelessness level (1-10)
2. Which emotions are difficult to manage?
3. What situations trigger those emotions?
4. Identify early warning signs of emotional distress
5. Have a plan to cope (at least 5)
6. Contact information for support system (friends, family, school, church, counselor, doctor, etc)

Hope Kit

Instead of a no-suicide contract where the at-risk young person promises not to kill themselves, helping the person remember what there is to live for has been found to be protective (Leahy, 2018). The person should gather pictures of family, friends, and/or pets, symbols of what he/she is hoping will eventually happen in life (advanced degrees, a particular profession, marriage, parenthood, or other goals in life). This can be done with physical objects or collected in a digital file. When a person is feeling hopeless, he/she can focus on what can give hope in the future.

Medication

There are times medication is appropriate to address the underlying mental illness that is causing the self-harm or suicidality. Though SSRIs are known to cause these symptoms, that is in only a minority of users. Most actually improve with its use (Preston, O'Neal, Talaga, & Moore, 2021). If the mental illness is treated, a person would less likely feel a need to self-harm or consider suicide to cope. Mood stabilizers and low dose anti-psychotics have also been found to be helpful depending on the diagnosis (Saunders & Smith, 2016). When a person has a physical illness, a person will take medication to treat that illness if needed, the same should apply to mental illness, a disease of the mind.

Conclusion

The increasing rates of self-harm and suicide are discouraging, but not surprising in a sinful world. There are many reasons for these increases and ways to know who is most at risk. Though these higher rates are a cause for alarm, there are known ways to prevent, treat, and manage these symptoms. There are many ways faith can play a role.

Resources

Apps

Suicide Safe https://store.samhsa.gov/product/suicide-safe
Virtual Hope Box
Abide – Christian mindfulness

Suicide Crisis Phone numbers

Bahamas - The Crisis Centre Hotline: 328-0922, 322-4999
National Helpline: 322-2763
Canada - Talk Suicide Canada: 211 or
Crisis Line: 833-456-4566
Crisis Line: 866-277-3553
(Residents of Quebec)
Text Line: 45645

Guam – Suicide Prevention Resource Center
- Life Works Guam: (671) 477-3574
- Youth for Youth LIVE Guam: (671) 688-8878
- Sanctuary Inc.: (671) 475-7101

United States - Suicide & Crisis Lifeline: 988
- Crisis line: 1-800-273-TALK (8255)
- Text line: 741741

Websites

National Alliance on Mental Illness https://www.nami.org/About-Mental-Illness/Common-with-Mental-Illness/Self-harm

National Institute of Health https://www.ncbi.nlm.nih.gov/books/NBK56398/

National Institute of Mental Health https://www.nimh.nih.gov/health/publications/suicide-faq

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HOW ADVERSE CHILDHOOD EXPERIENCES (ACES) MAY RESULT IN SERIOUS MENTAL ILLNESS, AND HOW TO MITIGATE THESE EFFECTS

For decades we have heard the saying, "children are resilient" because we see them often bounce back from being hurt. But studies initiated in the 1990s have shown that Adverse Childhood Experiences (ACEs) have a life-lasting, negative effect in the life of those children physically, emotionally, and spiritually. At the same time, more recent studies have shown that Positive Childhood Experiences (PCEs) can do much to mitigate the negative effects of ACEs.

Introduction

In the mid-1990s, the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente discovered that when a child is exposed to traumatic experiences it dramatically increased the risk for seven out of ten of the leading causes of death in the United States. Evidently, severe traumatic experiences affect brain development, the immune system, hormonal systems, and even how our DNA is read and transcribed. Those who are exposed at very high levels have triple the lifetime risk of heart disease and lung cancer and a 20-year difference in life expectancy.

An understanding of how traumatic experiences in childhood results in serious negative physical and emotional consequences started in an obesity clinic in San Diego, California. In 1985 Dr. Vincent Felitti, chief of Kaiser Permanente's Department of Preventive Medicine was mystified as to why each year for the last five years, more than half of the people in his obesity clinic dropped out. A passing review of all the dropouts' records surprised him because it appeared they had all been losing weight when they left the program, not gaining, which made no sense at all. Why would people who were 300 pounds overweight lose 100 pounds, and then drop out when they were on a roll? The mystery turned into a 25-year journey involving researchers from the CDC and thousands of Kaiser Permanente's San Diego care program. As Jane Ellen Stevens (2012) explained, "It would reveal that adverse experiences in childhood were very common, even in the white middle-class, and that these experiences are linked to every major chronic illness and social problem that the United States grapples with – and spends billions of dollars on." As Stevens (2012) describes:

The turning point in Felitti's quest

came by accident. The physician was running through yet another series of questions with yet another obesity program patient: How much did you weigh when you were born? How much did you weigh when you started first grade? How much did you weigh when you entered high school? How old were you when you became sexually active? How old were you when you married?

"I misspoke," he recalls, probably out of discomfort in asking about when she became sexually active – although physicians are given plenty of training in examining body parts without hesitation, they're given little support in talking about what patients do with some of those body parts. "Instead of asking, "How old were you when you were first sexually active," I asked, "How much did you weigh when you were first sexually active?' The patient, a woman, answered, 'Forty pounds.'" He didn't understand what he was hearing. He misspoke the question again. She gave the same answer, burst into tears and added, "It was when I was four years old, with my father."

He suddenly realized what he had asked.

Felitti (1998) and his colleague interviewed 286 people, most of whom had been sexually abused as children. Following a speech Felitti made to the North American Association for the Study of Obesity, Dr. David Williamson from the CDC, invited Felitti to meet with a small group of researchers at the CDC, among whom was Dr. Robert Anda, a medical epidemiologist. Felitti and Anda asked 26,000 people who came through the Department of Preventive Medicine at Kaiser Permanente if they would be interested in helping understand how childhood events might affect adult health, of which 17,421 agreed. Anda spent the next year going through the research literature to learn about childhood trauma and focused on the eight major types that patients had mentioned so often in Felitti's original study and whose individual consequences had been studied by other researchers. These eight included sexual, verbal and physical abuse, as well as five types of family dysfunction, that is, a parent who is mentally ill or alcoholic, a mother who's a domestic violence victim, a family member who's been incarcerated, and a loss of a parent through divorce or abandonment. Anda later added emotional and physical neglect for a total of ten types of what came to be known as Adverse Childhood Experiences, or ACEs.

The data that resulted from the study was shocking. First, the study showed that there was a direct correlation between childhood trauma and adult onset of such things as chronic disease, mental illness, doing time in prison, and also work issues, such as absenteeism. Second, the data showed that about two-thirds of the adults in the study had experienced one or more types of adverse childhood experiences. Furthermore, 87 percent of those had experienced two or more types. As an example, people who had an alcoholic father were also likely to have experienced physical or verbal abuse. In other words, ACEs were usually not isolated events but were accompanied by other ACEs. Thirdly, as if that were not enough, more adverse childhood experiences

resulted in a higher risk of medical, mental, and social problems as an adult.

In order to assess a person's ACEs, Anda and Felitti developed a scoring system. Each type of adverse childhood experience counted as one point. If a person did not experience any traumatic experiences in his or her background, their ACE score was zero. On the other hand, if a person was verbally abused multiple times during their childhood, but had not experienced any other types of childhood trauma, they would receive a score of one point in the ACE score. However, if someone experienced several traumatic experiences, for instance they suffered verbal abuse, lived with a mentally ill mother, and had an alcoholic father, his or her ACE score would be three.

When a person scores four or above, things really become concerning. As Stevens (2012) explains, "compared with people with zero ACEs score, those with four categories of ACEs had a 240 percent greater risk of hepatitis, were 390 percent more likely to have chronic obstructive pulmonary disease (emphysema or chronic bronchitis), and a 240 percent higher risk of a sexually-transmitted disease." According to Stevens (2012), not only do they have serious physical ailments, but people with high ACE scores are more likely to be violent, to have more marriages, more broken bones, they need more drug prescriptions, have more depression, more auto-immune diseases, and also more work absences. From the mental side of things, those with high ACE scores were twice as likely to be smokers, seven times more likely to be alcoholic, ten times more likely to have injected street drugs, and twelve times more likely to have attempted suicide.

Are ACEs limited to a certain group or class? Stevens (2012) writes that "The ACE Study participants were average Americans. Seventy-five percent were white, 11 percent Latino, 7.5 percent Asian and Pacific Islander, and 5 percent were black. They were middle-class, middle-aged, 36 percent had attended college and 40 percent had college degrees or higher. Since they were members of Kaiser Permanente, they all had jobs and great health care. Their average age was 57."

One person's experience

Pedro recalled the time, as a young child, when his father was heavily inebriated and was cleaning his hunting shotgun. As Pedro describes, "I was sitting on the floor, playing with my toys. When I looked up, daddy was pointing the shotgun at me… he was going to kill me." It appears that Pedro's dad, as he was cleaning his shotgun, was looking down the barrel to inspect it and it happened to be pointing in the direction of where Pedro was sitting on the floor. The shotgun was not loaded at any time, nor did his father ever have the intention of harming anyone in his family, much less the baby of the family. But for Pedro, seeing his inebriated father "pointing the shotgun" at him was a traumatic moment.

Just a year or two later, his dad died of a myocardial infarction when Pedro was about eight years old. His life was dramatically changed on that day. His mother gave herself to her grief, which affected Pedro deeply. Two years later, Pedro, with his mom and older brother, moved from their country of birth to the United States to have a new start at life which caused him to leave his beloved dog behind. In the United Sates he was enrolled in an elementary school where he was teased, perhaps even

bullied, because he did not speak English and was small in stature. While his family were loved and appreciated in their church, Pedro always felt as if he was not loved by anyone.

While in high school he started dating a young lady of a different faith tradition. After his high school graduation, he joined the Air Force and shortly after that he married his high school girlfriend. Their marriage lasted ten years and after it ended Pedro revealed to his family that his wife had been verbally and physically abusive toward him. As he told them, "She would slap me, kick me, punch me, and then she would threaten me that if I ever said anything she would accuse me before my supervisors at the Air Force that I was abusing her."

After that marriage dissolved, Pedro moved in and subsequently married for a second time. Sadly, his second wife was also very controlling and abusive and often told him, "If you think your first marriage and divorce were bad, you try to leave me and it will be a lot worse." He remained married to his second wife for fifteen years, unhappy, resentful, frustrated, and angry. In 2015, Pedro attempted suicide by asphyxiation, but when one of his colleagues found him, he laughed it off and told him he was just joking. One day in January of 2016, Pedro used his own gun to complete suicide at the age of fifty, one year younger than his father was when he died.

While we don't know whether Pedro ever heard of or completed an Adverse Childhood Experiences questionnaire, it seems obvious that his father's drinking, the perception of violence as his father "pointed" the gun at him, his father's death, the move to the United States, having to leave his dog behind, being teased and bullied in school, all of which happened within two to three years before the age of ten, evidently created a downward spiral in his mental health and well-being that eventually lead to his dying by suicide.

Pedro's story is very personal as he was my (Claudio) younger brother. While he was alive, we recognized he was dealing with mental health issues and recommended repeatedly he seek help, but he always dismissed our suggestions and instead continued to sink lower into the darkness in his own mind.

How prevalent are ACEs?

According to the Centers for Disease Control and Prevention (CDC), About 61% of adults surveyed across 25 states reported they had experienced at least one type of ACE before age 18, and nearly 1 in 6 reported they had experienced four or more types of ACEs. It is important to note, as Sameroff, Gutman and Peck (2003) assert, that it is not only the exposure to any specific event of this type but rather the accumulation of multiple adversities during childhood which is associated with especially harmful effects on development. Using the 2016 National Survey of Children's Health (NSCH) to describe the prevalence of one or more ACEs among children from birth through age 17, as reported by a parent or guardian, Sacks and Murphy (2018) summarized four key findings:

- Economic hardship and divorce or separation of a parent or guardian are the most common ACEs reported nationally, and in all states.
- Just under half (45 percent) of children in the United States have experienced at least one ACE, which is similar to the rate of exposure

found in a 2011/2012 survey.* In Arkansas, the state with the highest prevalence, 56 percent of children have experienced at least one ACE.

- One in ten children nationally has experienced three or more ACEs, placing them in a category of especially high risk. In five states—Arizona, Arkansas, Montana, New Mexico, and Ohio—as many as one in seven children had experienced three or more ACEs.
- Children of different races and ethnicities do not experience ACEs equally. Nationally, 61 percent of black non-Hispanic children and 51 percent of Hispanic children have experienced at least one ACE, compared with 40 percent of white non-Hispanic children and only 23 percent of Asian non-Hispanic children. In every region, the prevalence of ACEs is lowest among Asian non-Hispanic children and, in most regions, is highest among black non-Hispanic children.

These numbers are staggering, and the implications for the mental health of all those who have experienced ACEs are very concerning.

Another person's experience

As a young boy, Roger attended his church's Pathfinders Club (the Seventh-day Adventist Church alternative to the Boys/Girls Scouts). The club director sexually molested Roger. His family is not sure whether it happened one time or several times as he didn't tell anyone the details or extent of the abuse. The outward manifestation of the molestation Roger experienced was a obsessive compulsiveness about his police uniform and his police car, both of which kept impeccably clean. On one occasion, while performing his duties as a police officer, he received a call to the home of the man who had molested him as a child. Roger arrested the man and took him to jail. That event led him to share with his sister what had happened to him.

Roger was married twice and had two children with his first wife. Due to a number of financial and personal circumstances, and as a direct result of the childhood sexual abuse he experienced, Roger made the sad decision to end his life, with his service weapon, at the young age of thirty.

As it was in the case with Claudio's brother, Roger's experience is very personal to me (Pamela) because he was my youngest brother. The evil actions of an adult led this child, now a grown man, to feel unclean all the time and to choose death by suicide.

ACEs categories definitions

According to the CDC all ACE questions refer to the respondent's first 18 years of life and are divided into three main categories: Abuse, household challenges, and neglect.

Abuse

- **Emotional abuse**: A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
- **Physical abuse**: A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- **Sexual abuse**: An adult, relative, family friend, or stranger who was

at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.

Household Challenges

- **Mother treated violently**: Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
- **Substance abuse in the household**: A household member was a problem drinker or alcoholic or a household member used street drugs.
- **Mental illness in the household**: A household member was depressed or mentally ill or a household member attempted suicide.
- **Parental separation or divorce**: Your parents were ever separated or divorced.
- **Incarcerated household member:** A household member went to prison.

Neglect

- **Emotional neglect**: Someone in your family never or rarely helped you feel important or special, you never or rarely felt loved, people in your family never or rarely looked out for each other and felt close to each other, or your family was never or rarely a source of strength and support.[2]
- **Physical neglect**: There was never or rarely someone to take care of you, protect you, or take you to the doctor if you needed it2, you didn't have enough to eat, your parents were too drunk or too high to take care of you, or you had to wear dirty clothes.

Testing for ACEs

You can easily access online free ACEs questionnaires. We share here the one provided by the Center on the Developing Child, out of Harvard University. For each "yes" answer, add 1. The total number at the end is your cumulative number of ACEs. Before your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Were your parents ever separated or divorced?
7. Was your mother or stepmother:
8. Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
9. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
10. Was a household member depressed or mentally ill, or did a household member attempt suicide?
11. Did a household member go to prison?

You may have noticed that there are several other stressors missing from this list of ACEs. For instance, stressors outside the household such as violence (gang, bullying), poverty, racism, other forms of discrimination, isolation, chaotic environment, and lack of social or community services. Also missing are protective factors such as supportive relationships (extended family, church, friends), community services, skill-building opportunities). It is also important to remember that there are individual differences that may help or hurt them. That is to say that not all children who experience multiple ACEs will have poor outcomes and not all children who experience no ACEs will avoid poor outcomes. It is clear that a high ACEs score is simply an indicator of greater risk which should be taken into account when observing someone else, or ourselves, experiencing physical, emotional, or spiritual challenges which are causing harm or to harm ourselves.

What can be done to help children with ACEs

Childhood should be a time of healthy growth and development in a safe, loving environment. ACEs disrupt that experience in the life of a child and produce life-long negative consequences for the person. At the same time, Positive Childhood Experiences (PCEs) can also produce life-long consequences. In recent years, researchers have started to examine the impacts of positive childhood experiences (PCEs) on children and adults. Bethel et.al (2019) found there's a dose-response association between positive childhood experiences and adult mental and relationship health among adults who had experienced ACEs, irrespective of how many ACEs they had. The logical conclusion is that is it critical to have positive childhood experiences regardless of how much adversity you may experience in life. To put it another way, if you have a lot of adversity, but at the same time enjoy a lot of positive childhood experiences, you are less likely to suffer the consequences of ACEs. If, on the other hand, you have few or no positive childhood experiences, even if you have few ACEs the consequences of the ACEs are more likely to appear.

What are considered PCEs? Jane Stevens, editor of ACESTooHigh (n.d.) shares a list of questions (much like the ACEs questionnaire) to help you find out what positive

childhood experiences you have. Answer the following questions. How much or how often during your childhood did you:

1. feel able to talk to your family about feelings;
2. feel your family stood by you during difficult times;
3. enjoy participating in community traditions;
4. feel a sense of belonging in high school;
5. feel supported by friends;
6. have at least two non-parent adults who took genuine interest in you; and
7. feel safe and protected by an adult in your home.

Individua and family resilience, therefore, serve as an antidote to ACEs. As Yamaoka and Bard (2019) stated, "The number of adverse childhood experiences was associated with both social-emotional deficits and developmental delay risks in early childhood; however, positive parenting practices demonstrated robust protective effects independent of the number of adverse childhood experiences." They further conclude that "This evidence further supports promotion of positive parenting practices at home, especially for children exposed to high levels of adversity."

PCEs are crucial for juvenile offenders. Baglivio and Wolff (2020) concluded that "high ACE scores were associated with increased reoffending, and high PCE scores were associated with decreased recidivism, as measured by both rearrest and reconviction. Further, among juveniles with four or more ACEs who have six or more PCEs, reconviction was 23% lower and rearrest 22% lower when compared to those youth with four or more ACEs and less than six PCEs, controlling for a host of demographic and criminal history measures."

How can ACEs be prevented

Benjamin Franklin famously advised fire-threatened Philadelphians in 1736 that "An ounce of prevention is worth a pound of cure." Rather than dealing with the negative aftermath of ACEs, it is important to understand how to prevent it from happening in the first place. explores risk factors (things that increase the likelihood of experiencing ACEs) and protective factors (things that protect people and decrease the possibility of experiencing ACEs).

Risk Factors

Individual and Family Risk Factors

- Families experiencing caregiving challenges related to children with special needs (for example, disabilities, mental health issues, chronic physical illnesses)
- Children and youth who don't feel close to their parents/caregivers and feel like they can't talk to them about their feelings
- Youth who start dating early or engaging in sexual activity early
- Children and youth with few or no friends or with friends who engage in aggressive or delinquent behavior
- Families with caregivers who have a limited understanding of children's needs or development
- Families with caregivers who were abused or neglected as children
- Families with young caregivers or single parents
- Families with low income
- Families with adults with low levels of education

- Families experiencing high levels of parenting stress or economic stress
- Families with caregivers who use spanking and other forms of corporal punishment for discipline
- Families with inconsistent discipline and/or low levels of parental monitoring and supervision
- Families that are isolated from and not connected to other people (extended family, friends, neighbors)
- Families with high conflict and negative communication styles
- Families with attitudes accepting of or justifying violence or aggression

Community Risk Factors

- Communities with high rates of violence and crime
- Communities with high rates of poverty and limited educational and economic opportunities
- Communities with high unemployment rates
- Communities with easy access to drugs and alcohol
- Communities where neighbors don't know or look out for each other and there is low community involvement among residents
- Communities with few community activities for young people
- Communities with unstable housing and where residents move frequently
- Communities where families frequently experience food insecurity
- Communities with high levels of social and environmental disorder

Protective Factors

Individual and Family Protective Factors

- Families who create safe, stable, and nurturing relationships, meaning, children have a consistent family life where they are safe, taken care of, and supported
- Children who have positive friendships and peer networks
- Children who do well in school
- Children who have caring adults outside the family who serve as mentors/role models
- Families where caregivers can meet basic needs of food, shelter, and health services for children
- Families where caregivers have college degrees or higher
- Families where caregivers have steady employment
- Families with strong social support networks and positive relationships with the people around them
- Families where caregivers engage in parental monitoring, supervision, and consistent enforcement of rules
- Families where caregivers/adults work through conflicts peacefully
- Families where caregivers help children work through problems
- Families that engage in fun, positive activities together
- Families that encourage the importance of school for children

Community Protective Factors

- Communities where families have access to economic and financial help
- Communities where families have access to medical care and mental health services

- Communities with access to safe, stable housing
- Communities where families have access to nurturing and safe childcare
- Communities where families have access to high-quality preschool
- Communities where families have access to safe, engaging after school programs and activities
- Communities where adults have work opportunities with family-friendly policies
- Communities with strong partnerships between the community and business, health care, government, and other sectors
- Communities where residents feel connected to each other and are involved in the community
- Communities where violence is not tolerated or accepted

Having considered and understanding the above risk and protective factors, we can then talk about how to prevent ACEs. As the CDC states, "Creating and sustaining safe, stable, nurturing relationships and environments for all children and families can prevent ACEs and help all children reach their full potential." The CDC also shares a very useful, clear table with practical ideas to prevent ACEs:

Strategy	Approach
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality child care • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programs • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders

Positive Religious Experience and ACEs

Having considered the potential benefits of Positive Childhood Experiences (PCEs), we also need to look at the role that spirituality, and in particular Positive Religious Experiences (PREs) may play in mitigating ACEs. In a study conducted by Reinert, et.al.(2016), they concluded that while adult survivors of early trauma experienced worse mental and physical health, forgiveness, gratitude, positive religious coping, and intrinsic religiosity were protective against the resulting poor mental health. While their study was limited to Seventh-day Adventists who experienced Early Traumatic Stress (ETS), it provides valuable insights as to the value of PREs. As Reinert et.al. concluded, "Although religious coping, intrinsic religiosity, forgiveness, and gratitude are difficult to implement as treatments, some small studies have examined the effectiveness of counseling interventions that support these coping mechanisms in people who valued them with some effectiveness."

Another study conducted by Freeny, et.al. (2021), examined the prevalence of ACEs and the association between ACEs and the risk for depression in African-American adolescents and examined whether this association is moderated by resilience and spirituality. From this study they concluded that higher levels of resilience and spirituality suggest a lower likelihood of depression.

Conclusion

As family life professionals and practitioners, we help change how people think about the causes of ACEs and how ACEs can be prevented. We can also help reduce the stigma about seeking help with parenting challenges or even the more serious issues such as substance misuse or abuse, depression, or suicidal thoughts. We can also promote safe, stable, nurturing, and loving relationships and environments where children may live, learn, play, and grow to healthy maturity physically, emotionally, and spiritually.

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CHALLENGES OF DEPRESSION: BIBLICAL BACKGROUND AND IMPACT ON THE DYNAMICS OF FAMILY RELATIONSHIPS

Today we are witnessing a global epidemic of rapidly spreading mental health problems among all age groups. However, a growing mental health crisis among youth is of particular concern. According to the World Health Organization, "1 in every eight people in the world live with a mental disorder."[1] *The informative data are more than impressive. For many reasons, the accurate picture of various mental health disorders is much more widespread than the latest accessible information indicates. The fundamental question revolves not only around the mental health challenges of the afflicted but especially around its practical aspect: How can ordinary people become empathetic agents and function as channels of hope and support by their presence? How can they create a loving atmosphere without stigmatization as an indispensable factor in the mental health recovery process of the one suffering in the family or church? To better understand the cause of all the pain and suffering, including the worsening mental health situation, it is also necessary to briefly turn to the biblical background for some basic answers.*

Introduction

The topic of mental illness and ministering to suffering is too broad, complex, and challenging to address in an article of this length. That is why this article is written in a generalized way from a pastoral perspective focusing mainly on one psychological aspect called depression.[2] Such mental illnesses as major depression, bipolar disorder, schizophrenia, posttraumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), panic disorder, borderline personality disorder, etc., are considered "serious" challenges.[3] Today everybody knows that the magnitude and impact of COVID-19 on one's mental health has enormously affected not only individuals but the entire global population by causing disruption, anxiety, stress, depression, stigma, and xenophobia.[4] It will not be an overstatement to assert that every individual has either dealt with anxiety or heavy depression or knows somebody who has. The prevalence of mental issues is so evident and widespread in our society today that no comments are needed. In her article, "*Mental Illness Is Mainstream,*" Amy Simpson states, "All mental illness, by definition, impairs a person's basic functioning and disrupts the kind of social connections God created us to enjoy (see Gen 2:18-23; Col 3:12-15;1 John 4:7-12)."[5]

Secular-Scientific Approach

Theories of medical research concerning the causes of depression and related mental illnesses are multiplying. The more ideas and models we have, the greater our confusion. It is a well-known fact that, for example, many medical researchers focus on the nature of biological changes in the chemistry of the human brain and body that contribute to mental disorders. According to this approach, depression comes from within the person. Many physicians refer to it as a functional imbalance in the body's chemistry.[6] As a result of this, there have been developed and used antidepressant medications.[7] While these are not miracle pills that work in all cases and are suitable for anyone, they can provide alleviation of the number of symptoms and some normality to life.

Psychological theories are less defined and generally determined by the assessment of personality.[8] Different schools focus on various causes. The psychodynamic model is a type of approach to psychotherapy that deals with the unconscious elements.[9] A psychodynamic approach will focus on inward aggression and the loss of a "love object." In contrast, others will argue that depression results from a disturbance of cognition rather than emotion. The behaviorist sees it in terms of learned helplessness, while the existentialist as the loss of meaning of existence.[10] Of course, these views and theories are an oversimplification of more complex ideas, but they illustrate the diversity of information and speculation surrounding the subject. Mary Boyle, for example, notes that while other diseases are identified by scientific evidence of impaired bodily dysfunctions, psychiatrists identify changes in behaviors without having demonstrated clear links between these behaviors and brain functioning.[11] While acknowledging the contribution of science and medical research, there is a biblical approach that cannot be ignored, as it unavoidably causes us to look deeply and thoughtfully at mental illnesses through the spiritual lenses of our relationship with God and His Word.

Biblical-Creation Paradigm

The biblical background helps us understand why people suffer from various mental and physical health problems and how to competently minister to and support someone who struggles with mental illness. The first book of the Bible is about the beginnings, where we find the first modest factual reference to the creation of man, "So God created man in his own image, in the image of God created he him; male and female created he them" (Gen 1:27). It is one of the most extraordinary statements found in the Bible. What does it mean? Today the most widely scholarly held views concerning the "image of God" spin around the concepts of presence, rule, power, spirituality, and relationship.[12] David exclaimed, "for I am fearfully and wonderfully made" (Ps 139:14), and Job proclaimed, "The Spirit of God has made me, And the breath of the Almighty has given me life" (Job 33:4). God created humans to be much like himself. In our inmost being, we have the very breath of God that is placed into our form of dust (Gen 2:7; Eccl 12:6-7). That is how we differ from the other living creatures: both were created from the ground (Gen 2:7, 19), but only humanity is created in the image of God. Ellen White states, "Man came from the hand of his Creator perfect in organization and beautiful in form."[13] Claus Westermann says, "Humans

are created in such a way that their very existence is intended to be their relationship to God."[14] Likewise, Robin Routledge argues, "Human beings are made for a relationship with God."[15] To describe a person as a spiritual-relational being seems almost heretical from a scientific perspective. Although neuroscientists talk about the human mind and various processes taking place there, which is an invisible aspect of our being, they often use words like "consciousness" or "self-awareness" to make it sound more "scientific." So here we have the fact that God created perfect humankind, and everything he did was "very good" (Gen 1:31).

The Tree of Death

God's original intention for people was to live forever and never die, but before giving them access to life eternal, they had to be put on probation. The first couple was endowed with free will and unique privileges that entailed responsibility. This is an axiomatic statement, but the first human beings had to be tested to see "whether he[they] will obey God or not."[16] The creation story informs that God had prepared and entrusted to Adam the garden. "Then the Lord God took the man and put him in the garden of Eden to tend and keep it" (Gen 2:15). God gave him occupation. The next verse speaks about the freedom and joy the man had.[17] "And the Lord God commanded the man, saying, 'Of every tree of the garden you may freely eat'" (v. 16). Here is the first command in the Scripture, followed by a permission statement.[18] However, there is no such thing as freedom without prohibition. The boundary for Adam is but one tree. Only one authoritative prohibition contains the absolute requirement of obedience. God says, "but of the tree of the knowledge of good and evil you shall not eat, for in the day that you eat of it you shall surely die" (v. 17). God informed Adam that the consequence of disobedience is death. Nothing more is said. No explanation. Hebrew double verb construction states this prohibition in the strongest possible terms, meaning "you will certainly die" or "you will die for sure."

The warning is more than mandatory because only humans have the potential to cross all God-given moral boundaries. What is at stake is people's trust and obedience. The triangle of occupation, permission, and prohibition describes the fundamental functional essence of human beings before God. The triangle represents a wholistic paradigm of divine design. Missing only one facet of the three will unavoidably bring ruin. Similarly, human health depends on the balance of the wellness triangle, which consists of physical, mental (emotional), and spiritual (social) dimensions. Each component is interdependent and interactive and should be maintained in its best available order and condition.

The Point of Tragedy

Whenever we talk about the origin of all pain and suffering of body and mind, the consequences of sin, death, and estrangement from God, including all the tragedies of this life, we look back to one event—the Fall (Gen 3). As soon as Eve accepted the alternative interpretation of the serpent that "you will not surely die" (Gen 3:4), she was unintentionally about to introduce the greatest tragedy in the universe. Events follow one after another; they are rapid and tragic. The serpent rejoiced, seeing that "she ate … and he ate.…" (v. 6). Eating from the forbidden tree culminated in catastrophic

effects.[19] Now the wholeness triangle is destroyed. The only prohibition is dishonored. The permission is perverted. The occupation is abandoned.[20] As a result, a new distorted triangle has been generated: God, man, and sin. Instead of being like God, they are driven out of the presence of God. Disobedience to God led them to death.[21] The power of guilt generated various mental and spiritual problems, like blame, anger, shame, terror, frustration, fear, depression, self-justification, and death. Atkinson summarizes this section in the following way, "Adam's death is a change of place (from within the Garden to outside the Garden) and a change of situation before God (in fellowship with God, to alienated from God). And all death can be so understood."[22]

Ruined by the Fall

Morales makes a powerful statement, "Exile from the divine Presence, then, is *the* point of tragedy . . .."[23] And Wenham adds to this by saying, "Only in the presence of God did man enjoy the fullness of life.… The expulsion from the garden of delight where God himself lived . . . was more catastrophic than physical death."[24] From this point on, the once perfectly created human beings slowly but surely moved towards the destruction of themselves. Through disobedience and sin, people have lost access to the tree of life, and their relationship with God has downgraded their physical, mental, and spiritual powers. The Bible informs that the first ten generations of the antediluvian patriarchs lived almost 1000 years.[25] Sinful lifestyle and environmental changes following the Flood drastically reduced human life span down to about 75 years.

Moreover, the Bible shows that various mental and physical health problems resulted from people's separation from God. The way of Cain's life was bitterness, unforgiveness, and hatred, which led him to murder his brother, Abel. The phrase "his countenance fell" (Gen 4:6) constitutes the first mention of depression in the Bible.[26] Thus, Cain's depression holds truths for us who live today.[27] "Why are you cast down, O my soul?" David asked when he faced depression like ours. What was his prescription? "Hope in God" (Ps 42:11). On another occasion, being heavily depressed, David wrote of his feelings because of his unconfessed sin (Pss 38; 51). Overwhelmed by deeply heavy depression, Jeremiah cried, "Desperate is my wound. My grief is great. My sickness is incurable, but I must bear it" (Jer 10:19, TLB). His cure was in: "Let us lift our hearts and hands to God in heaven" (Lam 3:41). It sounds strange, but God used depression to get Nehemiah's attention (Neh 1–2). Job's losses led him to curse the day he was born (Job 3:1). Elijah was so depressed over the situation with Israel's leaders that he wished to die (1 Kgs 19:3–4). Many people are surprised to read the account of Jesus' depression in the garden of Gethsemane (Matt 26:36–38).[28] Frequently depression comes with highly challenging circumstances, even in the life of a believer.[29] It is no coincidence that the Bible has chronicled seven suicides and one attempt to commit suicide.[30] When depression hits, it is easy, natural, to lose one's perspective. Whatever the cause, suicide is one of the most tragic depression outcomes. Because of the Fall, everything is ruined. On the other hand, as Routledge states, "In the OT, physical death also has a spiritual dimension: it brings the relationship with God to an end. Similarly, life is more than

mere existence: it is also about continuing to enjoy the blessings of God's presence."[31]

What Is Depression?

While depression is "the second most common mental disorder,"[32] it is often considered a mood disorder because its predominant feature is a disturbance in mood.[33] On the other hand, the word 'depression' is more than problematic, as it can have a hundred different meanings[34] [a]nd may indicate itself in various forms. One of the most striking things about depression is its inevitability. There are different kinds and levels of depression with countless labels, like some of them: "endogenous depression, reactive depression, manic depression (a bipolar disorder), cyclic depression, post-natal depression, anxiety state, etc."[35] Clinical depression as a disorder is not the same as brief mood oscillations or the feelings of sadness, disappointment, and frustration that everyone experiences from time to time and that last from minutes to a few days at most. "Clinical depression is a more serious condition that lasts weeks to months, sometimes even years."[36] The most common symptoms are "decreased energy, fluctuating body weight, depleted concentration, irritability, bouts of crying, hopelessness or despair, a disinterest in pleasurable activities, social withdrawal, and thoughts of suicide.[37] Severe depression is recognized as one of this century's most significant health concerns,[38] and it is considered "a potentially fatal illness that should be taken seriously."[39] Because there is no exact definition for depression, a medical professional or a psychologist may determine its cause and meaning by the context, and often use a descriptive word to avoid misinformation.[40]

Causes of Depression

Nobody knows what exactly causes depression, and that is why various theories regarding its origins abound. Different schools of thought concentrate on multiple causes. Much medical research has taken place to investigate the nature of biological changes in body chemistry that contribute to mood disorders.[41] Observations show that may run in families and have a vital genetic component. Yet, it can be associated with external stress, such as grief or internal stress related to a stroke or heart attack.

Consequently, there is a strong interaction and interdependence between genetics and the environment, physical body and mind, and spiritual and emotional worlds. Scientists also realize that affective disorders are brain disorders. Recent imaging studies defining abnormalities in brain areas associated with emotion, memory, and reward confirm this conclusion.[42] Exactly why brain areas develop abnormalities and exactly how these abnormalities interact remain a mystery. Still, researchers continue to progress in understanding brain function. Although depression is, at its core, a brain disease, its effects on the body are far-reaching.[43]

Impact on Family Relationships

When a person suffers from a mental health problem like severe depression, it impacts not only the depressed person but every family member. It can be very problematic and exhausting to deal with the challenge. A detailed study published in 2016 showed that family members of a person with severe depression "often experience a combination of burnout, guilt, psychological stress, and anxiety." Moreover, "after a while, it can become challenging

to watch a family member go through the ups and downs of depression."[44] In other words, everyday family life becomes more difficult. Mental health problems can create an exasperating impact upon those who are closest.[45] In this sense, mental illness functions as a contagious disease. If one person is depressed in a family, there is a two-fold problem.

On the one hand, every family member tries to help the one they love. On the other hand, they must also consider the impact on their health. Marriage life can become burdensome when a spouse is not able to function as a spouse. It is tough on children when their mother or father suffers from depression. They may feel unloved, unwanted, and rejected. When a child is depressed, parents find themselves under tremendous stress. Often the dynamics of daily family life are impacted by disrupted sleep patterns, interruption of traditional weekly activities, neglected regular chores, not paid bills, and the further existence of the whole family seems to be under threat.[46]

Other Repercussions

Whatever the cause or case, mental problems are worrisome and disorienting. For most people, depression is temporary. For others, suffering may be a long road, and counseling or medication may alleviate their pain. However, some can become disabled and lonely, unable even to work. As if this were not enough, people with mental health problems have to endure the torment of the illness itself and often experience rejection by their families, friends, and the general public. They are stigmatized, marginalized, and rejected by mainstream society because they are different. The stigma and discrimination are too often associated with mental illness.[47] As repercussions of stigma are a constantly present sense of shame, loneliness, isolation, and avoiding opening oneself, "which precludes such illnesses from being treated and openly embraced, discussed, and treated."[48] It seems that the well-known symptoms of depression, the sense of being excluded, and the feeling of loneliness are experienced by almost every person. The erroneous generalizations and preconceived ideas about mental illnesses are primarily based on ignorance. The assessing judgments of the mentally suffering by others often result not only in humiliation but sometimes degradation. Such approaches undermine the integrity and respect of the afflicted, irrespective of their diagnoses. These dynamic repercussions have a profound and far-going effect on the sufferer. Finally, as Carson puts it, "stigma is not limited to those who are patients or 'users' of mental health services. Families of the mentally ill can also find themselves feared and rejected as if they are somehow contaminated."[49]

Biblical Perspective on the Ministry to the Afflicted

It is impossible to overestimate the meaning and importance of the ministry of presence. Every Christian can be involved in this ministry to bring comfort to the afflicted. One does not need to be an eloquent orator or convincing speaker. On the contrary, the main requirement is to be available and listen.[50] This ministry took place in the life of Job, who had to go through indescribable pain and suffering. Job 2:11-13 says, "When Job's three friends … heard about all the troubles that had come upon him, they set out from their homes and met together by agreement to go and sympathize with

him and comfort him … They sat on the ground with him for seven days and seven nights. No one said a word to him because they saw how great his suffering was." They truly supported him through their silence. If they only left him at that moment and did not open their mouths to blame him, the story of Job would have been different. Moreover, Christ, our best example, left the heavenly courts to be united with us in our sorrows and pain (Isa 53:3). Immanuel extended the celestial presence of the Omnipotent God on this earth (Matt 1:23).

At the same time, presence without showing compassion does not mean much. When a person suffers from depression, it is not the time for criticism or rebuking.[51] Paul writes, "Rejoice with those who rejoice; mourn with those who mourn" (Rom 12:15). God is the most excellent example. "As a father has compassion on his children, so the Lord has compassion on those who fear him; for he knows how we are formed, he remembers that we are dust" (Ps 103:13-14). God knows how fragile we are, and He has empathy for us. Why not repeat His example in our ministry to the depressed?

Depressed individuals may have an inaccurate picture of life because darkness overwhelms their view of reality. Therefore, one of the functions of the ministry of presence is to invite the afflicted to the light and hope in Jesus.[52] As Erikson noted, this "maturing hope" may preserve itself in the face of changed facts. Even more, "it proves itself able to change facts"[53] (Matt 17:20). If the depressed individuals are willing, there is a privilege to pray not only for them but with them, to look them in the eye, to hold their hand, and tell them with deep sincerity and compassion that for those who put their trust in Jesus it will get better because He said, "Blessed are those who mourn, for they will be comforted" (Matt 5:4; Rom 12:12).[54] The One who experienced the most darkest part of life in Gethsemane and the cross invites everyone, "Come to Me, all *you* who labor and are heavy laden, and I will give you rest. Take My yoke upon you and learn from Me, for I am gentle and lowly in heart, and you will find rest for your souls" (Matt 11:28, 29). This invitation includes the depressed and those who are around them.

Family Ministry to the Afflicted

It is a highly complicated issue as there are no easy answers or prescriptions, and each case is different. Each person has a specific array of needs and available resources. How can a family minister to the afflicted in the best way? That is the real question because if to refer to such disciplines as science, medicine, and Christianity, we see that each of them offers a very different approach and assessment when confronting mental illnesses. For example, science seeks a solution to a problem; medicine seeks a cure to a disease; but believers seek God's face and find His favor. Therefore, there are some general hints to help family members to assist the depressed:

1. They must learn to control their moods and emotions, especially when they see that sympathy alone does not work. They cannot allow themselves to lose their temper, to become annoyed, irritated, or angry. It will leave only a negative effect on the depressed, and they will feel more helpless, hopeless, and guilty than they already are.
2. The afflicted person must be present when the entire family dis-

cusses the situation. Every family member should recognize, address, and accept the problem.

3. When an adult family member is depressed, especially a mother or father, various tasks should be shared by others.
4. Family members must avoid blaming anyone for the mental problems of the afflicted they are facing together.
5. These are days or years of tremendous stress and anxiety for every family member, and that is why they are more than essential to support each other in any possible way.
6. If the depressed needs to use medication, the family members should support this and be informed about its side effects.
7. If it is a Christian family, they must pray, read Christ's promises, and have spiritual talks with the depressed person and each family member.
8. Although depression is an exceptionally nerve-wracking experience for the entire family, it is also a time when they can strengthen bonding and individuals can mature and grow spiritually. By confronting the problem together, the family can build unity that will positively affect every family member.[55]

The Importance of the Church

It is impossible to diminish the significance of the church and its role in the lives of those struggling with mental health problems, as it offers resources unavailable in secular institutions or from general social support.[56] The religious dimension is more than vitally crucial to recovery and wholeness. More importantly, God loves His creation, hears its desperate cries, and responds with sustaining mercy and grace.[57] One of the most potent and dynamic aspects is Christ's relational and revelatory presence.[58] Thus, the church can offer but is not limited to the following:

1. A hope that transcends all circumstances, driving the mental health recovery engine. This hope provides motivation and opportunity for change when the world sees the situation as hopeless. Hope enables believers to face the future or restoration with confidence. This hope is more than a feeling; it is Jesus Christ.
2. The church offers the person struggling with a mental health problem a wholistic approach[59] to treatment that involves all aspects of human being: physical, mental, spiritual, and relational.[60]
3. The church functions as a supportive community and environment where the suffering person can pursue healing and wholeness. It is where each one is called to "love one another" (John 13:34) and to demonstrate authentic friendship that applies to the relatives and friends of people who suffer mentally. The church should never be like a courtroom but a hospital for the wounded.[61]

Conclusion

Depression is not a respecter of any person. Although depression may become

a devastating experience for individuals or families, it can also become a positive, even transforming journey. The Bible says that God created humans as relational beings, and that is one of the reasons why Jesus gave us the church so that people might be together supporting each other, extend their ministry of presence, and never be alone (Acts 2:42; 1 John 1:7). Church is that place where love manifests its beauty and healing qualities, where stigmatization finds no expression. When ministering to the afflicted person, all four dimensions of the wholistic approach, namely, spiritual, mental, physical, and relational, play their role in the recovery process, as they are interdependent and constantly interacting. Finally, there is a fervent eschatological hope that the day is coming when every suffering believer will rejoice as "God will wipe away every tear from their eyes; there shall be no more death nor sorrow, nor crying. There shall be no more pain, for the former things have passed away" (Rev 21:4).

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ELLEN WHITE AND MENTAL HEALTH WHAT CAN WE LEARN FROM HER EXPERIENCES AND ADVICE?

Ellen G. White was one of the three principal founders of the Seventh-day Adventist Church. She held a unique leadership role in the emerging church: she had the gift of prophecy. In her public ministry of more than 70 years, she received hundreds of visions and dreams with messages ranging from personal counsel to issues pressing upon the newly founded church—in such areas as faith and doctrine, organization and mission, health and education, etc. Although she wrote prolifically and with authority, she never understood her writings to be additional Scripture. Throughout her life and ministry, she pointed to the Bible as the Christian's rule of faith and practice.

One of her major roles was to help individuals and the church organization to understand and follow God's will. Though she had no formal mental health training, she often served as a spiritual counselor for people who had various emotional and psychological needs. She touched the lives of thousands of people and gave them new hope with a healthy spiritual, mental, and emotional focus. Her extensive writings demonstrate sympathy for mental health issues. Among other material, she wrote an important chapter titled "Mind Cure" in her book The Ministry of Healing. In 1977, the Ellen G. White Estate published a two-volume compilation titled Mind, Character, and Personality: Guidelines for Mental and Spiritual Health.

This article will briefly present Ellen White's understanding of mental health, her personal and family experiences, and her role as a counselor on issues affecting mental health.

WHAT'S MENTAL HEALTH?

When Ellen White used the term "mental health," she associated it with "mental clearness, calm nerves, a quiet, peaceful spirit like Jesus."1 In order to understand her observations on mental health issues, it is necessary to understand her use of 19th-century language. For example, she used the words "diseased imagination" to refer to delusional thinking or emotional imbalance and "despondency, which increases to despair" when speaking of depression.[2] She also used the term "mind cure" to describe mental health issues.

Ellen White's understanding of human nature was based on the biblical view that human nature is inherently sinful and needs external help from God. To her, Jesus was the great healer of the sin-damaged human mind. "It is impossible for us, of ourselves," she wrote, "to escape from the pit in which we are sunken. Our hearts are evil, and we

cannot change them." She then quoted Job 14:4 and Romans 8:7 to support this view. She continued: "Education, culture, the exercise of the will, human effort, all have their proper sphere, but here they are powerless. They may produce an outward correctness of behavior, but they cannot change the heart; they cannot purify the springs of life. There must be a power working from within, a new life from above, before [men and women] can be changed from sin to holiness."[3]

For Ellen White, there was a convergence of psychology and theology. The two must interplay and, when correctly integrated, provide the most help for the human mind and emotions. For her the true source of mental and emotional health was God the loving Father, Jesus the "Great Physician," and the Holy Spirit the "Counselor."

Ellen White strongly advocated a proper connection between the physical, mental, and spiritual in the human experience. "The spiritual life is built up from the food given to the mind; and if we eat the food provided in the Word of God, spiritual and mental health will be the result."[4] True mental health was dependent upon establishing a proper balance between the body and the mind. "We cannot afford to dwarf or cripple a single function of the mind or body, by overwork or abuse of any part of the living machinery."[5] She used the phrase "physical and mental health" to show the link between the two: the physical and mental dimensions are closely connected and require proper balance and care. She believed that a right environment, right actions, and a proper diet facilitated mental health. She was also a strong advocate of the healing benefits of nature, a right attitude, and acts of service for others.[6]

PERSONAL EXPERIENCE

Ellen White's philosophy on mental health, while informed by her study of the Bible and her visions, was connected to her own experience. Through her long life, she was no stranger to emotional pain and psychological challenges. As a child she was introverted, shy, and emotionally sensitive. To this was added the complication of a physical disability. During her younger years, she experienced fearfulness and hopelessness that brought about protracted periods of depression. In addition to her personal struggles, her immediate family was touched with mental disability issues.

Ellen White's fundamental touchstone for mental and emotional health was an understanding of the loving character of God. As a child she viewed God as a "stern tyrant compelling men to a blind obedience."[7] When preachers would describe the fires of an eternally burning hell, she personalized the horror of that experience. She wrote: "While listening to these terrible descriptions, my imagination would be so wrought upon that the perspiration would start, and it was difficult to suppress a cry of anguish, for I seemed already to feel the pains of perdition."[8] This led her to doubt her acceptance by God and caused periods of depression. She recalled one occasion: "Despair overwhelmed me, and … no ray of light pierced the gloom that encompassed me."[9] Her "feelings were very sensitive" and at one point she feared she would "lose" her "reason." Ellen White recollected that "sometimes for a whole night" she would not dare to close her eyes but "kneel upon the floor, praying silently with a dumb agony that cannot be described."[10]

Her pre-teen and early-teen years were burdened by physical disability. She was

severely injured through an accident at about age 9. A broken nose with other complicating damage caused equilibrium problems and prevented her from continuing her education. She also developed a chronic pulmonary disorder that was diagnosed at the time as "dropsical consumption," or in modern terms, "tuberculosis with complicating congestive heart failure." Her fears were exacerbated by the thought that she could bleed out at any time from an arterial rupture in her lungs.[11] Her physical and emotional trauma combined with her introverted personality prevented her from seeking help.

Finally, at about age 15, she talked with someone who helped her to better understand the loving character of God. She pointed to her interview with Levi Stockman, a Millerite Methodist minister, as providing her with the most help. Stockman was sympathetic to Ellen's emotional pain and even shared her tears. She wrote that she "obtained" from Stockman "more knowledge on the subject of God's love and pitying tenderness, than from all the sermons and exhortations to which I had ever listened."[12] She specifically identified what helped her most: "My views of the Father were changed. I now looked upon Him as a kind and tender parent. … My heart went out toward Him in a deep and fervent love."[13] The love of God became Ellen White's favorite theme throughout her life. She also believed that "Christ's favorite theme was the paternal tenderness and abundant grace of God."[14] Her five-volume masterpiece series on the cosmic conflict between Christ and Satan begins and ends with this theme.[15] Her most popular book, published in scores of languages with millions of copies, has as its first chapter "God's Love for Man."[16]

Ellen White's own visions and dreams confirmed her conviction of a loving God and compassionate Savior. An early personal dream that occurred before her first prophetic vision brought her into the presence of Jesus, where she realized He knew all her "inner thoughts and feelings." Yet, even with this knowledge He "drew near with a smile," laid His hand on her head, and said, "Fear not."[17] In an interview in the last year of her life, Ellen White said, "I find tears running down my cheeks when I think of what the Lord is to His children, and when I contemplate His goodness, His mercy, [and] His tender compassion."[18]

FAMILY CHALLENGES

Besides her own emotional struggles during childhood and at times during adulthood, Ellen White faced mental health challenges within her family. Her second son, James Edson, evidenced some of the characteristics of attention deficit/hyperactivity disorder. Her niece, Louisa Walling, seems to have had some mental instability with a divorce from her husband. Out of concern for Louisa's two children, James and Ellen White brought them into their home. Ellen White ended up raising the girls, and they called her mother.[19] Even James White suffered from a series of strokes during the 1860s and 1870s that altered his mental state and brought marital conflict. In 1879 Ellen White realized her husband did not "have sufficient physical and mental health" to give counsel and advice.[20] At one point she wondered if he was a "sane man."[21]

Ellen White's personal experience, combined with her visionary guidance, helped her to provide a unique ministry to

individuals who also suffered with mental and emotional brokenness. Her writings reveal a consistent compassion for people who sometimes had serious life dysfunction. She engaged to a remarkable degree in close personal work with many such people.

ELLEN WHITE AS A COUNSELOR

Throughout her life, Ellen White addressed mental health and social dysfunction issues. Her scope of interaction with people was varied and diverse. Below are four examples that show how she addressed serious mental health issues, such as obsessive behavior, emotional abuse, alcohol addiction, and sexual dysfunction.

Obsessive behavior. Ellen White's letter to "Brother Morrell" shows her perception of his mental condition. She described this man as having "large conscientiousness" and "small self-esteem." It seems that Morrell was obsessive and pathologically perfectionist about his conduct. He felt guilty for the smallest perceived mistake, to the point of mental instability. White wrote of this man's condition thus: "Brother Morrell's nervous system is greatly affected and he ponders over these things [his perceived sins and failings], dwelling upon them. His imagination is diseased. … The mind has suffered beyond expression. Sleep was driven from him." She wrote directly: "I saw, Brother Morrell, you must cast away your fears. Leave consequences with the Lord and let go. You try too hard to save yourself, to do some great thing yourself which will commend you to God. … Jesus loves you, and if you will consecrate yourself and all you have to Him, He will accept you and will be your Burden-bearer, your never-failing Friend. … Believe Jesus loves you and in your efforts to obey the truth, if you err, don't feel that you must worry and worry, give up your confidence in God and think that God is your enemy. We are erring mortals." As a complement to her spiritual and emotional related counsel, she urged this man to adopt health reform and avoid stimulants. "Then," she wrote, "can the brain think more calmly, sleep will not be so uncertain."[22]

Emotional abuse. Ellen White wrote several letters of counsel to women who were either emotionally or physically controlled by their husbands. In December 1867, she visited the Washington, New Hampshire, Seventh-day Adventist Church with her husband and J. N. Andrews. She first gave oral counsel and followed up with a written "testimony" based on a vision she had received. She provided pointed counsel to Harriet Stowell. After the death of her first husband, Harriet married Freeman S. Stowell, who was 12 years younger and was not practicing his faith.[23] Ellen White's words are clear and explain the situation: "She [Harriet] is beloved of God, but held in servile bondage, fearing, trembling, despondding, doubting, very nervous. Now this sister should not feel that she must yield her will to a godless youth who has less years upon his head than herself. She should remember that her marriage does not destroy her individuality. God has claims upon her higher than any earthly claim. Christ has bought her with His own blood, she is not her own. She fails to put her entire trust in God, and submits to yield her convictions, her conscience to an overbearing, tyrannical man, fired up by Satan when his Satanic majesty can make effectual to intimidate the trembling, shrinking soul who has so many times been thrown into agitation that her

nervous system is torn to pieces and she [is] nearly a wreck."[24]

Ellen White supported individuality in marriage and rejected the idea that a spouse must give up his or her personality and self-identity. This testimony was a help to this woman who was driven almost to emotional collapse.

Alcohol addiction. In a letter to a troubled young man in England, Ellen White recognized the effect of alcohol addiction. Henri Frey worked as a translator for the European mission in Basel, Switzerland. He had a drinking problem. Because of his actions, he was removed from his position as translator. He then wrote Ellen White that he was being persecuted. She supported the decision of the mission but personally appealed to Frey. "I feel the tenderest feeling of pity, and of love for your soul; but false words of sympathy … shall never be traced by my pen." She cogently described his condition: "You find your emotional nature untrue to your best resolutions, untrue to your solemn pledges. Nothing seems real. Your own inefficiencies lead you to doubt the sincerity of those who would do you good. The more you struggle in doubt, the more unreal everything looks to you, until it seems that there is no solid ground for you anywhere. Your promises are nothing, they are like ropes of sand, and you regard the words and works of those whom you should trust in the same unreal light."[25]

She continued by emphasizing the power of the will in meeting emotional dysfunction. "You may believe and promise all things, but I would not give a straw for your promises or your faith until you put your will over on the believing and doing side." Her letter of counsel was interwoven with appeals for this young man to see the help Jesus can give. "I tell you that you need not despair. You must choose to believe, although nothing seems true and real to you." She concluded with words of hope. "A life of usefulness is before you, if your will becomes God's will. …Will you try Henri, will you now change square about? You are the object of Christ's love and intercession."[26]

Sexual dysfunction. Ellen White often dealt with sensitive issues. In 1896 she wrote to a leading minister in South Africa. He was guilty of sexually abusing young girls and perhaps boys. This man had written to Ellen White of his struggles but believed he was not guilty of adultery. She began her letter with a prayer: "May the Lord help me to write you the very words that will be for your restoration and not for your destruction." She then wrote most directly to him: "I feel sorry, very sorry for you. Sin, my brother, is sin; it is the transgression of the Law, and should I try to lessen the sin before you, I would not be doing you any good. … Your mind and heart are polluted else all such actions would be loathsome." She described for this man the long-term effect of sexual abuse on children, including generational effect. She cited several cases and described how psychological damage was often lifelong. "How can I present it in such a manner that you will no longer look upon it, as you have done, as no great wrong?" After a lengthy direct and sometimes painfully graphic description of his conduct, she appealed to him: "You are a free moral agent. If you will repent of your sins, and be converted, the Lord will blot out your transgressions and impute unto you His righteousness. … He will undertake your case, and angels will guard you. But you must resist the devil. You must educate yourself to a different train of thought.

Put no confidence in yourself. Never seek the companionship of women or girls. Keep away from them. Your moral taste is so perverted, that you will ruin yourself and ruin many souls if you do not turn square about. … Everlasting life is worth a life-long, persevering, untiring effort." Finally she urged him to make himself accountable to "brethren who know this terrible chapter in your experience."[27]

These four examples illustrate the level of involvement Ellen White had in the lives of many people who had emotional and mental health difficulties. One of the remarkable characteristics of her work is her consistent optimism that people can recover, no matter how broken they may be. Ellen White always pointed them to God as the great healer of mind and soul. Ellen White was wholistic in her approach to healing. She realized that the mind was linked to the body and that God intended humans to have restored social relationships. For her, the most important connection was with a loving and holy heavenly Father.

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THERAPEUTIC LIFESTYLE CHANGE AND MENTAL HEALTH

Loma Linda University's motto "To Make Man Whole" is a very appealing way to promote the Christian health message. The motto implies that health is not just the absence of disease but the ability to live fully and completely. The World Health Constitution (1946) shares a similar thought about health as, "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Jesus said it even more succinctly in John 10:10, "I am come that they might have life, and that they might have it more abundantly.

Mental health providers are committed to deliver the best counseling service to enhance the client's well-being. The author believes the counselor who decides to focus on Therapeutic Lifestyle Change (TLC) will be in the best position to practice the motto "To Make Man Whole" and help their clients live the abundant life.

Therapeutic lifestyle change can have a dramatic impact a person's mental health (Walsh, 2011;Fullen, 2019). TLC can enhance physical and psychological health without the many side effects from medication. The TLC approach allows the client to make important self-directed life-style changes. These changes are believed to help decrease many physical and mental disorders that develop during the lifespan.

The TLC approach is also directly related to the principles found in such inspirational books as: Ministry of Healing (1905), Education (1953), Healthful Living (1976), and Counsels on Diet & Foods(1976). Divinely inspired counsel by Ellen White (1905,p.241) addresses the issue of TLC when she stated, "The relation that exists between the mind and body is very intimate. When one is affected, the other sympathizes."

The Life Wheel's Eight Dimensions of Wellness, as found on page 74, is a tool that can assess an individual's degree of mental health fitness. This article will briefly explore each of these eight dimensions. They are as follows: Religion-Spirituality, Exercise-Recreation, Social Involvement, Love-Relationships, Nutrition-Health, Finance-Money Management, Home-Family Environment, and Career Satisfaction. The Life Wheel can be used by counselors as a part of the intake assessment process. Additionally, it may help to establish a treatment plan and counseling strategy to use with individuals or families toward complete health. The reader is directed to the appendix to review the Life Wheel.

It is the purpose of this article to encourage healthcare professionals to utilize the TLC approach to understand and promote better mental health. The TLC approach is a cost-effective way to deal with mental and physical health problems encountered over the life-span.

Religion-Spirituality

For I say, through the grace given unto me, to every man that is among you…; but to think soberly, according as God hath dealt to every man the measure of faith." Romans 12:3. "True religion brings man into harmony with the laws of God, physical, mental, and moral…Religion tends directly to promote health, to lengthen life, and to heighten our enjoyment of all its blessings (White,1970, p.600).

Religion and spirituality may be broadly understood as the search for meaning and purpose in life. The counselor may freely explore with their client what are those values or principles that give direction in life. For others, religion/spirituality may mean to appreciate and explore life through nature, art, music, and meditation. Activities can be recommended that will encourage the client to explore or contemplate their spiritual side. This can be done by exploring various worship styles, reading spiritual materials, attending religious services, and forming small community discussion groups. Romans 12:3 reveals that everyone has been given a *"measure of faith"* but clearly not everyone responds to it.

Koenig (2008) reports that many clients welcome exploring spirituality, religious, and spiritual practices and like to know more about how to become spiritually connected. As a result, we are not surprised that the American Counseling Association (ACA) has made recommendations for counselors who are exploring spirituality and religious practices with their clients as found in the document "Competencies for Addressing Spiritual and Religious Issues in Counseling" (Cashwell & Watts, 2010). The document reviews such spiritual-religious competencies that are essential for the counseling practice as: 1) understanding the client's cultural and worldview, 2) how the counselor needs to be self-aware of their own spiritual views, 3) understand the process of human and spiritual development, 4) maintaining essential communication styles, and 5) spiritual assessment, diagnosis and treatment of the client. The ACA has endorsed those spiritual competencies that recognize the importance of spirituality in the therapeutic practice for counselors working with families or individuals.

Research has consistently established a strong support for a relationship between a religious faith and enhanced mental health (Schumaker, 1992; Weber & Pargament, 2014; Koenig, 2018). It appears that a religious faith can help to alleviate depression and promote inner healing and well-being. Schieman et.al.,(2012) found that religion may help to promote certain health benefits. Individuals who have a religious belief have increased resources to help alleviate stressors and increase life coping strategies. Furthermore, Koenig (2018) found that those individuals with a religious faith have increased their life expectancy by seven years for those who consistently attend religious services. Additionally, Koenig (2018) those who have a religious belief system have a reduction in anxiety, less substance abuse, and experience fewer suicide attempts.

A religious-spiritual foundation provides hope for a better future. It is a recognition that God knows us and we are to trust in Him. Scripture clearly supports this view with the following statement: "*Hope thou in God for I shall yet praise Him, who is the health of my countenance and my God."* Ps.42:1. If the client is willing and open, the TLC approach would include as a part of the counseling process to explore the

religious-spiritual lifestyle for mental health improvement.

Exercise-Recreation

"For thou shalt eat the labour of thine hands: happy shall thou be, and it shall be well with thee." Ps. 128:2

Exercise has been found to be a potent way not only to reduce the number of physical disorders but as an effective treatment for mental health disorders. Harvard Mental Health Letter about Therapeutic Effects of Exercise (2000,pgs.5-6) reports that exercise is a "healthful, inexpensive way, and insufficiently used treatment for a variety of psychiatric disorders." Some of the most promising findings regarding exercise and mental health has found significant reductions in depression, anxiety, and addictive disorders (Deslandes et al., 2009; Kramer & Colcombe, 2018; Swanson, et.al. 2019). Other studies indicate there is an increase in self-efficacy, self-esteem, and improved sleep with the use of physical exercise on a daily basis (Deslandes et al., 2009; Aguiar & Latini, 2018).

Mendolesi et al.(2018) have found that exercise and recreational activities have led to a decrease in stress levels, help to promote self-healing, better cognitive functioning, and increase positive emotional states within individuals. Physical activity translates into an important dimension for the TLC approach for overall health improvements shown in cognitive, cardio, and mental health benefits.

Recreational activities may also involve engaging in a sense of playfulness. Lester & Russel (2008) reports that play enhances well-being, social skills and maturation in children. Recreational Interactions with nature such as boating, swimming, biking, walking may increase emotional regulation and a sense of inner peace. Stress levels decrease and are displaced by engaging in various kinds of outdoor activities. Physically active adults report better mental alertness, feelings of hopefulness and less fatigue (Lester & Russel, 2008).

Most health care professionals recommend 30 mins of physical activity daily (Byrne & Hills, 2018; Laskowski, 2021). The effects of physical exercise have been shown to be very dramatic. According to Ratey (2013), exercise has an impact on increasing memory capability, lowering stress levels, increasing immune system functioning, decreasing potential for depression, preventing ADD and Alzheimer's disease. A sedentary lifestyle is the opposite for maintaining good mental health. White (1953,p.207) explains it in this way, "*The whole body is designed for action, and unless the physical powers are kept in health by active exercise, the mental powers cannot be used to their highest capacity."*

It has been suggested by Leitma (2013) that for individuals who have chosen not to engage in regular exercise may be due to a mismatch between a specific activity and personality type. Type A, B and C personalities have very different energy needs. For example, a Type A personality feels compelled to engage in competitive high level of physical activity such as rock climbing, weigh training, power walking and lap swimming. Type B personality feel more relaxed, peaceful within themselves, and are easy going and slow to anger. Their activities are more adapted for easy walking, stationary cycling, rowing, and canoeing. Type C personalities internalize their feelings and anger and seek low energy type of activities such as aerobics, skating, and

swimming. Less active individuals may have not found the right personality match for exercise enjoyment.

The TLC approach suggests there are many significant mental and physical health benefits gained from some form of physical exercise.

Social Involvement

"Two are better than one; because they have a good reward for their labour. For if they fall, the one will *lift up his fellow: but woe to him that is alone when he falleth; for he hath not another to help him up. Again, if two lie together, then they have heat: but how can one be warm alone?* And if one *prevail against him, two shall withstand him; and a threefold cord is not quickly broken*." Eccl. 4:9-12

Social involvement means to connect in healthy ways with other people through various social options as: community support networks, with colleagues at work, and with family members. Social engagement means to actively pursue a sense of belonging and contributing to the community. Examples include engagement in various social activities in the neighborhood, church & school events, club memberships, and various kinds of volunteer associations etc. We are all socially wired to some extent to be engaged with others. Research has shown significant mental health benefits from meaningful social relationships throughout the life span (Fowler & Christakis, 2008; Jetten et.al., 2009). Social involvement has been shown to reduce health risks and enhance positive moods, happiness, health resilience, and enhanced cognitive processing (Catherine Haslam et. al, 2021). Social relationships are important for mental health. Social relationship problems are one of the many reasons why a great majority of people seek therapy and counseling (Yalom, 2017). It was no surprise to discover that social isolation caused by COVID 19 had a negative impact on social relationships. For many young people, the harmful consequences of the lockdown due to COVID 19 led to increase feelings of loneliness and depression. Anxiety, panic attacks, obsessive-compulsive symptoms, insomnia, digestive problems, as well as depressive symptoms and symptoms of post-traumatic stress have also increased due to social isolation (Piettrabissa & Simpson,2020). For some young people, less time spent with family and friends led to more time with social media. Consequently, social media involvement has been found to either exacerbate or compensate for the loss of social interactions (Piettrabissa & Simpson,2020). Jetten et.al. (2009) feels that consequence of long-term social isolation places the person at the same health risks comparable to smoking, high blood pressure and obesity.

TLC approach means to encourage the client to be socially involved in order to enhance the client's sense of wholeness and life satisfaction. One of the important therapeutic goals for counseling is to assist the client to become better equipped to be engaged in healthy social relationships at home, work and community.

Love-Intimate Relationships

"Set me as a seal upon thine heart, as a seal upon thine arm: for love is strong as death; jealousy is cruel as the grave: the coals thereof are coals of fire, which hath a most vehement flame. Many waters cannot quench love, neither can the floods drown it: if a man would give all the substance of his house for

love, it would utterly be contemned." Song of Solomon 8:6-7

Erik Erikson (1980) in his seminal work *Identity & the Life Cycle* has accurately described the ego's need for establishing intimacy and to overcome social isolation during the young adult years. According to Erikson (1986), establishment of intimacy is an important part for the development of a healthy personality that begins to be nurtured in childhood.

Intimacy has often been described as the need to achieve a level of self-disclosure by forming a special loving relationship. The challenge is to form a deep personal bond with someone outside one's own family. If that is not achieved, a sense of social isolation emerges. Intimacy for Erikson means to practice close relationships in a personal, meaningful, and relevant way that creates connections with other people and form strong relationships. The result is an important step in forming a healthy emotional sense of self.

Erikson(1986) has emphasized the importance of establishing a romantic-love relationship through marriage. He also believes a sense of intimacy may include close, enduring friendships with people outside of the family circle. Adults who struggle with intimacy experience few or no friendships. They lack any kind of close personal relationships or self-disclosure opportunities. They experience poor romantic relationships, fear of intimacy and weak social support. Much of this is learned and experienced in unhealthy families as a child.

Research (Edwards et al. 2016, Smith, 2019) has supported Erikson's view of intimacy in several important ways. Emotional healthy relationships are important for overall well-being. However, a healthy relationship is dependent on several factors. According to Edwards (2016) and Smith (2019), it is important to first establish good communication skills. Healthy communication means your partner talks with you and not at you. A healthy communication implies that one is listening with an understanding what your friend or romantic partner is really trying to say. It shows a strong level of respect and a mutual level of understanding. Listening implies that trust has been established for maintaining a mature relationship. It means one can be vulnerable with one's thoughts and feelings with another person. Trust means to know that their communication is held in confidence. A healthy relationship means support in good times as well in times of trouble. Intimate love relationships help to maintain a balanced life without the individual developing a rigid and narcissistic personality.

Marriage and similar intimate relationships play a central role for enhancing strong mental and physical health benefits. Holt-Lunstad et. al.,(2010,p.7) review of 148 studies found that *"involvement in healthy relationships exceeds the risks for, mortality associated with physical inactivity, obesity, smoking, and even alcohol consumption*."

Other research (Sullivan & Fenelon 2013) supports the important impact a long-time love relationship has on the well-being of the partner. A phenomenon known as "widowhood effect" means that older adults who have lost a spouse have an increased risk of dying themselves. The risk appears to be the highest (66% greater) during the first three months following a death of a spouse (Moon et. al., 2013). The symptoms of "widowhood effect" are: increased anxiety, chronic sleep disturbances,

intestinal-digestive problems, personal loss of energy, increased physical illnesses, weight gain or loss and reported more bodily pains (Moon et al., 2013).

TLC approach suggests the counselor carefully review the level of relationship engagement. Those clients who have suffered a loss of a significant person are encouraged to increase use of personal hobbies, utilize family and friends for support, engage in community-church volunteer activities, and tutor children in local schools etc.

Nutrition-Health

"The knowledge that man is to be a temple for God, a habitation for the revealing of His glory, should be the highest incentive to the care and development of our physical powers. Fearfully and wonderfully has the Creator wrought in the human frame, and He bids us make it our study, understand its needs, and act our part in preserving it from harm and defilement." (White,1905, p.271).

TLC approach would also include the influential role nutrition has on the client's mental health. Without question, there is a considerable amount of research to support the relationship between nutrition and mental health. Several important research studies (Sofi et al., 2008; Gomez-Pinilla, 2008; Willis et al., 2009) have shown strong support for a Mediterranean style diet (e.g., whole grains, vegetables, legumes, fruits, nuts, seeds) has for significant reductions in Alzheimer's and Parkinson's diseases.

Selective changes in dietary habits have been found to lessen or even prevent many psychopathologies that may develop over the course of the lifespan. For example, researchers (Haddock & Poston, 2000; Owen and Corfe,2017) have found that a nutritionally healthy diet, as is found in the Mediterranean style diet, has strong implications for dealing with mental health issues and various kinds of mood disorders. As a result, a new field has emerged called nutritional psychiatry. Nutritional psychiatry believes that medication alone may not always be the solution to the treatment and prevention of mental illness.

Owen and Crofe (2017) has suggested from a review of cross-sectional and longitudinal nutritional studies that a highly processed diet commonly found in Western countries carries with it a much higher risk for developing depression and anxiety. A very interesting and prophetic statement by White (1976,p.110) indicates just how powerful the relationship is between diet and health:

"Many are made sick by the indulgence of their appetite. They eat what suits their perverted taste, thus weakening the digestive organs, and injuring their power to assimilate the food required to sustain life. The stomach is often made to do at one meal the work of two or three meals. So many varieties are introduced into the stomach that ***fermentation*** *is the result. This condition brings on acute disease, and death frequently follows."*

The negative relationship between fermentation in the stomach and mental health may result in a condition now known as auto-brewery syndrome (Cordell et.al 2021; Eske, 2021). Auto-brewery syndrome is the result of fermentation found in the digestive system. This is the consequence of consuming a diet rich in carbohydrates that produces a high level of gut fungi causing alcohol or ethanol to accumulate in the body. Several risk factors appear to be the overuse of antibiotics, high sugar and carbohydrate consumption (Eske, 2021; Malik, 2021). The cognitive and physical characteristics

of auto-brewery syndrome are brain fog, fatigue, dizziness, slurred speech, mood changes, delirium, headaches, nausea, vomiting, memory problems, and loss of concentration.

Dietary recommended changes to prevent auto-brewery syndrome include the elimination of white bread, white rice, flour, pasta, pastries, and high fructose corn syrup from the diet. The adoption of a Mediterranean style diet may help to prevent many debilitating mental health issues. The TLC approach for mental health would include a careful review of the client's dietary lifestyle.

Finance and the Family

"Train up a child in the way he should go: and when he is old, he will not depart from it." Proverbs 22:6

Money alone doesn't guarantee happiness or fulfillment but certainly can influence a person's health and mental stability. Consequently, financial satisfaction is a popular topic among researchers and practitioners in the fields of financial planning and counseling.

Financial turmoil and loss of employment is a significant challenge for the family's ability to cope and function. For example, Leitma (1980) found that financial hardship had a very distinct impact on the family's well-being. The child is often made the target of parent's displaced frustration and anger that was directly related to loss of family income.

One pattern that emerged as a result of family financial hardship was the age of the parent. Leitma (1980) has suggested that younger parents who were financially stressed were more likely to become physically and emotionally abusive toward the child. Specifically, mothers who attained only a high school education and became unemployed presented a greater risk for child abuse.

Further research suggests that marital discord, lack of job skills, less education are significant predictor variables for abuse of children in the home. A recent study by Lefebvre et.al.,(2017) reports there is very strong evidence for a relationship between childhood maltreatment, cognitive-emotional and economic hardship problems. Lefebvre and his team (2017) discovered that children living in families facing economic hardship were almost two times more likely to be involved in various kinds of childhood maltreatment compared to those without such hardships. Sadly, Lefebvre et.al., (2017) suggests that families with financial hardships were more likely to have children with delayed developmental progress, lack of cognitive maturity and difficulties handling academic pressures, and greater drug abuse.

Other studies (Roberts,1998; Welding, 2022) indicate that college students who experience financial stress at home are more likely to leave school prematurely and experience a higher degree of social problems, perceived loss of self-esteem, poorer mental health and physical health outcomes.

An important finding by Archuleta et.al., (2011) found that financial satisfaction and religiosity led to more stable homes and marriages. Using a sample of 310 married respondents from one U.S. Midwestern state, research was conducted to examine the association of financial satisfaction and financial stressors in a spouse's decision to stay married to the same person or leave the relationship. Those individuals with financial stability and satisfaction were more likely to say they would marry the same person again. Not surprisingly,

the relationship between financial stressors and marital satisfaction was negative. This means that as the number of financial stressors increased, the less likely individuals were to say they would marry the same person again. Archuleta et.al., (2011), discovered as the number of financial stressors increased, they were more likely to report lower financial satisfaction and a lower likelihood that they would stay with their partner. Religiosity played an important role for individuals reporting that they would be more likely to stay married even with financial stressors present.

The TLC approach suggests there is a need for psychologists, financial counselors, financial planners, marriage educators, financial literacy educators, and therapists to include an assessment of the family's financial health. It is clear there is an underlying relationship between financial health and marriage stability.

Career Satisfaction

"Transformation of character, purity of life, efficiency in service, adherence to correct principles, all depend upon a right knowledge of God. This knowledge is the essential preparation both for this life and for the life to come." (White,1905,p.409). "Whatever your hand finds to do, do it with all your might, for there is no planning or knowledge or wisdom in grave…;And also that every man should eat and drink and enjoy the good of all his labour, it is the gift of God." ; Eccl.9:10;Eccl.3:13

It is said that if you enjoy your work, you never have to work a day in your life. There is a wealth of studies supporting the relationship between career/job satisfaction and mental health. Positive work experiences seem to contribute to personal enrichment and opportunities to grow both professionally and encourage mental health stability. Furthermore, scripture teaches us to make use of our gifts, talents, and skills for the service of humanity thereby reducing egocentricity and selfishness *(Eccl.9:10;Eccl.3:13)*.

Leitma (1987) suggests there are several important family dynamic factors that may promote a child's work identity and commitment. The findings indicate that the best overall explanation for the son's ability to obtain a work identity/commitment is explained in terms degree of parental involvement, job satisfaction, and how the fathers defined work. Specifically, fathers who defined work as primarily as "hard labor" (laborious, tedious) or only as a means for "earning money" had sons who had lower work commitment/identity status. Same was true for fathers who expressed lower job satisfaction. Fathers who indicated higher parental involvement were more likely to have sons with high work identity status and were more likely to be work committed. Low parental involvement meant sons would achieve lower sense of a work identity. Parental involvement by the father had a strong influence on the son's work identity achievement and generativity as predicted by Erikson (1980).

Work significantly influences a person's self-esteem, ability to develop a positive affect and to achieve self-actualization. This has been found to be also true for those who perform volunteer work and provide altruistic services which seems to enhance positive affect and psychological well-being (Dietz, 2007). Zunker (2008) found those who view their work as a service opportunity were often able to improve their quality of life and reduced feelings of greed,

jealousy and egocentricity. Consequently, individuals who are career satisfied were often found to be healthier both mentally and physically.

Further studies indicate that working parents who can establish a strong work-home life balance was positively related to life satisfaction. A person's ability to find meaning in their work did not interfere with home life satisfaction. A positive relationship was found between both job and life satisfaction (Haar et.al.,2014). Further evidence for the significance for a work-life balance was found by Haar et.al.,(2014) to be negatively related to anxiety and depression across seven cultures: Malaysian, Chinese, New Zealand Marori. New Zealand European, Spanish, French and Italian. This was particularly true for societies that emphasized individualism and gender egalitarianism.

Research has indicated how career and work satisfaction has emerged as strong contributors to mental health. This pattern suggests that career and work satisfaction may serve as important factors to enhance positive mental health. Studies by Wiener et.al. (1981); Moreau & Mageau (2011) indicate that when workers have perceived autonomy at work it predicts work satisfaction and better psychological health, subjective well-being and lessens suicidal ideation. Researchers Wiener et.al. (1981); Moreau & Mageau (2011) confirms that when supervisors and colleagues perceived there is greater work autonomy and supervisor support there was greater work satisfaction and psychological health. Consequently, career satisfaction plays an important overall role for the TLC approach.

Family-Home Environment

"The restoration and uplifting of humanity begin in the home… The well-being of society, the success of the church, the prosperity of the nation, depend upon home influence." (White,1905,p.349).

Relationship between adverse childhood experiences and adult mental health have been well documented (Felitti et al.,1998;Hughes et. al., 2016; Nakazawa, 2016). A definitive study of home life and the impact of adult dysfunction on the psychological functioning of children has been reported by the work of Nakazawa (2016) and her Adverse Childhood Experiences (ACE) research. According to a book review by Clark (2017), Nakazawa's ACE study is "*considered to be the most wide-ranging and illuminating public health research of our generation*." Adverse childhood experiences have been a very meaningful way to examine the impact of the home environment on the psychological well-being of children. ACE scores have been predictive of drug usage, depression, suicide, and sexual promiscuity later in adult life as measure by the ACE inventory (Nakazawa, 2016).

Early childhood experiences can strongly influence later adult mental health. Adverse childhood experiences such as child abuse and dysfunctional home environments show strong cumulative relationships with physical and mental illness. The ACE score is based upon such factors as: 1) parents who are abusive—sexually and physically, 2) parental drug usage in the home, 3) a parent who is in prison, 4) loss of parent through death or divorced, and 5) exposure to violence in the home. These types of life home experiences and childhood trauma have an obvious negative impact on children's well-being.

Not surprisingly, ACE research has been found to have strong associations for a wide range of adult problems. Clark (2017) discovered individuals with ACE scores 4 or higher (0 to 10 scale) compared with those with none have a 1220% increased risk of suicide attempts, 1000% increased risk of intravenous drug use, 460% increased risk of depression, 430% increased risk of alcohol abuse, 400% increased risk of experiencing intimate partner violence, a 170% increased risk of multiple body symptoms,

430% increased risk of alcohol abuse, 400% increased risk of experiencing intimate partner violence, and a 170% increased risk of multiple body symptoms.

Furthermore. there is strong research evidence to support the relationship between a child's mental health, parental support with four types of parenting styles (Punamaki .et.al.,1997; Baumrind, 2013; Kerig & Wener,2014; Laff & Ruiz, 2019). For example, Baumrind (2013) found that authoritative parenting has shown to increase a child's feelings of personal competence, achievement, and self-confidence. The authoritative parent places reasonable and consistent expectations for a child's behavior. They treat them with respect and are responsive to their individual needs. The child enjoys the best mental health outcomes as adults when authoritative parenting is displayed at home.

Baumdrind (2013) also found that the authoritarian parent is very rigid and uncompromising with their child. They communication a message that is high in demanding obedience with low emotional support. Children are taught to obey or are disciplined harshly without the close emotional support. Consequently, children obey out of fear. They have children who suffer more from anxiety and low self-esteem and feel less competent as an adult.

According to Baumrind (2013), the permissive parent supports the emotional wellbeing of the child but lack the ability to set boundaries for their child. They tend to indulge their child but do not assist the child with self-regulation and self-control. They are lenient parents. They seek to show love by allowing the child freedom of choice but lack to impose control over the child's behavior. Children from permissive parents are often more rebellious and have problems with authority figures. On the other hand, Baumrind found that for some children will emerge as creative adults from this type of parenting style.

Lastly, the uninvolved or indifferent parent is neglectful of the child. According to Baumrind (2013), neglectful parents are not interested in the child's welfare, or giving any kind of emotional or physical support. The uninvolved parent is more likely to be self-absorbed with their own issues. The uninvolved parent is neglectful of the mental and physical needs of their child. This rejecting type of attitude often produces children who are delinquent, exhibit low self-esteem, lack self-control, and less competent with peers. They are more prone to be attracted to friends for support and nurturing.

For the counselor, this means that he/she will need to be well versed in family-home dynamics. The TLC approach will place a strong emphasis on the quality of the home environment and family mental health functioning. Parent-child relationships often determine the quality of the family-home environment. Such parental-child factors as attachment, bonding, trust, and responsiveness, are all potential factors that

can enhance or diminish the child's emotional and psychological well-being.

Positive family life experiences and healthy parental involvement are necessary for the development of a child's mental well-being. TLC approach would utilize parental family therapy, parent training classes, and individual counseling to enhance the mental health of children.

Conclusion and Application

Therapeutic Lifestyle Change as reviewed in this article appears to have an important impact on a person's mental health. TLC is a robust way to integrate such practices into the therapeutic approach to be used by counselors. The TLC approach avoids the over reliance of medication and places the emphasis on making significant lifestyle changes.

Ellen White's book *Ministry of Healing* (1905,p.365), has identified how important TLC is for mental health when she stated, "The more nearly we come into harmony with God's original plan, the more favorable will be our position to secure health of body, and mind, and soul." The original plan stressed natural environmental/home remedies rather than expensive drug treatments. The eight dimensions of wellness, as found on the Life Wheel, captures the essence of physical and mental health. The question was asked by Jesus to the paralytic "Wilt thou be made whole?"(John 5:6) is an invitation for each of us to submit to Him for complete spiritual, mental, and physical healing. As a result, we can safely declare "To make man whole" is the object of Christian medical and psychiatric care.

The author invites the reader to review and use the Life Wheel as an easy and direct approach to assess an individual's degree of satisfaction for each lifestyle component. The respondent is asked to rate their degree of satisfaction on a scale from 1 to 10. The inner most circle starts with 1 and increases with higher satisfaction to 10 for each ring that is shaded in by the client. Please refer to the appendix to review the Life Wheel. The Life Wheel is an adaptation of the Wheel of Life used by many life coaches.

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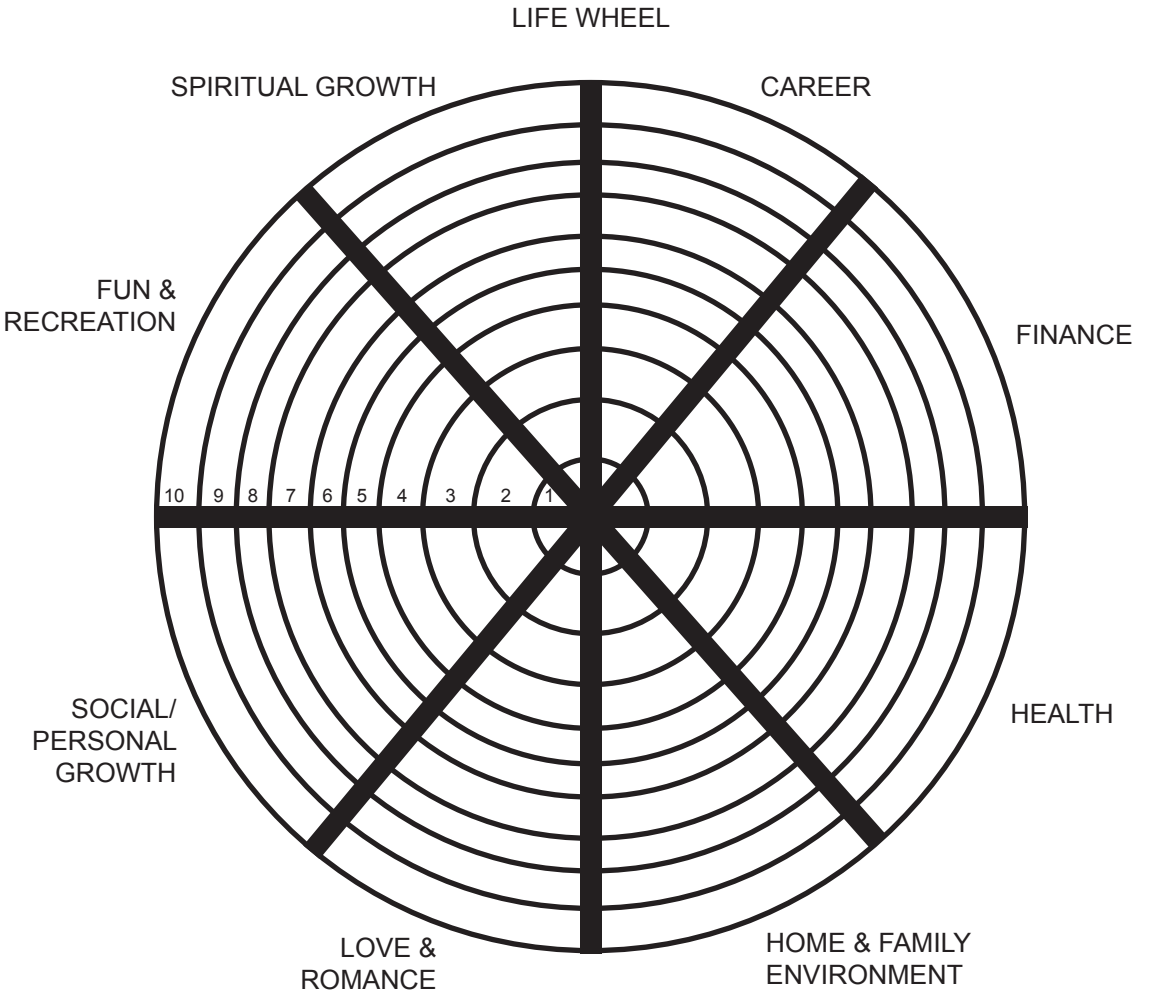
LIFE WHEEL'S EIGHT DIMENTIONS OF WELLNESS



SCORE FROM 1 TO 10
ON DEGREE OF SATISFACTION FOR EACH AREA

Karen Holford, MA Ed.Psych,
MSc Family Therapy, MA Lead

FAMILIES AND MENTAL HEALTH: GROWING CHARACTER, BUILDING BONDS, BALANCING EMOTIONS, AND LISTENING WELL - PROTECTING YOUR CHILDREN'S MENTAL HEALTH

Mental illness amongst children and young people has been increasing over the past decade[1]. Currently 1:6 5-16-year-olds in the UK have a mental health issue – that is 5 children in a class of 30. 52% of 17-23 year olds have also experienced an increase in mental distress in the last few years. Although there are many uncontrollable factors that can affect the mental health of children and young people, such as genetics, bullying, social media, abuse, pandemics, wars, and bereavements, families can still play a part by making choices that can reduce some of the risks of mental illness.

Some of the family factors that can help to protect the mental wellbeing of children and young people are bonding, loving kindness, and healthy attachment; positive discipline and parenting skills; developing character strengths; learning how to balance emotions; developing supportive relationships; active listening and communication skills; and daily checking-in with their experiences, emotions and needs.

Introduction

Fourteen-year-old Ellie is extraordinarily thin. Two years ago, she was bullied at school. For a joke, someone modified a photo to make her look 30 pounds heavier. Since then, she has been anxious about her weight. Her mom has tried everything to encourage her to eat. But she's thinner than ever, and now she's too tired to go to school.

David is ten. Ever since the COVID-19 pandemic he's become so anxious about going anywhere outside the home that he screams and kicks his parents whenever it is time to leave.

We live in an imperfect and broken world that has countless invisible effects on our minds and bodies. However much we do at home to support each other's wellbeing, we cannot control many of the external factors that can lead to distress, trauma and mental illness.

Mental illnesses are often complex, and they can develop from a combination of factors: genetics; environmental factors; traumatic life experiences; abuse; family beliefs and relational factors. Just as it is impossible to live a lifestyle that guarantees our physical well-being and health, it is also

impossible for families to develop lifestyles that will guarantee the mental well-being of a child, young person, or adult. However, parents can make healthy choices that will support the emotional well-being of their children and help to protect them against some of the risks and challenges of mental illness.

Begin before birth

Taking care of the emotional well-being of your children can start before conception. Are there patterns of depression, anxiety, addictions, schizophrenia, bipolar disorder, or any other serious concerns in your families? If so, what stories are there about how these illnesses developed, and how people cared for and supported those with mental illness? This useful information may help you to be proactive about caring for the mental health of your own family.

When Phil discovered that several men in every generation of his family had struggled with depression, he starting to learn more about the illness. Once he was better informed, he began to make wiser lifestyle choices for himself, and learn how to protect his own mental health. He also worked with a counsellor to explore some of the messages and beliefs passed on by his family that had contributed to other people's depression.

Grow in your understanding of God's loving care

An important way of caring for the mental health of your family is by ensuring that you have a healthy picture of God as loving, forgiving, and gracious. He is a Father who delights in you and your child, is always there for you, and who will never stop loving you. Immerse yourself in His infinitely amazing love for you so that you can be healthy channels of God's loving grace to your children. When children grow up knowing that there's nothing they can do that will ever change God's powerful and eternal love for them, they can feel safe and secure in His love, whatever happens to them. A healthy understanding of God helps to take away fears and anxieties (1 John 4:18) and nurtures the fruit of the Spirit in people's lives: love, joy, peace, patience, goodness, kindness, faithfulness, gentleness, and self-control (Gal 6:22-23).

If you have a choice, look for a supportive church community that is family friendly, welcoming, gracious, kind, blesses their community, and is intentional about involving people of all ages in their worship, including children and teens.

Prepare to parent well

Parenting is probably one of the most challenging tasks given to human beings, and yet it can also be one of the most enjoyable and rewarding experiences. Before becoming a parent, make sure that you are in good emotional, physical, spiritual, and relational health. Bonding with your unborn baby can start as soon as you are aware of the pregnancy. Pre-birth, consider attending a marriage retreat to strengthen your couple relationship and enrol in a parenting seminar that focuses on parent/child attachment and loving, gentle approaches to childcare and discipline.

One of the most helpful ways to support the emotional well-being of a child, is to provide good emotional and relational support for the child's mother[2]. When she feels supported and understood, and she is in a safe, kind, and caring relationship, she is better able to bond with her child. She is also more likely to make bright and positive

eye contact with the baby, be playful, comfort the baby when he or she is upset and respond quickly to the baby's needs, reducing the child's distress and anxiety. These are a few ways in which the parents' early relationship with the baby can develop healthy patterns of thinking and bonding in the child's brain.

Understand children's development and behavior

It's also important to earn about child development so that you know what to expect from your child at different stages in their development. This will help you to be realistic about what a child might be able to do, or what they will struggle with until they have reached that level of development. One Jewish parent said, 'We think of children as learning how to behave until they are 12. We try to make this learning a happy experience! If a child struggles with an aspect of their behavior, they are not being naughty, we just need to find a better way to love them, listen to them and teach them!'

When children struggle to manage their behavior, it is often because they are dealing with a complex muddle of powerful emotions. Harsh punishment can add even more distress to their world and make it more difficult for them to behave in the way that we might expect. When a child loses control of their emotions and behavior, they usually need a parent to be present and calm and help to soothe their distress. Once the child is calm, listen to their story (see the section 'Listen well'), identify their physical needs (food, water, sleep, calming environment, playful interaction, etc.), understand their relational needs (see the section 'Create warm and loving bonds'), and help them to explore their emotions (see the section 'Help children to manage their emotional balance').

The best discipline is warm and loving and follows a time of strong relational connection and comforting between the parent and the child. The discipline then involves creating and understanding behavioral boundaries and using logical consequences, because they are important lessons for life. If they break something, they need to work to pay for it or help to fix it. If they miss chores one day, they need to do double chores the next day. When parental discipline makes sense, and is related to their behavior, it is much more meaningful and effective.

Nurture your child's character strengths

A worldwide research project into the character strengths valued by almost every culture, highlighted twenty-four character-strengths that we can nurture in our children. Amazingly, all these character strengths describe the character of God! The more character strengths a person has, and the more they use and develop them, the happier and more resilient they are likely to be (2 Peter 1:5-8). Character strengths are like tools in the toolbox of life. The more tools a person has, and the stronger or sharper they are, the better they are equipped to meet the challenges, tragedies, setbacks, and traumas that they will face in life.

The character strengths have been listed under six main categories:

1. Wisdom: creativity, curiosity, open-mindedness, love of learning, perspective.
2. Courage: honesty, bravery, persistence/patience, enthusiasm.
3. Humanity: kindness, love, social intelligence.

4. Justice: fairness, leadership, teamwork.
5. Temperance/restraint: forgiveness, modesty, prudence, self-regulation.
6. Transcendence: appreciation of beauty, gratitude, hope, humor and spirituality.

Once we are aware of the main character strengths, it is easier for us to notice them and affirm our children and teens when they have made good choices. Each time we do this, we are taking small steps to develop their character and protect their mental health[3].

We can start to nurture character strengths in our children from a very young age, even before they can understand the words, because they will still experience the positive reinforcement from a loving parent, such as a smile, encouraging words and a warm hug. However, the younger the child, the more immediate the reinforcement needs to be, so that the child makes a clear connection between their positive behavior and choices, and the parent's affirmation.

Two-year-old Billy is building a tower of bricks. The tower tumbles, and he calmly picks up the blocks and starts again. He does this several times until he is pleased with his building project. He sits back on his heels and beams at his mother. She smiles back and holds out her arms for a cuddle. 'Billy, well done for being so patient when you were building your tower! Even though it fell down several times, you kept trying, and starting again, until you made the tower you wanted! That's what it means to be patient.' Billy may not understand everything mommy said, but he knows he has made a good choice, and he is beginning to learn what 'patient' means.

Once we know the list of key character strengths, we can easily spot our children making good choices, and encourage them straight away. This is much better for the emotional wellbeing of the child, than only noticing and responding to their misbehavior. A good way to nurture character strengths in older children is by telling them which character strengths you saw them using during the day. It is very calming and reassuring for a child to fall asleep thinking about what they did well, rather than thinking about all the mistakes they made. You can also write out the character strengths on a large heart or star for your child to keep by their bed. They can look at the words and think about which character strengths they used during the day, and which ones they would like to work on tomorrow.

Try exploring some of the characters in the Bible who used these strengths. Abraham, Sarah, Joseph, Moses, and Job were patient. Noah, Moses, Joshua, David, Daniel, and Esther showed bravery. Weave these stories into creative and inspiring moments of family worship. Act out the story, discuss the character's feelings and choices and think about how they might have developed this trait during their life. Help your children to notice which people in their story books, films and TV shows use these character strengths, and what happens when they do. Encourage them to create posters, artwork, poems, and stories about character strengths. The whole family can work together on developing a character trait, such as creativity, teamwork, kindness, or gratitude, etc. so that children see their parents developing character strengths too. It is the work of a lifetime! 'Every act of life, however unimportant, has its influence in forming the character. A good character

is more precious than worldly possessions, and the work of forming it is the noblest in which men can engage.' Ellen G. White, 4T 657 (1881).

Help children to manage their emotional balance

We live in a very unbalanced world, with pandemics, lockdowns, wars, violence, abuse, and unexpected disasters. However, we can learn how to balance our emotions, and teach our children how to balance their theirs[4]. This helps them to develop emotional resilience. There are 10 common emotions that tend to leave us feeling drained and depleted (these are called 'negative' emotions because they subtract our energy): anger, contempt, disgust, embarrassment, fear, frustration, guilt, sadness, shame, stress. There are also 10 common emotions that tend to leave us feeling uplifted and energized (these are called 'positive' emotions because they increase our energy): amusement (when something makes us smile or laugh), awe, gratitude, hope, inspiration, interest (having a positive and distracting hobby), joy, love/kindness, peace, and a sense of purpose and value.

Most people tend to have a 2:1 ratio of positive to negative emotions. But the research suggests that a healthy baseline is closer to 3:1, and that we need even higher ratios to enable us to flourish. However, if the ratio is too high, we may have lost contact with reality! The goal is to balance our emotions wisely, rather than eliminate all our negative emotions, which is impossible.

The concept of balancing our emotions is important because we can 'choose' to experience some of the positive emotions that will help to prevent us from being tipped over into unhealthy levels of negative emotions. This is not a new concept, because the apostle Paul teaches these skills in Philippians 4. Paul is in prison, awaiting a horrific and public execution at any time. Humanly speaking, this is an exceptionally challenging life experience. However, Paul has been through many difficult situations which have developed his resilience (2 Cor. 11:24-28). Writing to his friends in Philippi, he shares some of his 'secrets' for remaining emotionally balanced:

- Choose to rejoice in God, because whatever is happening, God is always good (Phil 4:4).
- Be kind to others, because when we are kind it usually makes us feel good too (Phil 4:5).
- Instead of being anxious, be thankful to God (Phil 4:6). Gratitude is an antidote to anxiety because our brains can't be anxious when they are being grateful.
- Choose to live in God's peace (Phil 4:7), perhaps by spending time in nature and His creation.
- Focus on positive thoughts instead of negative ones – imagine putting negative thoughts in the garbage and choosing to focus on lovely and positive thoughts from a 'treasure box' of messages, Bible verses and uplifting thoughts (Phil 4:8).
- Learn to be contented with your circumstances – there are blessings in more places than we imagine (Phil 4:11-12).
- Paul concludes his list by encouraging his readers to put these lessons into practice (Phil 4:9).

Life is unpredictable and we will experience a full spectrum of feelings. When sad things happen, we can acknowledge the

sadness, because it is important to grieve and be comforted, and we can also choose to engage with some positive emotions whilst we are going through our grief and sadness, as part of the healing process.

We can teach our children to choose uplifting emotional experiences that will help them to rebalance after a painful or tiring day. Here are a few ideas[5]:

- Joy – do something enjoyable together like playing a game, going to their favorite place, or making their favorite meal together.
- Amusement – tell each other funny stories, share appropriate cartoons, watch short videos of funny animals, pull funny faces, or race to see how can put on the weirdest outfit.
- Hope – plan something fun to do together very soon and follow through on the plans.
- Gratitude – list some things you are thankful for that begin with each letter of the alphabet. Or send everyone to find three things that fill them with gratitude.
- Interest – help your children to find an absorbing hobby they can do at home, at any time, which can distract them from anxious and negative thoughts.
- Peace – listen to peaceful music, do quiet activities together, go for a walk and listen to all the sounds in nature, or blow bubbles, because the breathing involved in blowing large bubbles naturally calms the body and mind.
- Sense of purpose – help children to find something that they can do well, and to have a sense that they are valuable and make positive differences to their world.
- Wonder – pause and help your child give their full attention to something God has created. Watch sunsets and stars, and notice the different pattern of bark on the trees, etc.
- Inspiration – provide opportunities for your child to be inspired by God, and by the amazing things that humans can do – science, art, music, sport, etc.
- Love and kindness – help your child to do kind things for other family members and friends

Other ways to support children's emotions

- Ensure that your children have a broad vocabulary of feeling words so that they can express their emotions and describe them to others, rather than acting out their emotions.
- Check how they are feeling at least once a day. A simple way to do this is by asking questions during the evening or at bedtime, such as: 'What made you happy/afraid/sad/laugh/stressed, etc. today?' 'What are you most thankful for?' 'What filled you with wonder?' 'How was someone kind to you?' 'What was the kindest thing you did?' 'What was your greatest achievement?' 'What did you discover today that surprised you?'
- Tell your children stories about how you managed one of your draining emotions during the day, such as stress, fear, sadness, anger, or disappointment. This helps them learn

techniques for managing similar situations in their own life.
- Encourage children and young people to solve their own problems. Be there to support them in their discovery and be careful not to take control and fix their life for them. Discuss options with them, help them to search the internet for possible solutions, affirm their good choices, and be there to comfort and listen to them when something doesn't turn out as they hoped.

Explore emotions with an 'emotional pie'

- It is useful for parents to have a simple way to explore feelings with children and teenagers. An 'emotional pie' can help them to express themselves, especially as they are not always aware of what they are feeling, how they show those feelings, and what they would like others to do, or not do, when they experience some of those feelings.
- An emotional pie is a pie chart that can express our different emotions. Each 'pie' slice can show how much of each emotion we are experiencing. Creating an emotional pie can help others to understand our inside feelings, how we show them, and how other people can help us with our emotions.
- Draw a large circle on a sheet of paper – this is the 'pie'.
- Make a list of 'emotion' words with your child.
- Show them how to make a pie chart of feelings. If they are feeling a 'quarter' happy, then draw lines to create a pie slice that is a quarter of the pie. Let them color in the 'slice' with a marker or crayon of their choice and label the slice 'happy'.
- Ask them to describe how other people could tell that they were happy, and how they like other people to respond when they are happy.
- Create slices for the other emotions they are experiencing, such as sadness, fear, excitement, peacefulness, etc.
- This can be done with people of any age. You can also ask children to guess what your emotional pie might look like, and draw it, and you can guess theirs.
- At a deeper level, with older children, you might also ask, 'So this is your inside pie, the feelings that you have inside you. What emotions do you show on the outside? If you made a piecrust 'lid' for the pie, what might it look like in terms of emotions, and how much of each emotion you are feeling?
- An alternative way of making an emotional pie is by cutting several circles of paper in different colors. cut each of these circles into different sizes of pie slices. Let your child decide which color represents which emotion and invite them to use the colored slices to create their unique emotional pie. They can include two slices of the same color to indicate when they have a larger 'slice' of that emotion.

Create warm and loving bonds

Experiencing healthy relationships is an important dimension of emotional

wellbeing. Even before the fall God told us that we needed to be there for each other and that it was important for us to take away each other's aloneness (Gen 2:18).

Today there is plenty of researched evidence that emphasizes the importance of babies and children experiencing healthy bonding and attachment6. Love is being intentional about building healthy bonds with each other and caring for each other in ways that reduce aloneness and alienation. Loneliness is widespread and leads to a wide range of physical and mental health issues. Even when we live in the same house, we may not always be aware of each other's loneliness and the deep sadness it can cause.

Paul encouraged the early Christians to be intentional about putting love into action and finding ways to uplift, comfort, appreciate, respect, support, protect, value, and accept each other, as well as to pay attention to each other, and to be kind to each other. All these actions that we do for 'one another' are different ways to show love and different ways to bond with each other.

Peter and Cherry decided to create each one of these bonds with their children every day. They looked for opportunities to encourage, comfort, thank and bless their children in each of the ways listed below, with a simple, warm comment, and a little more patience. They soon discovered that their children were happier and needed much less discipline than ever before! Peter said, 'Whenever I wasn't quite sure which loving bond the children needed most, I imagined that I was looking at their hearts through God's loving eyes. I asked Him to help me see their needs as He saw them. It always helped!'

- Encouragement (1 Thess 5:11) – being your child's cheerleader, regularly affirming their effort rather than their achievement, reminding them of past successes, and saying I believe in you!'
- Comfort (Rom 12:15, 2 Cor 1:3,4) – listening quietly, saying 'I am so sad for you that this happened', offering hugs, and asking how you could comfort them best.
- Appreciation/gratitude (1 Cor 11:2, Phil 4:14-16) – appreciating what your child has done well is a more effective way of helping them make positive changes than nagging them about their mistakes and imperfections. Thank them as often as you can and find fun ways to let them know they are appreciated.
- Respect (Rom 12:10) – relating to our children respectfully and treating them as Jesus treated children (Matt 18:2-4). Speaking calmly, quietly, and politely to them, and offering them simple choices.
- Support (Gal 6:2) – training your children in practical life skills so that they know how to deal with life's needs and emergencies, working alongside them to tidy their room and teach them how to organise their things, and regularly asking what you can do to help them.
- Protection (1 John 4:18) – making sure your children feel safe, protecting them from harm and danger, encouraging them to tell you about their fears, and supporting them when they face challenges and bullies.
- Value (Mark 1:11) – treasuring your children and letting your

them know that they bring you joy and delight.

- Acceptance (Rom 15:7) – accepting your children, no matter what they have done, especially when they have made a big mistake, or hurt you, or are being rejected by others. We are to accept each other as Jesus has accepted us, which is as totally and completely, as the loving father welcomed his wayward son (Luke 15:11-32).
- Focussed attention (Phil 2:3-4) – giving our children our full attention, putting away our phones, joining them in joyful play, listening carefully for the emotional and relational needs underneath what they are saying.
- Affection and kindness (Eph 4:32) – showing them love and kindness in ways that bring them joy. Ensuring that they never need to wonder if you really love them.

Each time we relate to our children in kind and nurturing ways, we help to develop their emotional and relational resilience. However, when we do the opposite actions, such as ignoring, criticising, judging, abusing, shaming, hurting, despising, and rejecting our children, we can undermine and damage their emotional resilience.

Listen well

Good listening is a gift that supports your child's emotional wellbeing. It involves your ears, eyes, mind, mouth, heart, and hands. Get down to their level if they are small, or hold them on your lap, sit at a table together, or drive your teen somewhere they want to go. Focus on their face and their eyes so they know they have your full attention. Listen, really listen with your ears, to what they are saying. Think about their words, reflect on them in your mind, be curious and ask more questions to show that you have thought about what they said. Listen to their emotions with your heart, and respond warmly to the feelings, they are experiencing, rather than reacting critically to their words. Think about the different relational needs that your child might have, and what you could do to meet them (see previous section on creating warm bonds). Finally, ask what you can do to help them and support them (with your hands).

When we listen with our eyes, ears, mind, mouth, heart, and hands, we listen in ways that help and heal our children's minds and hearts. When they know that we will listen with warm acceptance, even when they have made mistakes, and when we do what we can to support them in their little troubles, they will be more likely to talk to us about their bigger concerns, fears, and hurts. One Adventist family told their teenage children, 'If you are ever struggling, or you find yourself in a difficult situation, we will always be here for you. We want to be the first people to know, so that we can love and support you. If you are struggling with an addiction, unsure about your sexuality, pregnant, or in trouble with the law, or anything like that, please know that we will always accept and love you.' This helped to reassure the children that they could talk to their parents about absolutely anything.

Time for bed!

Bedtimes are a good time to wind down with your child. Make the time gently fun as you bathe and dress them. Laugh at something silly or funny together. Read small children a reassuring and calming story

from their favorite book or Bible story. Pray simple, short, and caring prayers that lower their anxiety. Debrief the day and tie up any emotional loose ends. It is important for you to take the initiative to resolve any conflicts or disruptions to your relationship with your child or teenager, because current research illustrates the importance of parental warmth on high conflict days7. Also, when we sleep on unresolved conflict or broken relationships the pain goes deeper into our minds and this can lead to anxiety and depression.

As a parent you can comfort their sadness, delight in their joys, share their moments of wonder at God's creation, or a kindness from a friend. You can talk about where you saw your loving Father in heaven at work in your life and community and ask where they experienced God's love during the day. Thank God together for at least three things. Affirm the character strengths you have noticed in your child during the day. And, when they go to sleep, they will know without the shadow of a doubt that they are loved and treasured by you and by God.

When your child is distressed

Even when we do our very best to support our children through the ups and downs of life, we are all at risk of struggling with our mental health from time to time. If you notice behavioral changes in your child, such as changes in eating patterns, signs of distress and sadness, disrupted sleep patterns, strong fears, a loss of energy or appetite, angry responses, social withdrawal, etc. talk to your child and listen to their story. Find out what's troubling them. Talk to their teachers and doctors and share your concerns. It is important to get help as soon as possible so that their suffering can be relieved, and their patterns of behaviour and thinking can be adjusted before they become too established. Visit the website www.handsonscotland.co.uk for help with many signs of mental distress experienced by children and teenagers.

Taking care of you

As parents we can easily feel overwhelmed by our responsibilities and feel guilty that we are not doing enough to support our children in these anxious times. These are just a few simple ideas that many parents have found helpful. Every time you choose to do one of these activities, you are helping to protect your child's mental health by nurturing their character, their value as a beloved child of God, and their resilience.

Use what you have learned from this article to help yourself too, and notice what you are doing well. Every evening take time to pause, thank God for His love and support during the day, identify three things you have done well as a parent, and perhaps one thing you will do differently tomorrow. You are God's child, and you are also co-parents with God of your own child. Feel His hug of love around your heart, so that you can pass it on to your children. He cares for your mental health as well as your child's and He will never leave you nor forsake you (Deut 31:8).

Closing prayer

And, finally, 'This is my prayer: that your love may abound more and more in knowledge and depth of insight, so that you (and your children) may be able to discern what is best and may be pure and blameless for the day of Christ, filled with the fruit of righteousness that comes through Jesus

Christ – to the glory and praise of God
(Phil 1:9-11, NIV)'[8].

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HEALING A BROKEN SPIRIT

Abuse of any kind as well as significant losses such as death of a loved one can result in a broken spirit (Proverbs 15:13, 17:22). However, we have a wonderful God who heals the brokenhearted and binds up their wounds (Isaiah 51:3). He often leads us into communities where we can experience being seen, soothed, safe, and secure. This chapter describes the experience of brokenness and the process of healing integrating both biblical and interpersonal neurobiological perspectives.

What is the human spirit? This question is of vital importance to understand the topic of healing a broken spirit. Ellen G. White gives valuable guidance in defining the human spirit when she says, "The spirit, the character, returns to God, there to be preserved" (6 BC 1093). In this quotation, she equates the spirit with one's character, the essence of human beings. In 5T 310, she further elaborates, "The thoughts and feelings combined make up the moral character." So, as we explore the wounding of the spiritual part of humans, we must examine our thoughts and feelings. Our spirit also connotes the human heart, both conscious and unconscious. When we humans are intimate with one another, we share the deepest parts of ourselves, our thoughts and feelings, joys and sorrows, dreams and disappointments, successes, and defeats. The Holy Spirit often brings to our conscious awareness things that have been hidden in the unconscious heart so that we can begin processing them. When our spiritual selves are safe with and connected to God, we share our deepest thoughts and feelings with him, both the good and the bad, which is the ideal. Prayer is meant to be a time of intimacy with God, not just a time of asking for things from him. However, Satan attempts to interfere with this intimacy by creating spiritual brokenness within us.

Scripture offers a detailed physiological description to help us to understand what happens when this spiritual brokenness occurs. Proverbs 17:22 tells us, "A merry heart is good like a medicine, but a broken spirit dries the bones." When a person's spirit is broken through trauma or abuse, the bone's capacity to produce bone marrow is diminished. A 1998 study by Diane Pappas, MD, JD, reveals that emotional abuse is a factor in the depletion of the production of red blood cells (Diane Pappas, "Iron Deficiency Anemia," Pediatrics in Review 19 (1998) 321-322). The Bible clarifies that "the life of the flesh is in the blood" (Leviticus 17:11, KJV).

The blood is produced in the marrow of the bones.

Have you ever observed the behavior of an abused animal? Adam Katz, a professional dog trainer, on his website, defines an abused dog as "any dog that shows specific

signs of extreme timidity in response to regular behavior by you." He also reports that abused dogs are confused and engage in fleeing, fighting, or freezing behavior (Katz, 1999). It is frequently the same with abused or traumatized people. Repeatedly, we have worked with people who have not only been mentally depressed but physically ill due to traumatic experiences that have led to a broken spirit. A woman we worked with experienced the trauma of losing both parents before the age of six and was sexually abused by her brother from the age of three until the age of thirty. As a result, she developed a death wish, a term used for an unconscious desire to die, with no conscious plan to commit suicide-the ultimate manifestation of a broken spirit. After several unsuccessful suicide attempts, she slowly began overeating, which would produce the ultimate result-death. In her early thirties, she developed lupus, an autoimmune disease in which the body gradually destroys itself-a death wish physically manifested.

Childhood reactions to trauma and abuse are not limited to the early years of a child. Ellen White elaborates, "By the thoughts and feelings cherished in early years every youth is determining his own life history. Correct, virtuous, manly habits formed in youth will become a part of the character and will usually mark the course of the individual through life" (CG 196). It is the responsibility of parents to model the life and love of Jesus to their children through instructions and interaction with them. When children are positively affirmed and given copious amounts of time and attention, they experience and come to know that they are valued. They develop a positive identity unrelated to what they do or how well they perform. When children have a sense of being seen and soothed by parents, they feel safe and secure in themselves and their parent's love for them (Thompson, 2021, p. 31). They develop a secure attachment to their parents and can then develop secure relationships with others and God. A broken spirit results from insecure attachment to parents, and the negative sense of self developed through neglect, and negative, shaming messages the child may hear. If children are neglected or poorly treated, the narrative may be "Something must be wrong with me" The negative and shaming messages spoken to the child include (but are certainly not limited to), "You are stupid!" "You are damaged goods; no one would ever want you!" "You are too fat, skinny, dark, tall, short, etc." Based on parental mistreatment and what parents may say, children will internalize into their hearts the messages or treatment, with significant results, and create a narrative that attempts to make sense of their experience. Parents are the first glimpse of God to their children. Since young children have no capacity to filter out the truth of who God is from parents, toxic messages or neglect and abuse become associated with God. Shaming messages are particularly heinous because they lead the child to question their value and worth, which may lead to beliefs that trigger toxic stress with its harmful effects.

Toxic stress is the body's response to severe prolonged stress without enough support from a primary caregiver (Burke-Harris, 2018). The Adverse Childhood Experiences (ACEs) study (Felitti, et al, 1998) provided a groundbreaking picture of the harmful effects of toxic stress on physical, emotional, and behavioral health. Dr. Vincent Felitti, one of the primary architects of the study,

had been the director of a successful weight-loss clinic run by Kaiser Permanente Hospital in San Diego, CA. Patients lost weight successfully, but upon six-month follow-up interviews, they had regained the weight. Dr. Felitti reported that childhood sexual abuse was one factor he uncovered in these interviews. This one factor changed his approach because he began to see weight gain as a symptom rather than a problem. He and a team of researchers began to think of adverse childhood experiences that might also be traumatic. They designed the ACE study in conjunction with the Centers for Disease Control.

The original ACE Study was conducted at Kaiser Permanente from 1995 to 1997 with two waves of data collection. Over 17,000 Health Maintenance Organization members from Southern California received physical exams and confidential surveys regarding their childhood experiences, health status, and behaviors. The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the most extensive investigations of the link between various types of childhood trauma and later-life health and well-being. The original ACE study included physical, emotional, and sexual abuse, neglect of basic needs, and experiencing domestic violence, divorce, mental illness, addiction, or imprisonment in parents. These ACEs are called household ACEs. Since then, the categories of ACEs have been expanded to include community ACEs such as poverty, racism, substandard schools, or generational oppression. A final category of ACEs is environmental ACEs, such as trauma connected to wildfires, floods, tornadoes, hurricanes, or other natural disasters.

Felitti's original study reveals that ACEs are common. Almost two-thirds of the participants in the sample reported one ACE, and 20% reported three or more. 28% of study participants reported physical abuse, and 21% reported sexual abuse. They also found that ACEs cluster. Almost 40% of the Kaiser sample reported two or more ACEs, and 12.5% experienced four or more. Because ACEs cluster, several subsequent studies now look at the cumulative effects of ACEs rather than the individual effects of each. As researchers followed participants over time, they discovered that a person's cumulative ACE score has a strong, graded relationship to numerous health, social, and behavioral problems throughout their lifespan, including substance use disorders.

As the number of Adverse Childhood Experiences grew from one to three, each of the adult health risk behaviors and diseases studied increased. Persons who experienced four or more categories of childhood ACEs, compared to those who had experienced none, had 4-to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt. They also had a 2-to 4-fold increase in smoking, poor self-rated health, 50 or more sexual intercourse partners, sexually transmitted disease, and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity.

The number of adverse childhood exposure categories showed a graded relationship to the presence of adult diseases, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. The categories of adverse childhood experiences were strongly interrelated, and persons with multiple types of childhood exposure were likely to have multiple health risk factors later in life. There are also relational

patterns, such as losing oneself in relationships, emotional reactivity, frequent arguments, domestic violence, hiding, not being open or vulnerable, and social isolation.

Before we begin discussing the healing of a broken spirit, we see another essential biblical concept found in Proverbs 15:13. "A glad heart makes a cheerful face, but by sorrow of the heart the spirit is broken" (NIV). We commonly associate sorrow of the heart with grieving the loss of loved ones. Still, anyone can experience grief at any age, not only in relationships, but a plethora of other losses such as the loss of possessions, bodily functioning, health, one's virginity, or even a relationship with an addiction. An example of a broken spirit related to death is my (David's) parents. My father died at the age of 95. My parents were married for 70 years, and my mother was 90 years old. She died ten months after my father, and during those ten months, she often was heard lamenting my father's death, wishing she could go to be with him in death. She missed my father after being married for so long and grieved to the point that she gave up on life.

Now that we have discussed various manifestations and causal factors related to a broken spirit, we want to focus on healing a broken spirit. It is essential to understand that there is typically no instantaneous cure for a broken spirit (of course, God can and does perform miracles). Instead, healing is usually a process that unfolds over time. Healing of a broken spirit is not something that is done to a person but with a person. God respects our freedom to choose so much that he does not heal without a person's consent or willingness to be healed. This God-given freedom implies that a person must be willing to face their pain rather than avoid it. Pain avoidance is a natural human response as old as Eden itself. Since a broken spirit results from trauma, we naturally want to feel better, so we shut off our feelings to avoid the pain or actively try to medicate the pain through some addictive process. Therefore, a comprehensive approach is necessary for complete healing. The healing process described below must address the wounding event. Our healing requires reprocessing our responses to the trauma, including conscious and unconscious heart responses, the shame-based lies we believe, and the survival mechanisms programmed into our brain.

The first step on the healing journey is to embrace our story, both the positive and the painful elements. Our first instinctive response to painful memories it to forget them. "What is forgotten is unavailable, what is unavailable cannot be healed" (Nouwen, p. 22). For many years, I (David) viewed my story through rose-colored glasses. I idealized my family because I internalized the message from my family that we had to be perfect and better than other families. I was in denial of the dysfunctional state of my family. If anyone pointed out a flaw in my family, I would automatically become defensive and deny what I interpreted as a false accusation. After I began my healing journey, I could honestly face the truth of my family's imperfections and brokenness, as well as my own. From my own experience, I learned to be patient with others who, for various reasons, have difficulty seeing the reality of their own stories. "Forgetting the past is like turning our most intimate teacher against us. By refusing to face our painful memories we miss the opportunity to change or hearts and grow mature in repentance" (Nouwen, p. 21). The

more we can see our stories objectively and accurately, the more we can see our need for healing.

It takes courage to face the truth of our brokenness. We recommend that we first write out our stories after we pray the prayer of Ps. 139:23-24, "Search me, O God, and know my heart! Try me and know my thoughts! And see if there be any wicked (hurting, anxious, grieving) way in me, and lead me in the way everlasting!" You can be assured that if you ask God to reveal your brokenness to you, he will do so as soon as you are emotionally ready to handle the reality of your story. We often see this revelation occurring in the 30s and older because individuals consciously suppress or repress painful memories. Writing out your story instead of typing helps make brain connections, and memories come that might not otherwise come when the pen is put to paper. For a person working a 12-step program, the story can be done as part of a Fourth Step Inventory.

Once the individual is satisfied the story-writing is complete, sharing our stories with another safe person such as a counselor, a sponsor, or a pastor/chaplain is the next step. Getting involved in a small group provides another significant, safe opportunity for sharing and processing our stories. Our greatest fear is that if others knew us, they would reject us. We also fear that once we start crying, we will never stop. When we are vulnerable with others and do not experience rejection but an acceptance and loving embrace, the journey of healing our brokenness can begin. When others share their stories in a safe setting, we hear elements of our own stories in what others share. Memories come back that we can more easily embrace. Our stories become normalized when we learn that we are not alone. We are not the only ones to have suffered that pain. Tears may come and in a group setting, to experience the comfort and encouragement of others as we cry is a balm to our hurting hearts. To have others stay on the journey with us, with no time frame as to how long one "should" cry, is transformational in that we have the presence of Jesus in the person of others with us.

The power of healing originates in God, not man. Psalm 147:2-3 states, "He gathers together the outcasts of Israel. He heals the brokenhearted and binds up all their wounds." God is the healer. Healing the brokenhearted was embedded in the mission statement of Jesus found in Luke 4:18-19, "The Spirit of the Lord is upon me, because he hath anointed me to preach the gospel to the poor; he hath sent me to heal the brokenhearted, to preach deliverance to the captives, and recovering of sight to the blind, to set at liberty them that are bruised, to preach the acceptable year of the Lord" (KJV). As the Healer, Jesus gave his disciples the power to heal (See Matthew 10: 1). We may access his healing power through prayer, through connection with the indwelling Holy Spirit. Healing involves retrieving our wounds from isolation and connecting them to the suffering of God himself: What a glorious privilege we have to be used as instruments of healing to connect a hurting individual with God. (See Paul Coneff's excellent work "The Hidden Half of the Gospel). The Holy Spirit guides when we ask (James 1:5). We often minister to people and have no idea how to proceed. Our intimate connection with the Holy Spirit enables us to hear His voice and follow His promptings.

Making time to pray before, during, and after a healing encounter is vital. Before beginning a prayer ministry, connecting with God, and asking for guidance is essential. During the healing ministry, prayer is needed for openness to God's leading the healing process. Finally, a prayer of thanksgiving upon completion of the intervention is appropriate. Inviting the person to pray openly and then joining the person in prayer is what we suggest (Wardle, 2003). Ellen White gives the following words of encouragement, "Through all our trials we have a never-failing Helper. He does not leave us alone to struggle with temptation, to battle with evil, and be finally crushed with burdens and sorrow. Though now He is hidden from mortal sight, the ear of faith can hear His voice saying, Fear not; I am with you. "I am He that liveth, and was dead; and, behold, I am alive forevermore." Rev. 1:18. I have endured your sorrows, experienced your struggles, encountered your temptations. I know your tears; I also have wept. The griefs that lie too deep to be breathed into any human ear, I know. Think not that you are desolate and forsaken. Though your pain touch no responsive chord in any heart on earth, look unto Me, and live. 'The mountains shall depart, and the hills be removed; but My kindness shall not depart from thee, neither shall the covenant of My peace be removed, saith the Lord that hath mercy on thee'" (Isa. 54:10). DA 483

The Healing Power of the Word of God

Another essential element of healing a broken spirit is recognizing and using the healing power of the Word of God. The Bible is filled with healing passages that can be spoken into the heart of a hurting person. Often, as we have worked with broken persons, the Holy Spirit has impressed us to use a particular Scripture and speak it into the person's heart. The value of putting healing Scriptures to memory cannot be overstated. The Holy Spirit has a fantastic way of bringing His Word to life when it is used as a part of a prayer ministry. "For the word of God is alive and active. Sharper than any double-edged sword, it penetrates to dividing soul and spirit, joints and marrow; it judges the thoughts and attitudes of the heart" (NIV).

Personalizing the scripture you are using is not a misuse of the Bible. For example, using a verse such as Isaiah 51:3, "For the Lord shall comfort Zion: he will comfort all her waste places; and he will make her wilderness like Eden, and her desert like the garden of the Lord; joy and gladness shall be found therein, thanksgiving, and the voice of melody" (KJV). When we use this verse asking for comfort for "Zion," we substitute the name of the person in the verse. Zion refers to God's people, not a place. Places do not need comfort, people do. When we ask God to "comfort all her waste places," we ask the person to either silently or verbally to identify the hurts and wounds that they know need comfort. Again, these wounds are found through the ministry of story. After the individual verbalizes the wounds, we pray for comfort in those hurting places using the promise of 2 Corinthians 1:3-5 "Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God" (NIV).

After we pray for comfort, we continue, "and he will make her wilderness like Eden, and her desert like the garden of the

Lord." Here we ask the person to consider how they are confining themselves to the wilderness or desert of life by relying on their self-destructive coping mechanisms such as being controlling, self-dependent, emotionally reactive, or engaging in addictive behavior. We ask if they are willing and ready to surrender these structures of self to God so that the power of God can replace them at work within them. More will be said of this shortly.

The Healing Power of Prayer

Inner healing prayer can connect the hurting person with God powerfully. Many hurting persons have been severely traumatized and are filled with fear, shame, and distrust even of God. They have real questions that need to be answered, such as "God, why did you allow this to happen to me?" or "Why did you give me these parents who did not care for me?" Broken persons must have a way of asking God whatever questions they have without feeling guilty for doing so. The Safe Place exercise provides a way to lay our hearts out to God in an authentic, interpersonal way to experience His leading tangibly.

This type of prayer ministry (See Wardle, 2003) begins by asking the Holy Spirit to lead. The prayer facilitator invites the suppliant to open their heart to experience whatever healing God has for them. Afterward, the facilitator asks the person to take a couple of deep breaths to relax and imagine a place where they feel safe. In our experience, it is sometimes a place the person already experienced as safe such as a room or cabin in the woods. Other times, the person sees themselves in a place they might imagine safe, such as on a beach, by a stream, or on a cloud in the sky. The important thing is that the Spirit leads the person into a place where they can first feel safe for experiencing the presence of God.

We ask the person to describe what they are experiencing using their senses. "What are you seeing, hearing, feeling, etc." We invite them to let themselves be in their safe place for a few minutes experiencing the peace and relaxation of being there. Then, when they feel ready, we invite them to ask God to come into their safe place. The person is in charge of their process and can say at any time that they are not ready to do that. However, if they are comfortable, they can ask God to come as Father, Jesus, or the Holy Spirit, whichever person of the Godhead with whom they are most comfortable. After they have invited God into their picture, they can speak with Him about whatever is on their mind or ask him the questions they have of him. Then, they listen to hear what He has to say to them.

For many persons, this is as far as they go during the first prayer ministry. The objective is to create an experience of a safe, intimate interaction between the person and God. The person learns that they are important to God, that He cares enough about them to respond to their fears and questions. Sometimes, the Holy Spirit leads the person to a painful memory during the initial session or in a subsequent one. As the person relives the pain of this memory, the Holy Spirit shows the person where He was and what He was doing then. We have had some powerful healing experiences with this type of inner healing prayer where God has shown the person his suffering with the person (Isaiah 63:9) or how He was protecting them during the painful experience. We ask the person to share with us what they are

experiencing, and we process the experience with them after their encounter with God.

Addressing Our Responses to Brokenness

Fallen Responses

Since we are born as sinners with a fallen human nature (Psalm 51:5), we respond to hurt and pain through the lens of our fallenness. We are not condemned for these fallen responses but experience their natural consequences. For example, the 5th commandment tells us to honor our parents, and Ephesians 6:2 instructs us that this is the first commandment with promises connected to it. "If you honor your father and mother, things will go well for you, and you will live a long life on the earth" (Ephesians 6:3). These two natural consequences: long life and life going well, are the blessings that come with the choice and ability to honor our parents. The biblical definition of honor is to hold in high regard, to respect the God-ordained position of parents in a child's life. However, what if a child is abused or neglected by a parent? With their natural bent toward fallenness, it is nearly impossible for a child to honor an abusive parent. Therefore, instead of blessings or positive natural consequences, these children receive adverse effects such as engaging in life-shortening emotional states or behaviors. We also often see that their lives don't go well in the very same areas where they struggle to honor their parents. For example, if their parents are controlling, they may become just like them or go to the opposite extreme of being permissive. Rarely are they balanced.

Another example of a fallen response relates to the law of judgment. Jesus said, "Do not judge others, and you will not be judged. For you will be treated as you treat others. The standard you use in judging is the standard by which you will be judged" (Matthew 7:1-2 NLT). Jesus admonishes against judging motives, placing others as sinners, and casting them as the "other." When we rest in God's non-judgmental love for us, we no longer need to judge "others." Many of us automatically judge others without thinking and for various reasons. Romans 2 cautions us against such judgments of persons because as we judge others, we condemn ourselves to do the very same thing (v 1). The basis of our confession is because our hearts have been broken as we acknowledge that we are not in harmony with the non-judgmental love of God toward us. The great hallmark of a Christian is humility. "I am capable of the same evil and more if it were not for the grace of God. Therefore, I have no right to judge others." The basis of our confession is that our hearts have been broken as we acknowledge that we don't possess the non-judgmental love of God.

These are just a few of the fallen responses we as humans use in response to what happened to us. When identified, we encourage individuals to confess these responses as sins and repent of these patterns of thinking and behaving so God can be who he says he is in our lives. We can learn to thrive rather than survive in life, as the tools we use to survive are not the same used to thrive. (Please see the book Cleansing the Sanctuary of the Heart: Tools for Emotional Healing by the authors for a deeper dive into this aspect of healing.)

Shame: The Lies We Believe

Children who experience trauma often internalize negative messages about

themselves. These messages may be verbalized by primary caregivers or authority figures such as teachers, pastors, or Sabbath School personnel. Shaming messages include, "There's something wrong with you; you are not smart, pretty, athletic, etc. enough." Messages are also often conveyed non-verbally—for example, sexual abuse results in a devaluing of one's body and one's personhood.

Identifying the foundational lies is vital. Categories of foundational lies include:

- Helplessness-"I can't change what is happening to me"
- Fear-"something bad is going to happen to me"
- Abandonment-"I am all alone"
- Invalidation- "I am unlovable"
- Shame- "it was my fault"
- Hopelessness-"It's never going to get better"
- Tainted- "I am 'damaged' goods" (We are indebted to Dr. Ed Smith for this list of foundational lies).

I was told by my father that I was "damaged goods" and that no man would ever want me. This pronouncement was related to my getting pregnant at 13 after a young man manipulated me into having sex. It was hard to believe that David wanted me, and it took me many years to believe in my heart that he loved me. The power of these lies is that they are wired into our brains' unconscious, implicit memory, and healing involves rewiring our brains (Thompson, 2010, p 59). This rewiring consists of first, paying attention to the emotional reactions to the lies we believe and the events connected to the genesis of these lies. Evaluating your reactions to others' words, actions and body language is an invaluable means of helping to change your experience of what you remember and so change your memory, hence rewiring your brain. As we pay more attention to our reactions, we become more aware of what Jesus is doing in real time and space, to reinforce the truth about us as found in the scriptures (Thompson, 2010, 69-73). Jesus loved us and gave his own life to save us (John 3:16). This means we are of infinite value. The righteousness of Jesus covers us, which means that God sees us as righteous in Christ and loved even when we fail. We counsel persons to renounce each lie and replace it with a truth found in God's Word. Jesus declared, "You will know the truth and the truth will make you free" (John 8:32).

Survival Mechanisms

Those with a broken spirit often unconsciously build survival mechanisms that rob them of intimacy with others and God. These survival mechanisms include but are not limited to controlling behavior, self-dependence, victim/victimizer, performance orientation, fight or flight responses, and addictive self-comfort. These mechanisms are certainly understandable. We believe that God has allowed such survival mechanisms to exist after the fall in Eden. In His wisdom, God knew that fallen humans would need to cope with the pain they would experience. However, these mechanisms will hurt us. They drive us deeply within ourselves and communicate to God that He is insufficient, cannot control our lives, is not to be trusted, is a poor comforter, etc. When persons with broken spirits have experienced comfort and healing from God, they have a basis to begin trusting Him and surrendering their lives to Him in reality. When God knows that we are ready, He will invite us to surrender

our survival mechanisms to Him, to bring them to death so that we can experience the fullness of resurrection life. He gives us so much more in return when we make the decision to turn our will and our lives over to His care.

We would like to encourage you that even though you may not have been formally trained to use these biblical interventions, God can use you in an inner-healing ministry. God taught us many of these things as we learned from Him how to heal the broken hearts and spirits of those that He brought to us. We subsequently read from many of the authors that we have cited in this article. Our abilities to be used more effectively grew as we read and practiced these skills. However, the most important things we learned were first, that we ourselves needed to be connected to God, and second, that we needed to apply these healing principles to our own lives to be effective tools in God's hands with others. We pray that you will be blessed on your journey as you are led by God.

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HOW GRATITUDE PROMOTES SPIRITUAL, MENTAL, AND FAMILY HEALTH

The recent body of research on the subaject of gratitude demonstrates many spiritual and psychological benefits that come from gratitude. To summarize the conclusion of most of these studies, Peterson (2006, p. 145) states, "Gratitude connects someone directly to goodness." In the following article, the many benefits of gratitude will be explored in depth. It will be shown that gratitude is a sign of spiritual health which has the ability to benefit one's life. Gratitude is also a crucial determinant of well-being. Studies show that gratitude is positively correlated with both life satisfaction and mental health. These three major benefits of gratitude help promote prosocial behavior by encouraging people to serve others and increasing an individual's ability to relate positively to others. This strongly supports the family and allows individuals within families to function optimally. The practice of gratitude is foundational to spiritual, mental and social health. It is essential to the well-being of families. What is the evidence for these claims? This article will set forth the documented benefits that gratitude brings into one's life.

Gratitude Linked to Spiritual Health

Gratitude is one of the signs of spiritual health that lays the foundation for all of the other benefits that gratitude adds to human life. Tsang et al. (2012, p. 41) describe the connection between religion and gratitude, pointing out that "correlational studies have generally found a positive link between religiousness and gratitude. For instance, religious individuals mention that gratitude toward both others and God is important to their faith." In addition, McCullough and Emmons (2003, 388) assert that gratitude helps people grow spiritually, since it is a virtue that is often promoted by religion. Ronald Rolheiser (1999, p. 66) sees gratitude as a sign of spiritual maturity, "To be a saint is to be fueled by gratitude, nothing more and nothing less."

However, mature spirituality must be defined in order to gain a sense of how this spirituality relates to gratitude. The following is a definition that Sandage et al. use in their research:

> Spiritual maturity is something more than just an authentic expression or commitment to one orientation over the other, or even a delicate balance between the two. Rather, it is a process of moving back and forth stressing connectivity with a spiritual community and tradition

> (dwelling) while recognizing the value of individual differentiation and even questioning of that orientation (seeking). This dialectical process may keep one from a spiritual complacency that can accompany a blind acceptance of the familiar in a dwelling orientation, or a seemingly endless trail of questing that may characterize a seeking orientation (2011, p. 3).

Within the context of such mature spirituality, gratitude stands as a means of appreciating one's spiritual tradition by being thankful for the dwelling as well as a means of being thankful for the journey of faith, the seeking element. In this context, gratitude is likely to help support the energy of mature spirituality.

At a more basic level, Solomon Schimmel (2004, p. 38) connects gratitude to a belief in God. "The Hebrew Bible is replete with the motif that humans owe God gratitude for life, health, and sustenance. There are numerous thanksgiving psalms and other prayers in which the person or the community that is praying pours forth expressions of gratitude. Many of the sacrifices offered on altars and, later, in the Temple in Jerusalem, were infused with the sentiments of gratefulness and thanks, as was the elaborate ceremony of bringing the first fruits—*bikkurim*—to the priests, the representatives of God in the Temple." According to Schimmel, gratitude to God is an essential spiritual practice that began with the Israelites and continues to be a vital element of spiritual health.

The connection between gratitude and spiritual health goes even deeper. The believer who cannot express gratitude to God for all of the gifts that they consistently receive from God's hand is in some ways expressing idolatry. Romans 1:21-23 (NIV) puts it this way, "For although they knew God, they neither glorified him as God nor gave thanks to him, but their thinking became futile and their foolish hearts were darkened. Although they claimed to be wise, they became fools and exchanged the glory of the immortal God for images made to look like a mortal human being and birds and animals and reptiles." Here we see a direct correlation between ingratitude and idolatry. How can that be? When one fails to thank God for the gifts that come from God, then that person is essentially believing that the gifts they enjoy must come from some other source. Maybe they credit their job, their money, or another person for the gifts they enjoy. Regardless, this is a form of idolatry, when some object other than God gets the credit for all that is good in one's life. The simple act of giving thanks to God grounds the believer in their faith and supports their spiritual life. But gratitude doesn't stop here. It also has a foundational role in supporting one's overall well-being.

A Crucial Determinant of Well-being

Robert Emmons and Michael McCullough (2003, p. 378), two leading voices in the field of gratitude research, have greatly expanded the study of the subject of gratitude. One of their important findings regarding gratitude is how it relates to overall well-being. Here is how they describe this particular advantage of gratitude. "A grateful response to life circumstances may be an adaptive psychological strategy and an important process by which people positively interpret everyday experiences. The ability to notice, appreciate, and savor the elements of one's life has been viewed as

a crucial determinant of well-being." The importance of gratitude to well-being is almost self-evident, but the human brain is so likely to focus on the negative, this obvious truth becomes obscured. If a human being experiences something good and enjoyable in his or her life, the ability to remember that good experience and to savor it is certainly an important skill to develop. The act of reflecting on the good things in one's life is itself a positive experience which creates the sense that one's life is blessed (Roberts, 2004).

Strong Correlation with Life Satisfaction

More than just supporting well-being, the act of thankfulness also supports a sense of life satisfaction. Emmons (2007, p. 34) discovered that participants who practiced more gratitude in their lives "showed significantly more positive affect and satisfaction with life, while also showing less negative affect than the control group." He also found that "participants in the gratitude condition reported getting more hours of sleep each night, spending less time awake before falling asleep and feeling more refreshed upon awakening." This further supports the evidence of gratitude promoting well-being, since getting poor sleep is a crucial factor in individuals reporting a low sense of well-being.

In addition, gratitude is a strong antidote against a consumerist culture that promotes dissatisfaction. Shelton (2010, p. 15) points out, "The sheer number of choices, the rapid nature of change, and the pressures to keep up and acquire more, hinder and frequently undermine the capacity for gratitude. A consumer-oriented mentality focuses on, and increasingly preoccupies itself with, acquiring, replenishing, depleting, and competing." Thus, the consumer mindset is focused primarily on what one does *not* have which is unlikely to produce contentment or life-satisfaction. However, Roberts (2004, p. 75) shows how, in contrast, "the deeply grateful person will participate less, or even not at all, in the miseries of envy. In the first place, the virtue of gratitude is a disposition to be satisfied with what one has and is: it is an eye for benefits already received."

The key element in the sense of well-being that comes from gratitude appears to be what the mind is focused on. The mind focused on blessings is a satisfied mind that is more able to relax and sleep soundly at night. The individual thus refreshed with good sleep is more likely to feel alive and revitalized in the morning and have more to be grateful for in the future. And thus, a cycle of gratitude and well-being is started in one's life. The research of Emmons and McCullough (2003, p. 388) confirms the concept of a positive gratitude cycle. "Gratitude not only makes people feel good in the present, but it also increases the likelihood that people will function optimally and feel good in the future." The mind that is focused on the positive is also more likely to make good choices in the present and then reap the benefits of those good choices in the future, giving such an individual more to be grateful for and a greater sense of satisfaction with one's life.

Further research also backs up this assertion as Watkins (2004) points out that those who practiced gratitude also reported that they were happier than their peers who did not engage in the practice. They went on to explain that they had fewer health problems and tended to exercise more than those in the control group. The results of

this practice tended to promote the health of the whole person, both emotionally and physically and lead to further feelings of subjective well-being. All of these benefits support a healthy body and a sound mind. Consequently, it is not surprising to discover that gratitude is also strongly correlated with mental health.

Positively Correlation to Mental Health

Since gratitude enables the human mind to dwell on the positive and feel a stronger sense of life satisfaction, and get better sleep, there is a strong correlation that gratitude may lead to mental health. The freedom from negative thinking, allows one's mind to make better choices and to interact with others in a positive way. This helps an individual avoid the pitfalls of expecting the worst and then making choices that ensure that the worst does indeed happen (Sandage et al. 2011). Fredrickson (2004, p. 147) takes this a step further, demonstrating the power that gratitude has to broaden and build. "Noting that traditional models based on specific action tendencies did not do justice to positive emotions, I developed an alternative model for the positive emotions that better captures their unique effects. I call this the broaden-and-build theory of positive emotions (Fredrickson, 1998, 2001), because positive emotions appear to *broaden* people's momentary thought-action repertoires and *build* their enduring personal resources." This occurs when individuals feel the positive emotion of gratitude. Fredrickson (2004, p. 150) goes on to explain that "grateful individuals appear to creatively consider a wide range of prosocial actions as possible reflections of their gratitude." The freedom to consider broader possibilities leads to better decision making and thus creates a positive cycle of mental health.

Gratitude also helps an individual stay grounded in reality. When the mind is not disciplined to focus on gratitude it naturally defaults to focusing on the negative (McGonigal, 2012). This is a distortion of reality, since all the good in one's life is being overlooked. The ability to see reality and respond to it appropriately is one of the hallmarks of mental health (Cloud, 2006). Consequently, the capacity to see positive reality even when one feels bad, can only help an individual strengthen his or her mental health. McCraty and Childre describe what it feels like to function at an optimal level of emotional health:

> You feel a deep sense of peace and internal balance--you are at harmony with yourself, with others, and with your environment. You experience increased buoyancy and vitality. Your senses are enlivened--every aspect of your perceptual experience seems richer, more textured. Surprisingly, you feel invigorated even when you would usually feel tired and drained. Things that usually would irk you just don't get to you as much. Your body feels regenerated--your mind, clear. At least for a period of time, decisions become obvious, as priorities clarify and inner conflict dissolves. Intuitive insight suddenly provides convenient solutions to problems that have previously consumed weeks of restless thought. Your creativity flows freely. You may experience a sense of great connectedness with others and feelings of deep fulfill-

ment (2004, p. 231).

The benefit described here enables grateful people to function at the peak level of their abilities. The benefit of well-being that gratitude confers leads to a mind that is healthy and at peace. This in turn, enables grateful people to interact with others in positive ways.

Gratitude Promotes Pro-social Behavior

Since grateful people are more likely to acknowledge the gifts they receive from other people, it is not surprising that they are better suited to engage in pro-social behavior. This kind of pro-social behavior is actually contagious and is likely to be paid forward from one person to the next. Grant and Gino (2010) discovered that helpers who were thanked for their service were motivated to serve even more effectively in the future. Therefore, gratitude is an important element in healthy social relationships. In this same study Grant and Gino (2010) found that gratitude is the fuel for prosocial behavior, helping to initiate positive behavior and keeping it going for the long term. It is immediately apparent how gratitude can support relationships. The tangible effects of expressing gratitude to others confirms its importance to forming a healthy family system. Gratitude is a key ingredient in developing positive social bonds. These bonds built on positive interactions strengthen over time and encourage more pro-social behavior in the future (Fredrickson, 2004). It appears that people appreciate being appreciated which can lead to positive social relationships and bonds.

Since gratitude encourages individuals to act in more helpful ways, it is not surprising that another study revealed that gratitude also strengthens marriages. The research of Lambert and Fincham (2011, p. 59) proved conclusive on this point. "In all four study designs, we found that expression of gratitude was related to comfort in voicing relationship concerns, an important aspect of relationship maintenance." When one partner voiced her gratitude about her spouse, she began to perceive her spouse more positively. This allowed her to trust her spouse enough to voice important concerns, feeling he would respond positively to this information. Thus, gratitude is a key element for strong marital bonds.

Furthermore, gratitude is an important skill for creating a loving relationship in marriage. This is due to the fact that "gratitude also builds people's skills for loving and showing appreciation. That is, to the extent that gratitude broadens people's momentary thought-action repertoires, it prompts them to stretch themselves to think creatively about how to repay kindnesses. Those creative efforts will yield new ideas about how people might make a gift of themselves (e.g., using expressive touch or words, caring for others in need). Once generated and practiced, these new methods of repaying kindnesses can become lasting skills in a person's repertoire for expressing love and kindness" (Algoe et al. 2008, p. 429). It is becoming increasingly clear that mastering the art of becoming a more grateful person is something that can benefit one's relationships in all areas of life.

Algoe et al. (2008, p. 429) have further documented the ways in which gratitude encourages individuals to bond and form healthy relationships. They found that "gratitude is a detection-and-response system to help find, remind, and bind ourselves to attentive others. Relationships with others who are responsive to our whole

self—our likes and dislikes, our needs and preferences—can help us get through difficult times and flourish in good times." Gratitude helps people connect with each other in compatible ways. Thus, gratitude is essential to all good relationships, especially for the family unit.

Furthermore, there is more evidence of the importance of gratitude to social relationships. Gratitude is a form of justice in human relations that encourages humans to function optimally with one another (Roberts, 2004, p. 77). It has a protective role where it keeps humans from affecting each other negatively by limiting the negative emotions that generally lead to negative interactions. All of these positive traits of gratitude are essential ingredients to forming a healthy family, which makes gratitude a high priority practice to develop within the lives of family members. In fact, the pro-social behavior promoted by gratitude may be its most important function in the life of the family.

The Practice of Gratitude

The full benefits of gratitude will only be realized by one who determines to practice gratitude on a regular basis. Since the human mind naturally tends to focus on the negative, this can be difficult. However, the practices themselves are simple to understand. The challenge is to commit to these practices long enough to form gratitude habits that will eventually become automatic. The following practices are samples of what can be done to focus the mind on gratitude. Any practice that successfully accomplishes this is an effective practice that can be used.

Expressing Gratitude

The basic practice is to express gratitude in some way. This can be done by writing down what one is thankful for in a gratitude journal or posting it on social media. It can be done by praying a prayer of gratitude to God. Or one can share gratitude with another person. All of these practices are effective as they can help focus the mind on what is good in the world. It is important for an individual to discover an approach that appeals to them in some way. The specific practice is much less important than the consistency of the practice.

Families may want to establish some kind of gratitude practice within their regular routine. Each member of the family could share something they are grateful for at the dinner table each day as this simple practice has the potential to increase the health of the family greatly. Sharing thankfulness could be a regular part of family worship. A more contemporary approach would be setting up a family text group where each member of the family texts something good that happened to them that day. Once again, the specifics of the practice are far less important than the frequency of the practice. Families will want to draw on their intuition and creativity in order to find the practices that will work best for them.

Spiritual Practices

Furthermore, one can engage in spiritual practices that will also greatly support the mind's ability to focus on the good things in life. Praying prayers of thanksgiving have already been mentioned above. If prayer is already a regular practice, adding thanksgiving to the beginning of every prayer is an effective way to practice gratitude. Moreover,

worship can also be a strong practice. The choice to engage with one's church community regularly is very likely to support the practice of gratitude. Often spiritual music and messages are designed to produce gratitude in the heart of the listener. The support of a healthy faith community will lead to gratitude. Sadly, some entire faith communities sometimes deny their own beliefs and end up practicing ingratitude as a group. These faith communities should be avoided as they will do more harm than good.

The practice of listening to and singing along with uplifting spiritual music is a fun way to support one's gratitude practice. This is a more general form of thanksgiving, but still quite effective. One can praise God for all of God's good qualities—love, power, grace, compassion, goodness, gentleness, and joy. Lifting one's voice in songs of praise is a fantastic way to thank God. Since most are going to be drawn towards different practices, what matters is that one actually engages in some form of gratitude practice. These simple practices have the ability to change one's life in many amazing ways.

Since gratitude is contagious, even one family member who commits themselves to the practice can begin to effectively change the family system by causing positive emotions to spread through the network of the family. It is far more effective to focus on one's own gratitude practice than to try to force others to be more grateful. Demanding gratitude of someone else usually creates more friction and ingratitude in the family system. However, the family member who commits to their own gratitude practice will have a very positive effect on the overall family system.

Conclusion

Gratitude is an essential practice that supports spiritual, mental, and social health, supporting one's ability to enjoy life. Gratitude strengthens mental health and as such, it bolsters the social functioning of the family unit. If everyone in the family is constantly complaining and upset about things in their lives, the joy of the family will quickly fade away. However, when the family engages in individual and collective practices of gratitude, their joy will continue to grow. This will deepen the bond between family members and lead to healthy interactions between members of the family. As a result, the family now has even more to be grateful for. Thus, a beautiful upward cycle of gratitude and joy begins and will continue as long as the family stays committed to practicing gratitude on a regular basis.

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Julian Melgosa

A HEALTHY MIND

Mental health is a current concern, particularly because of the recent COVID-19 pandemic and its adverse effect on people's minds and behavior. Significant barriers to mental health (i.e., poor mental health education and promotion, lack of healthcare provisions globally, and stigma—both public and self-stigma) are discussed. Self-help strategies and general advice to prevent and palliate symptoms of mental and emotional disorders are outlined. These are applied to cognitive processes, feelings/emotions, and behaviors. Self-help approaches include social support, adequate family life and school environment for children, thought management techniques, physical activity adequate to personal situations, a balanced self-esteem, altruistic service, and religiosity and spirituality. Although self-help may contribute to the prevention and soothing of symptoms, it must be understood that professional mental health care should be sought when manifestations persist.

Mental Health Defined

Conversations on mental health have been most frequent over recent times due to the increase of symptoms of depression, anxiety, substance use disorders and other mental health complications. Starting at the turn of the 21st century, the trend has been growing (Blomquist, Hägglöf, & Hammarström, 2019; Czeisler et al., 2020) and become alarming recently due to the breakout and sequels of the COVID-19 pandemic and its multi-faceted impact on people's lives (World Health Organization, 2022a).

What is mental health? The concept is defined (World Health Organization, 2022b) as "a state of mental wellbeing that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community." Mental health is one of the most desirable states one can aspire to have, for it is the path to general wellbeing and satisfaction, that is, happiness.

Mental health cannot be understood as the absence of mental illness. Some clinical disorders are well established, like major depression, generalized anxiety, schizophrenia, posttraumatic stress, bipolar, or substance use disorders. However, oftentimes people suffer and cause others to suffer because of partial symptoms which do not merit a full diagnosis.

There are three areas that are foundational to mental health and illness: thoughts, feelings, and behaviors. Mental health (or lack thereof) is manifested via these areas. Mentally healthy people think cogently and perceive experiences in balanced ways, not judging events always in negativistic or even catastrophic ways. They can manage their feelings/emotions, look at the past with satisfaction, at the present with calm, and at the future with hope. Their behaviors

fit basic societal expectations and cultural norms, they relate pleasantly with others at home, work, and other social contexts.

On the other hand, those with an unhealthy mind may be unable to come out of despondency or incapable of controlling their fear; they may be often suspicious of others, assess issues as either black or white, or think illogically to cause problems to themselves and others. Likewise, they may be easily upset by small changes or challenges, feel unwarranted envy or jealousy, be too impatient, experience easy anger, resentment, vindictiveness, and lack of empathy. They may consistently avoid social contact, display verbal and/or physical aggression, carry out their duties poorly (at work, school, or family), sob without reason, laugh for no cause, or they may be inclined to addictions (chemical or behavioral).

The cognitive, emotional, and behavioral components are intimately related: Thoughts determine psychological states (feelings, emotions), which in turn give way to behavior. At times, behavior affects our mental processes, like someone repeatedly acting in an abnormal way (say, displaying constant verbal aggression on others), may end up thinking that such behavior is acceptable and even necessary. This connection helps us understand why most psycho-therapeutic interventions focus on modifying cognition, feelings/emotions, and behavior.

Barriers to mental health

Mental healthcare faces even greater challenges than its physical counterpart. Lack of sufficient mental health education and promotion, limited access to treatment, and social stigma are among the most significant barriers to mental health.

The amount of basic information on mental health in the general population is clearly limited. In terms of physical maladies, many know what over-the-counter product to take or natural remedy to apply for an upset stomach, a sore throat, or a sprained anckle; and when those do not work, they know what to do to approach their local healthcare system. But many fewer people are able to overcome sadness, worry, obsessive thoughts, or know how to manage adverse emotions, such as fear, jealousy, or anger. Would they go to a mental health professional if they experienced notable, disturbing thoughts, feelings, and behaviors? Probably not. Most likely, they will wait indefinitely for symptoms to go away, but unfortunately this does not happen so. A good understanding of the nature of mental and emotional disturbances would be very useful for people to prevent them and to develop willingness to treat them professionally when necessary.

But even good understanding plus motivation to seek specialized care are not enough when healthcare options are deficient or absent. Although particularly scanty in countries/regions of low and middle income (Wainberg, 2017), post-industrial societies are not providing adequate care to sufferers of mental disorders either. For example, according to the National Alliance on Mental Illness (NAMI, 2022), in the USA, only 46.2% of those with mental illness received treatment in 2020 and 64.5% of those with *serious* mental illness received treatment in the same year. Globally, data show a much worse scenario: more than 75% of the mentally ill people receive no treatment at all (WHO, 2020).

Possibly, the worse barrier to mental health is stigma. While those touched by

physical maladies tend to draw sympathy, those suffering from mental and emotional disorders are too often considered wholly responsible for their misfortune, dimmed incompetent, or without moral strength. In religious communities they may be judged as having walked away from God and deserve the pain they are enduring. Stigma is at times found even among health practitioners. That is why Katie Owen (Owen 2021) implemented changes in a Bachelor of Nursing curriculum in New Zealand to promote a change in nurses' attitude toward patients with mental disease. Program variations included narratives of persons who had lived through mental illness and addiction experiences and had been able to recover as well as opportunities to interact with individuals with mental disturbances. Post-intervention assessment showed that the program had a significant impact on student nurses' understanding of mental health issues and thus participants were able to overcome stigma and discrimination to a great extent.

Stigma is not only found in those near people with mental issues, but in the patients themselves. This is called self-stigma. For those affected by these problems, the challenge is double: In addition to enduring their painful symptoms, they realize that others hold stereotypes and prejudices and, as a result, many end up believing those prejudices and seeing themselves as incompetent and weak of character, thus diminishing their self-esteem and becoming increasingly unmotivated to seek employment, search for relationships, engage in leisure activities, or avail from housing opportunities.

The adverse effect of stigma is such that there are recent efforts to compensate for the risk of self-ruin in psychiatric patients due to self-stigma. That is why Young and his associates (2020) conducted a randomized controlled trial to evaluate the effectiveness of cognitive behavior therapy (CBT) on reducing self-stigma of people with major depression. Researchers randomly assigned participants to either a CBT program to counteract the effect of self-stigma or treatment as usual.

After 10 clinical sessions, standardized assessment results showed that the treatment group (CBT program) had a significantly lower self-stigma mean score than the control group. These results are promising and represent a good strategy against the effect of stigma on patients with depression. Of course, it would be much more desirable to reduce stigma from the root than having to resort to remedying its effects. Therefore, changing the general attitude towards a more understanding and accepting outlook of mental disorders is a highly desirable goal. Such move would permit mental illness to be seen in a positive manner and would elicit compassionate action.

Self-help strategies for mental health

"Try a gluten-free diet for a month" or "a heating pad helped me a great deal to relive my knee pain," are common messages contained in casual conversations. Hopefully soon we will hear people say: "Try thought stopping to prevent those ideas to take over," or "I only could keep my cool with constant self-instruction."

Many people create their own coping mechanisms to deal with mental and emotional turmoil, but others do not, and would benefit from learning self-help strategies and general advice to preserve psychological wellbeing. The rest of this article

outlines examples of approaches that may improve mental health notably. But before that, a word of caution is in place. Self-help techniques and strategies are very useful ways to increase control over thoughts, emotions, and behaviors. Indeed, when we apply such control, we can shorten the times of distress and prolong the moments of pleasant mood and psychological well-being. However, sometimes discomfort reaches levels where people are insufficient to tackle the issues. This is the time to seek professional mental healthcare in the same way that people seek professional physical healthcare. This is not the time to keep trying home remedies, but to seek professional assessment and treatment.

We must also caution against the simplistic "pray about it and the Lord will get you out of those silly thoughts" approach that some church members send to fellow believers. Prayer is a strong source of support amidst mental illness, as we see later in this article, but we also must trust in the professional and skillful means that are available to us and that God may use to channel his blessings.

Although it is becoming increasingly common to make an appointment with the counselor, psychologist or psychiatrist, stigma and fear must diminish still further to benefit widely from existing treatment options of proven efficacy. Having said this, a few self-help strategies and pieces of advice are outlined below.

Adequate social interactions are a sure source of mental wellbeing. A quick review of what makes us happy and what brings distress to our lives is likely to include people. People can provide joy, but also misery. It will depend on the quality of the relationship. That is why practically all mental disturbances benefit from balanced, and consistent social connections, including family, friends, relatives, peers, neighbors, business partners, and so on.

Efforts toward strengthening relationships will result in a better prognosis of mental health (Werner-Seidler et al., 2017; Hancioglu & Yazici, 2020; Sibalija, 2020). Simple things like the following will go a long way to attain mental and emotional wellbeing:

- Approach encounters focusing on the other person. Ask about things of their concern instead of rushing to talk about yourself and your experiences. Show interest, willingness to listen, and empathy, smiling when appropriate and displaying warmth.
- Always show patience, respect, and consideration when the other person takes longer than you expect to understand or express their ideas.
- When the time comes, be ready to move from chit-chatting to a deeper level of interaction if necessary, exchanging feelings and emotions, like fear, insecurity, uncertainty, discouragement, frustration, guilt, and the like.
- Remember that non-verbal content (i.e., facial and hands' expressions) makes a great difference in making communication not only more accurate, but also more pleasant and appealing.
- When committing a mistake, apologize sincerely and show humility, remembering that arrogance is one of the chief enemies of optimal interpersonal interactions.

- Nurture trust in your relationships, knowing that trust is foundational to quality interactions. A recent study (Xiahong He, 2022) showed how crucial interpersonal trust is in relationships in college-aged students. He also found out that females in his study had more difficulty to achieve trust than males, and this was particularly noticeable in women coming from rural (vs. urban) areas. In addition, trust was a mediator between self-esteem and social anxiety, a knowledge that provides theoretical bases to enhance mental health education.
- Believers can find in the Bible a powerful source of motivation to practice good person-to-person interactions. For example, reading, repeating, and reflecting on passages such as Proverbs 15:1, Romans 12:14-16, Philippians 2:3, 4 or 1 Peter 3:8, 9 can inspire the reader to achieve better relationships.

Family life and school environment. This is an extension of the previous point, and it is particularly significant to the mental health of children and adolescents. It is well understood in the academic and clinical communities that mental health is forged during the growth years as parents are the main emotion regulators for their children.

And when complications appear, childhood and adolescence provide the context for resilience and the improvement of symptoms of mental disorders. This is what Mirisse Foroughe and her associates (2019) found in their experiment. They conducted a 2-day psychoeducational intervention to 124 parents of children with mental/emotional symptoms, with a 4-month follow-up. Results showed that participant parents reduced their emotion blocks (inability to set limits or difficulty in handling their child's emotions) significantly and improved their self-efficacy in connection to their child's disturbances. Most importantly, their participation in the study improved their children's symptoms significantly.

Another study with adolescent immigrants from Central America conducted in southwestern USA (Venta et al., 2019) assessed the protective effects of being engaged in school life on teenagers' mental health. Findings show that when youth were involved in school life, they increased their chances of coping better with psychopathology, displaying prosocial behavior, and showing resilience.

It is therefore necessary to remember that children and adolescents need a supportive family environment with emotional stability, opportunities to dialogue, moments of leisure and in sum a place where they may feel understood and loved. Likewise, they will benefit from a caring and participatory school environment, both at the elementary and secondary levels.

Thought management. Many forms of mental disturbances have their origin in thoughts and thinking processes. Thoughts may produce pleasant or depressed mood, anxious or tranquil state of mind, balanced or radical analyses of realities, and so on. Depending on how toxic they are, how frequently they return, for how long they stay, and how strong the individual is, they will cause more or less damage. That is why cognitive behavioral therapy (CBT) is at the top of psychotherapeutic intervention. Its main goal is to teach people how to manage their thinking processes.

Take worry, for example. Someone may be very concerned with matters that are important to their lives and those of dear ones. They may consider and debate possible solutions. This is legitimate. But when these thoughts become compulsive, exaggerated, and preoccupied with things that *might* happen, they cross the line into the realm of pathological worry, which is not just useless but may become precursor of anxiety and obsession. This kind of thinking must be rejected as early in the chain as possible, and that is the purpose of a technique called "Thought Stopping".

Thought stopping is a good strategy to avoid intrusive, discouraging, and fearful thoughts that contribute to maintain symptoms of anxiety, depression, obsessive-compulsive disorder, and others (Bakker, 2009; Reinecke et al., 2013; Laela, Keliat, & Mustikasari, 2018; Hardayati, Mustikasari & Panjaitan, 2020). If you would like to respond to adverse thinking, try and follow the following steps:

1. Identify the undesirable typical theme/s that comes almost automatically to your head.
2. Learn to detect the precursors (or triggers) of the unwanted thought (for example, a person, object, situation, or place with close linkage to that thought). Early detection will make rejection easy.
3. At the onset of such precursor or when the undesirable thought begins to crawl in, say 'STOP' loudly or snap your fingers.
4. Fill immediately your mind with a pleasant or desirable theme, ready beforehand; for example, a travel experience, a funny memory, the remembrance of a loved person, or the anticipation of an enjoyable activity.
5. Prolong this distraction with the new thought and, if necessary, initiate a motor activity different from what you are doing, like getting out, snaking something, turning music on, making a phone call, or seeking the company of a friend.

Learning and practicing techniques like thought stopping will help change thinking habits, which in turn cause adaptative feelings and behaviors to prevent and remedy unhealthy mental, emotional, and behavioral manifestations.

Activity and physical exercise. Movement/exercise is these days a regular component of most treatment plans. They include an activity program which is a detailed inventory of things to do at each hour. Almost invariably, there will be some form of physical exercise or movement activity, according to the ability and preference of the person. This is so because of the vast empirical evidence of the benefits of physical exercise on mental health.

The professional literature abounds in evidence on the beneficial effects of exercise is beneficial to mental disorders at large and particularly in patients with major depression. A study by Morres et al. (2018) reviewed (via meta-analysis) 11 high-quality trials involving 455 adults (aged 18-65) with major depressive disorder engaged in 45 minutes of aerobic exercise, at moderate intensity, three times a week. When compared with treatment as usual (without exercise), aerobic exercise emerged as an effective antidepressant treatment.

Exercise does not need to be vigorous, especially when there are health limitations, but activity must be frequent when possible:

crafts, drawing, sowing, cooking… and if these things are done for someone else who needs help and support, then the benefit will increase.

A balanced self-esteem. Inadequate (typically low) self-esteem goes together with common disorders like major depressive disorders, attention-deficit/hyperactivity disorder (ADHD), or eating disorders. A study conducted at the University of Trier in Germany (Colmsee et al., 2021) analyzed well-designed studies connecting self-esteem and eating disorders and found out that self-esteem is an important factor in the development of eating disorders and that this effect is robust for all ages and for all types/subtypes of pathological eating. A poor self-esteem seems like a universal risk factor in this area.

This is advice for someone challenged by recurring thoughts of low self-esteem or doubt about their abilities:

1. Use ways to dodge self-deprecating thoughts, like the thought stopping technique described above.
2. Remind yourself of your strong points. If you are patient, know how to sing, have sensitivity to others' needs, or are creative in certain tasks, remind yourself often—sometimes you may have to write them down and pull the list when feelings of low self-esteem assault you.
3. Write down negative thoughts about yourself. Go through them one by one and ask yourself: Is this true or is it my own interpretation? If there is some truth, to what extent? Do I need to correct anything? What steps should I follow? It may be helpful to ask a good friend to accompany on this task.
4. Exercise thankfulness. List things you are grateful for: Healthy, friendly, approachable, have a satisfying job, have a loving pet… This will help you be content and feel better about yourself.
5. Be aware of relationships. Seek friendships that are affirming, able to build you up, rather than somber, negativistic and critical individuals.
6. Nurture faith. The value that society places on people is based on temporary standards of great variability. However, when we have transcendental principles founded on faith and belief we will value traits such as honesty, compassion, or faithfulness, and will look at our Creator as the supreme source of love and self-esteem—"I am fearfully and wonderfully made…" (Psalm 139:14).

Altruistic service. It is quite common that psychotherapists suggest patients with mood disorders and mental illness in general to join a group of volunteers or lend a hand to someone in need in their communities. It is well known that charitable/helping behaviors favor the production and secretion of important mood hormones and neurotransmitters, such as dopamine, serotonin, or oxytocin, that are clearly associated with love, warmth, empathy, and meeting the needs of others. These promote a sense of happiness, which is incompatible with mental disorders.

Moll et al. (2006) carried out an interesting study that became a classic and caused a multitude of replications and

related studies in the field of psychoneuroendocrinology. Researchers obtained MRI scans from the brains of 19 healthy adults as they received $128 for participating. They were offered the opportunity to donate part of their honorarium to charity, discussing alternatives for their donations. Recorded brain activity showed intense activity in the mesolimbic system (capable to ameliorate pain and achieve a sense of wellbeing) when donating, whereas mesolimbic activity was minimal when refusing to donate. Remarkably, the prefrontal cortex was distinctively engaged when altruistic, rather than selfish, choices prevailed.

Fortunately, there is an abundance of opportunity to serve others in our midst and helping may provide great benefit not only to the receiver but to the giver as well (as stated in Acts 20:35), especially gains in mental health and psychological wellbeing.

Religiosity and spirituality. The growth of research bringing together religiosity, spirituality and mental health has been exponential over the past three decades. Thankfully, we have moved from blaming faith and religious experiences as a cause of mental illness (an idea prevalent the first two thirds of the 20th century) to promoting religion and spirituality as sources of significant support of mental health. Harold G. Koenig has done extensive work in collecting and reviewing research in the area (Koenig, 1998, 2018). Religiosity and spirituality have been found to facilitate the promotion of wellbeing, hope, optimism, meaning and purpose, self-esteem, personal control, as well as a soothing effect on depression, suicide, anxiety, and substance abuse (Koenig, 2011).

Research on religiosity and mental health is quite extensive. At the time of preparation of this article (September 2022), the Academic Search Premiere and EBSCO databases returned 3,095 *religiosity and mental health* peer-reviewed studies over the last 10 years. The return was 1,771 of such articles during the same time for *religiosity and depression* and 1,256 studies for *religiosity and anxiety* under the same parameters. To mention an example, I cite a trial (Koenig et al., 2016) performed using religiously integrated cognitive behavioral therapy (RCBT) versus conventional cognitive behavioral therapy (CCBT). Researchers randomly assigned 132 participants (ages 18-85) with depression associated to medical illness to either RCBT or CCBT therapeutic conditions. The intervention consisted of ten 50-minute counseling sessions over a period of twelve weeks. The dependent variable was the daily spiritual experiences of participants. Results showed that both groups benefitted in terms of an increase of daily spiritual experiences, but therapy with integrated religion elicited a much greater level of spiritual experiences. Furthermore, it was observed that the presence of religious activities (religious services, prayer, meditation, and scripture reading) predicted a decrease in depressive symptoms.

Prayer is perhaps the most studied variable in the field of religion and mental health. It also provides the most significant benign effect on mental illness, particularly on depression (Anderson & Nunnelley, 2016; Boelens et al., 2012). Of all religious practices, prayer has been identified as the number one religious coping mechanism, followed by going to religious services (Rogers et al., 2002). In fact, belonging to a community of faith and attending worships can help moderate the negative impact of

live event stressors on mental wellbeing (Rainville, 2018), and this effect strengthens when private prayer is added.

Bible reading has brought guidance and comfort to many people of faith and is highly recommended by many therapists. Research shows that the African American community obtains extra benefit from this blessing (Hamilton et al., 2016). The blessings of Bible reading, however, seem intricate. Krause & Pargament (2018) failed to find that often Bible reading was associated with hope. However, they observed that those who read the Bible often and adopted benevolent coping responses to deal with disturbing life events did experience greater hope than those unable to develop such coping responses.

Forgiveness cannot be claimed as strictly religious, but it is true that religions, and specially Christianity has placed a great weight on the virtue of forgiveness with its strong benign effect on mental health (Reinert, 2021), especially to those granting forgiveness.

Although the benefits of spiritual and religious factors (R/S) keep appearing in the literature as beneficial in the treatment of mental illness, not all studies go in the same direction. For example, Harold Koenig (2011) reviewed 444 quantitative studies on the relationship between R/S interventions and depression and found less depression and faster remission with R/S mechanisms in 61 percent of the studies. The remaining studies showed weak relationships, and only 6 percent reported a direct correlation (ie., greater levels of depression when accompanied by R/S strategies). Likewise, when Koenig reviewed 326 well-being quantitative studies, found that 256 (79 percent) of them yielded a positive correlation with R/S variables—more sense of well-being when R/S elements were present. The remaining studies did not find sufficient evidence to claim statistically significant correlations.

Conclusion

Mental health is currently one of the areas of health with greatest challenges and deficiencies. The good news is that people can be educated about the nature and mechanisms of mental illness. This knowledge, together with self-help skills, may reduce present and future prevalence. Of particular usefulness are the spiritual and religious interventions. Whilst they cannot always claim a significant effect on mental illness, there is enough empirical evidence showing that mental health education and the use of self-help strategies connected to religious practices will be beneficial to mental and emotional illness. These include prayer, sacred readings, attendance to religious services, acts of worship, music, discussion of religious themes, faith sharing, and other activities. They will not only support spiritual health, but mental health as well.

It seems fitting to close with a gospel text found in John 16:20-24. This teaches the believer how to reject moods that may lead to disturbing mental/emotional states. In this passage, Jesus addresses the unfairness of life—his disciples are harassed for doing the right thing; but he promises that their grief will be turned into joy. He acknowledges that there will be sorrow, but assures the believer that help is available. He compares this transitory pain to a mother giving birth that quickly gives way to joy when her child is born. Jesus knew that much of human misery has to do with painful emotions from the past and anxiety about the future. He assures the believer

that unpleasant memories will be definitely wiped away. While grief is sometimes necessary ("now is your time of grief") and pain can sometimes carry meaning, Jesus points to the permanent joy that he will give his children upon his return and that nobody can take away (John 16:22).

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Adam Fenner, PhD

TECHNOLOGY USE AND ITS EFFECTS ON THE MENTAL HEALTH OF CHILDREN AND FAMILIES

There is simply no going back to a world where we aren't constantly connected by digital technology. We must find a way to live as individuals and families in a digital world that is rapidly changing and increasingly consuming. To this end, I review the literature regarding technology use and its effect on our mental and physical well-being. This new world offers advantages such as connectivity and productivity, but also brings a host of potential dangers we need to be aware of. There is also a substantial opportunity cost we face by spending our time online. By removing ourselves from God's Creation and time with our families and Creator we miss out on a multitude of blessings.

In the twenty-first century, technology is nearly ubiquitous, and its proliferation is increasing at an incredible rate. In 2019, the average U.S. home had eleven internet connected devices, but by 2021, the number of devices had increased to an average of 25 per household (Deloitte, n.d.). Average screen time approximations in the U.S. vary depending on the study, but most results point to around seven hours of screen time each day (Datareportal, 2022). Considering this explosion in connected and mobile technology use has occurred within the last two decades both behavioral scientists and the general public at large are struggling to understand the implications of what the integration of humanity and electronic machines are.

With such an abundance of technology in our daily lives and the variety of human experiences present on our planet, it should come as no surprise there are a plethora of findings as to its impact emerging both in academic and popular literature. Like any field of study, research on the effects of technology on humanity can be complex, contradictory, and biased depending on who commissioned the study and who might benefit from the results (Vuorre & Orben, 2021). Nevertheless, when it comes to issues of family and mental health, parents and caregivers need to understand the potential risks often associated with technology use and weigh those potential risks with the benefits their families might receive. Additionally, if optimal family health is the goal, then exploring validated alternatives to technology use such as spending time as a family together in God's natural Creation are essential.

Technology's Impact on Children

There are many reasons caregivers may use technology to occupy a child's time.

These reasons are often practical, well-intentioned, and may be the only option available. Avoiding judgment and extending Christian grace and empathy are important when considering the childrearing practices of ourselves and others. Simply put, caregivers are usually doing the best we can within a difficult set of circumstances.

Anyone who has ever indulged a young child in a significant amount of screen time only to later tell them to turn the device off, put it away, or do something else knows the child can often act out or express undesirable behaviors. My own children, when told to stop watching television or to turn off the iPad have cried, yelled, and sulked much more frequently than I would like to admit. As a caregiver, I know I'm not alone in situations like this, because I see similar outcomes wherever children with access to such technology are present. Although these observations are anecdotal, those who witness them can't help but feel they represent the tip of the iceberg regarding mental and physical health outcomes of excessive technology use.

Emotional outbursts and other affects associated with technology use are both anecdotally and clinically verifiable yet represent a small part of the negative influences excessive technology use can have on people, particularly children and adolescents. Studies have shown technology consumption is a predictor for children's "ill-being… independent of the negative health impacts of exercise and eating habits." In other words, even when other factors are considered, technology use alone is an indicator for undesirable outcomes in children (Rosen et al., 2014). This should give parents and caregivers reason to pause and seriously consider how much, how often, and what types of technology they allow their dependents to experience and interact with.

The following list is adapted from Digital Detox, an initiative aimed at creating "better relationships with technology." This list is a sampling of the empirically validated negative effects of imbalanced technology use.

- Poor sleep quality and less sleep overall (Alonzo et al., 2021)
- Physical isolation
- Sedentary lifestyle
- Distraction
- Poor posture and body pain
- Shorter attention span
- Bullying
- Creativity stunting in children
- Issues with seeing and hearing
- Family separation
- Exposure to sex, drugs, and violence
- Increased stress
- Stunted empathy (Digital Detox, 2019)

Beyond this list, special attention needs to be given to the social media habits of Millennials and Generation Z (Gen Z) who daily spend around 3.8 and 4.5 hours on social media respectively (Ypulse, 2021). Social media use has been associated with negative outcomes including increased moodiness, higher levels of stress, and heightened anxiety (Ewumi, n.d.). One need not look far to find both anecdotal stories and scientific studies confirming the polarizing effects of social media use on relationships (Kubin & von Sikorski, 2021).

In June of 2022, Meta the parent company of Facebook and Instagram confronted eight serious lawsuits filed in eight separate states accusing the company of "exploiting young people for profit" and creating a digital environment that "has led

to actual or attempted suicides, self-harm, eating disorders, anxiety, depression and reduced ability to sleep, among other mental health conditions" (Conklin, 2022). While lawsuits remain ongoing against major social media platforms such as Meta, behavioral scientists have found direct correlations between college student's mental health and their use of Facebook. A 2022 study of Facebook usage amongst college students found "increased symptoms of poor mental health, especially depression." Additionally, the researchers found the more Facebook usage increased for students so did their use of mental healthcare services and "impairments to academic performance from poor mental health" (Braghieri & Makarin, 2022).

Caregivers should give particular attention to the explosion of cyberbullying sometimes referred to as "cybervictimization," which is a form of mistreatment using technology. Researchers in Canada found teens that were cyberbullied were significantly more likely to have suicidal thoughts in the short-term than those that did not experience cyberbullying (Perret, et al., 2020). While many behavioral scientists are reluctant to correlate technology use and adolescent suicide rates, technology usage seems to "amplify or intensify" mental health issues in teens (Hollis & Sonuga-Barke, 2020). A situation that should never be taken lightly.

Any discussion on how technology is affecting the mental health of children and families would be incomplete without attention dedicated to pornography. Pornography consumption is alarmingly high. Approximately 60-98% of men and 30-90% of women express they use pornography (Ballester-Arnal et al., 2022). Research has found children as young as 8-11 years old are exposed to pornography (Woda, 2019). Pornography addiction has a wide range of symptoms, which can cause significant disruption to personal and familial well-being. de Alarcon explores "a problematic consumption model" with cybersex addiction resulting in "loss of control, impairment, and risky use" (de Alarcon et al., 2019).

While a Senior Fellow and the Director of the Center for Marriage and Religion Research at the Family Research Council, Dr. Patrick F Fagan, performed notable studies on "The Effects of Pornography on Individuals, Marriage, Family, and Community." Dr. Fagan's work identified men feeling less sexually fulfilled with their wives, wives feeling betrayed and sexually unsatisfied, and pornography in general as contributing to divorces (Fagan, 2009). The scientific literature on pornography is more united than other fields of study regarding the negative effects of technology on our lives and is therefore more alarming than ever.

Although volumes could be filled summarizing the negative effects of social media and technology use on mental health; unsurprisingly, one of the largest meta-analyses or "*umbrella review*" of the literature found a lack of consensus amongst researchers. Using a substantial data set, the authors concluded most researchers found the links between social media usage and adolescent mental health were "small to moderate;" but there are still plenty of authors who argue there are "serious, substantial, or detrimental" evidence linking the two. Seeking to offer explanations for the interpretation disparities, the authors of the "*umbrella review*," stated "each adolescent is subject to unique dispositional, social-context, and situational factors" that make empirical consensus elusive. Additionally, it is entirely "plausible to assume that both optimistic

and pessimistic conclusions…are valid" (Valkenburg & Meier, 2022).

Conclusive agreement as to the effects of social media and technology use is hard to find, yet there are a sufficient number of studies demonstrating negative outcomes that warrant serious concern from parents and caregivers (Boer et al., 2021). Mental health disorders are on the rise across the United States (Mental Health America, 2022), and youth and young adults are particularly vulnerable to negative influences at a time when their brains are rapidly developing and sensitive to undesirable influences (Schwarz, 2009). Although the unique context of each person influences their susceptibility to the potential negative effects of technology use, there is wisdom in mitigating undesired outcomes and providing young people with the best possible opportunities for positive mental health. Simply put, the risks of excessive technology use for many people are too great to leave to chance. A balance between the risks and rewards should be the goal.

On a positive note, one of the rapidly emerging trends amongst mental health providers is the improving access to digital therapy and tools. With nearly a thousand mental health apps for smart phones, technology has given us ready access to meditative exercises, mood tracking, healing music, and even artificial intelligence companionship (Ramadan et al., 2021). Many of these digital tools were developed in partnership with mental health professionals with beneficial results and should be explored and utilized by those seeking mental health support (Chandrashekar, 2018).

Perhaps the most important development in mental health technology in recent years has been the improved access to primary care providers. Often less expensive than an in-person visit and available when needed most, digital consultations are possible wherever a smart phone is present (Ewumi, n.d.). Those finding travel difficult due to pandemic, anxiety, or other issues can find care from the comfort of their own homes. Furthermore, digital therapy can be less of a hurdle for those who feel mental health treatment is "stigmatizing" (Spiers, 2021). Families struggling with mental health issues would be wise to explore these digital treatment options to see if they might be a good fit for their unique needs.

The Beneficial Alternative to Technology Use

While this essay has explored some of the validated and potential risks of modern technology use on children and families, it would be incomplete without examining beneficial alternatives for how we spend our time. According to the Environmental Protection Agency, US Americans spend approximately 90% of their time indoors (United States Environmental Protection Agency, n.d.). Taking into consideration other data indicating US Americans' screen time is on average around seven hours a day, it's evident we are becoming increasingly sedentary, isolated, and unknowingly exposed to indoor air that is up to "5 times more polluted than outdoor air." Furthermore, missing out on natural sunlight diminishes are mood and interferes with our sleep patterns. The problem has become so widespread and acute one report called ours the "Indoor Generation" (Velux, 2018). It's not just the negative effects of technology and living almost our entire lives indoors that must be considered, but also the benefits of getting outside. In other words,

there's an opportunity cost we have when we use indoor technology.

God designed us to be active, relational, and spiritual beings. One of the best ways we can tap into these fundamental human characteristics is by spending time outdoors in God's Creation. Each year, there is a growing body of evidence demonstrating the myriad of health benefits associated with time spent in the natural world. A 2019, study involving 20,000 participants found that by simply spending a total of 2 hours a week outside we can dramatically improve our physical and mental health. These advantages occurred regardless of visit frequency or how long the duration into nature was if the total time spent weekly was at least 2 hours (White et al., 2019). In 2018, researchers writing for *Environmental Research* published findings from a meta-analysis of five scholarly databases with "103 observational and 40 interventional studies" that investigated over "100 health outcomes." While the researchers noted problems in the scholarly literature, they found evidence for dozens of positive health outcomes such as improved blood pressure, fewer cases of diabetes, and decreased cortisol levels for those who spent time in outdoor greenspaces (Twohig-Bennett & Jones, 2018).

The Japanese government has encouraged its citizens to spend time in nature for over forty years, and even created a special term to capture its importance; *shinrin-yoku*, or "forest bathing," which means to "absorb" the sights and sounds of the natural world. Doing so can have significant mental health benefits including reducing stress, enhancing mood, and even increased levels of happiness (Furuyashiki, 2019). Forest bathing is easy and only requires a person to be in a natural setting and to focus on the beauty of their surroundings away from the distractions of modern life. Forest bathing has shown so much promise in positive health benefits it is even prescribed by medical professionals (The Forest Bathing Institute, n.d.).

My faith is strengthened daily as I routinely see science proving Biblical truths, and in the case for spending time in nature, the Bible's authors made the case thousands of years before science did. One of my favorite verses on the importance of the relationship of the natural world and our faith, and therefore our well-being, is Job 12: 7-10 which states:

> But ask the animals, and they will teach you, or the birds in the sky, and they will tell you; or speak to the earth, and it will teach you, or let the fish in the sea inform you. Which of all these does not know that the hand of the Lord has done this? In his hand is the life of every creature and the breath of all mankind.

While each person will have their own perspectives and interpretations of these verses, I personally understand them to highlight God's power, His love of variety, His desire for us to live adventurously, and that by spending time in his Creation we are spending time directly with Him. In other words, we can know God, at least in part, by simply spending time with His Creation.

Professionally, I spend a great deal of time using technology to train people how to be better ministers for Christ, how to find Jesus, and connecting people to resources and people that can help them in their faith journey. I know the value and sincerely believe in the potential for enlarging Christ's

kingdom that the digital environment offers Christ's workers. However, I have seen too much anecdotal and empirical evidence to not take the negative effects of the digital world on individuals and families seriously. In my experience as a digital minister, we should not fear technology because of its potential for good, but we should treat it with a great deal of respect and care, because its misuse and abuse can lead to the worst possible outcomes.

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Torben Bergland, MD

HOLISTIC STRATEGIES FOR TREATING MENTAL DISORDERS

Our strategies for treating mental disorders rely on our understanding of what they are. There is, however, no simple answer to the questions: "What is a mental disorder?", or "How should mental disorders be treated?" Are the causes, disturbances, and cures biological, psychological, social, and/or spiritual? The understanding of mental disorders has developed and changed throughout humankind's history, and though much progress has been made, there are still many unknowns and much yet to discover and understand. Because of stigma and misconceptions, many who need treatment do not seek appropriate help and care, and even when patients seek treatment, the quality of treatment provided may be insufficient. In this article, I will discuss why we need a holistic understanding of mental health and holistic strategies for care and treatment.

Introduction

The brain is one of the most complex structures in the universe. The 86 billion nerve cells of the brain communicate by various chemical messengers, known as neurotransmitters, in trillions of nerve cell connections, called synapses (Herculano-Houzel, 2012). Even if we know many parts of this complex brain machinery and its interaction with the rest of the body, our understanding of exactly how everything works is rather limited. That makes it difficult to know precisely what is malfunctioning in various mental illnesses.

The complex biologic machinery of the brain produces the psychological mind. Just as the heart pumps blood, the gut digests food, and the muscles move the body, the mind is a bodily function of the brain. As with any organ of the body, when the brain does not develop properly, when it's not nurtured, cared for, stimulated, and exercised appropriately, or when it is hurt, harmed, and injured in some way, it may malfunction. The mind is impacted, and the dysfunctions may manifest as mental illnesses.

The mind is where we experience and reflect on ourselves, our relationships, our environment, and the world. It is comprised of thoughts and feelings that direct our behaviors. Memory, sensation, interpretation, imagination, desire, intention, willpower, planning, and execution are essential mental faculties that constitute the mind. In mental disorders, our ability to exercise these faculties may be impaired. This in turn impacts how we function and relate to ourselves, others, and the social context we live in.

The historic conceptualizations of mental disorders have tended to focus either on

causes related to the supernatural, the biology of the human body (somatogenic), or the psychology of the mind (psychogenic). "Supernatural theories attribute mental illness to possession by evil or demonic spirits, displeasure of gods, eclipses, planetary gravitation, curses, and sin. Somatogenic theories identify disturbances in physical functioning resulting from either illness, genetic inheritance, or brain damage or imbalance. Psychogenic theories focus on traumatic or stressful experiences, maladaptive learned associations and cognitions, or distorted perceptions (Farreras, 2022)." While supernatural theories have dominated the understanding of mental illnesses throughout much of history, and still are commonly held beliefs in various cultures and faith traditions, contemporary psychology and psychiatry predominantly focus on somatogenic and psychogenic theories, and consequently biological and/or psychological treatment strategies.

In its constitution adopted in 1948, health was defined by the World Health Organization (WHO) as; "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"(World Health Organization, 1948). Rather than focusing on one dimension of health, often to the exclusion of others, this definition of health seeks to reflect a more holistic model and perspective of health. The more holistic 'biopsychosocial model' of health and illness (Engel, 1977) has since gained widespread acceptance in healthcare, though clinical practice often fails to be truly holistic and often predominantly focuses on one aspect or another of health.

What is missing from WHO's and Engel's definitions and models, is the supernatural, or spiritual aspects of existence. Materialistic worldviews dominate medical and psychological sciences and may leave little or no room for a spiritual dimension of existence. There has been some reluctance to move toward an even more holistic 'biopsychosocial-spiritual model'. In 1999, at the 52nd Assembly of WHO, it was proposed to revise the definition of health and insert "spiritual", so it would state that: "Health is a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1999). The proposed amendment failed, but the WHO has still emphasized the importance of the spiritual dimension in the prevention and treatment of illness.

The term 'spiritual' may have different meanings for different people. A broad and comprehensive definition is "the search for ultimate meaning, purpose and significance, in relation to oneself, family, others, community, nature, and the sacred, expressed through beliefs, values, traditions and practices" (Puchalski et al., 2014). Another term for the study of mental disorders is "psychopathology". It is a derivative of three Greek words: ψυχή (psychē), πάθος (pathos) and λόγος (logos)—which literally translated would be something like "soul suffering study" (McRay et al., 2016). Many people experience that sooner or later in life, issues of meaning, purpose, and significance become of utmost importance. In mental illness, many people also experience existential and spiritual questions and suffering. Meaning, purpose, and significance are matters of the soul, and spirituality should therefore be included in concepts of mental illness and our strategies for treating them.

A holistic strategy

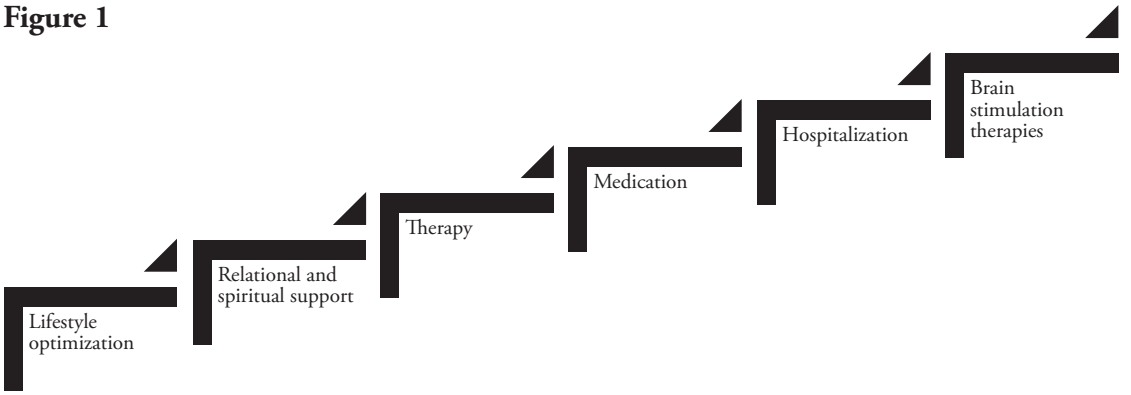
Sometimes, because of the preferences and beliefs of the patient, family, peers, and even healthcare professionals, some may avoid and reject a holistic strategy for management and treatment. They may, for example, be unwilling to try out lifestyle interventions, medication, or counseling and psychotherapy. Despite these being well-proven strategies for treatment and recovery, some may only be willing to accept certain kinds of treatment or none at all. It is important to respect the convictions and wishes of a patient, yet when the patient has the mental capacity and ability to make informed decisions and provide informed consent, one may seek through empathetic dialog to convey information and understanding that may encourage them to accept appropriate interventions and treatments. Unfortunately, estimates suggest that only half of the people with mental illnesses receive treatment (National Institute of Mental Health, 2022d). A further problem is that the quality of care people with mental disorders receive too often is insufficient (World Health Organization, 2021). Whether due to insufficient availability and quality of care or choices of the patient, many who could be helped do not receive appropriate and sufficient care and thus their suffering is needlessly prolonged and the chance of recovery diminished.

If we seek to apply a truly holistic approach to managing and treating mental disorders, we ought to adopt a biopsychosocial-spiritual model that takes an interest in and seeks to optimize every dimension of human existence; physical, mental, social, and spiritual. Appropriate healthcare providers will be consulted, and appropriate interventions initiated in a timely manner, and not delayed unnecessarily. Unfortunately, many suffer from mental disorders for months and years before seeking treatment. The course of the illness and the effect of the interventions will be properly monitored and evaluated, and adjustments made when indicated. The goal of the treatment may be full recovery, or optimal management of the illness if it is of a more chronic nature. When the treatment goals have been achieved, appropriate measures should be taken to prevent relapse or deterioration.

A key principle in any treatment plan is to assure, optimize, and expedite the desired effects of the treatment, meanwhile minimizing the risk of undesirable side effects and potential harm. Treatment plans for moderate to severe mental disorders require the expertise of competent mental health professionals, and in complex and/or severe cases, often multi-disciplinary teams.

The chosen strategy depends on the nature, severity, and duration of the illness. A common approach to treating mild to moderate mental disorders may be a stepwise strategy where one level builds on the preceding ones, as illustrated in figure 1, and each step increasingly requires more professionalized, sophisticated, and comprehensive care and interventions. Treatment may start with the basics of self-care, optimizing lifestyle, and relational and spiritual support. These "steps" may be supported by primary care providers, family, friends, and spiritual care providers. When this is not sufficient, counseling or psychotherapy will often be recommended. For this, trained mental health professionals are required. When this isn't sufficient, or the illness already is moderate to severe, then we'll go on to trying out medication, and possibly hospitalization. If we still haven't achieved

Figure 1



recovery, then various brain stimulation therapies may be indicated.

In moderate to severe mental disorders, and especially when there is a risk of harm to the patient by suicide or self-harm, or harm to others by violence, a treatment plan will often follow a different sequence of interventional "steps". Hospitalization may be the first "step", followed by other "steps", like medication, depending on what is considered to be necessary and what the patient is considered to be able to benefit from. Again, determining and designing a treatment plan for such patients requires the expertise of competent mental health professionals.

In the following sections, we'll take a closer look at the various "steps" of treatment and management of mental disorders:

Lifestyle optimization

Lifestyle impacts the risk of developing mental disorders, as well as recovery and management of mental disorders. It is well-documented that the following lifestyle factors may play a significant role in the trajectory of mental well-being:

Sleep: Almost all adults need somewhere between seven to nine hours of quality sleep every night. That means seven to nine hours of actual sleep time, not simply that many hours in bed. Kids and teenagers need more. Unfortunately, many fail to get adequate amounts of sleep (Bergland, 2019). Sleep deprivation destabilizes the brain, impairs memory function, and makes us more likely to swing between extremes of emotions. When the brain is underslept, the frontal lobe's ability to control the centers of the brain that drive emotion, impulsivity, and reward-seeking is significantly impaired. Thus, the risk of negative mood, irrational actions and decisions, aggression, behavioral problems, and addictions is significantly increased. Sleep disruption is a symptom of most mental illnesses; but beyond being a symptom, insufficient sleep in itself may lead to mental illness (Walker, 2017).

Exercise: Physical activity is one of the quickest ways to boost our brains. Within a few minutes of just about any activity, we may be reaping benefits. Many who exercise regularly say that the positive effects it has on the mind are as important to them as the beneficial physical effects. But there's more to exercise than instant, desirable, short-term effects. The long-term benefits of exercise are well-proven. People who exercise report significantly fewer days of poor mental health than people who don't exercise (Chekroud et al., 2018). Exercise releases endorphins that relieve physical and emotional pain and make you feel better. Exercise also boosts the neurotransmitter

networks of serotonin, noradrenaline, and dopamine. It can actually be as potent as antidepressant medication, though that does not mean it is a substitute for medication. Exercise improves blood flow to the brain, reduces inflammation, promotes growth and healthy functioning of the nerve cells, and reduces stress (Korb & Siegel, 2015). Exercise may have preventative as well as therapeutic benefits on various mental disorders, such as depression, anxiety, and others, as well as Alzheimer's and Parkinson's diseases (Walsh, 2011).

Nutrition: The foods we eat and the fluids we drink become the bodies we are. For optimal functioning of the brain in a healthy body, the raw materials matter. "Diets higher in whole foods, such as vegetables, fruits, whole-grain cereals, beans and legumes, nuts and seeds, fish and olive oil, are consistently associated with a reduced risk of depression" (Jacka, 2019). On the other side, "diets higher in 'junk' foods, such as sugar-sweetened drinks, fried foods, pastries, doughnuts, packaged snacks, and processed and refined breads and cereals are consistently linked to a higher risk of depression" (Jacka, 2019). Similar results for anxiety and other mental disorders have been found.

Nature: Many of us live and spend most of our time in man-made urban environments with little access to nature experiences. This may contribute to mental distress, meanwhile, nature exposure may be beneficial to mental well-being. Research "links nature experience with increased positive affect; happiness and subjective wellbeing; positive social interactions, cohesion, and engagement; a sense of meaning and purpose in life; improved manageability of life tasks; and decreases in mental distress, such as negative affect. In addition, with longitudinal studies, as well as natural and controlled experiments, nature experience has been shown to positively affect various aspects of cognitive function, memory and attention, impulse inhibition, and children's school performance, as well as imagination and creativity" (Bratman et al., 2019).

Rest and relaxation: Many mental disorders are characterized by chronic stress. It is well-proven that strategies for rest and relaxation may be beneficial in prevention and treatment. Research indicates that "many important mental processes seem to require what we call downtime and other forms of rest during the day. Downtime replenishes the brain's stores of attention and motivation, encourages productivity and creativity, and is essential to both achieve our highest levels of performance and simply form stable memories in everyday life. A wandering mind unsticks us in time so that we can learn from the past and plan for the future. Moments of respite may even be necessary to keep one's moral compass in working order and maintain a sense of self" (Jabr, 2013).

Relational and spiritual support

Relationships are foundational for mental well-being. Most people sense a need for connection with others. We are social beings in need of fellowship and community. We need intimate emotional bonds in nurturing relationships. Yet, mental disorders may make it more challenging to successfully satisfy these relational needs. The patient may struggle with fears, worries, negativity, avoidance, isolation, a sense of worthlessness, misinterpretation, aggression, and even delusions. Such symptoms may interfere with the relational ability of

the patient, yet the need and desire for connection may be even greater because of the suffering.

"Social connection (or disconnection) can affect health through biological pathways such as immune function or the regulation of stress hormones. Relationship quality can affect health by influencing psychosocial factors such as mood, motivation and coping skills. Friends and family members can also influence a person's health-related behaviors such as eating and exercise habits. Together, those pathways can have long-term outcomes for physical and psychological health" (Weir, 2018).

Beyond providing practical help, assistance, and encouragement, quality relationships may contribute to maintaining a sense of hope, meaning, purpose, and significance. Thus, they may also be foundational for maintaining spiritual well-being. It is also recognized that faith leaders often are the first point of contact when individuals and families face mental health problems or traumatic events. In times of crisis, many will turn to trusted leaders in their communities before they turn to mental health professionals. When spiritual leaders and the community respond appropriately, they become significant assets in supporting the patient (U.S. Department of Health & Human Services, 2022).

Therapy

Another term for counseling and psychotherapy is 'talk therapy'. In counseling and psychotherapy, a therapist will guide the patient in processing what happens in the present, maybe what happened in the past, and strategize about the future. Therapy takes place with a licensed, trained mental health professional and a patient meeting one-on-one or with other patients in a group setting.

The goal of therapy may be to become aware of thoughts, feelings, and behaviors, identify ways to cope with stress, develop specific problem-solving strategies, examine a person's interactions with others, develop social and communication skills, learn to tolerate the distress, and create a safety plan to help someone who has thoughts of self-harm or suicide, recognize warning signs and use coping strategies such as contacting friends, family, or emergency personnel. There are many different types of therapy, and one may not be generally superior to others. For many therapies, research has provided evidence that specific therapies are effective for specific disorders and specific patients. These "evidence-based therapies" have been shown to reduce symptoms of depression, anxiety, and other disorders (National Institute of Mental Health, 2022c).

Some may be reluctant to seek therapy out of fear that a therapist may not share their worldview or faith and therefore be critical and disrespectful. Though this may happen, it is considered to be a breach of professionality. The role of a therapist is to provide a safe, non-judgmental environment where the patient may explore all their thoughts, feelings, and behaviors. The relationship between the patient and their therapist is based on confidentiality, benevolence, and trust, and a good relationship is essential to working together effectively and benefiting from therapy. If the relationship between the patient and therapist over time proves to be unsatisfactory, it may be advisable and necessary for the patient to end the therapy and start a new one with a different therapist.

Medication

Medications may be beneficial and necessary in treating mental disorders. They are often used in combination with other treatment approaches such as psychotherapies and brain stimulation therapies. Medications can affect people in different ways, and it is difficult to predict how a particular medication will affect a specific individual. It may take some trial and error to find the medication that is most effective with the fewest side effects. The goal is that the positive effects of any medication far will outweigh any negative effects (National Institute of Mental Health, 2022b). Starting and stopping medication should only be done in collaboration with and as supervised by a qualified health professional.

Antidepressants: Antidepressants are medications used to treat depression, but they may also be effective for anxiety, pain, and insomnia. Antidepressants take time to work - often 4 to 8 weeks. It is therefore important to take the medication for sufficient time before deciding whether or not it works. Antidepressants are not addictive (National Institute of Mental Health, 2022b).

Anti-anxiety medications: Various anti-anxiety medications help reduce symptoms of anxiety, such as panic attacks and extreme fear and worry. Antidepressants are commonly used to treat anxiety. Benzodiazepines are used to treat the short-term symptoms of anxiety, but taking benzodiazepines over long periods may lead to drug tolerance or even dependence. Beta-blockers may help manage anxiety symptoms such as rapid heart rate, sweating, and tremors (National Institute of Mental Health, 2022b).

Stimulants: Stimulant medications may markedly improve daily functioning for people with significant focus problems, such as people with ADHD. Some worry that stimulant medications may lead to misuse or dependence, but evidence shows this is unlikely when the medications are used as prescribed (National Institute of Mental Health, 2022b).

Antipsychotics: Antipsychotic medications are typically used to treat psychosis, a condition that involves some loss of contact with reality. Psychosis can be related to drug use or a mental disorder such as schizophrenia, bipolar disorder, or severe depression. Healthcare providers may also prescribe antipsychotic medications to relieve symptoms associated with delirium, dementia, bipolar disorder, depression, or other mental health conditions (National Institute of Mental Health, 2022b). Antipsychotics are not considered to be addictive.

Mood stabilizers: Mood stabilizers are typically used to treat bipolar disorder and mood changes associated with other mental disorders, such as depression, and schizoaffective disorder. Commonly used mood stabilizers are lithium and some anticonvulsant medications (National Institute of Mental Health, 2022b). Mood stabilizers are not considered to be addictive.

When medication is indicated, there are many options. If medication is not initiated and monitored by a psychiatrist, it may be time to consult with a psychiatrist if the desired effect is not achieved, or if there are unexpected or excessive side effects.

Hospitalization

When sufficient care and safety cannot be achieved as an outpatient, it may be appropriate to admit a patient into a hospital or some other institution where they may receive the appropriate care and treatment.

Admission to a hospital may be elective or urgent, voluntary or involuntary, for shorter or longer stays. In most countries, there are comprehensive laws and regulations for hospital admissions that define the rights of the patient and the duties of the healthcare institution. When a patient is involuntarily admitted because they refuse voluntary admission, or because they are deemed incapable of making informed decisions and providing informed consent, they will usually be represented by a lawyer or some other advocate that is designated to protect the patient's rights. Being an inpatient allows for thorough observation of the patient, intensive treatment and monitoring, and measures to keep the patient safe from suicide and self-harm, and others from violence.

Brain stimulation therapies

Brain stimulation therapies involve activating or inhibiting the brain directly with electricity. The electricity can be given directly by electrodes implanted in the brain, or noninvasively through electrodes placed on the scalp. Electroconvulsive therapy is the best-studied brain stimulation therapy and has the longest history of use. The electricity can also be induced by using magnetic fields applied to the head. While these types of therapies are less frequently used than medication and psychotherapies, they hold promise for treating certain mental disorders that do not respond to other treatments (National Institute of Mental Health, 2022a).

Conclusion

A holistic perspective on mental disorders adopts a biopsychosocial-spiritual framework for understanding and treatment strategies. This allows care and treatment to address all dimensions of human existence through the many and varied interventions available in order to minimize the duration and extent of suffering. When interventions are complementary, one should not exclude another. Such a holistic strategy for treating mental disorders increases the likelihood of achieving remission or optimal management of a chronic mental disorder.

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