CHRISTIAN COUNSELLING AND FAMILY THERAPY

VOLUME 5

THEOLOGY AND PSYCHOLOGY II
ETHICS
PSYCHOPATHOLOGY II
STRESS MANAGEMENT AND GRIEF THERAPY

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FOREWORD

Doctor Bruce and Nellie Litchfield have teamed up together as one of those powerful husband and wife partnerships to develop this sound biblical work.

In their years of study and service with us in the University of the Nations, they have proved themselves able and diligent students of both the word of God and secular models in counselling. I was impressed with the way Bruce's research and analytical abilities were complimented by Nellie's excellent people skills.

This compilation of latest counselling theory and its integration into six concise and clear manuals, is an example of their combined giftings and skills. These are days when the provisions of parameters that do not compromise biblical presuppositions are absolutely vital.

Bruce and Nellie have pioneered the Family Therapy School and a Masters program for the College of Counselling and Health Care in the University of the Nations. They have also developed a Family Therapy Clinic, which serves a sizeable community in Canberra, Australia, and is a training centre for our undergraduate and graduate programs.

If you are a serious worker in the field of contemporary Christian counselling, or plan to be, the six volumes will be of immense value in guiding you along the way.

I am convinced these works should be on the shelves of all Pastoral Counsellors, Family Therapists and those who desire a well-integrated, biblical base for their ministry.

Dr. Bruce Thompson, International Dean, College of Counselling and Health Care, University of the Nations, Lausanne, Switzerland. Author of "Walls of My Heart."

ABOUT THE AUTHORS

Bruce, a dentist for many years, following a major crisis in his life, experienced a dramatic Christian reconversion in 1985, resulting in a major change of direction.

He completed a Diploma in Biblical Studies at Vision College in Sydney in 1986 and a Bachelor of Christian Ministry at Rhema College of External Studies in Queensland in 1988.

Bruce and Nellie have been working since 1986 with Youth With A Mission (YWAM), a large interdenominational missionary organization. YWAM is engaged in mercy work, training and evangelism. Its training arm is the University of the Nations, now present in each continent.

In 1992, they returned from USA, where they spent four and a half years studying, teaching and practising in counselling and family therapy.

Bruce completed a Master of Arts degree in Counselling at the University of the Nations in Hawaii with a thesis entitled *Australian Culture - A Christian Perspective*. He also completed a Doctor of Philosophy degree in Counselling at Vision International University in California with a dissertation entitled *Sexual Healing - With emphasis on Sexual Addiction. Counselling and Sexual Immorality in the Church*.

Nellie also had a dramatic conversion in the mid 1980s, and completed the Diploma of Biblical Studies at Vision College of Ministry in Sydney in 1987. She then joined YWAM in September 1987 and completed a Bachelor of Arts in Counselling at the University of the Nations in Hawaii. She also completed the Diploma in Christian Counselling and Family Therapy in Canberra.

Bruce and Nellie have been engaged in professional therapy practice since 1992 at Dickson, Canberra, where they counsel as a husband/wife team. They have a special interest and expertise in marriage and family therapy, addiction therapy, sexual therapy and individual psychotherapy. Bruce still does some dentistry but his main interest is in family ministry, teaching, and writing.

Bruce and Nellie are the National Directors of the one-year Certificate IV and two-year Diploma in Christian Counselling and Family Therapy course, which is conducted in Canberra, Brisbane, Melbourne, Newcastle, Sydney, Perth and Madang (PNG). This is their primary ministry.

Bruce and Nellie also are the Directors of the Family Resource Centre, Institute for the Nations (YWAM) in Canberra, which conducts seminars in Australia and overseas (especially in Eastern Europe) on family, marriage, parenting, addiction and counselling.

ACKNOWLEDGMENTS

The authors are indebted to the University of the Nations (Youth With A Mission), Hawaii, and Vision International University, California, where much of this material was learnt. The teachings and writings of Dr Larry Crabb, Dr Mark McMinn, Dr Gary Collins, Dr Gary Sweeten, Dr William Kirwan, Dr David Augsburger, Dr Bruce Thompson, Dr Grant Martin, Dr William Backus, Dr Sandra Wilson, Dr Bruce Stevens, Dr Albert Ellis, Luther Matsen, Dr John Tickell, Bruce Reddrop, Tom Marshall, Paul Tournier, Joy Dawson, workers at the Minirth-Meier Clinic in Dallas, Leanne Payne, John and Paula Sandford, Darrell Furgason, Dr Bruce Stevens, Helen Middelmann and others have been heavily drawn upon. The authors express gratitude for the input these authors and teachers have had in their lives.

The authors also express gratitude to the various publishers and authors who have granted permission to quote from their publications.

DEDICATED

This work is dedicated to the Lord Jesus Christ - the one in whom, *We have redemption through His blood, the forgiveness of sins, according to the riches of His grace* (Ephesians 1:7).

Blessed be the Lord my Rock,
who trains my hands for war,
and my fingers for battle
(Psalm 144:1)

We do not wage war according to human standards;
for the weapons of our warfare are not merely human,
but they have divine power to destroy strongholds.
We destroy arguments and every proud obstacle
Raised up against the knowledge of God,
And we take every thought captive to obey Christ
(2 Corinthians 10:3-5)

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STRESS MANAGEMENT AND GRIEF THERAPY

INTRODUCTION

The Six Training Volumes

Four Christian counselling volumes were initially compiled by Bruce and Nellie Litchfield and introduced to the Christian community in 1992. These were also used in seminars they conducted.

After some two years, they then decided to use the volumes as a framework for a government accredited Advanced Certificate in Christian Counselling and Family Therapy course they established as directors of Family Ministries (YWAM) in Canberra in 1994. This course was designed to meet a need in the church community. Many requested that such is made available for church leaders and others who felt called to counselling, in order to be better equipped to face the increasingly difficult problems appearing in the church. In addition to this, many of those who do any significant counselling realise that they need proper qualifications to meet the current requirements of the emerging counselling profession.

The four volumes have since been expanded into six comprehensive, systematic and up-to-date training Volumes in Christian counselling and family therapy, for use in the general Christian community.

Extreme views on Christian counselling are avoided and a traditional generally accepted middle-of-the-road position is taken. This makes the Volumes acceptable to most denominations.

The six volumes also form the framework for the accredited Diploma in Christian Counselling and Family Therapy course conducted by the authors in many centres.

Any creditable training program in counselling must have two major outcomes:

- An inward effect in the counsellor leading to personal insight and growth (the counsellor cannot help another person beyond where they themselves are).
- An outward effect in an increased ability to help others through training.

It is hoped that both these outcomes will occur in all who study the Volumes and who undertake such courses.

VOLUME 1 THEOLOGY AND PSYCHOLOGY I, BASIC COUNSELLING CONCEPTS, THE EIGHT CORE CONDITIONS

THEOLOGY AND PSYCHOLOGY I
The nature of humanity, the nature of God, role of secular psychology, epistemology and counselling worldviews, models of psychotherapy, a definition of Christian counselling.

BASIC CHRISTIAN COUNSELLING CONCEPTS

Jesus-style counselling, the Holy Spirit and counselling, the role of prayer and Scripture, goals of counselling, qualities of a Christian counsellor, levels of counselling, phases of counselling, excellence and ethics, God's ways in healing and growth, blockages to healing, facilitating change, the supernatural power of God, tools, contracts, goal-setting and action, basic counselling procedure.

THE EIGHT CORE CONDITIONS
Introduction to listening, listening to God, the work of Rogers, Charkuff, Egan, Collins, Sweeten and Kirwan, basic counselling skills training, self-exploration, active listening (attending, respect, empathy), the other five core conditions (genuineness, self-disclosure, concreteness, challenging, immediacy), conflict resolution, a general Christian counselling model.

VOLUME 2 COGNITIVE BEHAVIOUR THERAPY, RECONSTRUCTION OF THE PERSONALITY, PSYCHOPATHOLOGY 1

COGNITIVE BEHAVIOUR THERAPY
The role of the mind, renewing the mind, development of CBT, the work of Ellis, Beck, Sweeten, Backus, McMinn and others, cognitive restructuring, the PO Chart, other cognitive-behaviour interventions.

THE RECONSTRUCTION OF THE PERSONALITY
Defence mechanisms, rejection, centrality of redemption, revelation, personal responsibility, confession and repentance, spiritual warfare, the role of casting out demons, hurt of injustice, the two keys to inner healing, resentment and forgiveness, identity, self-acceptance, cross-cultural counselling, Australian culture and counselling.

PSYCHOPATHOLOGY I
Defining mental health and psychopathology, introduction to the DSM-IV, anger, guilt, shame, Anxiety Disorders, Mood Disorders, Chronic Fatigue Syndrome.

VOLUME 3 PRINCIPLES OF FAMILY, FAMILY THERAPY 1, MARRIAGE THERAPY

PRINCIPLES OF FAMILY, MARRIAGE AND PARENTING
Biblical principles of family, marriage and parenting, effects of contemporary society, the family in Australia.

FAMILY THERAPY I
Murray Bowen and family systems theory, healthy and dysfunctional family systems, secular models of family therapy, a Christian model of family therapy, the genogram, communication, conflict resolution, codependency, glossary of terms.

MARRIAGE THERAPY

Differences in the sexes, marriage tests, intimacy, sexuality in marriage, basic needs of the husband and wife, other issues, adultery, divorce and remarriage, procedure in marriage therapy, premarital counselling.

VOLUME 4 ADDICTION THERAPY

ADDICTION THERAPY I
Definitions and incidence, biblical considerations, nature and characteristics of addiction, underlying factors, a Christian multidisciplinary model for recovery, principles of recovery, group therapy, the Twelve-Step program, steps of recovery, relapse, coaddiction, adult children of addiction.

ADDICTION THERAPY II
Specific addictions - Alcohol and Drug, Food, Sexual, Gambling, Workaholism, People, Money, Computer and the Internet, Exercise and Sport, Thrill-Seeking, Power, Rageaholism, Religious, Kleptomania, others.

VOLUME 5 THEOLOGY AND PSYCHOLOGY II, ETHICS, PSYCHOPATHOLOGY II, STRESS MANAGEMENT AND GRIEF THERAPY

THEOLOGY AND PSYCHOLOGY II
The link between theology, psychology and spirituality, theological tension areas in counselling, more on the nature of God and the nature of humanity, suffering and evil, the justice and mercy of God, repentance, psychology.

ETHICS
Nature of morality, humanism, biblical world-view in relation to ethical and moral issues, conscience, practical counselling ethics (competence, autonomy, confidentiality, neutrality, dual relationships, exploitation, special clients, records, supervision, continuing education, referring, ethical codes of conduct), legal issues and counselling.

PSYCHOPATHOLOGY II
Classification of mental disorders, The DSM-IV and ICD-10, the MMPI, Dementia, Schizophrenia, Somatoform and Factitious Disorders and Malingering, Dissociative Identity Disorder, Sleep Disorders, Personality Disorders, etc.

STRESS MANAGEMENT AND GRIEF THERAPY
Stress management, burnout, chronic pain management, soul therapy, grief therapy, sample therapy handouts.

VOLUME 6 FAMILY THERAPY II, SEXUAL THERAPY, PERSONALITY AND OTHER TESTS

FAMILY THERAPY II
Family categories, family violence and abuse, childhood development, counselling children and youth, Milan Systemic Therapy, Solution-Focussed Brief Therapy, Narrative Therapy.

SEXUAL THERAPY
Sexuality and spirituality, normal sexuality, sexual immorality, sexually transmitted diseases, homosexuality, prevention of sexual misconduct by therapists, Sexual Dysfunctions and sexual therapy

PERSONALITY, MARRIAGE AND OTHER TESTS
Tests in general, Myers-Briggs TI, MMPI, Firo B, Four Temperaments of Hippocrates, DISC, Wagner-Hout Spiritual Gift, Taylor Johnson Temperament Analysis, Prepare/ Enrich Inventories, Relationship Self Analysis (RSA).

REVIEW

Definition of Christian Counselling

Christian counselling has been defined in *Volume 1*, in a threefold manner as:

- Counselling according to the word of God (including divine revelation and the supernatural power of God).

- It is a comprehensive approach to the whole person - spirit (personal, relational), soul (rational, volitional, emotional), and body (physical).

- It is also a comprehensive biblical eclectic approach, being:
  - Insight oriented (the past - understanding a person's background).
  - Experiential oriented (present - the feelings).
  - Cognitive-behaviour oriented (present - the mind, changing false beliefs).
  - Medication oriented (use of drugs, when indicated).

Christian counsellors must tenaciously hold on to the following:
- The Bible is the greatest textbook on human behaviour (psychology).
- The Bible provides a framework for all counselling.
- Christ and the Holy Spirit provide supernatural healing power for every problem.
- The Christian community, functioning rightly, is the primary environment for healing and spiritual growth.
- Keeping the above prominently in mind, psychology can be of some help, if it does not conflict with the Bible.

The Bible is always more important than psychology. Psychology must be looked at through the lens of Scripture, not Scripture through the lens of psychology.

Active Listening

The most important counselling skill is active listening - thoroughly hearing the counsellee out. It must underlie all counselling and therapy. This is much more difficult than many realise. There are very few good listeners. It is a skill to be learned and practised. It is covered in *Volume 1*.

Active listening is the clear demonstration to the counsellee of:
- UNCONDITIONAL LOVE.
- NON-JUDGMENTAL ACCEPTANCE.

It involves Attending, Respect and Empathy - the first three core conditions.

Attending (Warmth)

- Non-verbal communication
- 65%+ communication is non-verbal
- Tone of voice
- No distracting mannerisms
- Facial expression
- Nods, grunts, etc.
- Reassuring appropriate touch
- **SOLER acronym:**
  - S - Squarely seated facing the counsellee
  - O - Open posture
  - L - Lean forward
  - E - Eye contact
  - R - Relax.

Respect

- Treat the counsellee as an equal
- Respect his views even if you don't agree
- Don't speak down to him
- **No quick advice**
- Stay on the topic
- Problem ownership:
  - Insist on personal responsibility
  - Don't carry the counsellee's monkey.

Empathy

Empathy is accurately perceiving the content and feelings of what the counsellee is saying and reflecting it back to them in your own words.
It is standing in the shoes of the other person and trying to understand them.
It is done by **summarising content and paraphrasing feelings**. Feelings must be **validated.**
Emphasis is on **accurately perceiving** the feelings and content. This means not **overstating or understating** what the other person has said.
It is the **most important of all counselling skills**.

Typical **empathy responses** that can be made after the other person has shared are:
If I hear you correctly you are saying...and you feel...Am I correct?
It sounds as though you feel...because of...Is that right?
From your point of view you think...and you feel...Have I got it right?
Excuse me interrupting, I want to make sure I am hearing you correctly...

The Eight Core Conditions of Counselling

The Eight Core Conditions of counselling, described in detail in *Volume 1*, provide a useful framework for counselling in general, including family therapy. The first three relate to active listening.

A summary of the Eight Core Conditions is as follows.

1. Attending

3. Respect

3. Empathy

- **Active listening** includes Attending, Respect and Empathy - the most important core conditions (Empathy is the most important single core condition).

4. Genuineness

- Being open and honest about one's thoughts and feelings.
- The most challenging of the core conditions.

5. Self-disclosure

- Sharing personal experiences to help the counsellee share theirs.
- The most used and abused of the core conditions.

6. Concreteness

- Moving from the general to the specific.
- Being concrete and focussed.
- Involves skilful questioning, probes, themes, summary statements, spiritual discernment.

7. Challenging (Confrontation)

- Pointing out discrepancies in what the counsellee has said and/or done.
- Helping the counsellee choose life and a better future.
- This and immediacy are the most difficult core conditions to master.

8. Immediacy

- Discussing, analysing and confronting the counselling relationship, especially when things don't appear to be going well.

Basic Counselling Skills

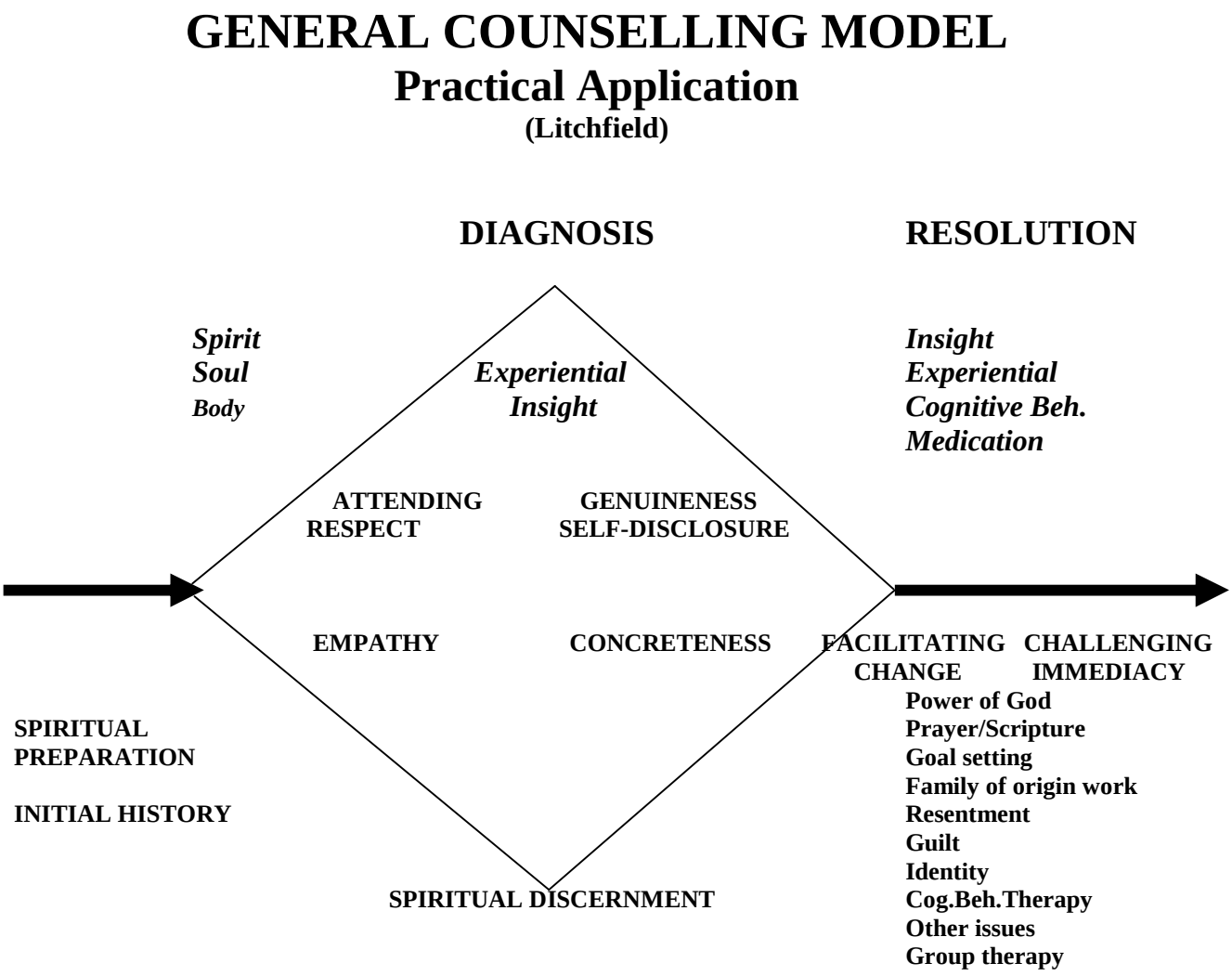
The basic skills of counselling are Attending, Respect. Basic Empathy, Self-disclosure, Concreteness, Challenging and Immediacy.

The General Counselling Model

It is most important, and it is the objective of this teaching, that every Christian counsellor develops a counselling model that is biblical, balanced, and effective.

The model, recommended by the authors, and which is described in *Volume 1*, uses a **theoretical framework** of the threefold definition of Christian counselling, the Eight Core Conditions and the two phases of counselling - Diagnosis (assessment) and Resolution (treatment). (Figure 1).

Figure 1



The Family Therapy Model

Theoretical Framework

The Christian Family Therapy Model (Litchfield) described by the authors is based on biblical principles and is eclectic, drawing from five different and popular approaches to therapy.

Bowen's Family Systems Theory (the Eight Interlocking Concepts) forms an important part of the model. This includes facilitating the process of self-differentiation, detriangulation, understanding family emotional processes, emotional closeness and distance, sibling position and dealing with multigenerational issues. The more directive Structural Family Therapy approach (family restructuring for improved functioning) is also used in the Model.

The Family Therapy Model is founded on the General Christian Counselling Model presented in *Volume 1*.

- It is biblical and makes room for God's supernatural interventions.
- A comprehensive approach to the whole person - spirit, soul, body.
- The Eight Core Conditions form a backbone structure to the counselling.

The Model uses a Systemic (family systems theory), a Strategic (actively working with the family to find solutions to their problems) and a Structural approach to therapy.

Aspects of Narrative Therapy may also be utilised.

The five family therapy streams the Model draws from are as follows.

- Psychodynamic (Object Relations Theory – family of origin - insight from past).
- Systemic (Bowenian and Structural).
- Experiential (the present - the feelings).
- Cognitive-behavioural (the present - the mind).
- Communication (family communication).

Both the family member with the presenting problem (the Identified Patient) and the whole family (as much as is possible) are involved in therapy. This means, in ordinary family therapy, the family is normally seen together and also each member is seen separately. This may extend beyond the nuclear family to the extended family. It may even extend to the wider system in which the family is involved.

> **The Christian Family Therapist is one who is grounded in the biblical ethical framework, and who seeks to help others, in their desire, to restructure their family in accordance with that framework.**

This restructuring will involve:

- Looking at and dealing with unresolved issues from the family of origin.
- Looking at generational patterns, and dealing with generational bondages.
- Looking at and improving the systemic dynamics of the current family.
- Facilitating greater emotional awareness of the IP and other family members.
- Facilitating cognitive restructuring of family irrational thinking patterns.
- Facilitating self-differentiation of the IP and other family members,

- Facilitating family communication and communication in the family subsystems.

The diagrams in Figures 2 to 7 will help illustrate the Christian Family Therapy Model.

- The Model illustrated as a wheel with the Eight Core Conditions appearing as the rim where the wheel meets the road; the spokes represent the five main streams; the hub represents the whole person; and the centre of the wheel represents the biblical central thread in therapy and the power of God.[1] (Figure 2)
- The Steps of Family Therapy. (Figure 3)
- The link between the Steps and the five main streams. (Figure 4)
- General procedure in Family Therapy. (Figure 5)
- General procedure in Marriage Therapy. (Figure 6)
- General procedure in Addiction Therapy. (Figure 7)

Figure 2

CHRISTIAN FAMILY THERAPY MODEL (Litchfield)

Identified Patient and Family

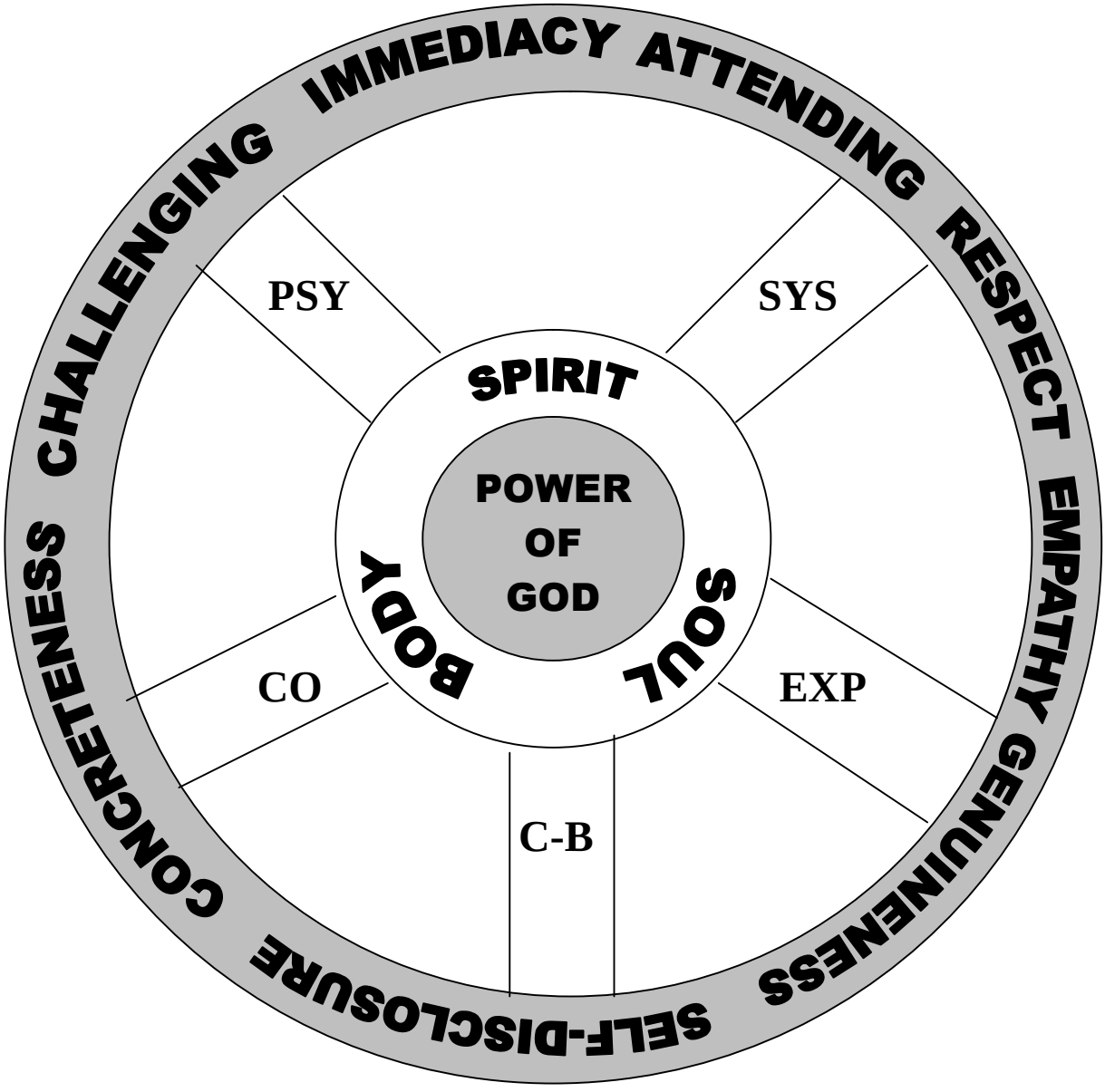


Figure 3

FAMILY THERAPY STEPS

Identified patient (and family)

The genogram

Understanding family of origin

Understanding current family

Learning to talk, feel, trust

Multigenerational transmission

Differentiation of self

- **Cognitive restructuring**
- **Dealing with resentment**
- **Dealing with guilt**
- **Making restitution**
- **Identity and self-acceptance**
- **Assertiveness training**
- **Letting go of control**

Communication

Building relationships

The Christian community

Other issues

Figure 4

LINK BETWEEN THE STEPS AND THE MODEL

(The whole person – spirit, soul, body, the Eight Core Conditions, and the supernatural power of God are all included in the following process. The five main streams are included as indicated)

Identified patient (and family) – Experiential, Systemic

The genogram – Experiential, Psychodynamic, Systemic

Understanding family of origin – Experiential and Psychodynamic

Understanding current family – Experiential, Systemic

Learning to talk, feel, trust – Experiential, Communication

Multigenerational transmission – Psychodynamic, Systemic

Differentiation of self – Mainly Cognitive Behaviour, Systemic

- **Cognitive restructuring**
- **Dealing with resentment**
- **Dealing with guilt**
- **Making restitution**
- **Identity and self-acceptance**
- **Assertiveness training -** Communication
- **Giving up control**

Communication – Communication, Systemic-Structural

Building relationships – Communication, CB, Structural

The Christian community – Experiential, Communication

Figure 5

GENERAL PROCEDURE IN FAMILY THERAPY

SESSION	CLIENT	THERAPY
1-3	**Identified Patient (IP) and family**	**Initial assessment (Active listening to each) Commence Genogram Diagnosis and Therapy Plan**
4	**IP**	**Complete Genogram**
5-6	**IP**	**Trauma List**
7	**IP**	**Resentment/Forgiveness List (may take more than one session)**
8+	**Other family members**	**Active listening (may take several sessions, and may come earlier)**
9	**IP**	**Guilt List**
10	**IP**	**Identity/self-acceptance Assertiveness training**
11	**IP**	**Other issues**
12+	**Family**	**Parenting, marital, sexual, communication, addiction, and other issues as indicated (may take several sessions, and may come earlier)**
13+	**IP/family**	**Every 6 weeks for maintenance and accountability for 12 months**

Figure 6

GENERAL PROCEDURE IN MARRIAGE THERAPY

SESSION	CLIENT	THERAPY
1-3	**Together**	**Assessment** **Active listening of each, first together then each separate** **Genogram commenced** **Therapy plan** **(may take more sessions)**
4	**Separate**	**Complete Genogram**
5,6	**Separate**	**Trauma List**
7	**Separate**	**Resentment/Forgiveness List**
8	**Other family members**	**Active listening** **(may come earlier, and may need more sessions)**
9	**Separate**	**Guilt List**
10	**Separate**	**Identity/self-acceptance** **Assertiveness training** **MBTI and RSA given**
11	**Together**	**Feedback on MBTI and RSA** **Communication exercise explained**
12,13	**Together**	**Report on Comm. Exercise** **Basic needs of husband and wife, intimacy, sexuality, etc.**
14,15	**Together**	**Report on Comm. Exercise** **Other issues**
16-20+	**Together**	**Every 6 weeks for accountability for 12 months**

Figure 7

GENERAL PROCEDURE IN ADDICTION THERAPY

SESSION	CLIENT	THERAPY
1	**The addict (IP)**	**Assessment commences** **Active listening** **Hope instilled**
2	**Spouse and other family members**	**Active listening** **Further assessment**
3	**Addict and spouse (parents if single)**	**Active listening** **Diagnosis and Multidisciplinary Therapy Plan submitted and agreed to** **(Is rehabilitation necessary?)** **(IP attends 12 Step Group)**
4/5	**IP**	**Feedback on 12 Step Group** **Teaching on fatherhood of God** **Genogram**
6/7	**IP**	**Trauma List** **Abuse Questionnaire**
8/9	**IP**	**Resentment/Forgiveness issues**
10	**IP**	**Guilt issues**
11	**IP**	**Christian disciplines** **Grieving losses** **Restitution (making amends)**
12	**IP**	**Cognitive restructuring** **Identity issues**
13	**IP**	**Spiritual abuse** **Christian community**
14	**IP**	**Rebuilding relationships commences**
15	**Coaddict – Spouse**	**Active listening** **Therapy plan submitted**

		Coaddict attends 12 Step Group (Al-Anon, etc.)
16-26	**Coaddict**	**Repetition of sessions 4-14 (This may commence earlier)**
27	**Other coaddicts (Family members)**	**Active listening (may take several sessions, and may commence earlier)**
28-32	**IP and spouse**	**Marriage therapy (Communication intimacy, financial, etc)**
33+	**IP and spouse**	**Every 4/6 weeks for maintenance and accountability for 2 years**

Counselling Skills

Counselling skills can be placed into three categories - basic, advanced and specific (See Figure 8).

Figure 8

COUNSELLING SKILLS

BASIC SKILLS	ADVANCED SKILLS	SPECIFIC SKILLS
Active Listening: - Attending - Respect - Basic Empathy Self-Disclosure Concreteness Challenging Immediacy	Advanced Empathy Advanced Challenging Cognitive Restructuring Therapy Model Genogram Assertiveness Training Circular Questioning Scaling Questions Reframing Reinforcement Role Playing Communication Training Resentment/Forgiveness Guilt Restitution Problem-solving Identity Paradoxical Intervention Teaching Journalling, etc.	Graded Exposure Hyperventilation Control Thought Stopping Relaxation Training Miracle Question Externalisation Reconstruction Sensate Focus Squeeze Tech. Casting out Demons Group Therapy Tests, etc.

THEOLOGY AND PSYCHOLOGY II

Review of Theology and Psychology I

It is recommended that students reread this Module in *Volume 1*, which covers the following:

The Nature of Humanity

- The tripartite nature of humanity (Spirit, soul and body).
- Depravity and dignity.
- The image of God.
- Three types of people.

The Nature of Sin

- Defining sin.
- Original sin and the sinful nature.
- Results of sin.
- The Seven Deadly Sins.

The Need of Humanity

- Basic needs:
  - Spiritual – security, self-worth, significance,
  - Rational – right thinking,
  - Emotional – in touch with but not controlled by emotions,
  - Volitional – right choices,
  - Physical – physical well-being.
- Identity.
- Acceptance.
- Peace and happiness.
- Relationships.

The Nature of God

- Names of God in Old Testament.
- Attributes of God in Old Testament.
- The fear of the Lord.
- Reasons why Jesus came.
- God is for us.
- The Fatherhood of God.
- Our knowledge of God determines our behaviour.

The Role of Secular Psychology

- What is counselling?
- Epistemology.
- Psychology and Scripture.
- Christian and secular worldviews.
- Secular psychotherapies compared.
- Comparison with the Christian approach.
- Shortcomings of the different therapies.

Defining Christian Counselling

- What is Christian counselling?

1. Theology and Psychology - History

Psychology no Longer an Enemy

The relationship between theology and psychology in the past has been very strained to say the least. It also has caused a good deal of controversy in the body of Christ. Several books have been written condemning all forms of psychology in Christian counselling.

Historically, the most well known attack by a psychologist upon religion was by the concepts of Sigmund Freud. Several of his writings in the 1920s and 1930s expressed the view that religious beliefs were merely human beliefs that sought to alleviate the fear of death. Freud also thought they helped people deal with the fear and frustration of renouncing our instinctual drives - an act necessary for our society to survive.

Freud described religious beliefs *as Illusions, fulfilments of the oldest, strongest and most insistent wishes of mankind.* He described religious ideas about God as cultural constructs in which a dehumanised idea of fate as remote, unappeasable and threatening could be replaced with a more personal idea - a fantasy father figure. This father figure may offer relief and support if appeased appropriately.

Other psychologists have also taken a sceptical view of religious beliefs. Some proposed that religious beliefs are the result of an effort to find meaning in the face of what appear to be incomprehensible aspects of life and environment.

B. F. Skinner, the father of behaviourism, attempted to reduce religious belief and practice to learned responses by applying the principles of learning and conditioning to the development and maintenance of religious behaviours.

Albert Ellis, the father of cognitive therapy and an avowed atheist, regarded religious beliefs came from irrational belief systems that need challenging and from which clients needed liberation. He believed that most people's psychological problems stemmed from religion. It is well known that Ellis believed that religion is the cause of virtually all psychopathology.

However, it is encouraging to note, in a 2000 article in *Professional Psychology: Research and Practice,* that Ellis states he has changed his views. He comments that the constructive philosophies of REBT are compatible with some important religious views in regard to unconditional self-acceptance, high frustration tolerance, unconditional acceptance of others, the desire rather than the need for achievement and approval, and other mental health goals.[2] It is interesting that he, like Charles Darwin and others, turned towards religion in the end.

These early workers (Freud, Skinner, etc.) believed in determinism – that people were determined by environmental factors and were not really responsible for their behaviour. Freud blamed internal psychic disturbance, Skinner blamed environments, Carl Rogers blamed the lack of self-expression. However, it was found that this was self-defeating and later researchers and therapists began to move towards personal responsibility. The beginning of the Twelve-Step spiritual journey of recovery in the 1930s helped promote this move. It is now

believed by most therapists that people must take responsibility for their thinking, choices and behaviour and be prepared to change these things, if they are to experience healing.

The effect of these attacks upon religious ideas from psychology has been to produce a deep mistrust towards psychology from many who value Christian faith. These psychologists were seen as enemies. However, many psychologist colleagues and contemporaries of these "enemies" engaged in a healthy and often respectful debate with them and argued against their views, with the result that psychology is no longer seen as an enemy if it is used rightly. Using it rightly means adopting a *Spoiling the Egyptians* approach, where the good is extracted and the bad (unscriptural concepts) is discarded.

It is interesting to note that a number of eminent psychologists have worked within a Judeo-Christian ethic. These include Gordon Allport, Victor Frankl, William James, Malcolm Jeeves, Carl Jung, O. Hobart Mowrer, and Abraham Maslow. This does not suggest that these psychologists were all Christians, but they had respect for the Judeo-Christian position. It is far from the case that psychology is a discipline whose adherents universally adopt a sceptical approach to the beliefs and practices of religion.

This point is also illustrated in a 1996 review of research studies by Worthington, Karusu, McCullough and Sandage in which they explored, in part, the relationship between religious commitment and mental health. The authors reported that, contrary to the expectation of a negative relationship between religious commitment and measures of mental health, the opposite was more likely to be the case. Indeed, the writers concluded that people who value faith as an end in itself rather than a means to achieve other goals gained definite positive health benefits from their religion.

Other studies found that families with a religious (spiritual) orientation were much healthier, stayed together longer and lived longer than those who did not.[3]

Family therapy has been considerably influenced by *postmodernism* (no true reality, discounting scientific truth and objectivity) and in particular, *social constructivism*. From a social constructivist perspective, actual reality cannot be known independently of an individual's meaning and interpretations. Definite problems arise here and have produced major concerns with some therapists. How can a therapist really help a family if objectivist knowledge and the insights of science are set aside? This situation is far from right, and recent developments are proving it so, such as the recent research of John Gottman in the field of marriage and couple therapy, and other research in attachment theory and neuroscience. Knowledge therefore cannot be dismissed simply as objectivist or pathologising.

Therefore, we need to no longer regard psychology as an enemy, even if many of the founding leaders of modern psychology were anti-Christian. We ought to be able with the help of the Spirit of truth to sift our what is unbiblical and embrace what is not, to our advantage. In this sense, it is no different to medical science in general.

The time has come for Christian psychologists and therapists to engage in their own research and make their presence felt, as *salt and light*, in the world.

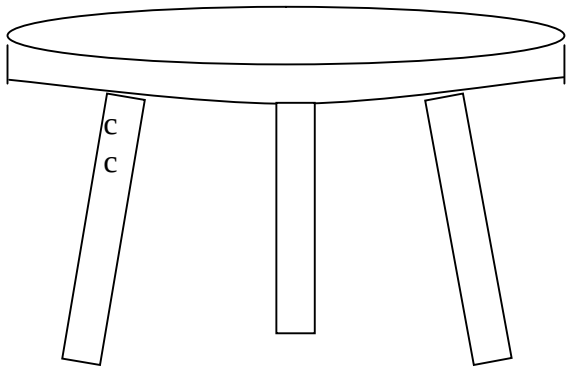
2. Spirituality Must Be Included

> *Those who are unspiritual do not receive the gifts of God's spirit, for they are foolishness to them, and they are unable to understand them because they are spiritually discerned. Those who are spiritual discern all things* (1 Corinthians 2:14,15 NRSV)

> *The prayer of the righteous is powerful and effective* (James 5:16 NRSV).

In addition to theology and psychology, the spirituality of the therapist must also be included to make a complete picture. It is like a three-legged stool (See Figure 9). A therapist may be very knowledgeable in theology and counselling techniques, but if he or she is lacking in spirituality their effectiveness in counselling will be greatly diminished.[4]

Figure 9



An effective Christian counsellor is one who has a passionate relationship with Jesus Christ and who knows what it is to be filled with the Holy Spirit. He, or she, is one who is born again and who takes the Bible, sin, prayer, spiritual warfare and involvement in the local church seriously.

Therefore, spirituality has to do with one's link with God – my knowledge of him and what he means to me. This includes the place given to the Holy Spirit in one's life and ministry. How deep is the relationship with God?

A spiritual person is a discerning person, and had access to the supernatural power of God, both of which can be brought to bear on client's problems.

This does not mean we have to be super-spiritual persons to be able to help others. It is true that we cannot help others beyond where we are ourselves, but this may still include many potential clients. We all have a long way to go to be fully conformed to Christ.

Henri Nouwen in his very helpful book, *The Living Reminder*, where he explores the link between ministry and spirituality states that, *Genuine ministry is born out of woundedness.*[5] We are all *wounded healers* and can never move from that position, but that doesn't mean we cannot be spiritual in our approach, he states. He also mentions that intimacy with God keeps ministers and healers (counsellors) alive, vital, energetic, and effective. To be a healing presence requires a spirituality, a spiritual connectedness and a depth of relationship with God.

The Christian counsellor therefore needs to be Christ centred, Bible based and Spirit filled to be fully effective in representing God to the counsellee.

Many spiritual interventions are possible in Christian counselling, and the level of our spirituality determines their effectiveness. Interventions include prayer, Scripture quotation and meditation, breaking bondages, confrontation of sin, confession, forgiveness, and others.

Spirituality in Therapy

In addiction to the spirituality of the therapist being so important in effective Christian counselling, there is also the issue of the spirituality of the client and how much spiritual issues can be raised in therapy.

The topic of spirituality is currently popular even among non-Christian. Now it is being realised that human beings have a spiritual component to their being which needs to be addressed in therapy.[6]

3. Some Important Questions

When Should We Pray With Clients?

> *Again, I say to you that if two of you agree on earth concerning anything that they ask, it will be done for them by my Father in heaven* (Matthew 18:19)
>
> *Therefore I say to you, whatever things you ask when you pray, believe that you receive them, and you will have them* (Mark 11:24)
>
> *Most assuredly, I say to you, whatever you ask the Father in My name He will give you* (John 16:23)
>
> *This is the confidence we have in Him, that if we ask anything according to His will, He hears us* (1 John 5:14)
>
> *First of all. then, I urge that supplications, prayers, intercessions, and thanksgivings be made for everyone* (1 Timothy 2:1 NRSV)
>
> *The prayer of faith will save the sick, and the Lord will raise them up, and anyone has committed sins will be forgiven. Therefore, confess your sins to one another, and pray for one another, so that you may be healed. The prayer of the righteous is powerful and effective* (James 5:15-16 NRSV)
>
> *If I regard iniquity in my heart, the Lord will not hear* (Psalm 66:18)

God clearly hears and answers the prayer of faith, as the above Scriptures indicate. This brings the supernatural power of God to bear upon difficult situations.

Prayer is primary for Christian growth. It involves more than asking God for things. Communion with God in prayer is more important than simply asking.

In therapy, we need to consider what kind of prayer is appropriate, for which clients, and when should we pray.

Pray with Eyes Open

It is recommended that therapists pray with their open and observe the client. The client's behaviour gives an indication of how to pray. Scripture nowhere states that eyes should be shut during prayer!

Types of Prayer

The Christian therapist can effectively pray in many ways.

- Private prayer before the session.
- Invoking the Lord's presence and blessing at the beginning.
- Inner healing prayer for the client.
- Prayer of cleansing for the client.
- Assurance of God's forgiveness for the client.
- For grace for a specific action by the client.
- Renunciation and deliverance.
- Silent prayer during the session.
- Silent prayer in tongues during session in difficult situations.
- Closure prayer.
- Prayer for the client after the session.

Care Needed

Care needs to be exercised with routine praying aloud in therapy sessions. It may become mere repetition like the Pharisees.

It may also be threatening to some immature Christians. One knows of a committed Christian lady over 90 years of age who says she has never prayed aloud, and she is uncomfortable when others pray aloud for her.

It could hinder openness on the part of the client and interfere with their accountability to God. In such cases the client may think, *I don't need to pray, my therapist prays for me!*

There is also the question of how well trained is the therapist in praying effectively. If he or she is not then it becomes an ethical issue.

When Should Scripture be Used?

And you shall know the truth, and the truth shall make you free (John 8:32*).*

The Holy Scriptures, which are able to make you wise for salvation
(2 Timothy 3:15)

In His law he meditates day and night. He shall be like a tree planted by the rivers of water, that brings forth fruit in its season, whose leaf also shall not wither; and whatever he does shall prosper (Psalm 1:2).

For the word of the Lord is right…by the word of the Lord the heavens were made…He spoke and it was done (Psalm 33:4,6,9)

I will meditate on Your precepts, and contemplate Your ways (Psalm 119:15).

Your word is a lamp to my feet, and a light to my path…The entrance of Your words gives light (Psalm 119:105, 130).

> *We through the patience and comfort of the Scriptures might have hope* (Romans 15:4)

The Scriptures set out God's thoughts and ways. They give us access to the knowledge of God and the knowledge of self. They afford comfort and hope. They tell us of the many promises of God.

How Can Scripture be Effectively Used?

In therapy Scripture can be used in the following manner.

- Kept in the mind of the therapist as a guide.
- Quoted by the therapist.
- Used for meditation by the client.
- Used for Scripture memory by the client.

Regular meditation on Scripture has been proved to be very healing.[7] Psalm 1 clearly indicates that persons who meditate on God's word will flourish and prosper.

Dangers

There is always the danger of misinterpretation. No one is infallible and has a perfect understanding of Scripture. This, therefore, requires humility on the part of the therapist.

Quoting Scripture can be tantamount to giving *quick-fix* solutions.

A therapist may say all the right things and quote the relevant Scriptures, but minister death into the counsellee. *Death and life are in the power of the tongue* (Proverbs 18:21).

Mere Scripture memory on the part of the client could contribute to denial and unhealthy defences?

Many clients know the Scriptures that apply. The quoting of these Scriptures is not what they are seeking and often hinders rather than helps. Many simply want to be heard, non-judgementally.

There is also the question of how well trained the therapist is in quoting Scripture effectively. If he or she is not then it becomes an ethical issue.

When Should We Suggest Forgiveness?

This is an important question and has been referred to before.

In cases of severe hurt it is important for clients to fully get in touch with the incident and the pain and process it, before any thought of forgiveness can be considered. Otherwise, the forgiveness is likely to be superficial and unreal. In the process of therapy it could take quite a few sessions before the client is ready for forgiveness. The need to forgive those who have caused us hurt is both a divine command, and a process.

The client must first be given time and freedom to fully verbalise details surrounding the incident, feel and express the hurt and pain, and the anger against the one who caused it.

Scripture states, *To everything there is a season, a time for every purpose under heaven…A time to love and a time to hate* (Ecclesiastes 3:1,8). For example, if an adult was sexually abused as a child, and they are processing the whole matter in therapy, it is quite appropriate for them to go through a period, short though it may be, of actually hating the abuser. Until they have done that they cannot properly forgive.

If the process of forgiveness described in *Volume 2* is fully gone through (the *Resentment/Forgiveness List*) these issues should be well covered.

When Should We Confront Sin?

> *Convince, rebuke, exhort, with all longsuffering and teaching* (2 Timothy 4:2).
>
> *Warning everyone and teaching everyone in all wisdom, that we may present everyone perfect in Christ* (Colossians 1:28 NRSV).

When confronting sin, care needs to be exercised, especially with non-Christians and immature Christians.

With non-Christians and immature Christians it could jeopardise the therapy relationship. Peter cut off the ear of the soldier with his sword. Jesus healed it. We need to avoid cutting off people's ears! It is better to be patient and work through things with people. Jesus did this very effectively with the Samaritan woman.

When there is a need for confrontation of sin we must consider the following:

- Have I earned the right to confront?
- Have I thoroughly listened to the client's story?
- Is there a background of previous affirmation?
- Have I dealt with the beam in my own eye?
- Is the timing right?
- Is it loving confrontation?
- The person must be separated from their behaviour.
- Conviction is the aim, not condemnation.

Different methods of confrontation can be used, such as:

- By silence.
- Pondering (the *Colombo Technique*).

- Indirectly (Nathan was very skilful in confronting David, using a parable)
- Questioning.
- Directly.

When Should we Cast out Demons?

> *Testifying…repentance towards God and faith towards our Lord Jesus Christ* (Acts 20:21).

This matter has been fully discussed in *Volume 2*.

All that needs to be said here is that the presence of the demonic is real and should not be minimised (under-emphasised). On the other hand it should not be maximised (over-emphasised).

Many confuse the workings of the *flesh* (or *old self*), which springs up from within a person (Mark 7:15, 20-23, Galatians 5:16-22) with demonic activity (which enters a person from without). The writers of the Epistles emphasised that the works of the *flesh* have to confessed and renounced. We believe that what is needed is a declaration of allegiance to Jesus Christ as Lord, confession and repentance. Any demons present must go in such a situation.

As mentioned before, there is little or no reference to casting demons out of people in the Epistles and no reference to it in John and Revelation. This is significant.

Therefore, we believe that the casting out of demons has some place in therapy, but only a minor place. The authors are casting out demons less and less.

Likewise, we see no Scriptural support for breaking soul or spirit ties in cases where sexual relationships have occurred. Again, where there is repentance, the soul ties are dealt with.

Generational sins (bondages) can be confessed and renounced in Jesus name (Nehemiah 1:6,7).

These statements are in line with the teachings of mainstream, well-respected authorities in counselling.

Is Reconciliation Always the Goal?

> *That He might reconcile them both to God in one body through the cross, thereby putting to death the enmity* (Ephesians 2:14).

> *God…has committed to us the ministry of reconciliation* (2 Corinthians 5:18).

Reconciliation is a wonderful truth of the New Testament based on redemption, and is always God's goal in relationships.

However, in cases of marriage breakdown, there are some cases where reconciliation is impossible.

Both parties must want to get reconciled - one party cannot do it alone.

Jesus does refer to sexual immorality as grounds for divorce. To this could be added physical and sexual abuse. If these things persist divorce is inevitable.

The authors are very slow to recommend divorce, knowing that God hates it (Malachi 2:16). It is far better in most cases to work on one's marriage rather than walk away from it.

Are Spiritual Disciplines Always Necessary?

> *On his law they meditate day and night. They are like a tree planted by streams of water, which yield their fruit in its season, and their leaves do not wither. In all that they do, they prosper* (Psalm 1:2 NRSV).
>
> *You will show me the path of life; in Your presence is fullness of joy, at Your right hand are pleasures forevermore* (Psalm 16:11).
>
> *Those who wait upon the Lord shall renew their strength.*…(Isaiah 40:31).
>
> *But we all, with unveiled face, beholding as in a mirror the glory of the Lord, are being transformed into the same image from glory to glory* (2 Corinthians 3:18).

While it could not be absolutely said that practising spiritual disciplines is essential for emotional healing, it clearly leads to peace of mind, strength, refreshment, transformation and joy. Focussing on God and his ways and promises, rather than on our own problems, is very healthy and beneficial, and is healing in itself.

Many go to secular therapists and get a good deal of emotional help without resorting to spiritual disciplines. If such can move on to this higher level of therapy the healing would be even greater.

Is Building Self Esteem Wrong?

> *I have learned in whatever state I am, to be content…I can do all things through Christ who strengthens me* (Philippians 4:11,13).

Positive thinking and building self-esteem are two very controversial areas.

The way positive thinking is generally referred to, is wrong, as it has to do with affirming the *old self,* which has been put to death at the cross (Romans 6). God has begun anew on the other side of death in resurrection.

However, so many people are negative thinkers, and need cognitive restructuring to switch to positive thinking. Learned pessimism can be converted into learned optimism. This is not unscriptural, as we are encouraged in Scripture to be grateful, receive the promises of God, understand our Christian identity, ask and receive, and be occupied with our bright future – our inheritance in Christ. Paul certainly was a positive thinker (2 Corinthians 4:7-10).

Self-esteem, likewise, is wrong if it is only promoting the *old self*. Scripture emphasises self-denial and self-sacrifice.

However, so many are low in self-esteem, and again need to have their thinking aligned with Scripture. Scripture tells us who we are in Christ – how God views us. If the self-esteem is based on this it is right.

Should You Preach to Non-Christians?

To preach to non-Christians in the therapy context is an imposition, disrespectful and unethical. We must accept people where they are, as God does. This is covered in the section on ethics in this volume.

On the other hand, we are always looking for, and praying for, during the course of therapy, an opening where we can skilfully share the gospel, and encourage people in relation to the spiritual side of their lives. It is God who works in people's lives and bring them to Christ, and as we wait on Him sensitively, he will direct us in what is said in this regard.

4. Theological Tension Areas and Counselling

Several important theological tension areas are very relevant to counselling. What is meant by theological tension areas is two opposite concepts related to each other and both being true. It is like a train that runs on two parallel tracks that never meet. The train (counsellor/therapist) must run on both to function effectively.

However, if an extreme position is taken in relation to any of these opposites the result is theological error and ineffective therapy. Five of these tension areas will be examined in relation to counselling and family therapy.

God's Sovereignty and Human Responsibility

For by grace you have been saved through faith, and that not of yourselves; it is the gift of God (Ephesians 2:8).

Faith by itself, if it does not have works, is dead (James 2:17).

Work out your own salvation with fear and trembling (Philippians 2:12).

God's sovereignty (Calvinism, Grace) emphasises that everything depends on God's sovereign actions in the lives of people. Human responsibility (Arminianism, Free Will) emphasises the choices people make.

Where is the correct position to be on the following continuum? Some are more towards one side than the other. Is that wrong? It depends on what needs emphasising at any given moment.

In the days of Charles Finney there was a good deal of looseness, so the Lord gave Finney a strong message to present emphasising human responsibility. Likewise when YWAM began in the mid-1950s, many joined it from the *Jesus Movement.* While these young people were Christians who had a desire to please God, many were also loose in their behaviour. Much of early YWAM teaching had a strong emphasis on human responsibility. Later there was a drift to an emphasis on grace.

If we were to err at all we would prefer to err on the side of grace. We never cease to be amazed by the wonders of God's grace.

Where do you think you fit on the following continuum?

God's Sovereignty **Human Responsibility**
Calvinism **Arminianism**
Grace **Free will**

0 **100**

Human Dignity and Depravity

God created human kind in his image (Genesis 1:27 NRSV).

I am fearfully and wonderfully made (Psalm 139:14).

I know that in me (that is in my flesh) nothing good dwells (Romans 7:18).

Another tension area is that of human dignity and human depravity. Some emphasise one at the expense of the other, but both have to be held in balance.

Where do you fit on this continuum?

Human Dignity **Human Depravity**

0 **100**

Grace and Truth

Often in the Old Testament and in the New Testament both grace (mercy) and truth are placed alongside each other, again indicating the need for balance.

> *Prepare mercy and truth, which may preserve him* (Psalm 61:7).
>
> *Mercy and truth have met together, righteousness and peace have kissed each other* (Psalm 85:10).
>
> *Not unto us, O Lord, not unto us, but to your name give glory, because of your mercy and because of your truth* (Psalm 115:1).
>
> *The word became flesh and dwelt among us…full of grace and truth…Grace and truth came through Jesus Christ* (John 1:14,17)

Some therapists are strong on insisting on truth, others are weak in emphasising grace. Where do you think you fit on the following continuum?

Grace **Truth**
Unconditional love **Challenging**
Non-judgmental acceptance

0 **100**

Confrontive and Non-Confrontive
(Direct versus Indirect)

Be gentle to all (2 Timothy 2:24)

Convince, rebuke, exhort, with all longsuffering and teaching (1 Timothy 4:2).

Our understanding of Grace and Truth will determine how confrontive we are in therapy. What is the correct position for a Christian therapist? Certainly it depends on the situation, as one may be more confrontive sometimes than others with the same client, and more with some clients that others. Nevertheless, a therapist's general therapy style is important. Is it more indirect (or *being with* the client) or more direct (or *doing with* the client) in their approach to clients? Where should it be? Where do you stand?

It is generally conceded among Christian and non-Christian therapists to be more towards the non-directive side of the continuum. We believe at about the 30 or 40 position would be about right. Where do you think you fit on the following continuum?

Non-Confrontive **Confrontive**
Indirect **Direct**
Being with ***Doing with***

0 **100**

We believe, and so do many others, that about ten minutes of the hour would be an appropriate average period of time for the counsellor to engage in speaking. Some would say less. However, with our model involving cognitive behaviour therapy, which usually requires more talking (teaching, etc.), we believe it would be about 10 minutes.

Process and Progress

Work out your own salvation with fear and trembling; for it is God who works in

you both to will and to do for His good pleasure (Philippians 2:12,13).

And such were some of you. But you were washed, but you were sanctified, but you were justified in the name of the Lord Jesus Christ and by the Spirit of our God (1 Corinthians 6:11).

I will go anywhere – providing it is forward (David Livingstone).

Another very important tension area in therapy relates to emphasis on ongoing process in working though issues compared with emphasis on progress (resolution and healing).

Some therapists emphasise prolonged process. This is often seen in the Recovery Movement. Alcoholics Anonymous believes, *Once an alcoholic always an alcoholic,* and it regards recovery from addiction to be a life-long process. Many subscribe to this view in relation to deep problem issues that clients have. When you meet some of these people and you ask them how they are, their frequent response is, *Well, I'm still working though things.* They never seem to experience much progress or get to a point of resolution!

Other therapists believe in God's supernatural power to heal and to heal completely, not only physical problems but also deep psychological problems. Some believe in immediate healing of all problems. Among secular therapists, Solution-Focussed Therapy and other forms of Brief therapy are becoming increasingly popular.

Where is the correct position for a Christian therapist, who believes in God's supernatural interventions?

We believe that the correct position is, as far as deep psychological problems are concerned, that the process concept is right but not prolonged process. Otherwise where is the healing power of God? Where is the victory of the cross and the victorious Christian life?

It must always be kept in mind that God is sovereign and can heal anybody completely at any time from any thing. However, he generally does not do this, and allows his children to walk the path of progressive sanctification.

After the children of Israel spent some 40 years walking through the wilderness to cover a journey that should only have taken 11 days, God spoke to them quite strongly to get moving forward into their inheritance, the Promised Land. They were going around in circles – around and around the mountain. It is so easy to drift into this pattern.

You have skirted this mountain long enough; turn northward (Deuteronomy 2:30).

As the Children of Israel moved forward they had to face two giants, Sihon the King of Hesbon and Sihon the King of Og – two inveterate haters of the people of God. They represent the workings of the flesh that would hinder spiritual progress. (Galatians 5:16,17). Og had a bed that was some three metres long, speaking of self-indulgence!

Reference has been made before to the *Seven Blockages to Healing* (see *Volume 1*). These are like the two giants, which must be overcome for healing to be experienced.

These blockages are as follows.

- Denial.
- Ignorance.
- Fear.
- Unbelief.
- Apathy.
- Disobedience.
- Unforgiveness.

Where do you think, in your general approach to counselling, you fit on the following continuum?

Process **Progress (Resolution)**

Recovery Movement **Solution Focused**

0 **100**

5. Theology and Psychology

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Introduction – Developing a Biblical Mind

The greatest problem we have in the United States is not ignorance;
it is believing things and concepts that are not true![10]

As you think so you will live (Proverbs 23:7).

> *Thus says the Lord: Do not let the wise boast in their wisdom, do not let the mighty boast in their might, do not let the wealthy boast in their wealth; but let those who boast, boast in this, that they know and understand me, that I am the Lord; I act with steadfast love, justice, and righteousness in the earth, for in these things I delight, says the Lord* (Jeremiah 9:23,24 NRSV)

> *And you shall love the Lord your God with all your heart, with all your soul, with all your mind, and with all your strength* (Mark 12:30).

The general condition of the human mind is to believe in concepts that are not true. God commands us to love him with our heart, soul, mind and strength.

Condition of the Human Mind

The Bible describes the human mind as follows:

- Hardened (2 Corinthians 3:14).
- Blinded (2 Corinthians 4:4).
- Hostile (Colossians 1:21).
- Fleshly (Colossians 2:18).
- Depraved (1 Timothy 6:5, 3:8).
- Futile (Romans 1:21).

Theology

The Nature of God

What is your concept of God? (See Tozer, A.W. *The Knowledge of the Holy*)

The Natural Attributes of God

The natural attributes of God are as follows**.**

- Eternal.
- Spirit.
- Personal.
- Trinity.
- Powerful.
- Knowledgeable.
- Omnipresent.

The Moral Attributes of God

The moral attributes of God are as follows.

- Love.
- Holy.
- Just.
- Merciful.
- Truthful.
- Faithful.
- Wise.
- Patient.

How God Governs the Universe

God governs the universe in three areas: the inanimate, the animate and the moral.

Inanimate
Rocks, plants.
Laws (cause and effect).
Laws of force.

This tells what WILL happen.

Animate
Animals, etc.

Instinct.
Laws of force.

This tells what WILL happen.

Moral
Human beings.
Free will.
Laws influence.

This tells what OUGHT TO happen.

The KEY is to understand the nature and function of LOVE!

God's Right to Rule

The grounds - our nature.
The conditions – God's nature.

- God has a right to rule human beings.
- His right to rule is founded on his value.
- His law is founded on his being.
- God's rule over creation is moral, and not coercive.
- God's being is timeless, but he acts in sequence.
- We are sinful and guilty, by choice, not inheritance.
- Our choices originate in ourselves – human beings are finite creators.
- Our sin has truly hurt God.
- Sin is essentially selfishness.
- Love is an unselfish choice for the highest good of God.
- We must meet conditions to be saved.
- Salvation is nothing less than making Christ Lord and King.
- The atonement is a SUBSTITUTION not a payment.
- Holy living is daily, loving obedience to growing light. God hods us responsible for what we truly know about him and his laws.

God governs through INFLUENCE and CONSEQUENCES.

The Dilemma of God (Justice and Mercy)

How can God be both Just and Merciful?

- God allowed himself to be treated as though he was guilty so we could be treated as though we were innocent.

The Cross

Justice and mercy are both visible.

Suffering and Evil

Perspectives:

- Arminianism - emphasis on free will.
- Calvinism - emphasis on God's sovereignty.
- Judgement - right and necessary.
- Discipline – just and loving.

Conditions of Salvation

- Awakening.
- Conviction.
- Brokenness.
- Repentance.
- Faith.
- Continuing in faith.

How to Preach and Share with Others

- Human beings are moral agents.
- Human beings are in rebellion against God.
- We are guilty of rebellion against God.
- We are guilty because of our rebellion against God.
- God's dilemma.
- God initiated reconciliation - he didn't have too.
- Repent and meet conditions for salvation.
- Urge person to continue living in relationship with God.

Worldview – Four Basic Philosophical questions

Who am I? – Epistemology.
Where from? – Ontology.
Where to? – Teleology.
Morals? – Axiology.

Philosophies Today

> *See to it that no one takes you captive through philosophy and empty deceit, according to human tradition, according to the elemental spirits of the universe, and not according to Christ* (Colossians 2:8 NRSV).

Atheism – individualism, materialism.
Marxism – political evolution, revolution.
Humanism – abortion, euthanasia, pornography.
Feminism - Male? Female? Family?
Relativism – deconstruction? Female "truth," no truth.
Environmentalism 0- nature is the highest value/priority. "Mother" earth, Gaia Goddess – Buddhism.

Scientism – science can lead us to all truth.
Determinism – Environmental, chemical, genetic, Gay genetics.
Globalism – national political, social, economic agendas must be directed, for the sake of the planet.
Pessimism – doomsday scenarios, global warming, ozone layer, overpopulation, finite resources.
Nihilism – there are no values.
New Age – Hinduism reincarnated.
Nationalism – collapse of the nation state.
Tribalism- ethnicity is the highest value.
Escapism – "This in not our world." (some churches and Christians).
Fatalism – this is the way it is meant to go.

The University

Origin in Eleventh Century – to produce Christian minds. God is Lord over all life.
What doe your department/professor teach at the moment?
Popular does not necessarily mean true.
Curriculum – neutral? Or philosophically guided/

Psychology

Humanistic View

Humanist View of Human Nature

A humanistic view of human nature includes:

- The inherent goodness of humanity.
- Humans are PERFECTIBLE.
- Moral failings blamed on society or environment.
- Value comes from self-realisation and fulfilment.
- Society hinders us from fully realising our potential.
- We need to get in touch with our "real self."
- Guilt is social, not real and objective. Conscience is a social product.
- Determinism: social, environmental, chemical, genetic. Humans are not free.

Humanistic Psychology

Humanistic psychology involves:

- Behaviourism – people are simply stimulus receptors, who respond in only one way to their environment. The individual is controlled by the world around them.

- Monist ontology. Materialism - mind and spirit just reflections of the human brain. Therefore, psychological problems and even ideas are physical and chemical (eg. Shock Treatment – ECT).
- Reductionism (reducing the spiritual mind to a function of the physical brain).
- Consciousness changing as it is physical (in brain).
- Attempts to alleviate all suffering for individual. Suffering is absurd.
- Human centred values.
- Humans encouraged to experiment with values, morality and sexual relations.
- Human role models.
- Mental health is restored by getting in touch with the "real" self, which is basically "good."
- Social engineering to create ideal society.

Summary

A summary of the humanistic view of psychology is as follows:

- Humanity is good by nature (perfectible).
- No dualism, just materialism.
- Evil society corrupts individuals.
- Society must be changed, then people can "learn" to do right.
- The goal is a "good life" and "freedom."

Christian View

Christian View of Human Nature

The Christian view of human nature, on the other hand, includes the following.

- Dualisms - mind/brain.
  - body/soul-spirit.
- Humans are created in the image of God (with free will).
- Human beings are fallen.
- Getting in touch with self is not a final solution to psychological problems.
- We need to recognise our sinfulness. Inherent in our nature is a drive for autonomy and unlimited freedom.
- We need to be freed from the sin nature, and to realise we are sinners: not helpless.
- Humans have a tendency to rebel against God.
- Humans have "suppressed the truth in unrighteousness" (Romans 1).
- Guilt is real. Conscience comes from God.
- Individual moral responsibility - repentance is necessary.

Psychology

The Christian psychology view includes the following.

- Dualist ontology; body and spirit - no reductionism of mind to brain.
- Consciousness - a supernatural feature, not a physical brain.

- Unity of identity. There is no change of consciousness through time. Identity is undisrupted throughout life – maturation of the intellect.
- Avoids nihilism, because there is spirit, not just matter.
- Psychological and mental problems are not just physical, but include sinful attitudes, motives, and behaviour.
- The individual is held personally responsible for sin.
- Solution for all non-organic "mental illnesses" - confession of sin, forgiveness of sin through Christ, reconciliation to God, sanctification through the discipling work of God's Spirit.
- Suffering has meaning. In the midst of suffering, the individual can turn to God for strength and grace and experience positive character development. (Care needs to be exercised not to attribute suffering to God)

Summary

A summary of the Christian view of psychology is as follows.

- Human moral responsibility is insisted upon.
- It works to reconcile the individual to God.
- It gives meaning to suffering.
- Society is the result of individual actions.
- The individual is responsible for evils in society.
- The goal is to reconcile individuals to God and others.
- God centred values.

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ETHICS

1. Foundations for Christian Ethics

The word, *ethics*, relates to the study of morals, of standards of conduct and moral judgement (or moral philosophy). Morals have to do with right and wrong.

In the Epistle to the Ephesians, Paul deals with the three areas in which Christians have problems.[11]

- The area of sin (Ephesians 4:17 to 5:17).
- The area of relationships (Ephesians 5:18 to 6:9).
- The spirit area (Ephesians 6:10-20).

What is Morality?

The words moral and ethical are used in two different senses.

An Approval Sense

Thus, morality has to do with questions of right and wrong in terms of actions and attitudes. For example, *That is a moral action.* Christian ethics therefore deals with how one should behave as a Christian, in a word with one's lifestyle. The opposite of moral in this usage is *immoral*.

A Descriptive Sense

In a descriptive sense, morality, uses terms to classify kinds of actions and attitudes. Where moral issues are involved, it is not a matter of preference or taste. It is a situation where there is something I ought to do because it is right or ought not to do because it is wrong, regardless of preference or convenience and regardless of whether other people do it or not. The opposite term in this case is 'non moral.' We say, it *is not a moral issue; it is just a matter of taste.*

When are Moral Issues Involved in a Situation?

Moral behaviour in the second sense above has to do with the following.

Our Values

Values involve the things we consider valuable in them, in determining our behaviour or expressing our goals. (For example: truth, love, and salvation).

Our Relationships

This also means our relationships with other people and with God. Righteousness in the Bible is a relational term - it means being 'right' with God.

Managing Desires and Feelings

Managing our own desires and feelings is also included, even if no one else is involved. That means our sense of being accountable to God.

What we do Freely and Intentionally

It also includes what we do freely and intentionally, and for its own sake that is not from fear or compulsion or blind conformity or mistake.

God's Provision for Moral Behaviour

God's provision for moral behaviour is to enable us to live a holy and therefore ultimately satisfying way.

God has Made the Following Provisions

Conscience

God has given us conscience to guide us in making moral choices and decisions (Acts 2:16, 1Peter 3:15,16).

Biblical revelation

In the Bible God has given us a sufficient revelation of what he approves and what he disapproves so that we can understand right from wrong (Psalm 119:105, Proverbs 6:16-19).

The model of Jesus Christ

In Jesus Christ God has given us a model of what he wants our lives to be like. Christ is our ideal and likeness to Him is our aim (Romans 8:29, Galatians 4:19).

The Holy Spirit

The Holy Spirit indwells us to give us the power to become the kind of people God wants us to be (Romans 8:8-17).

Conscience

Conscience is the function of the human spirit, with the ability to "see" general moral truths, such as honesty and faithfulness and the ability to apply them to particular cases so that we tell the truth, even at a cost, and keep our promises when it is inconvenient to do so.

Obedience to conscience is fundamental to moral behaviour.

To understand how conscience functions we must distinguish its form and its content.

> **Form** is the way that conscience works. This is the same for all, regardless of race, sex, age or background. It tells us when we are doing right and when we are doing wrong (Romans 2:15; 9:1). Like a judge in a court of law, it does not make the laws, it merely passes judgement on our behaviour in the light of those laws.
>
> **Content** is the basis on which conscience makes its judgements. It tells us what is right and what is wrong (2 Corinthians 1:12). The content of conscience varies with culture, age, background and learning. The Christian conscience depends above all on our exposure to the Word of God. We need our conscience cleansed from much wrong content and refurnished by the Holy Spirit from the Scriptures (Hebrews 9:1; I Timothy 1:5).

In dealing with conscience the Bible makes a clear distinction between the following.

Moral weakness

This means the person has the right standards but fails to live up to them (Romans 7:22-4). This person needs strengthening and encouraging.

Wickedness

This is where the person has wrong mora1 standards (Romans l:28-32; Ephesians 2:1-3) so that his conscience approves evil acts. This person needs reformation.

Bondage

Bondage occurs when the person's moral freedom is impaired by addiction or demonic power (Mark 5:1-17, 2 Timothy 2:26). This person needs liberation.

Defiled and seared conscience

Note also that the conscience can be defiled and seared so that it no longer responds (Titus 1:15, 1 Timothy 4:2).

The Bible - The Maker's Handbook

God's Rules for Living

God has not left us without clear guidance as to the quality of life he requires from his people. We are called to imitate God by living in harmony with the precepts that reflect the loves and hates making up his character (Ephesians 5:1-8). Therefore when we sin we are not only breaking his law, worse still, we are offending against his character.

Creation Ethics

God's rules for living are also the clues we need as to the way in which our human nature works best, both individually and socially. The infinite all-wise and all-loving God who created humanity in his own image knows exactly how we ought to live for our own best good.

Old Testament Ethics - The Ten Commandments

In the Old Testament, the Ten Commandments summarise God's boundary rules for our life. They have never been revoked and are binding on the whole human race (Exodus 20:1-17, Deuteronomy 5:6-21).

Taken together the Ten Commandments express:

Our duty to God	1. Exclusive worship and service to God 2. Against idolatry 3. Against dishonouring his Name
Man's vocation	4. The Sabbath (living to God's glory)
Sanctity of family	5. Honouring parents
Sanctity of life	6. Against murder
Sanctity of marriage	7. Against adultery
Justice and equity	8. Against stealing

Truth and honesty	9. Against false testimony
Inner motives and desires	10. Against envy and covetousness

Note the comprehensiveness of biblical ethics. For example in the Old Testament the aim of the wisdom writings (eg. Proverbs) is the application of prophetic truth to the whole of life - family, marriage, business, social, political and religious.

Rewards and Punishments

The Bible is not afraid of sanctions, neither should we be. The moral law is not a matter of taste or opinion; it is not even that it is the best for us. It is a matter of duty and obligation. People are guilty before God for breaking his law.

New Testament Ethics

The New Testament repeats and reinforces the Old Testament moral rules but also goes far beyond mere conventional morality to a spiritual revolution in behaviour only possible as the Holy Spirit is allowed to possess and control us.

Therefore, in New Testament ethics the following need to be observed.

a. Not only must we avoid the wrong act, but also the thought that fathered the act. For example, lust, greed, anger and so on (Matthew 5:20-48).

b. Not only are we to stop doing wrong, we are to replace wrongdoing by positive acts of good. Therefore, the thief, instead of stealing, is to work so that he can give to those in need (Ephesians 4:28-32).

c. Wrongs of neglect are as bad as, if not worse than wrongful acts, that is, omitting to do good that we could do (James 4:17, Matthew 25:41-42).

d. Our motives must be right as well as our behaviour. Only obedience with the right intent is pleasing to God (1 Corinthians 13:1-3).

e. There is no division between ethics and theological truth. How we behave is a mark of our standing as a Christian (I John 3: 10).

f. There is also a very strong sense of responsibility for the conscience of the weaker brother. Over-riding any effect on my own character is the effect of my actions or attitudes on my brother (Romans 14, 1 Corinthians 10:l9).

A New Character

The creation of a new character from which new behaviour patterns will emerge naturally and freely is the supernatural work of the Holy Spirit. It begins with a heart change. Our responsibility is to co-operate with the Spirit in dealing with the sinful acts and attitudes that obstruct his work in us (Ephesians 4:22-24).

God's Principles for Living

The Bible does not give us detailed instructions that cover every situation. Instead, it gives us broad guiding principles, with a few fixed points to give them relevance, and some examples to get us going (Romans l3:8-10).

Within these boundaries, we are expected to learn to apply the biblical principles as faithfully and as creatively as possible to particular situations. Understanding and obeying moral principles create character - and character is what God is after (Hebrews 5:l3-14, 2 Peter 1:5-7).

Biblical principles of behaviour can be found from three main sources.

- Specific directions and suggestions about the way in which a Christian ought to live, for example in the areas of sex, moral possessions or speech (1Corinthians 6:9-20, 1Timothy 6:7-10, James 3:6-10).

- Examples of behaviour which God wants us to follow and examples of what he wants us to avoid. For example the kindness of the Good Samaritan, the deceit of Ananias and Sapphira, the penitence of David.

- Ways in which Jesus acted in various life situations. For example, his compassion, his forgiveness, his humility and faith (Luke 23:34, John 13:1-15, John 11:41).

Some of the important biblical principles that are given to motivate and to guide our behaviour are described below.

The Principle of Kingdom Life (Matthew 6:33)

The dominant motive and guiding principle in every situation is that I am to seek the Kingdom of God and his righteousness. It is possible for us to seek to be obedient to the Lordship of Christ every time his will crosses ours but yet not to actively seek his will and government for each specific area of our life. Seeking the Kingdom means that I seek his commandments for my behaviour as a husband, worker, father, citizen and member of his body, that is:

- What are the directions God lays down as to this area of life?
- What examples does the Bible provide of living to please God in this area of

life?
- How did Jesus handle such situations?

The Principle of Stewardship (1 Peter 4:10, Matthew 25:15-28, Luke 19:11-26)

Our talents, gifts, possessions and opportunities, our life itself, are all received from God and are to be used in trust for him. Therefore, we have to account to him for the way in which we use our time, our finances and our personal capacities.

The Principle of Agape love (Mark 12:30,31)

Jesus summarised the whole law as firstly - love of God, and secondly - love for one's neighbour.

Love towards God is expressed in quite different dimensions from love towards neighbours. Love towards God means obedience, faith, gratitude, trust, humility and the set determination to live for his glory. Therefore, we are to do nothing that would dishonour God, the Holy One, or Christ (in terms of his character described in 1 Corinthians 13) or the Holy Spirit (characterised in Galatians 5:22,23).

Love towards one's neighbour, whoever he or she happens to be, friend or enemy, means that I will:
- Value him for himself and not for any attributes or abilities that he has.
- Seek his best good to the same extent as I seek my own.
- Do so as consistently and faithfully as I do for myself.

The Principle of Service (Galatians 5:13, Luke 22:27)

As Christians, we are called to a particular vocation of service. I am called to serve God and to serve the world for whom Christ died. My actions are to be guided by how they will serve my brother.

The Principle of Obedience (Psalm 143:10, 1 Peter 1:14)

Freedom is found in the willing acceptance of the authority of Christ over our lives. Only willing obedience pleases God and produces fruit in our lives.

The Principle of Humility (Luke 14:11)

This means not thinking more highly, or more meanly of ourselves than is justified, but being willing to be seen and recognised for what we are. It means walking in truth and honesty with one another, trusting and being trusted, forgiving and being forgiven and being responsible to and for each other.

Applying the Principles

How are we to learn to apply biblical rules and biblical principles to make right moral

decisions?

The following are some simple guidelines.

Gain a thorough knowledge of the whole range of obligations that God requires us to meet. The more we learn about them the better will we be able to discern right and wrong (Hebrews 5:14).

In the particular situation, we face the following need to be observed.

- Get as much relevant information as you can about the actual causes of the specific situation.
- Think out possible courses of action.
- Envisage the likely consequences of possible courses of action.
- Measure the possible actions and consequences against biblical moral standards.

With all the possibilities and results as far as you can honestly and impartially discern them, ask the Holy Spirit to guide you in applying biblical principles as creatively as possible to the situation.

If you are not well placed to make a judgement either through lack of knowledge or through bias due to personal or emotional involvement, ask advice from those qualified to give it.

Priorities in Moral Values

The Fall creates the need from time to time, for priorities in moral values because sometimes the ideal cannot be reached at all. One of the weaknesses of legalism is that it makes no provision for priorities.

Jesus had no difficulty in expressing priorities (Matthew 22:36-40).

Therefore if faced with two choices, both good always choose the best (Philippians 1:9). The good must not stand in the way of the best.

If unavoidably faced with the choice between options, both of which are wrong, choose the least evil, but remember that the wrong chosen does not thereby become right.

Finally, remember that there is room for genuine difference of conscience within the boundaries set by the law of Cod (Romans 14:5). The rule is not conformity but honest obedience to the light we have while yet being willing to be led further into truth. Genuine conviction must always be respected and room for differences allowed for.

2. Ethics and Morality

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Morality

The Basis or Foundation for Morality

What is the basis or foundation for morality, and for moral judgements?[13]

Possible bases

- God and natural Law. The Bible as a foundation. Natural law as the special features of creation. Morality is part of the nature of things.
- Human nature. But how do we know what humanity is? What is "natural."
- Individuals. Human ideas, will and intuitions.
- The State - people and policies. But these will change.

For example, the issues of human rights, euthanasia and abortion are interrelated and require a theory of morality before each can be discussed adequately.

A look at the humanist moral foundation

- Humanity centred - ethics of humanity, by humanity, for humanity.
- No absolutes - if no God, then no reference point. Subjectivity.
- No definition of "normal" behaviour or "human nature." No manufacturer's manual for people to follow. People write their own manual out of the context of his or her own experience. But whose experiences are the right ones? What is right?
- Ethical relativism. No absolute standard of right and wrong - relativism, situational ethics, cultural relativism. Charles Colson sums up the inconsistency of relativism when he says that today, *everyone has a right to express his or her own views .... as long as those views do not contain any suggestion of absolutes that would compete with the prevailing standard of relativism*.
- No definitions of "good" or what is "beneficial."
- Utilitarianism the aim - the greatest good for the greatest number. The end justifies the means.
- CHOICE becomes the highest value.

How then do humanists decide the "right" thing to do

The following reference points are used by humanists today in trying to decide the "right" thing to do.

- Cultural consensus. But why is culture right?
- Reason. But whose? What is a "reasonable" decision?

- Minority wants. Which perspective is right?
- Courts. Which judge is right? (Eg. *Roe Vs Wade*).
- State. Which political philosophy is the right one?
- Evolution - biology. Evolutionary psychology (See Time magazine article, *Adultery: It may be in your genes*. Morality has evolved - genetic determinism.

The Biblical Basis for Morality

Origin of ethics, lies in the nature of God, not commands. It is a question of moral objectivity, not subjectivity.

Natural moral laws are like physical laws. Morality is a part of the nature of things, of Creation. They cannot be changed by humans.

Operation of moral principles

- Conscience - witness of absolutes.
- Free will - not genetic determinism.
- Objective truth - truth is knowable. (Biblical values/principles).

Deciding the Right Thing to Do

Revelation

- That which conforms to God's character and moral laws (Psalm 5:4,5)
- That which is loving, righteous and just (Jeremiah 9:25).

Reason

- That which is glorifying to God.
- That which treats others as special, made in God's image.

Results

- Definitions available - moral absolutes, to be applied in individual situations.
- Freedom - to act according to our natures...to do the right thing. Responsibility defined to others first.
- Love becomes visible, as the highest value, because *God is love.*

Rights

The idea of human rights is taken more seriously now than it has been for centuries.

Major Questions for Us Today

- What are rights?
- On what (philosophical) foundation can rights be based?
- How should rights be exercised?

What are Rights?

(Meaning: *A just claim: Authority,* according to The Universal English Dictionary)

Old Rights

Rights ideas became more prominent in the 17th and l8th centuries- *Declaration of the Rights of Man and the Citizen,* proclaimed by the French National Assembly in 1789 (French Revolution) in response to political absolutism, the Divine right of Kings. The major concern at the time was:

- Source, and
- Nature of political authority.

John Locke (*Two Treatises of Government*) - the paradigm of a theory of natural rights.

God was the source of natural laws.

- Protection from the government – the divine right of Kings.
- Rights had duties and obligations.
- Equality of all individuals.

New Rights

Benefits from the government (eg. right to housing, education, good job, etc) Rights are given as benefits. Welfare rights. Conferring of benefits means taking from one and giving to another. (eg. right to rain forest, unobstructed mountain views, no airport noise)

- Have no duty with them.
- Needs based (It is easy to make up rights on the basis of needs).
- Not what is in the interest of all, but rather what individuals are entitled to.

The Conflict Today

Individualism versus community

Individualism produces a theory of rights that extol the importance of things like - bodily security, personal liberty, privacy, material well-being. However, self-interest is not a viable basis for a theory of rights. How to judge between competing "interests" and limited resources. (eg. logging and employment, and preservation of the forest). Emphasis is on the right to individual wants rather than responsibilities to community, civic virtue and solidarity. Self-interest versus the well being of the whole (group, society, nation, etc). Abortion and the "right to choose." But what of the moral righteousness of a choice? Hilter made choices. Why are they wrong?

Communitarianism is a challenge to individualism, and rights based liberalism - rights limited by what is best for the whole community. But this requires a universal philosophy of morality.

Historical Search for a Philosophical Foundation for Rights

Nature - insufficient foundation, since one could not deduce; moral principles from nature alone. How to discern the norms?

Reason - no better foundation than nature. Reason required premises, but from where - intuitions? Immanuel Kant, failed to establish a "categorical imperative" - a reason based ethical absolute.

Rational science of ethics produced utilitarianism. Maximise pleasure, or the "good" of the greatest number, minimise pain or "evil." The "good" - what is best for all. But how to decide that. Utilitarianism does not take seriously the distinction between persons, individual wants.

Consensus - Sociological approach - the will of the people. But how to decide what the general moral will is? Whose moral ideas will be implemented? Ethical relativism.

Social contract - People agreed to 1ive by certain moral principles. However, who decided and when did we individually contract? Jean Jacques Rousseau (a political philosopher of the Enlightenment period) - *the people must choose their own political arrangements.*

Science - But what "is" does not yield clues to, what "ought" to be done; fact/value dichotomy.

Objective rights require there to be OBJECTIVE MORAL VALLUES. "Crimes against humanity" Adolf Hitler. But why is anything wrong? In USA rights became associated with individuality. Rights of the individual against the majority. Emphasis on individualism has led to the tyranny of the minority.

God's commands and natural laws

Locke - Natural rights seen as inherent in human nature, grounded in the fact of humanity being made in God's image. Duties were imposed by natural law. Rights were constraints against evil treatment by rulers. Rights were derived from God's commands and purposes. Equality of individuals.

Today there is a shift from "natural rights" to "human rights." Rights no longer justified on the basis of truth about human nature.

Human rights are now focussed on the issue of the "scope" of rights claims (eg. what rights can I have?), rather than, how to "justify" rights (do we have rights at all in this situation?)

What Basis is used Today to Determine what Rights People Have?

- Physical capacities for free action. (eg. foetus not having "self-consciousness" - no right to life).
- Value of a sense of purpose (I have a right to freedom to pursue my own life-purposes...but at what cost to others'? (eg. Gay minority).
- Material conditions for individual initiative. (The right to a good job, education, housing etc.).
- Individual definitions of the "good" life or way of living (eg. porn, legalised drugs,

abortion).

How Should Rights be Exercised?

To have a right is not to be automatically protected from moral criticism about the exercise of that right.

A theory of rights - particularly a theory about rights to liberty - is not capable of standing on its own. It must be complemented by a general theory of virtue or moral action.
The Bible talks of responsibilities rather than rights. All claims to rights have corresponding duties. For example, if I have a right not to be killed, then I have an obligation not to kill anyone else. If I claim a right to privacy, then I am responsible to respect the privacy of others.

Rights summed up in one statement, *Do unto others as you would have them do unto you* (Matthew 7:12).

The First Commandment - LOVE GOD.
The Second Commandment - LOVE OTHERS AS YOU LOVE YOURSELF.
We are responsible to God first, and to OTHERS second.

Giving up of rights is freedom. Jesus laid aside His divinity and took the form of a servant. Given that the Bible teaches that God holds us accountable for our actions and lives, it would appear that we have no absolute right claims when it comes to God. We have privileges. Even our lives belong to God. It is borrowed.

Euthanasia

Definition of euthanasia - the "good" death (Greeks). The University English Dictionary - An "easy" death; the putting to death by painless means,

Passive versus Active Euthanasia

Passive euthanasia means allowing the process of natural death to take its course. It can involve withholding unnecessary treatment that prolongs the inevitable (e.g. cancer) with the explicit request of the individual or family.

Active euthanasia means hastening death by deliberate choices (eg. administering drugs, injections).

The difference lies in the intention or motive. With active euthanasia the intention is to deliberately kill the patient. In passive euthanasia it is to minimise the pain, or allow the process of death to take its course.

There is a shift today in our society from arguments about the sanctity of life to arguments about the quality of life. Or moving from a concept with an absolute moral framework to a concept with a relative moral foundation.

Dr Leo Alexander (Consultant, Nuremberg Trials), regarding the Nazi genocide:

> *The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to live.* (LaGard Smith, p. 163)

Belief in the special worth of human life is at the heart of civilised society...Once a single human life is seen as expendable many other lives are placed in jeopardy (Francis Carroll: Roman Catholic Archbishop of Canberra and Goulburn).

Arguments for Active Euthanasia

The following have been submitted as arguments to justify active euthanasia:

- The right to die.
- A dignified death.
- To minimise suffering.
- In the best interests of the patient.
- In modern society - we have "progressed."

Arguments against Euthanasia

The following arguments have been stated against euthanasia:

- It is unnecessary. Alternative treatments are available. Palliative Care.
- Requests are rarely free and voluntary.
- It denies the patient the final stages of growth.
- It undermines medical research.
- Hard cases make bad laws.
- Autonomy is important but never absolute.
- It leads to euthanasia "tourism."
- Changes the public conscience.
- Violates historically accepted codes of medical ethics.
- It gives too much power to doctors.
- Leads to a death mentality. Influences the young - to opt out.

Other arguments against Active Euthanasia

Further arguments have been stated against active euthanasia:

- Definitions of “terminal,” “hopeless,” “brain dead.” Medical advances are occurring in these areas.

- Patient capacities - sound mind, will and understanding.
- The doctor's motives - to heal or kill.
- What is the basis of the decision? Whose interests, economic, social, administrative?
- Patient becomes a burden on society.
- Pressure to exit.
- It changes the patient, doctor trust relationship.
- The track record of human nature is not reliable ("Give an inch...").
- Cannot be monitored. Motives and intentions are invisible.
- Death is not a solution to any problem. It is corrosive to society.
- Killing is not an act of MERCY or CARE.
- It destroys people's dignity in their last days.
- It communicates rejection - the idea of a "life not worth living."
- It kills the patient rather than the illness.

Abortion

Presuppositions

The presuppositions in the arguments about abortion are crucial and must be understood.

The nature of human beings
It is just tissue? Do we believe in evolution or special creation?

Nature of morality
Is it objective or subjective? Is morality a quality given to a choice, or is it an eternal system that judges all choices?

Rights
Rights - but whose rights? Rights do not apply when it comes to the death of another.
The right to choose! The absolutising of the value of free choice over all other values (See, *When Choice Becomes God*. F. LaGard Smith, 1990). What about the value of the unborn?

Authority of science
This involves absolutising the perspective of the scientific method, as over against other value considerations. (Is a 200-year-old forest tree just individual tree "cells?" What is the value of a $100 dollar bill? In scientific terms, it is only wood fibre with ink impressions on it. Its value is attributed to it; it is not intrinsic.

Definition of Person

This is the key issue. We have allowed the term "human" to be divided into two subdivisions:

a) Person, and
b) Non-person.

Today there are many problematic and shifting definitions of what a person is:

- Based on physical qualities only (tissue).
- Based on mental qualities (i.e., Peter Singer...self-consciousness).
- Based on the desires of the mother (baby or foetus?).

Definitions lead to attributing a moral "status" to the unborn individual. Does the baby have a right to live, or is it a "parasite?"

A person is like an event

This is the philosophical chink in the abortionist's armour. Other events, such as birthdays, marriages, football grand-finals, etc. are not substances that physically exist in the real world. They are events that are expressed conceptually. A person is not a substance, but is like an event. It begins when it begins, and finishes at the end. At no point in between does the event cease to be an event.

The biblical view is that we are more than a physical substance. We are a unique event. Our moral status is not determined by our physical qualities, but by our placement in the created order, as beings made in the image of God.

Associated Issues Relating to Abortion

Associated issues are:

- The nature of man.
- Morality.
- Personhood.
- Rights.
- Protecting the vulnerable and innocent.

Scriptures Relating to Abortion

When the sound of your greeting reached my ears, the baby leaped in my womb for joy (Luke 1:44).

Before I formed you in the womb I knew you, and before you were born I consecrated you... a prophet to the nations (Jeremiah 1:5).

You shall not murder (Exodus 20: 13).

Payment for killing an unborn child (Exodus 21:20-23).

For You have formed my inward parts; You have covered me in my mother's womb (Psalm 139:13).

For you have been bought with a price: therefore glorify God in your body. (1 Corinthians 6:20).

They even sacrificed their sons and daughters to the demons, and shed innocent blood, the blood of their sons and their daughters, whom they sacrificed to the idols of Canaan (Psalm 106:37).

And they have built the high places of Topheth, which is in the valley of the sons of Hinnom, to burn their sons and their daughters in the fire, which I did not command, and it did not come into my mind (Jeremiah 7:31).

And he made his son pass through the fire, practised witchcraft and used divination and dealt with mediums and spiritists. He did much evil in the sight of the Lord, provoking Him to anger (2 Kings 21:6).

Then Solomon built a high place for Chemosh, the detestable idol of Moab, on the mountain which is east of Jerusalem, and for Molech the detestable idol of the sons of Ammon. Thus also he did for all his foreign wives, who burned incense and sacrificed to their gods. (I Kings 11:7).

For You are not a God who delights in wickedness; evil shall not sojourn with you...You destroy those who speak lies: The Lord abhors the bloodthirsty and deceitful (Psalm 5:4 NRSV).

3. Practical Christian Counselling Ethics

Excellence in Counselling

> *That you may approve the things that are excellent, that you may be sincere and without offence till the day of Christ, being filled with the fruits of righteousness* (Philippians 1:10,11).

Christians are called to a standard of excellence in the Lord's work.

In the counselling context excellence is difficult to measure as it is normally done in a place where it cannot be observed by others (except the counsellee, who usually is not able to judge). In this way it is different to the teacher in the classroom, the pastor in church, the lawyer in court, and the doctor and nurse in hospital.

Things that destroy excellence include mediocrity, laziness, and selfish ambition.

Integrity is closely related to excellence. Integrity means moral fibre, good character, uprightness, honesty, genuineness, reliability, and consistency. This is never more needed than in the counselling relationship. Integrity has to do with both our motives and our methods – who we are and what we do.

In counselling a commitment to excellence relates to:

- Effectiveness.
- Ethics.
- Education.[14]

The effectiveness of counselling has been under strong attack in the past. However, this has provoked a good deal of research, which has proved that properly conducted counselling does work. Research of the many psychotherapies in existence has shown certain common threads that relate to effectiveness. These transcend things such as the specific model used and the duration of counselling.

The common threads relating to effectiveness in counselling are as follows.

- A good counsellor/counsellee relationship.
- Character of the counsellor – integrity.
- Motivation and expectations of the counsellee.
  (These first three are more important than any framework or model used)
- The counsellor moves within a definite theoretical framework (he or she knows what they are doing).
- Support offered to counsellee in expressing their feelings.
- Information and education offered to the counsellee to help them.
- Reduction of anxiety and depression.
- Reduction of maladaptive behaviours.

- Changing misconceptions (irrational thinking).
- Help counsellees put their concerns into a better context.
- Expand counsellee emotional awareness.
- Enhance the counsellee's personal effectiveness.

To these must be added, in the case of Christian counselling, the following:

- Encourage spiritual growth (relationship with Jesus Christ, Christian disciplines, church involvement, confession and repentance, forgiveness, Christian identity, etc.)

The objective is helping counsellees change their feelings, thinking and behaviour.

Excellence is called for in ethics (see next section) and in ongoing education (see next section).

Definition of Counselling

Before ethical issues can be properly considered it is necessary to define counselling.

The definition given by the Australian Board of Certified Counsellors, a nationally registered, independent, non-profit body, is excellent and simple.[15]

> *The practice of counselling is the rendering to individuals, couples, families groups, or organizations, professional services involving the application of theories, principles, or procedures of the counselling profession, which include but are not restricted to: Assessment, Consulting, Counselling, Education, Guidance, Psychotherapy, Referral, and Research.*
>
> *Counsellors are highly trained mental health and educational specialists who are sought out by clients for assistance with a wide range of psychosocial and interpersonal issues. Services are offered via a contracted and principles relationship that is guided by respect for others, professional knowledge, current research, helping skills, and a Code of Ethics.*

The trend in Australia for professional counsellors, including anyone who is recognised and known as a counsellor, is towards mandatory certification. Certification is intended to display occupational identity and level of competence.

Practical Christian Counselling Ethics

> *For I say unto you, that unless your righteousness exceeds the righteousness of the scribes and Pharisees…* (Matthew 5:20).
>
> *Let all things be done decently and in order* (1 Corinthians 14:40).

Ethics has to do with values and moral principles. The Christian therapist is called to the highest level of ethics and morality. Nothing less than excellence in this area is required.

To reach and maintain this, the Christian therapist must to be committed to Christian growth, Christian disciplines, humility and involvement in accountability groups with both other Christians and other therapists.

The client will be affected by the values and beliefs of the therapist. It is impossible to be completely neutral as to this with the counsellee, and it is not necessarily desirable. In fact it is unfair and unethical to hide one's beliefs from the counsellee.

Ethical issues are becoming increasingly important in counselling, as in other helping professions. Ethics particularly apply to those engaged in professional counselling, but also apply to any voluntary unpaid counsellor and non-fee paying counsellee working within the framework of counselling as described earlier. Christian counsellors ought, because of their beliefs, be exemplary in this area. However, this is often far from the case, and the cause is usually ignorance.

Counselling is a non-exploitative activity, and its basic values are integrity, impartiality and respect.

Trainee counsellors need to be aware of their responsibilities to clients and to themselves and other counsellors, before they take on clients. Issues such as confidentiality, legal aspects, suicidal counsellees, record keeping, exploitation, and adequate supervision are of the greatest importance.

Some important ethical points that need to be observed by counsellors are as follows.

- Counsellors have to be available to their clients, by exercising proper attending skills. If a counsellor is unable to adequately do this, due to being unwell, excessively tired or heavily preoccupied, an ethical issue arises.
- Counsellors should beware of developing a *messiah* complex, where they believe they are the answer to everybody's problems and have a need to be needed.
- A core thing counsellors need to have is a sense of hope, so they can impart it to clients.
- Student counsellors need to realise that obtaining a diploma is only the entrance into counselling. Real learning and skill comes from experience, continuing education and supervision.
- It is good to videotape or audiotape some sessions for self-evaluation and self-supervision.
- Counsellors need to beware of countertransference (counsellor's emotional involvement in the therapeutic interaction). If this occurs, the help of a supervisor is needed.
- It is recommended that counsellors ask clients on completion of counselling to

complete a client feedback questionnaire form to assist in self-supervision. (See sample form in Appendix)

The following ethical standards are based on those defined in *The Code of Ethics and Practice for Counsellors* of the British Association of Counsellors.[16] Similar ethics are defined in USA and elsewhere. [17]

Counsellee Safety

The prevention of physical and psychological harm to counsellees must be constantly considered, and adequate insurance coverage (professional indemnity, public liability, libel and slander) is essential.

Great care in the area of advice giving must be included here, as giving advice can have legal implications if negligent advice is given. A marked increase in litigation over such issues indicates the need for great care on the part of the counsellor to take the role of facilitator rather than adviser. This issue also relates to counsellee autonomy.

Counsellee Autonomy

The maintenance of counsellee autonomy includes:

- Setting boundaries of responsibility.
- Ensuring that the counsellee is having counselling on a voluntary basis.
- Adequate informing of the counsellee of their rights and responsibilities.
- Contracting (especially informed consent to counselling).
- Respecting the counsellee's beliefs and values, and not imposing one's beliefs onto them (eg. non-Christian, nominal Christian, other denomination).
- Confidentiality (see later).

Christian counsellors have to very careful in the area of respecting counsellee's beliefs and values and not imposing Christian views onto them. This is considered unethical. Some Christian counselling has become discredited because of this.[18]

Counsellor Competence

Counsellors need to constantly monitor their level of competence and be willing to be accountable to their counsellees and to other counsellors on a regular basis.

How can you, as a therapist, prove to somebody who asks, that you are competent? Therapists need to satisfactorily answer this important question.

Counsellors, at least, should seek to observe the following.

- Know why they do and say what they do.
- Be sure they do and say what they intend.
- Know what its effects are likely to be.

- Adjust counselling to counsellee's responses, and not rigidly follow their own agenda.
- Review their competence regularly through supervision.
- Ascertain whether their competence is same or better than other counsellors doing similar work.

Competence relates to training, qualifications, experience, reputation, and continuing education.

Continuing Education

Continuing education, an essential element in counselling practice, includes the following.

- Membership of at least one respected counselling association, and regular attendance to their meetings and any special seminars arranged by it.
- Attendance, whenever possible, to other specially arranged seminars on counselling.
- Attendance, wherever possible, national counselling conferences.
- Pursuing further counselling studies and qualifications.
- Subscribing to counselling journals.
- Ongoing self-improvement by reading and discussing cases with supervisor, etc.

An organization, *Psychotherapy and Counselling Federation of Australia* ***(PACFA***), has recently been established in Australia to co-ordinate and standardise counselling in general in Australia. PACFA will keep a national register of counsellors who are clinically approved by their association. Mandatory registration is soon coming in Australia for anyone engaged in professional counselling and those who are known as counsellors in churches, etc.

RECOMMENDED COUNSELLING ASSOCIATIONS AND ORGANISATIONS

Students completing the Certificate IV and Diploma in Christian Counselling and Family are advised to become members of the following organizations. Most of these organizations have different levels of membership. In some cases letters after your name, relating to level of membership, can be used.

Christian Counsellors Association of Australia (CCA)

Addresses and phone numbers are as follows:
NSW - Dr Graham Barker, Wesley Institute for Ministry and the Arts. Phone: 02 9719 1711.
Queensland - Pastor Rod Bullpit, 3 Bateman Cres., Springwood, 4129. Phone: 07 3808 8709, and Irene Brown of the counselling department of Heritage College.
Victoria – Canon Bruce Reddrop. PO Box Surrey Hills, 3127. Phone: 03 9830 4096.
(Office: PO Box East Bentleigh, Victoria 3165)
SA – Peter Bean, 14 Boyle Street, Oaklands Park, 5046. Phone: 08 8377 1447.
WA – Genevieve Milnes, 330 Daly Street, Belmont, 6104. Phone: 08 9277 9109.
(Regional chapters of the state CCA exist in such places as Newcastle, and Canberra)

Australian Association of Marriage and Family Counsellors (AAMFC)

For membership details and State branches phone: 1 800 806 054.

Family Therapy Association

See phone book in capital cities for local addresses and phone numbers.
ACT – GPO Box 843, Canberra, 2601.

American Association of Christian Counsellors (AACC)
An excellent association, with leading Christian authorities as leaders and members, which produces an excellent quarterly journal (*Christian Counselling Today*) and regularly supplies audiotapes to its members. AACC Member Services, PO Box 739, Forest, VA24551, USA.

Australian Board of Certified Counsellors (ABCC)

The ABBC maintains a national register of counsellors, and provides certification of four types:

- Certified School Counsellor (CSC).
- Certified Mental health Counsellor (CMHC).
- Certified Couple and Family Counsellor (CCFC).
- Certified Career Counsellor (CCC).

Further information can be obtained from, The Secretary, ABCC, PO Box 226, Wilston, Queensland, 4051.

RECOMMENDED COUNSELLING JOURNALS

Recommended counselling journals are as follows.

Family Therapy Networker – Family Therapy Networker, Subscription Service, 9528 Bradford Road, Silver Spring, MD 20901. USA.

Psychotherapy in Australia – PsychOz Publications, PO Box 1221, Collingwood, Victoria, 3066. Phone:03 9419 2626.

The Australian and New Zealand Journal of Family Therapy – 98 Brown Street, Armidale, NSW 2350. Phone: 02 67171 3753.

Christian Counselling Today – AACC, PO Box 739, Forest, VA24551, USA.

Avoidance of Counsellor Exploitation

Counsellee exploitation includes both financial and sexual exploitation.

Financial exploitation is best avoided by careful discussion of what will be involved and an agreement being reached about costs. Other factors are the counsellor cutting sessions short,

unexpectedly changing frequency of sessions, and by prolonging counselling beyond what is necessary.

Sexual exploitation occurs in situations of a power differential when a person in a position of trust takes advantage sexually of somebody under their care. It occurs in about 10 percent of persons in the helping professions, and certainly includes the counselling relationship.[19] It is not uncommon even with Christian counsellors.

The *Code of Ethics and Practice for Counsellors* of the British Counsellors Association states, engaging in sexual activity with current clients or within twelve weeks from the end of the counselling relationship is unethical. This means any kind of sexual activity. This is clear and to be commended.

Violation of counsellee's boundaries can occur when the counsellor indulges in inappropriate sexual self-disclosure, questionable touching or hugging, and excessive and unnecessary questioning about sexual problems.

Confidentiality

Confidentiality is extremely important in counselling, as it provides the counsellee privacy and safety. It must be rigidly maintained at all times.

However, to make it absolute is unrealistic. Confidentiality is vital but not always complete. There are rare situations, where total confidentiality would make it impossible to discuss cases in counselling supervision, refer to cases in teaching, to protect some counsellees from serious harm, in reporting child abuse, and to disclose information in court. So there are times when breaking confidence is legally defensible.

There is a difference between confidentiality and secrecy. Secrecy is the absolute promise to never reveal information to anybody, regardless of the circumstance. Confidentiality is the promise to hold information in trust and to share it with others only if this is in the best interest of the counsellee or sometimes in the interest of society.[20]

In view of this counsellors are wise not to offer absolute or watertight promises of confidentiality.

Dual Relationships

A dual relationship occurs when a counsellor assumes more than one role with a client, during therapy and for an appropriate time afterwards. It covers a wide range of relationships from relatively simple social contacts to serious sexual exploitation.

What occurs in dual relationships is a blurring of boundaries, loss of objectivity, confusion of roles, and a distortion of the counselling relationship. It is almost impossible to be unbiased and to effectively challenge the client in such relationships. They often lead to client exploitation of some kind, and harm, and of which the client may not be fully aware.

Most dual relationships are clearly wrong and unethical, and others are best avoided. Those clearly wrong include counselling a relative, friend, business or church associate, a student, and when a romantic or sexual relationship occurs. Those not so clear include counselling persons in small rural areas who are usually well known by the counsellor. If this latter is unavoidable, the counsellor must inform the client of the limitations of the counselling.

Problems often arise in a church situation and these can range from a casual meeting of a client at church to a pastor counselling another church leader. Pastors should restrict their counselling to brief, supportive, crisis and referral counselling. Serious in-depth counselling of a church member is best done outside the church or by a fully qualified counselling team in the church that is more remote.

Dual relations can be very dangerous and often fail. The dual relationship easily becomes a "duel" relationship! Research has shown that over half of persons who have been counselled by a church leader soon leave the church.

Sexual dual relationships are particularly serious and can lead to deregistration and jail. It is strongly recommended that the only physical contact with a client should be shaking their hand and perhaps placing the hand on a person's shoulder should to pray for them. Hugging, kissing, sitting the client on the lap, undressing, physical fondling and actual intercourse have no place in any form of counselling.

The Suicidal Counsellee

The suicidal counsellee can be a real challenge to the counsellor. How far does autonomy go, and when does one intervene and take responsibility for the counsellee to prevent suicide? Statements such as, *either you inform a doctor or I will* should be avoided as it violates autonomy. Medical assistance should not be imposed upon a counsellee except in very extreme cases of mental disturbance.

Because suicide in increasing, counsellors need to be trained in the assessment of such, which includes consultation with an appropriate supervisor. If the counsellor is unable to do this they should explain the situation to the counsellee and suggest they see somebody else.

Record Keeping

Though not considered essential it is strongly recommended that adequate brief records be confidentially kept of all formal counselling sessions. Records are needed for possible legal purposes and to assist the counsellor in therapy. Records may be subpoenaed for court. In such situations the processes of justice overrides confidentiality.

Records need not be lengthy, they should be legible and they should be kept for at least seven years.

Responsibility to Oneself as Counsellor

Counsellors have a responsibility to themselves and their counsellees to maintain their effectiveness, resilience and ability to counsel. This involves monitoring and a preparedness to refer when necessary. Counsellors have a responsibility to themselves to have adequate training and commit themselves to ongoing training.

Responsibility to Other Counsellors

Counsellors should not conduct themselves in any way, which undermine public confidence in their role or in the work of other counsellors.

If a counsellor suspects misconduct in another counsellor, which cannot be resolved after discussion, he needs to discretely report it to the relevant authorities.

Counsellors should seek to relate well to members of other caring professions and not misrepresent their activities.

Counselling Supervision

It is a breach of the Code of Ethics for counsellors to practice without regular counselling supervision and consultative support. This means a formal confidential arrangement is undertaken. The supervisor is not to be a line manager to whom the counsellor is accountable, but an independent person.

The purpose of counselling supervision is to assist the counsellor develop the skill of counselling. This is where theory in converted into practice and where practical counselling is really learnt.

The counsellor can expect the following from supervision:

- A therapeutic approach (respect, genuineness, congruence, clear self-boundaries.
- Counselling skills (empathy, questioning, immediacy, challenging, guiding, contracting).
- Special supervisory skills (process orientation, hypothesising, making choices, avoidance of collusion, flexibility, etc.)
- Ability to unite with the counsellee's model of counselling.
- Willingness to self-disclose.

The volume of supervision should be in proportion to the amount of counselling done. Supervision should be done about every month and is particularly important for those in training and for those beginning therapy. For those much more experienced, meeting monthly with a peer group is satisfactory. However, peer groups may fail and such need to be prepared to go to a supervisor or have personal therapy if a difficult situation in therapy arises.

The minimal requirements for a supervisor are one who has more experience in counselling that the therapist and one who is remote from the therapist. The ideal requirements is for the supervisor to be highly qualified, trained and appointed as a supervisor and one who has a wide knowledge of theoretical counselling models.

While it is preferable to have a Christian as a supervisor there should be no problem about having a non-Christian filling this role. A lot can be learned from a non-Christian.

The supervisor does not need to use the same model of therapy, but will no doubt want to know about the model being used.

A contract needs to be made initially between the counsellor and supervisor involving coming to an agreement about supervision fees, frequency, length of sessions, expectations, roles, goals, method, use of audio/video, evaluation, etc.

The usual procedure is to record a counselling session on video or audiotape and send that, together with some notes of the case, to your supervisor a week in advance of your supervisor session.

Therapist should be prepared to pay for supervision, and amounts vary from around $40 to $100 per one-hour session.

Whatever other supervision is undertaken, continual self-supervision is necessary.

Ongoing Monitoring

Ongoing monitoring of the nature of the actual counselling services being offered is also necessary by the counsellor themselves and preferably by some independent authority.

When to Refer

Counsellors need to know when to refer a counsellee. It depends upon their level of competence as referred to above. It is not necessarily a sign of incompetence, but is simply a desire to have the counsellee get the best help available. Counselling covers a wide range of behaviours and methods and no counsellor is skilled in everything. It is a sign of honesty, integrity, and genuineness to refer when one should.

Referral can be to another counsellor, a psychologist, a medical practitioner, a psychiatrist, a solicitor, a pastor, a community service, therapy group, other self-help groups, a hospital or clinic, and others.

Counsellees should be referred when:

- The problem is beyond counsellor's ability.
- The counsellee shares something and there is a similar unresolved issue in the counsellor (what we call a squishy spot).
- It may be better for the counsellee to have a counsellor more remote.

- There is no sign of improvement after several sessions.
- There is need for legal or medical advice.
- The counsellee exhibits extremely bizarre or aggressive behaviour.
- There is a dislike of the counsellor or counsellee.
- When a sexual affinity occurs on part of counsellor or counsellee.
- The counsellee is severely depressed and suicidal (depends on level of
- competence).
- Addictions (depends on level of competence).
- Sexual dysfunctions (depends on level of competence).

Ethical Principles of the Australian Association of Marriage and Family Counsellors

Members are trained and experienced in dealing with marriage and family interactions. They are conscious of the special skills required and aware of their professional limitations. In order to maintain the highest standards of professional competence the members of the Association are required to adhere to the following rules of conduct:

1. A counsellor offers professional service to anyone regardless of race, religion, sex, political affiliations, social or economic status or choice of life style. When a counsellor cannot offer service for any reason, he or she will endeavour to make a suitable referral.

2. A counsellor will not use his or her counselling relationship to promote personal, religious, political or business loyalties or interests.

3. A counsellor will not accept or offer payments for referrals, apart from the ordinary counselling fee charged to clients for interview.

4. A counsellor will not attempt to diagnose, prescribe for, treat or advise on problems outside the recognised boundaries of that counsellor's competence.

5. The essential obligation of counsellors is to respect the integrity and protect the welfare of persons with whom they are working.

6. While offering support, the counsellor is cautious in prognosis and realistic in the counselling contract he or she makes with the client.

7. Where a person has been assured, or can reasonably expect, that information given by him or her will be treated confidentially, no counsellor may divulge such information without written permission granted by the client(s) involved. Confidentiality may be waived only to prevent immediate physical danger to a person or persons, or to divulge information, which if withheld may put the counsellor at risk.

8. A counsellor shall not misuse any client relationship for personal gratification.

9. It is unethical to use undue persuasion or to attempt to enforce the acceptance of any counselling service or procedure by any individual.

10. Counselling activities should be undertaken only with professional intent and not casually and/or in extra-professional relationships.

11. Every counsellor has an obligation to continue self-education and professional growth in all possible ways including active participation in the meeting and activities of the Association.

12. A counsellor will actively seek regular suitable supervision for his or her counselling and will use such supervision to develop his or her counselling skills.

13. Counsellors are committed to protect the public against unethical, incompetent and dishonourable practices and will be prepared to challenge these practices.

The Association encourages counsellors to affiliate with relevant professional groups, clinics and agencies operating in tile field of marriage and family life. Interdisciplinary contact and co-operation are also encouraged. Any member advertising, conducting training programmes and/or group work shall act in accordance with these ethical principles.

Ethical Guidelines for the Christian Association for Psychological Studies

CAPS, a large, well-respected, organization in the United States, includes an excellent preamble and adds additional clauses to its ethical guidelines relating to Christian counsellors, as follows:

Ethical Guidelines for the Christian Association for Psychological Studies

Introduction

The Statement of Ethical Guidelines that follows was adopted by the voting membership of the Christian Association for Psychological Studies (CAPS) on June 15, 1992 by the completion of an election about the guidelines and several other propositions. The proposition about ethical guidelines stated, *That agreement with the CAPS Statement of Ethical Guidelines be a requirement of membership*. It was passed by 84.1% of the ballots cast.

Thus, an overwhelming majority of the CAPS membership agreed strongly that guidance on ethical behaviours of members would be helpful. Many CAPS members do not belong to another professional association and therefore would not otherwise have written ethical guidelines to assist them in applying their Christian faith in their professional activities. The ethical guidelines that follow were eight years in the making, starting before the first draft of a code of ethics was presented at a CAPS Western Region convention in Buena Park, California on. June 23, 1984. Since that time the "code" became "guidelines," they were reviewed by CAPS members during several convention forums, they were also presented--with pro and con discussions--in the Fall, 1986 issue (Vol. 5, No. 3) of the *Journal of Psychology and Christianity,* and they were edited during committee meetings and regular meetings of tile CAPS Board of Directors.

The CAPS Board hopes that the *Statement of Ethical Guidelines* will be helpful to our members and, thus. to the people whom they serve. The guidelines are distinctively Christian in nature and emphasise restoration and reconciliation rather than punishment, if they are breached.

Preamble

The Christian Association for Psychological Studies (CAPS) presents the following *Statemerit of Ethical Guidelines* as a set of ideals for conduct of its individual members. The Guidelines derive from CAPS *Statement of Faith,* found in Article II of the CAPS Constitution and By-Laws:

The basis of this organization is belief in: God, the Father, who creates and sustains us; Jesus Christ, the Son, who redeems and rules us; and the Holy Spirit, who guides us personally and professionally, through God's inspired Word, the Bible, our infallible guide of faith and conduct and through the communion of Christians. These Guidelines are aimed at helping each number apply the message of the Gospel to his or her professional or pastoral service. The statements herein could not hope to explore all the richness of the Bible as it relates to

ethical conduct. Rather, each believer in Christ has the capacity----even the privilege and duty--to explore the depths of God's Word and discover personal guidance for daily living. The following scripturally based principles exemplify the foundation upon which the more specifically applied Guidelines are based. The cited biblical passages are meant as representative sources, not "proof texts" for the concepts expressed.

Biblical Principles

We are, as human beings as well as Christians, prone to hurts, conflicts and sin (Romans 3:23). Difficulties, power struggles, trials and tribulations are normal and to be expected (Psalms 37:7; John 16:33; Romans 2:9). We are to grow and mature through the conflicts, problems, trials, tribulations and discipline that we experience (2 Corinthians 7:8-13a; 1 Thessalonians 5:18: James 1:2-4). We are to support and encourage each other (John 13:35: 15:17; Ephesians 4:32}. We are to admonish and confront each other, especially those Christians in positions of leadership and trust. However, such confrontation is to be constructive rather than judgmental, done in love and with caution about our own shortcomings (Proverbs 27:5; Matthew 18:15-17; Galatians 6:1). We are to demonstrate the lordship of Christ in our lives by servant-like leadership, a sense of community and a lifestyle that reflects the will of God (Matthew 20:25-28; John 12:26; Colossians 3:12-17; 1 Peter 4:8-11). We are to reach out to others in love and concern (Matthew 25:31-40; 2 Corinthians 1:3-7; Hebrews 13:16).

These Guidelines are meant in part as an encouragement for all CAPS members to reach out to other members who are in distress. They do not constitute a quasi-legal document designed for disciplinary purposes by the organization. The Guidelines are written with recognition of the priesthood of all believers.

Applicability of the Guidelines

This Statement of Ethical Guidelines is applicable to all current, dues-paid Regular Members and Associate Members of CAPS. While CAPS is not a licensing or accrediting agency, it does desire that members who provide mental health, pastoral, teaching or other personal services do so with the highest possible level of Christian ethics, whether the member is a professional, layperson or student. The Guidelines are therefore intended to benefit members, their colleagues and the persons whom they serve.

Articles of the Ethical Guidelines

Note: In an effort to avoid awkward and lengthy descriptions of persons whom members serve or with whom they work, the somewhat neutral word "client" is used. According to the perspective of members, words such as "peer," "parishioner," "communicant," "patient" "helpee," "counsellee," "student," "subject" or even "prisoner" may be used. In addition, the word "service" or "serving" is used frequently in the guidelines to describe what members do. Again, according to the perspective of members, words such as "helping ministries," "psychological professions," "counselling," "ministering," "pastoring" "teaching" or "researching" may be substituted. Admittedly, no word is neutral, since language shapes and reflects reality. Thus, the word "service" or its derivatives are meant to reflect Christ's statement that he came to serve, rather than to be served.

1. Personal Commitment as a Christian

1.1 I agree with tile basis of CAPS, as stated in the Constitution and By-Laws.
1.2 I commit my service, whether as professional or layperson, to God as a special calling.
1.3 I pledge to integrate all that I do in service with Christian values, principles and guide lines.
1.4 I commit myself to Christ as Lord as well as Saviour. Thus, direction and wisdom from God will be sought, while accepting responsibility for my own actions and statement.
1.5 I view my body as the temple of the Holy Spirit and will treat it lovingly and respectfully. Balance in my priorities and activities will be prayerfully sought.

2. Loving Concern for Clients

2.1 Clients will be accepted regardless of race, religion, gender, sexual orientation, income, education, ethnic background, value system, etc., unless such a factor would interfere appreciably with my ability to be of service.
2.2 I value human life, the sanctity of person-hood, personal freedom and responsibility and the privilege of informed free choice by adults in matters of belief and action.
2.3 I will avoid exploiting or manipulating any client to satisfy my own needs.
2.4 I will abstain from unnecessary or prurient invasion of privacy.
2.5 I will take appropriate actions to help, even protect, those persons within my area of my responsibility who are being endangered and are relatively dependent on other persons for their survival and well-being.
2.6 Sexual contact or sexual exploitation - both covert and overt - with any client will be scrupulously avoided.
2.7 Members who provide professional services should make advance financial arrangements that protect the best interests of, and are clearly understood by, their clients. A portion of their services should be contributed towards work for which they receive little or no financial return.

3. Confidentiality

3.1 I will demonstrate utmost respect for the confidentiality of the client and other persons in a professional or pastoral relationship.
3.2 I will carefully protect the identity of clients and their situations. Thus, I will avoid divulging information about clients, whether privately or publicly, unless I have received freely given, informed consent of the adult client or legal holder of confidentiality privilege for minor clients, in the form of expressed, written permission and the release of such information would be appropriate to the situation.
3.3 All records of counselling, teaching and research will be handled in a way that protects the clients and the nature of their situations from disclosure.
3.4 The limits of confidentiality, such as those based on civil laws, regulations and judicial precedent, will be explained to the client. Examples of limits or exceptions to confidentiality include such situations as (1) legal mandate, e.g., if child abuse is suspected or apparent; (2) when divulging information would prevent a clear and immediate danger to a person or persons; (3) legal proceedings in which the member does not have privilege.

4. Competency in Services Provided

4.1 I pledge to be well trained and competent in providing services.
4.2 I will refrain from implying that I have qualifications, experiences and capabilities which are in fact lacking.
4.3 I will comply with applicable state and local laws and regulations regarding competency in the psychological and pastoral professions.
4.4 I will avoid using any legal exemptions from professional competency afforded in certain states to churches and other non-profit organizations as a means of providing services that are beyond my training and expertise.
4.5 I will diligently pursue additional education, experience, professional consultation and spiritual growth in order to improve my effectiveness in serving persons in need.

5. My Human Limitations

5.1 I will do my best to be aware of my human limitations and biases. I admit that I do not have complete objectivity or spiritual maturity. Thus, I also will endeavour to establish and maintain a relationship of mutual accountability with another Christian colleague or mentor.
5.2 I will avoid fostering any misconception a client could have that I am omnipotent, or that I have all the answers.
5-3 I will refer clients whom I am not capable of helping, whether by lack of available time or expertise, or because of subjective, personal reasons. The referral will be done compassionately, clearly and completely, insofar as feasible.
5-4 I will resist efforts of any clients or colleagues to place demands for services on me that exceed my qualifications and/or the time available to minister, or that would impose unduly on my relationships with my own family, other persons or God.

6. Advertising and Promotional Activities
6.1 I will advertise or promote my services by Christian and professional standards, rather than only commercial standards.
6.2 Personal aggrandisement will be omitted from advertising and promotional activities.
6.3 Since CAPS is not a licensing or accrediting agency, I will avoid using membership in CAPS as an advertising promotional.

7. Research
7.1 Any research conducted will be done openly and will not jeopardise the welfare of any persons who are research subjects. The confidentiality of such subjects will be protected. They will provide informed, written consent for their participation in the research.

8. Professional Liability
8.1 The value of professional liability ("mal-practice") insurance will be carefully considered, especially if a lawsuit, whether justified or not, would possibly drain financial resources.

4. Legal Issues and Counselling

The matter of legal issues and counselling needs to be included in a series of manuals on counselling. It is not that many counsellors have been called upon to give evidence in court in the past, but it can be anticipated that it will become much more common in the future as people (and solicitors) become more and more litigation minded.

Three important issues need to be addressed.

Written Legal Report

It is not uncommon for a solicitor to request a written report from a counsellor, such as in cases that involve psychological damage for insurance purposes, damage from abuse, custody issues an the like. These reports may be presented in a court so need to be done correctly.[21]

The following points need to be observed in writing such reports.

- Type neatly on your letterhead.
- At the top of the text type in full name and address of client, and date of birth.
- Give a history of the injury, etc. according to the client.
- Describe presenting symptoms when you first saw the client.
- Describe the therapy you rendered, number of sessions, and the client's co-operation.
- Describe in detail your therapy fees, and send an account to the solicitor if the client has not already paid it.
- Describe improvement in symptoms as a result of therapy.
- Describe any expected long-term or permanent results of the injury, etc.
- Mention any need for ongoing therapy.
- Give a prognosis.

In a separate letter, submit a statement of your report fee to the solicitor.

Subpoena to Produce Documents

You may receive a subpoena from a solicitor to produce documents (records) at court. This usually occurs in cases of divorce and custody. The records and any copies are normally returned on completion.

Concerns over confidentiality often arise here, and you may even wish to go to court to contest this with the magistrate. Occasionally the magistrate will comply with your requests to be exempted from submitting, or to allow submission of only the relevant portions. Normally it is best to simply supply a photocopy of all your records at court as requested.

A fee of some $50 given to the subpoena-submitting solicitor is reasonable for your labours in doing this.

Expert Evidence in Court

Occasionally you may be asked (subpoenaed) to attend court to give expert evidence. This needs to be properly prepared as follows (for further information see below).[22]

- Study the case history on the client's records.
- Do not alter or add to records.
- Take the records with you to court for your own help.
- The court may want to see them.
- The court will probably want to know your qualifications, experience, etc.
- Be prepared for cross-examination by a barrister, who is skilled in doing so.
- Answer the questions asked simply and respectively.
- A suitable fee for court attendance is $100 per hour including travel and waiting.

General Legal Issues

Further information appears in the following account of legal issues and counselling.[23]

Introduction

There are three important reference points to observe.

God the lawgiver and judge

What are his boundaries and the consequences of breaking his laws (Romans 13:1-7)?
He writes his laws on our hearts. (Matthew 5:22-26; James 4:12; Revelation 19:2; Mark 12:17; Exodus 20:1-26).

The social climate

Post-Christian era and loss of values, Consumerism demands perfection. People are driven and demanding, high divorce rates, stepfamilies, unemployment.

The legal system

The legal system is complex, varies from state to state, but influenced by international courts and agreements. Legal language is a barrier. The legal process aims for a "best result" out of an adversarial system, rather than for the "truth". The "sue anybody" attitude is becoming increasingly common with litigation experts.

Summary

Social, legal and ethical issues often are enmeshed in the life of the individual you are counselling. Unwittingly we are in a conflict and despite our best intention we may be caught in it. False witness may be brought against us. (Acts 19:38). Our best form of protection is to ask for heavenly wisdom and to have a professional attitude.

Statutory Obligations

Reporting of child physical and sexual assault

- Definition of child physical and sexual assault.
- Reporting is not mandatory for counsellors in Australia (it is for doctors, dentists, teachers and some other health professionals).
- Reporting by counsellors is often recommended for the protection of other children
- There has to be present, *Reasonable grounds to suspect.*

Subpoenas to present records/evidence

Issues involving counselling or psychological assessment for court include the following:

- Post Traumatic Stress Disorder (e.g. bank robbery).
- Psychological aspects of physical injuries (e.g. workers compensation, car accidents, assault, abuse).
- Family law issues (eg. child custody, kidnapping of children by parents).
- Counselling victims (e.g. domestic violence case ends up in court).
- Client referred to you by a court.

Malpractice

A malpractice case could be brought against counsellors on the following grounds:

- Impaired or sick (e.g. substance abuse).
- Competence (i.e. What is the *Standard practice of care*)
- Wrong advice (e.g. *You told me to .....*).
- Unethical (e.g. inappropriate sexual advances).

What to do in Court

An ordinary witness gives facts only. An expert witness (one who has expertise in a certain area) may, in addition, give their opinion.

- If subpoena requests, *Ducus Takum,* it means you must take your records to court.

- Entire records may be subpoenaed, including one's own notes on the records.

- You have to testify if subpoenaed.

- Insist on pre-trial interview with lawyers - ask them about the judge and the opposing lawyer's weaknesses.

- Spiritual preparation.
- Bring curriculum vitae (training, employment, previous times you've testified with dates for all).
- Try to think like a lawyer.
- Never assume the judge knows anything.
- Always refer to the judge as, *Your Honour*.
- Do not be intimidated (don't take cross-examination personally). Beware if they are too nice!
- Take your time (if a question is repeated, say, *I just answered that*) .
- If a cross-examiner takes long pauses - don't speak.
- Reputation is everything - once lost, it may take years to get it back (a case can be lost with one bad testimony).
- Know the details of the case (speak truth - avoid speculation or exaggeration).
- Maintain a neutral position.
- Do not answer complex questions with simple answers:
    - Be exact (eg. 3:45 p.m. not "afternoon."
    - No slang.
    - *I don't know* is an acceptable answer.
- Dress in appropriate professional attire.

Rights of the Counsellee

Confidentiality

Confidentiality is the corner stone of security for the counsellee. The basic rule is don't divulge without written consent. Even after death, gain the consent of the executor of the will.

Consent is valid if – it is freely given, recent and the person is legally capable of signing. Be aware of the implications of specific information released to a particular person.

Be careful of the following:

- Telephone calls.
- Relatives (no strong legal right).
- Secretaries.

- Letters of referral (often opened).

Confidentiality does not apply in the following cases.

- Statutory (mandatory reporting).
- Subpoena from court.
- Without consent (e.g. intended murder, HIV).
- Principle of "Public interest."

Aggrieved client - sue for damages, breach of contract.

Laws regarding individual rights

- Divorce, custody, property settlement.
- Adoption.
- Domestic violence and AVOs.
- Victims of criminal offences.
- Rights of children of abuse.
- Homosexuality.
- Discrimination (e.g. employment).
- Guardianship board.
- De facto status.
- Mental illness - Voluntary admission or involuntary admission.
- Suicide.

Safe Counselling Practice

- Peer Review.
- Licensing - gives protection.
- Spread the liability – networking.
- Safe environment - have help available, as a witness.
- Continuing education.
- Legible records - keep for at least seven years.
- Liability insurance - group rate.
- Honest earnings.
- Legible records.
- Know the local resources available.

Typical Resources

Chamber Magistrate, local Court House.
Legal Aid – Ph: 1 800-806913, (02) 9219 5000 (includes Child/Prisoners/Veterans Mental Health Advocacy).
Family Court Counselling Service – Ph: (02) 9217 7111.
NSW Child Protection Unit, P.O. Box E 262, St James, NSW, 2000.
Dept. of Community Services, local centre.
24 hour Child Protection and Family Crisis Service – Ph: 1 800-066777.
24 hour Domestic Violence Service – Ph: 1800-656463.
Victims of Crime Service (24 Hours) Ph: (02) 9217 1000 or 1800-819816.

Sydney Rape Crisis Centre – Ph: (02) 9819 6565, 1800-424017, and most Teaching Hospitals have a Sexual Assault Service.
Refuges available through “Lifeline" Ph: 131114.
Community Help and Welfare Services- front of telephone book.
Local Psychiatric Hospitals under *Hospitals* in Yellow Pages.
Guardianship Board ! 800-463928.
The Ombudsman, 3rd Floor, 580 George St., Sydney, NSW., 2000, Ph: (02) 9286 1000.
Redfern Legal Centre – Ph: (02) 9698 7277, publishes various books on legal rights.
Police - Customer Assistance Unit – Ph: 1800-622571.
Director of Public Prosecutions – Ph: (02) 9285 8611- Witness Assistance Scheme, Sexual Assault Liaison Officer.
NSW Attorney General’s Department, Level 18, 8-12 Chiffley Square, Sydney, NSW, 2000.

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PSYCHOPATHOLOGY II

1. Classification (DSM-IV and ICD-10)

Definition

Psychopathology (abnormal psychology or mental illness) is illness that is revealed in impaired behavioural or psychological functioning and is associated with distress or disability.[24]

The term refers to a broad range of conditions that involve abnormalities in sensations, cognition, and emotional states. A working assumption in the field is that psychopathological syndromes, or groups of symptoms, are not merely predictable responses to a specific stressful event, for instance, the death of a loved one, but rather a manifestation of a psychological or a biological dysfunction in the person. Psychopathologies range from relatively mild disorders (neuroses), such as mild depression, to serious disorders that involve major disability, such as schizophrenia (psychoses).

Psychoses are more serious mental disorders, which are often hereditary, involving wide areas of the personality, and particularly the person being out of touch with reality. The most common psychoses are Schizophrenia, Psychotic Depression and Bipolar Disorder. They all seriously affect the person's ability to function, and more so than other disorders.

The neuroses, a term used more in the past than today, refer to lesser disorders of shorter duration, such as anxiety, depression, and other stress-related disorders, which are largely learned disorders.

Another category, being increasing recognized as more common than previously thought, and increasing in incidence as family dysfunction increases, is the Personality Disorders. These involve pronounced personality flaws appearing early in age and usually lasting throughout lifetime.

Classification of Mental Disorders

DSM-IV

The primary diagnostic system used in the United States today, and in many other countries, is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), a publication of the American Psychiatric Association. The first DSM was published in 1952, and it has been

revised and expanded four times; in 1968 (DSM-II), 1979 (DSM-III), 1987 (DSM-III-R) and 1994 (DSM-IV). The manual is important to researchers and therapists because it provides a common language with which to communicate about mental disorders.[25]

Therapists using the DSM-IV employ several diagnostic criteria, such as psychological stress factors and an assessment of functional skills, in addition to delineating the various symptoms of each disorder. This is done because the presence of just one sign or symptom in a patient is not enough to form a firm diagnosis. In addition, more than one disorder may be present in a person.

Extensive information is gathered in an interview with the patient and is augmented through psychological measurement, a physical examination, and interviews with family members.

For most disorders the following guidelines may be used to describe the degree of the disorder - mild, moderate, severe, in partial remission, in full remission and prior history.

The DSM-IV uses a multiaxial assessment method. Each of the five axes refers to a different domain of information that helps the clinician plan treatment and predict outcome. The five axes are:

Axis I	Clinical Disorders (the major category).
Axis II	Personality Disorders and Mental Retardation.
Axis III	General Medical Conditions (related to the mental illness).
Axis IV	Psychosocial and Environmental Problems (such as a bereavement, educational, occupational, housing, economic, health and legal problems).
Axis V	Global assessment of functioning (overall level of functioning using a special scale).

In reporting disorders it is necessary to refer to the Axis, and code.

Examples are:

Axis 1 296.23 Major Depressive Disorder, Single Episode, Severe without Psychotic Symptoms.

Axis II 301.6 Dependent Personality Disorder, Frequent use of denial.

ICD-10

Another classification of mental illness, also widely used, is the *International Classification of Diseases, Tenth Revision (ICD-10),* developed by the World Health Organisation. Those preparing the ICD-10 and DSM-IV have worked closely to co-ordinate their efforts. The ICD-10 consists of an official coding system, which is compatible with the DSM-IV.

Classification

Listed below are the categories of mental illness contained in DSM-IV.[2]

DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE

1. Mental Retardation (Axis II)
2. Learning Disorders
3. Motor Skills Disorders
4. Communication Disorders
5. Pervasive Developmental Disorders (Autistic Disorder, Rett's Disorder, Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder).
6. Attention-Deficit and Disruptive Behaviour Disorders (ADHD, Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behaviour Disorder).
7. Feeding and Eating Disorders of Infancy and Early Childhood.
8. Tic Disorders.
9. Elimination Disorders.
10. Other Disorders.

DELIRIUM, DEMENTIA AND AMNESTIC AND OTHER COGNITIVE DISORDERS

1. Delirium (an acute, temporary state of mental confusion, often accompanied by hallucinations and delusions, due to general medical conditions, substance abuse, etc.)

2. Dementia (a more permanent deterioration of intellectual functioning and behavioural capacities. It is a degenerative disorder of the central nervous system.)

- Dementia of the Alzheimer's Type,
- Dementia due to various general medical conditions (eg. Vascular Dementia), and
- Dementia due to substances.

3. **Amnestic Disorders**, due to General Medical Conditions and Substances.
   This is commonly seen with brain trauma and alcohol abuse.

4. Other Cognitive Disorders.

MENTAL DISORDERS DUE TO A GENERAL MEDICAL CONDITION NOT ELSEWHERE CLASSIFIED

This includes catatonic disorder and personality changes resulting from general medical conditions.

SUBSTANCE-RELATED DISORDERS

1. Alcohol Use Disorders (dependence and abuse)

2. Alcohol-Induced Disorders (intoxication, withdrawal, delirium, dementia, amnesia, psychotic, mood, anxiety, sexual and sleep disorders).
3. Amphetamine (or Amphetamine-Like) Disorders
4. Caffeine-Related Disorders
5. Cannabis-Related Disorders
6. Cocaine-Related Disorders
7. Hallucinogen-Related Disorders
8. Inhalant-Related Disorders
9. Nicotine-Related Disorders
10. Opioid-Related Disorders
11. Phencyclidine-Related Disorders
12. Sedative, Hypnotic, or Anxiolytic-Related Disorders
13. Polysubstance-Related Disorder
14. Others.

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

A psychotic disorder is present when there is a substantial break from reality, and is characterised by one or more of the following five symptoms: bizarre delusions, hallucinations, disorganised speech, disorganised behaviour and negative symptoms (blunted affect, loss of will, etc.).

1. Schizophrenia

Schizophrenia, one of the more severe mental disorders, is diagnosed when two or more of the five psychotic symptoms are present for at least six months.

There are several diagnostic sub-types of Schizophrenia:

a. Paranoid Schizophrenia, manifests delusions of a persecutory nature and, frequently, auditory hallucinations, but no negative symptoms or disorganised speech or catatonic behaviour.

b. Disorganised Schizophrenia, is defined by the predominance of such symptoms as incoherent speech, inappropriate emotional reactions, and disorganised behaviour.

c. Catatonic Schizophrenia, is typically characterised by an extreme decrease in motor activity, often accompanied by muteness.

d. Undifferentiated Schizophrenia, involves a mixture of symptoms, including distinct delusions and hallucinations along with disorganised behaviour.

e. Residual Type, occurs when major symptoms have subsided and some lesser symptoms remain.

2. Schizophreniform Disorder

This is characterised by the same symptoms as schizophrenia but its duration last only one to six months.

3. Schizoaffective Disorder

This is a disturbance in which a mood episode (manic or depressive) occurs together with the other active phase symptoms of schizophrenia. However, there must be clearly defined periods of delusions and hallucinations apart from the mood disorders. It lies between schizophrenia and Bipolar Disorder with Psychosis.

4. Delusional Disorder

This is characterised by at least one month of nonbizarre delusions (ie. at face value they often seem believable) without other active-phase symptoms of Schizophrenia. It usually occurs much less commonly than Schizophrenia and in mid-late life.

Subtypes of Delusional Disorder are:

- ErotomanicType - delusion that another person (usually famous) loves them.
- Grandiose Type - delusion of some great talent, power, worth, or special relationship with some famous person or deity.
- Jealous Type - delusion that spouse or lover is unfaithful.
- Persecutory Type - delusion that others are conspiring, cheating, poisoning, etc. them.
- Somatic Type - delusions involving bodily functions (odours, infestations, etc.).
- Unspecified Type.

5. Brief Psychotic Disorder

This is at least one of the five psychotic disturbance that lasts more than one day and remits by one month.

6. Shared Psychotic Disorder

This is a disturbance that develops in an individual who is influenced by someone else who has an established delusion with similar content.

7. Psychotic Disorder Due to a General Medical Condition

This condition can be of two types; with delusions, or with hallucinations.

8. Substance-Induced Psychotic Disorder

These conditions also can have delusions or hallucinations, and can occur during intoxication or during withdrawal. Most nonauditory hallucinations are substance-induced Psychotic Disorder or due to a Psychotic Disorder due to a General Medical Condition.

9. Psychotic Disorder Not Otherwise Specified

MOOD DISORDERS

These disorders are characterised by mood disturbances, and they generally occur when normal human emotions reach extremes. The affective disorders can be mild or severe and

sometimes require hospitalisation. Similarly, the recovery rate for affected disorders varies from a few months to several years following an episode.

1. Depressive Disorders

a. Major Depressive Disorder

Major depressive disorder is characterised by depressed mood, disturbances in eating and sleeping, decreased energy, and feelings of hopelessness and low self-esteem.

b. Dysthymia

Dysthymia has similar, but milder, symptoms as major depressive disorder but of longer duration (at least two years).

2. Bipolar Disorders (Manic-Depressive Disorders)

Bipolar disorders are characterised by periods of depression as well as periods of mania, or extreme mood elevations. During Manic Episodes the individual may show high levels of activity, talkativeness, and elation, which impairs normal functioning. Hypomania is a milder form of Mania, which does not impair normal functioning. Mixed Episodes include depressive and manic episodes.

a. Bipolar I Disorder (one or more Manic or Mixed Episodes usually accompanied by Major Depressive Episodes).
b. Bipolar II Disorder (one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode).
c. Cyclothymic Disorder (a mild form involving at least two years of numerous episodes of Hypomania).
d. Disorders due to general medical condition or substances.

ANXIETY DISORDERS

These disorders include illnesses in which there is debilitating tension, anxiety, and avoidance. Typically, the anxiety is not based upon present circumstances, but rather upon actual or fantasised experiences from the past or in the future. The way in which a person manifests excessive anxiety determines the specific type of diagnosis rendered.

Anxiety disorders include

1. Panic Disorder without Agoraphobia.
2. Panic Disorder with Agoraphobia.
3. Agoraphobia without History of Panic Disorder.
4. Specific Phobia.
5. Social Phobia.
6. Obsessive-Compulsive Disorder (OCD).
7. Posttraumatic Stress Disorder (PTSD).

8. Acute Stress Disorder.
9. Generalised Anxiety Disorder.
10. Others.

SOMATOFORM DISORDERS

These disorders involve physical symptoms that do not have demonstrable organic bases. There are two general types of Somatoform disorders: those which are characterised by excessive concerns about physical conditions but are associated with no specific symptom, and those in which there is one or more identifiable physical symptom.

1. Somatization Disorder

This (formerly referred to as hysteria or Briquet's Syndrome), beginning before the age of 30 years and extending over a period of years, is characterised by a pattern of recurring, multiple, clinically significant somatic complaints (ie. it requires medication).

2. Conversion Disorder

These constitute the second group of Somatoform disorders. They involve actual physical disabilities without any physical basis. These disorders are typically easy to separate from organically based problems because the physical symptom usually appears suddenly during a period of extreme psychological distress and often tends to be psychologically symbolic, as when a person develops paralysis in a subconscious effort to avoid unpleasant situations.

3. Pain Disorder

Pain is the predominant focus of clinical attention, but psychological factors play a significant role.

4. Hypochondriasis

This involves exaggerated concerns and unrealistic fears about one's health.

5. Body Dysmorphic Disorder

This is the preoccupation with an imagined or exaggerated defect in physical appearance.

6. Somatoform Disorder Not Otherwise Specified

This simply refers to somatoform symptoms that do not meet the criteria referred to above.

FACTITIOUS DISORDERS

Factitious disorders are characterised by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role. They are distinguished from malingering in that in malingering the individual also produces the symptoms intentionally but has a goal that is obviously recognisable when the circumstances are known.

DISSOCIATIVE DISORDERS

These disorders involve a disruption of the patient's normal personality due to alterations in consciousness, identity, or memory for personal experience. The most common types of dissociative disorder are the following.

1. Dissociative Amnesia

This involves a total loss of memory for events associated with a traumatic experience. In the disorder the individual loses all awareness of his or her own identity.

2. Dissociative Fugue (formerly Psychogenic Fugue)

This is characterised by loss of identity and an inability to recall some or all of one's past due to a sudden, unexpected travel away from home or one's normal daily activities.

3. Dissociative Identity Disorder (formerly Multiple Personality Disorder)

The essential feature of DID is the presence of two or more distinct identities or personality states, that recurrently take control of behaviour. There is also an inability to recall important personal information beyond ordinary forgetfulness.

4. Depersonalization Disorder

Depersonalization is defined as a sense of being cut off or detached from one's self, as though one is in a dream. Everyone experiences to this at times, but when it becomes distressing to the person it is classified as a Disorder. Episodes are often precipitated by stress or emotional overload, and begin and end suddenly.

SEXUAL AND GENDER DISORDERS

These are disorders of sexual behaviour in which psychological factors seem to be at the root of the problem. There are three groups of Sexual and Gender Disorders: Sexual Dysfunctions, Paraphilias and Gender Identity Disorders.

1. Sexual Dysfunctions

The sexual dysfunctions involve abnormalities in sexual appetite or psychophysiologic changes that characterise the complete sexual-response cycle. (see *Volume 3*)

- Sexual Desire Disorders (Hypoactive Sexual Desire Disorder and Sexual Aversion Disorder).

- Sexual Arousal Disorders (Female Sexual Arousal Disorder and Male Erectile Disorder).
- Orgasmic Disorders (Female and Male Orgasmic Disorders, Premature Ejaculation).
- Sexual Pain Disorders (Dyspareunia and Vaginismus).
- Sexual Dysfunction Due to a General Medical Condition.

2. Paraphilias

The essential feature of the Paraphilias is an intense and recurrent sexual urge involving nonhuman objects, or the suffering of oneself or one's sexual partner, or of children or other nonconsenting persons. These include:

- Exhibitionism.
- Fetishism.
- Frotteurism.
- Pedophilia.
- Sexual Masochism.
- Sexual Sadism.
- Transvestic fetishism.
- Voyeurism.
- Others.

3. Gender Identity Disorders

These disorders can occur in children, adolescents or adults, and can take the following forms:

- Sexually attracted to males.
- Sexually attracted to females.
- Sexually attracted to both.
- Sexually attracted to neither.

EATING DISORDERS

These include Anorexia Nervosa and Bulimia Nervosa (see *Volume 4*).

SLEEP DISORDERS

1. **Primary Sleep Disorders**
   - Dyssomnias (Primary Insomnia - ordinary insomnia, Narcolepsy, Breathing-Related Sleep Disorder, Circadian Rhythm Sleep Disorder).
   - Parasomnias (Nightmare Disorder, Sleep Terror Disorder, Sleepwalking Disorder).

2. **Sleep Disorders Related to Another Mental Disorder.**

3. **Other Sleep Disorders.**

IMPULSE-CONTROL DISORDERS NOT ELSEWHERE CLASSIFIED

1. **Intermittent Explosive Disorder**
   This is characterised by episodes of aggressive impulses resulting in serious assaults or destruction of property.

2. **Kleptomania**
   This involves the stealing of objects not needed for personal use or monetary value.

3. **Pyromania**
   This is characterised by fire setting for pleasure, gratification, or relief of tension.

4. **Pathological Gambling**
   This is persistent maladaptive gambling behaviour.

5. **Trichotillomania**
   This is characterised by recurrent pulling out of one's hair for pleasure, gratification or relief of tension that results in noticeable hair loss.

6. **Others**

(These Disorders would better be considered as addictive behaviours and be treated as such. See Vol.4)

ADJUSTMENT DISORDERS

These are characterised by clinical significant emotional or behavioural symptoms in response to an identifiable psychosocial stress, such as Adjustment Disorders with Depressed Mood, with Anxiety, with Mixed Anxiety and Depressed Mood, with Disturbance of Conduct, and Others. The symptoms are in excess of what would normally be found in such conditions.

PERSONALITY DISORDERS

These disorders entail inflexible, maladaptive personality traits that cause functional impairment or inner distress. These traits are presumed to be characteristic of a person's functioning since early adulthood. DSM-IV classifies personality disorders as Axis II Disorders, and into the following ten types:

- **Paranoid Personality Disorder** (paranoia) shows unwarranted suspicion, jealousy, and anger. As a result they have recurring interpersonal conflicts.

- **Schizoid Personality Disorder** is characterised by marked indifference to social relationships and a restricted range of emotional expression.

- **Schizotypal Personality Disorder** is peculiarities of thought and behaviour, and deficits in social skills.

- **Antisocial Personality Disorder** displays a pattern of irresponsible, aggressive, and nonconformist behaviour that extends from adolescence through adulthood. This disorder is more common in males than in females.

- **Borderline Personality Disorder** occurs more often in women and is characterised by emotional instability, confusions about identity, and unstable interpersonal relationships.

- **Histrionic Personality Disorder** involves a pervasive pattern of excessive emotionality and attention seeking.

- **Narcissistic Personality Disorder** is characterised by a preoccupation with the self and a lack of empathy for others.

- **Avoidant Personality Disorder** involves the individual showing extreme shyness and fear of being negatively evaluated by others.

- **Dependent Personality Disorder** is characterised by submissiveness and a lack of initiative.

- **Obsessive-compulsive Personality Disorder** involves inflexibility and excessive concern with details and rules, as well as an inability to spontaneously express emotions.

OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION

These include various other conditions that do not fit into the preceding categories, such as:

1. **Psychological Factors Affecting Medical Conditions**
   This involves the presence of psychological or behavioural factors adversely affecting a general medical condition.

2. **Medication-Induced Movement Disorders**
   - Neuroleptic (antipsychotic medication) -Induced conditions, etc.

3. **Relational problems**
   This involves relational problems that result in significant impairment in functioning.
   - Due to a Mental Disorder or a General Medical Condition.
   - Parent-Child Relational Problem.
   - Partner Relational Problem.
   - Sibling Relational Problem.

4. **Problems Related To Abuse Or Neglect**
   This involves severe mistreatment of an individual by another physically, sexually or neglect.
   - Physical Abuse of Child.
   - Sexual Abuse of Child.
   - Neglect of Child.

- Physical Abuse of Adult.
- Sexual Abuse of Adult.

5. Additional Conditions That May Be A Focus of Clinical Attention

- Noncompliance With Treatment (discomfort, cost, beliefs).
- Malingering.
- Adult Antisocial Behaviour (criminal behaviour).
- Child or Adolescent Antisocial Behaviour.
- Borderline Intellectual Functioning (IQ 71-84).
- Age-Related Cognitive Decline.
- Bereavement (death of a loved one).
- Academic Problem.
- Occupational Problem.
- Identity Problem (uncertainty about issues relating to identity - long-term goals, career choice, friendships, moral values, sexual orientation, group loyalties).
- Religious or Spiritual Problem (loss of or questioning faith, conversion to new faith, etc.
- Acculturation Problem (problems associated with change to new culture).
- Phase of Life Problem (new school, leaving home, new career, marriage changes, divorce, retirement, etc).

ADDICTION is not classified in DSM-IV as such, but we believe, needs to be considered. The DSM places substance abuse, sexual compulsion, eating disorders, pathological gambling, and other similar conditions, in other categories. There is considerable controversy as to the right classification of these conditions. (see *Volume 4*)

Minnesota Multiphasic Personality Inventory

The widely used psychological test for assessing personality and psychopathology is the MMPI, which analyses counsellees in accordance with the DSM-IV. The test was first initiated at the University of Minnesota over 50 years ago. A revised MMPI-2 is now available.[26] It is a complicated and sophisticated test. Personalised computer interpretations of the test are available to those qualified to use it.

The MMPI, which has been extensively researched, consists of over 500 statements to which the counsellee is asked to respond true or false. These items are scored in batches called scales, each of which measures a particular personality trait.

The ordinary clinical profile is measured on 13 scales, and there are three separate scales that measure invalidity (the accuracy of the answers given). The validity scales make the test foolproof and informs the tester a good deal about the co-operation of the counsellee.

Computerised feedback on the MMPI can, for example, can inform you how depressed a counsellee is when he or she took the test, and presents differential diagnoses in accordance with DSM-IV. It will help you determine how chronic the condition is and the roots of it. It also gives some recommendations for therapy.

The test should not be considered simply by itself, but used in conjunction with other data gained from a full clinical assessment of the counsellee.

Many other psychological tests are also available, but the MMPI stands out as particularly valuable for those with pronounced psychological problems.

Figure 10

PSYCHOSES	PERSONALITY DISORDERS	NEUROSES
Schizophrenia, Bipolar	Ten Disorders	Anxiety, Depression, other stress-related Disorders
"Odd" Out of touch with reality	"Difficult"	"Distressed"
Often genetic	Heterogenous (family dysfunction) Some are genetic Usually lifelong	Transient
Intuition: listen to your gut	Structural faults	Guilt
Long term therapy	Hard to deal with Resistant to therapy	Easier to deal with
Medication (side effects have to be watched)	Listen Deal with shame	Counselling, medication

Psychoses, Personality Disorders and Neuroses

There are three main divisions of mental illness.

- Psychoses (Schizophrenia, Bipolar Disorder, etc.).
- Personality Disorders (Ten distinct Disorders).
- Neuroses (Anxiety Disorders, Depression, Stress-related Disorders. etc.)

They can be compared in the manner illustrated in the following chart (Figure 10).

2. Some Further Disorders

Dementia

Dementia is characterised by declining global brain dysfunction that interferes with normal functioning. There is impairment in both recent and remote memory, and at least one other brain function as follows:

- Aphasia (inability to understand or produce language).
- Apraxia (loss of a motor skill).
- Agnosia (inability to recognise and name objects).

Anxiety, depression and sleep disturbances may accompany dementia, and also delirium.

Dementia occurs late in life, and can progress, remain stable or improve.

Dementia of the Alzheimer's Type (DAT)

DAT is the most common of the Dementias, occurring in 2 - 4 percent of persons aged over 65 years.[27] Some say it occurs in 5 percent of 65 year old, and it increases in frequency as the age increases.[28] It is more common in women. About half of the nursing home beds in the US are occupied by persons suffering from DAT. Few cases are reported in persons less than 50 years of age.

Onset of the disorder is insidious and cause is unknown. Brain atrophy usually occurs. There is no known cure and the disorder is a degenerative one with a mean survival period of 8 years.

A definite diagnosis of DAT requires either a brain biopsy or post-mortem brain analysis. Therefore a diagnosis of DAT must be made when other possible causes are ruled out (such as Schizophrenia, Major Depressive Disorder, Factitious Disorder).

A tentative diagnosis can be made if the following criteria are present.

- Memory impairment.
- One or more cognitive disturbances (aphasia, apraxia, agnosia, disturbance in planning, organising ability).
- Gradual onset and continuing cognitive decline.
- The cognitive deficits are not due to other CNS, systemic and mental causes.

The Disorder normally passes through three stages.[29]

- Stage 1 (Mild, forgetfulness).
- Stage2 (Moderate, confusion).
- Stage 3 (Severe, dementia).

Associated behavioural and psychological problems can be substantial. Depression and psychotic symptoms often occur making a differential diagnosis difficult. DAT patients often

become suspicious, to the point of persecutory delusions, of their caregiver. They can also exhibit apathy, agitation, irritability, and become very demanding.

Therapy issues

DAT not only affects the person who has it but all around him or her as well. The emotional stress on the spouse and family can be enormous. This means individual therapy for the clients and family therapy will be necessary.[30]

Following a careful assessment and an accurate diagnosis, therapy will depend on how advanced the disorder is. In the advanced stages the client will not respond to therapy.

An ethical issue relates to when to inform the client of the condition. The right ethical approach is to inform the client and family as soon as it is diagnosed.[31]

In the earlier stages the conveying of warmth, respect and empathy is important, on the part of the therapist and all others connected with the client.

Dealing with denial and grief therapy will be necessary. So will any associated depression and anxiety.

Family of origin work, dealing with resentment, guilt, and any other issues can then be proceeded with.

Helping the client adapt to the new circumstances will form an important part of therapy.

Marriage and sexual therapy may well be necessary.

The primary carer (usually the spouse) and the immediate family will also need therapy and assistance in coping with the condition. Getting free of anger and resentment may well be issues that family members will have to face. Grief therapy and communication skills will need to be considered.

Family members involved can receive much help from an Alzheimer's support group.

Vascular Dementia

Vascular Dementia is similar to DAT except there are focal rather than global neurological deficits due to vascular brain lesions. It is caused by strokes, hypertension, and heart disease.

Clinical course is similar to that of DAT but it occurs more rapidly following a brain lesion (eg. stroke) and has a gradual recovery.

Other Dementias

Dementia Due to a General Medical Condition, Substance-Induced Persisting Dementia and Dementia Due to Multiple Aetiologies also occur.

Schizophrenia

During the second half of the twentieth century there has been increasing realisation that psychoses can have many causes.

The psychotic patient is out of touch with reality. The symptoms of psychoses are usually not hard to determine - delusions, hallucinations, disorganised speech and behaviour, and negative symptoms (flat or blunted affect, loss of will, etc.) - but differentiating the cause is more difficult.

Characteristics

Schizophrenia is characterised by distortions of thinking and perception and is usually accompanied by emotions that are inappropriate or blunted. Typically there is a disturbance of the most basic functions that give a person the feeling of individuality, uniqueness, and self-direction. Additionally, the person may lack insight and may not appreciate that there is anything wrong with them. [32]

Schizophrenic patients will have been ill for at least six months with at least two of the following five psychotic symptoms:

- Delusions (a false belief that cannot be explained, and can be of grandeur, guilt, ill health, jealously, passivity, persecution, poverty, reference, and thought control).
- Hallucinations (a false sensory perception in absence of sensory stimulation and can affect all senses, but auditory and visual are the most common).
- Disorganised behaviour (must be bizarre).
- Disorganised speech (illogical or loose associations).
- Negative symptoms (reduced emotions - flat or blunted affect, loss of will to do things, reduced speech fluency).

These disorders are characterised by the presence of some or more of these psychotic symptoms during active, or heightened, episodes of the illness.

The symptoms have been referred in the past as the Four A's

- Flat or inappropriate Affect (mood).
- Loose Associations.
- Autism (morbid self-occupation and out of contact with reality).
- Ambivalence (conflicting emotions).

Mood is usually shallow, frivolous, or inappropriate for the occasion. Social withdrawal and emotional detachment is common.

There are degrees of the illness and in diagnosing it is important to be accurate in determining its frequency, chronicity, and severity.

A summary of the common complaints given by individuals and their families are:

Individuals with Schizophrenia have problems with the following.

- Hearing voices when no one is around.
- Strange beliefs.
- Disturbances with thinking and concentration.
- Managing daily activities.
- Managing social interactions.

Families of such often report the following.

- Strange, frightening or annoying behaviour (eg. irritability, suspiciousness).
- Apathy, withdrawal or poor living skills.

Schizophrenia symptoms usually commence during the 20s and are usually gradual. The course of the disturbance is variable. Genetic factors do play a significant role in the aetiology, but so do environmental factors.

It is important to realise that no one is to blame for the Disorder. While there may be a history of Schizophrenia in the family, it is important to realise that families do not cause Schizophrenia!

Differential diagnosis includes eliminating Organic Mental Disorder, psychoses from substance abuse, psychotic depression and mania, and several of the Personality Disorders.

Types of Schizophrenia

There are several diagnostic sub-types of Schizophrenia.

Disorganised Schizophrenia is defined by the predominance of such symptoms as incoherent speech, inappropriate emotional reactions, and disorganised behaviour.

Catatonic Schizophrenia is typically characterised by an extreme decrease in motor activity often accompanied by muteness.

Paranoid Schizophrenia, manifests delusions of a persecutory nature and, frequently, auditory hallucinations.

Undifferentiated Schizophrenia, involves a mixture of symptoms, including distinct delusions and hallucinations along with disorganised behaviour.

Incidence

Schizophrenia is relatively common, with one percent of the population affected. Twenty three percent of all first time admissions to psychiatric hospitals, and 50 percent of all resident psychiatric patients are schizophrenic.

Course

The Disorder proceeds through three major phases - Prodromal, Active, and Residual phases.

The Prodromal Phase, before the first onset of typical symptoms is characterised by general loss of interest, avoiding social interactions, avoidance of work or study, irritability and over-sensitivity, odd beliefs and behaviour.

The Active Phase shows typical psychotic symptoms.

Residual Phase is similar to the Prodromal Phase.

The most common course of the Disorder generally involves numerous Active Phases with Residual Phases in between.

Therapy

Schizophrenia is somewhat resistant to treatment, and will depend upon the degree and the phase of the Disorder. It is primarily managed by medication prescribed by psychiatrists. However, psychotherapy, family therapy, and community support are also important.

Therapy during the Active Phase will involve ensuring safety of the person and family, reducing symptoms by appropriate medication (major tranquillisers or neuroleptics), minimising stress and stimulation, building a good therapy relationship with the person and carers, and developing a management plan. Hospitalisation is often necessary.

Side effects from medication are often a real problem and it has to be decided whether medication should be continued if this happens.

Care must be exercised by the Christian counsellor not to label Schizophrenia as demonic. It is no more demonic than any other disorder.

Somatoform Disorders

Therapists need to be aware of the differences between Somatoform and Factitious Disorders and Malingering. These disorders involve physical symptoms that do not have a clear organic cause. Physical symptoms are reported that suggest a general medical condition but thorough evaluation does not reveal such a condition.

There are two general types of Somatoform Disorders: those which are characterised by excessive concerns about physical conditions but are associated with no specific symptom, and those in which there is one or more identifiable physical symptom.

Somatization Disorder

This Disorder (formerly referred to as hysteria or Briquet's Syndrome), beginning before the age of 30 years and extending over a period of years, is characterised by a pattern of recurring, multiple, clinically significant somatic complaints (pain and mood symptoms requiring medication). It rarely occurs in men and has a chronic fluctuating course.

In order to make a diagnosis there must be a history of pain reported from four different sites or functions (eg. sexual intercourse). In addition to pain symptoms there must also be a history of two gastrointestinal symptoms, one sexual symptom, and one pseudoneurological symptom.

The language used by these clients is often very graphic and exaggerated. They usually see numerous doctors and therapists. Anxious and depressed mood is common.

Conversion Disorder

These constitute a second major group of Somatoform Disorders. The Disorder involves the presence of actual isolated physical disabilities (voluntary motor or sensory symptoms) but without any physical basis.

These disorders are typically easy to separate from organically based problems because the physical symptom usually appears suddenly during a period of extreme psychological distress and often tends to be psychologically symbolic, as when a person develops paralysis in a subconscious effort to avoid unpleasant situations.

Pain Disorder

Pain is the predominant focus of clinical attention without a physical or physiological basis. Psychological factors play a significant role. There is a preoccupation with pain, which causes significant distress.

Hypochondriasis

This involves exaggerated concerns and unrealistic fears about one's health for a period of at least six months. The patient is not reassured by accurate clinical investigation.

Body Dysmorphic Disorder

This is the preoccupation with an imagined or exaggerated defect in physical appearance.

Somatoform Disorder Not Otherwise Specified

This simply refers to somatoform symptoms that do not meet the criteria referred to above.

Therapy Issues

The therapist must always be concerned that the client does not actually have an underlying medical condition.

Special skill is needed in the management of these clients. Warmth, respect and empathy are essential and all possible done to alleviate the symptoms.

Factitious Disorder

Factitious disorders are characterised by physical or psychological symptoms that are intentionally produced or feigned in order to assume the sick role, but not for personal gain.

They are distinguished from malingering in that in malingering the individual also produces the symptoms intentionally but has a goal that is obviously recognisable when the circumstances are known.

Factitious Disorder clients tend to take on symptoms of a newly identified illness - the latest fashion - the *disorder du jour syndrome*.

Associated with Factitious Disorder is usually a severe personality disturbance.

Therapy Issues

These patients are usually difficult to manage and often disagreeable.

The therapist must always be concerned that the client does not actually have another Axis I disorder or an underlying medical condition.

Special skill is needed in the management of these clients. Warmth, respect and empathy are essential and all possible done to alleviate the symptoms.

Malingering

Malingering implies intentional faking or gross exaggeration of physical and/or psychological symptoms, motivated by a clear expectation of personal gain (money, compensation, avoiding work, evading criminal prosecution, obtaining drugs).[33]

Malingering can be suspected when the following criteria are present:

- A medicolegal context exists.
- Marked discrepancy in the alleged symptoms and actual clinical findings.
- Lack of co-operation during diagnostic evaluation and therapy plan.
- The presence of Antisocial Personality Disorder.

Malingering is easy to suspect but difficult to prove. A clever malingerer is almost impossible to detect, especially when symptoms are emotional. Therefore great care must be used in making this diagnosis.

Therapy Issues

The therapist must always be concerned that the client does not actually have an underlying medical condition.

Special skill is needed in the management of these clients. Warmth, respect and empathy are essential. It is important and ethical not to be drawn into the game the client is playing.

Dissociative Identity Disorder

Dissociation occurs when one group of mental processes becomes separated from the rest. There is a close association between dissociation and the phenomena of hypnosis. Severe memory loss is usually present.

Dissociative Identity Disorder (formerly Multiple Personality Disorder) is one of the five Dissociative Disorders identified in the DSM-IV, and the most controversial.[34] In fact it is one of the most controversial of all mental disorders. Christian writers have made it more complicated and controversial in connecting it with supposedly frequently occurring **Ritualistic Satanic Abuse** (RSA), and branding many other mental disorders as DID.[35] Because of this controversy the whole subject should be closely examined.

Characteristics

The essential feature of DID is the presence of two or more distinct identities or personality states, that recurrently take control of behaviour. There is an inability to recall important personal information beyond ordinary forgetfulness. There is often a history of severe childhood abuse.

There is also an inability to integrate various aspects of identity, memory and consciousness. Each personality state may be experienced as if it has a distinct personal history, self-image, and identity, including a separate name. There is usually a primary identity that carries the individual's given name, which is usually passive, dependent, guilty and depressed. The alternate identities (alters) frequently have different names and characteristics that contrast the primary identity (eg. hostile, controlling, and self-destructive). These particular identities can

emerge in specific circumstances and may differ in age and gender, vocabulary and general knowledge. Alternate identities are experiences as taking control in sequence, one at the expense of the other, and may deny knowledge of other identities, and be critical of and in conflict with other identities.

Dissociative phenomena can be viewed as following a continuum that starts with normal behaviour such a daydreaming, to Dissociative disorder, Depersonalisation, Post-traumatic Stress Disorder, and finally DID.

Symptoms of DID in children are: [36]

- Spontaneous trance states.
- Use of another name.
- A claim of dual identity.
- Referring to self as we.
- Denial of behaviour that has been observed by others.
- Changes in vision, handwriting, dress, etc.
- Drastic changes in behaviour.
- Hearing voices.
- Drawing self as multiple persons.
- Feels remote from environment, and others.

Causes

It is often associated with a history of severe physical and sexual abuse during childhood. This includes Ritualistic Satanic Abuse practised by cults. Controversy surrounds the accuracy of such reports, because childhood memories are often distorted and persons with this disorder are often very vulnerable to suggestive influences.

Dissociative Identity Disorder (DID), has been diagnosed with increasing frequency over the past decade, and has been subjected to very different interpretations.

Ritualistic Child Sexual Abuse (Ritualistic Satanic Abuse - RSA)

This is a brutal form of trauma, inflicted at an early age, consisting of physical, sexual and psychological abuse, which involves the use of rituals by religious cults. It takes place in the context of the magical or the supernatural. It does not have to involve satanic rituals, however, most reported cases state that satanic worship was present in the rituals.[37]

A wide range of activities occur in ritual abuse such as participation in and filming of sexually abusive behaviours, religious rituals, giving of drugs, Satan worship, ceremonial sexual abuse, ritualistic use of blood, urine, faeces and the sacrificial killing of animals and other children.

Signs and symptoms of ritualistic child abuse are similar to that of severe sexual abuse, with the following added.

- Preoccupation with the supernatural, occult symbols, religion.

- Claustrophobia.
- Fear of death.
- Fear of doctors, injections, etc.
- Fear of, or preference for, black and red colours.
- Destroying toys, hurting other children.
- Other fears.

Incidence of DID

Controversy surrounds the incidence of DID. Some state it occurs in as much as 1 in 50 North Americans, others state it occurs in about 1 in 10,000! It is much more diagnosed in North America than in Europe. The general consensus is that it is rare.

Although some clinicians caution against under-diagnosis of DID, many authorities believe it is a rare disorder, and that most presentations are either subcategories of Psychotic or Borderline Disorders, or inappropriately precipitated and diagnosed on the basis of, usually faulty, information about past memories or events (False Memory Syndrome).[38] It is suggested that the average therapist will not likely come across it during their career.[39] The diagnosis of DID should only be made with great caution.

It is more common in women than men, and the average number of identities women are said to have is 15, whereas with men it is 8. It takes a fluctuating course, which is chronic and recurrent, and affects mainly younger adults.

Those who routinely diagnose it among their clients need to carefully consider the possibility of iatrogenic symptoms caused by their suggestions.[40] Frieson, who has written quite a bit on the topic, on the other hand, discounts the False Memory Syndrome concept, said to be characteristic of DID, which he states could discredit the reality of the painful memories sufferers of DID have.[41] It is true that in paying much attention to patients who dissociate, it can actually encourage the development of DID cases.

Diagnosis

Diagnostic criteria for DID according to the DSM-IV are.

- Presence of two or more distinct identities or personality states (each with its own pattern of perceiving, relating to, and thinking about the environment and self).
- At least two of these identities recurrently take control of the person's behaviour.
- Inability to recall important personal information.
- It is not due to a general medical condition, or effects of a substance. In children, the symptoms must not be due to imaginary playmates or other fantasy play.

The differential diagnosis between DID and other mental disorders must be carefully considered. This includes disorders such as such as those due to a generalised medical condition and substances, other Dissociative Disorders, Schizophrenia and other psychotic disorders, Bipolar Disorder, Anxiety Disorders, Somatization Disorders, Personality Disorders (especially Borderline Personality Disorder), Malingering and Factitious Disorders.

Before diagnosing DID, four features need to be confirmed to begin with.[42]

- Time - Do you frequently have periods of time that you cannot account for? (rule out single episodes of Dissociative Amnesia).
- Space - Do you frequently find yourself somewhere and then cannot remember how you got there? (rule out single episodes of Dissociative Fugue).
- Recognition - Have you ever found strange things among your possessions (Eg. clothes, jewellery) that you had no recall of buying?
- Switching - (The therapist should personally witness evidence of switching to alternate personalities that is so clear, rapid and extreme that would make it difficult for the person to be simply acting. The therapist can ask an alter to appear, or use hypnosis or drugs to assist in this).

The following three supportive features are useful to confirm diagnosis.

- Alters - Do you feel as if several persons are inside this one body? Do these persons take over the body? (Rule out Schizophrenia and Schizotypal Personality Disorder).
- Safety - Are you unable to feel safe and comfortable, now or in the past, either when alone or with another person?
- Abuse - Were you ever abused as a child? How severe was the abuse, and how long did it last? Was there anyone to turn to for support? (rule out PTSD).

Positive answers to these questions give a very strong indication that DID is a likely diagnosis. However making a definite diagnosis should only be done with great caution.

Therapy

Therapy for multiple personality disorder is complex and lengthy. It commences with gathering information and forming an accurate diagnosis. It may require hospitalisation, outpatient psychiatric therapy and medication.[43] Only those properly trained and experienced in diagnosing and treating DID should attempt therapy for these clients.

Useful medication therapy is antidepressants (*Prozac*), anxiolytics (*Xanax*), and *Amytal*.

Individual psychotherapy (family of origin work, and abuse, resentment, guilt and identity issues) and family therapy will be necessary.
It is valuable for the therapist to attempt to communicate with and spend time with each of the alters.

Most therapists treating DID see all alter personality states as vital for healthy functioning and therefore work to integrate all personalities into a fused state of self. This can be done by letting each alter have access to all other alter's experiences and abilities, and then identify them as their own. The aim is to build a strong new self that contains all the resources in the group, rather than the death or disintegration of any of the alters.

Cognitive-behaviour therapy can assist the client to improve his or her functioning in daily life. Teaching coping and communication skills are also important.

Sleep Disorders

Sleep problems are one of the most common complaints in both general health and mental heath settings. It is estimated that over 20 percent of the adult population suffers from, some form of sleep disorder in their lifetime.

The Sleep Disorders discussed here are only those due to psychological, emotional or environmental causes. Those with an organic base form a different category.

There are five stages to sleep.

- Rapid Eye Movement (REM) sleep.
- Stage 1 - non-REM (NREM) - the transition from wakefulness to sleep.
- Stage 2 - NREM.
- Stages 3 and 4 - NREM (deepest, slow wave sleep).

Classification

Primary Sleep Disorders include the Dyssomnias and Parasomnias.

Dyssomnias

The Dyssomnias are concern with the amount, quality, or schedule of sleep, including insomnia, unwanted awakening, and excessive sleep.

- **Primary Insomnia** (ordinary insomnia), which involves difficulty in initiating or maintaining sleep, or of not feeling rested after sleep, for a period of at least a month, and which significantly affects one's functioning. The therapist needs to be aware of variations relating to age and other factors. Stress is often a factor.

- **Primary Hypersomnia**, involves significant excessive sleepiness not accounted for by inadequate sleep or another Sleep Disorder, for a period of at least one month. Night time sleep appears normal and may not be excessive.

- **Narcolepsy**, is characterised by daily for at least three months of repetitive, brief (few minutes) seizure-like sleep attacks. These episodes are refreshing and may include dreaming.

- **Breathing-Related Sleep Disorder** involves abnormal breathing that interferes with sleep. This may be due to obstructive sleep apnoea, and other sleep apnoeas. Sleep is not refreshing and daytime sleepiness is common. Obstructive sleep apnoeas is characterised by snoring or gasping, and is often associated with obesity.

- **Circadian Rhythm Sleep Disorder**, involves a mismatch between the sleep-wake schedule demanded by the person's environment and their endogenous circadian rhythm. It is usually associated with irregular changing lifestyles.

Parasomnias

The Parasommnias are characterised by abnormal events (arousal, activity, thinking) that occur during sleep. The focus is on the disturbing event not the actual sleep.

- **Nightmare Disorder**, involves vivid and frightening dreams that repeatedly waken the client, and which are fully recalled. It usually occurs during the second half of sleep.

- **Sleep Terror Disorder**, involves repeated episodes of abrupt awakening from sleep with vague but intense anxiety. Recall is obscure and confusing. It usually occurs during the first third of sleep.

- **Sleepwalking Disorder**, involves repeated episodes of complex motor behaviours such as leaving the bed and walking about, usually occurring during the first third of sleep, and usually lasting less than 30 minutes. The person is in an altered state of consciousness and cannot exercise normal co-ordination and judgement. The episode is rarely remembered. It is much more common in children than adults.

Other Sleep Disorders include Sleep Disorders Related to Another Mental Disorder or Substances.

Therapy Issues

Accurate assessment is essential initially. This will include taking a sleep history. The use of a sleep diary is very useful, and assists the assessment process.

Assessment of substance abuse will need to also occur.

For Primary Insomnia, individual psychotherapy and family therapy will be necessary. Stress management therapy may be needed.

Paradoxical intervention is very useful in managing Primary Insomnia. This is simply, rather than trying to anxiously fight the inability to sleep, purposely trying not to sleep but getting up and staying up for a while (perhaps having a warm milk or camomile drink and quietly watching television). This breaks the anxiety and facilitates sleeping.

Education about **good sleeping habits** may be needed and would include:
- A proper sleep environment.
- Allow for a wind-down period before sleeping.
- Remove from the bedroom all unpleasant stimuli.
- Avoid alcohol, caffeine and nicotine.
- Take a late drink of camomile tea or milk drinks (caffeine free).

- Take regular exercise in late afternoon or evening.
- Practice relaxation.
- A warm bath before retiring can help.
- Go to bed only when sleepy, but attempt to go to bed at regular times.
- If you cannot get to sleep in 15 minutes get up and wait until you are sleepy.

Medication with sedatives or hypnotics (short-term) and antidepressants may be indicated. Breathing-Related Sleep Disorder can be helped by specially breathing apparatus, dental appliances and an operation to reduce the length of the soft palate.

Personality Disorders

Personality can be thought of as an enduring pattern of thinking, feeling, or behaving that is persistent across time and situations. It is the expression of an individual's characteristic lifestyle and mode of relating to others.

Personality Disorders may be diagnosed when such personality traits reflect persistent inflexible and maladaptive patterns that cause significant functional impairment and distress and are abnormal for the person's culture. The pattern is of stable and long duration, and not associated with another medical condition, mental disorder or substance abuse. [44]

These disorders are usually recognised by adolescence or early adulthood, and they continue throughout life. The client may not be aware of them, until a crisis arises.

In the DSM-IV ten Personality Disorders are presented. Previously there were 11, including Passive-Aggressive Personality Disorder. This is now relegated to the Appendix alongside other disorders requiring further study.

The 10 Personality Disorders are placed into three clusters:

Cluster A (Odd - eccentric)

- Paranoid Personality Disorder.
- Schizoid Personality Disorder.
- Schizotypal Personality Disorder.

Cluster B (Dramatic - emotional)

- Antisocial Personality Disorder.
- Borderline Personality Disorder.
- Histrionic Personality Disorder.
- Narcissistic Personality Disorder.

Cluster C (Anxious - fearful)

- Avoidant Personality Disorder.
- Dependent Personality Disorder.
- Obsessive-compulsive Personality Disorder.

A significant paradigm shift in understanding and treating Personality Disorders has occurred in recent times. No longer are these disorders considered resistant to therapy. Prognosis has improved dramatically with the development of better assessment and therapy methods.

Assessment in the past was difficult due the vague descriptions of the disorders and the difficulty of drawing the line between normal and abnormal when it comes to personality. This has been refined and while there is still a good way to go it is vastly better than it was before the DSM-IV.

Therapy also has markedly advanced. Combined therapy methods (individual, group, marital, and family therapy, with cognitive behavioural, psychodynamic and medication approaches) are now being successfully used.

DSM-IV classifies Personality Disorders into Axis 2 and in the following groups:

Paranoid Personality Disorder

This Disorder is characterised by unwarranted suspicion, jealousy, and anger. Other person's actions are interpreted as deliberately threatening or malevolent. As a result such person they have pronounced and recurring interpersonal conflicts. These persons tend to be rigid and self-sufficient. The disorder is quite common with about 2 percent of the population being affected, and with a higher incidence in males.

Paranoid persons are usually reluctant for therapy except when a crisis arises. They tend to be distrustful of therapists.

When therapy occurs it is important to build a strong relationship, avoid being too friendly and inquisitive, use good listening skills, explain everything, concentrate on the here and now, avoid group therapy.

Schizoid Personality Disorder

This Disorder is characterised by marked indifference to social relationships and a restricted range of emotional expression. These persons tend to withdraw and be loners, with little desire for intimacy and sexual activity. These persons are usually single. It is a little more common in males. It is uncommon in clinical settings.

These persons tend to be resistant to therapy and if they do come they hold the therapist at a distance.

Schizotypal Personality Disorder

This Disorder is characterised by peculiarities of thought and behaviour, and deficits in social skills, which not severe enough to be classified as Schizophrenia. Close relationships are difficult and uncomfortable. Persons with this disorder tend to be suspicious, have eccentric

speech and appear peculiar. Anxiety and depression may be associated with the condition. There is often a bizarre component present and odd beliefs. It is more common in schizophrenic families.

About 3 percent of the population are affected and it is a little more common in males. A small proportion go on and develop Schizophrenia.

Antisocial Personality Disorder

This Disorder, formerly known as psychopathic or sociopathic disorders, displays a pattern of irresponsible, antisocial, aggressive, and nonconformist behaviour that extends from adolescence through adulthood. There is a disregard of the rights of others. This disorder is more common in males than in females. Difficult relationships and domestic aggression is common. Deceit and manipulation are common. There is also usually a lack of remorse for wrong behaviour.

Early substance abuse and sexual promiscuity are commonly seen. These persons often have difficulties with the authorities (parents, teachers, police, etc.).

Incidence is 3 percent in males and 1 percent in females in the general population, with high incidence in some other settings (drug abuse, prisoners, some cultures).

Therapy issues will include ensuring safety, listening skills, don't be a hero, remove dangerous objects and clothing from clinic, avoid excessive stimulation, maintain warmth, respect and empathy. Family of origin work and cognitive behaviour therapy can certainly help if the person is open to therapy.

Full rehabilitation of these persons rarely occurs, but the degree of symptoms usually lessens as the person gets older.

Borderline Personality Disorder

This Disorder is characterised by a pervasive pattern of unstable interpersonal relationships, low self-image, unstable moods, and confusion about identity.[45]

It was originally called Borderline because it appeared to be something between, and bordered on, psychoses and neuroses.

Five or more of the following must be present to form a diagnosis:

- Frantic efforts to avoid abandonment.
- Unstable and intense interpersonal relationships.
- Identity disturbance (unstable self-image).
- Impulsivity in at least two areas (spending, sex, substances, driving, eating).
- Recurrent suicidal behaviour (10 percent actually complete suicide).
- Self-mutilation (quite common in this Disorder, but not in the other Disorders).[46]
- Unstable moods and anxiety.
- Chronic feeling of emptiness.
- Poor anger management.

- Transient stress-related paranoia and severe dissociative symptoms.

These clients have episodes of a sudden drop in mood, like major depression, which can cause considerable distress.

The emotional turmoil and impulsive behaviour that characterises Borderline Personality Disorder are often accompanied by alcohol and drug abuse. Many with alcohol and drug addiction problems have a masked BPD.[47]

Some 2 percent of the population have the disorder, and it is more common in women. It is often over-diagnosed, due to its broad inclusive definition. The course of the disorder is variable, but it tends to improve with age.

Therapy is difficult with these patients and will depend on the extent of the condition. Cognitive behaviour therapy may help. Antidepressant medication doesn't help. These clients don't like therapy and therapists.

Histrionic Personality Disorder

This Disorder involves a pervasive pattern of excessive emotionality and attention seeking. Emotions are inappropriately exaggerated in response to minor stimuli. Clients with this condition can be physically provocative. They may also attempt to control another person by their behaviour. They like to be the centre of attention and tend to be sexually provocative.

Incidence is 2 - 3 percent and it is more common in women. Course of the disorder is variable but it tends to diminish with increasing age.

Therapy issues will include avoiding being distracted by the person's behaviour, do not be diverted, do not reward histrionic behaviour, avoid sexual seduction, and leave the door open or use a chaperone if in doubt.

A typical good question to ask is, *It must have been distressing for you, but can you tell me from the beginning exactly what happened?*

Narcissistic Personality Disorder

This Disorder is characterised by a preoccupation with the self and a lack of empathy for others. There is a pervasive pattern of grandiosity, insensitivity to other's evaluations and criticisms of oneself, and lack of empathy. While there is grandiosity, in reality it is usually the opposite. Self-esteem, while appearing high, is low and fragile. Persons with this disorder need the admiration of others. It has been described as a state of *splendid isolation*.

Children often exhibit these characteristics but most grow out of them, in which case it cannot be diagnosed as Narcissistic Personality Disorder.

About one percent of the population is affected with a slightly higher incidence in males. The incidence is probably much higher than this.

Cognitive-behaviour therapy and Narrative Therapy helps in this Disorder.

Dr Bruce Stevens has done an excellent study of this condition amongst Christians (see article following). He has described nine forms of narcissism – The Craver, The Special Lover, The Fantasy Maker, The Power Broker, The Rager, The Trickster, The Body Shaper, The Martyr, and The Rescuer.

Avoidant Personality Disorder

This Disorder involves the individual shows extreme shyness and fear of being negatively evaluated by others. There is a pervasive pattern of social discomfort and feelings of inadequacy. Persons with this disorder are timid, hypersensitive and easily wounded. The person may have associated phobias, social inhibitions, depression, anger at self, and general anxiety.

It is somewhat similar to Social Phobia, the main difference being an earlier onset of Avoidant Personality Disorder.

Incidence is about one percent equally distributed between males and females.

Therapy may be successful in reducing the stress of the avoidant behaviour. Cognitive behaviour therapy will need to be intense and persistent to be effective in this regard. Anxiety management by relation, breathing exercises and systematic desensitisation are helpful. Assertiveness training will also help.

Dependent Personality Disorder

This Disorder is characterised by submissiveness, dependency and a lack of initiative. There is a clinging to others and fear of separation even when there is no grounds for it. If they leave one partner that quickly find another to cling to. There is a dread of functioning alone. Low self-esteem is present. Such persons find it hard to make decisions.

This Disorder is the closest one in the DSM-IV to codependency, people dependency, and relationship addiction.

This is the most common of the Personality Disorders and appears equally among males and females.

Therapy issues include avoiding client dependency, set limits and rules, assist decision making, teach assertiveness, promote outside interests, reassure and affirm as much as possible.

Obsessive-Compulsive Personality Disorder

This Disorder involves inflexibility and excessive concern with details, rules, lists, control, perfectionism and orderliness. There is a preoccupation with work to the exclusion of pleasure and good relationships. Decision-making is affected and harsh judgements on oneself are common. Difficulty in expressing feelings and depression also commonly occur. These clients believe there is only one correct way to do things.

Sufferers of this disorder, however, do not experience the more serious and uncontrollable compulsions and obsessions and purposeless repetitive behaviours in the way those who suffer from the similarly named Obsessive-Compulsive Disorder do. OCPD clients do not dislike what they do – they see it as a lifestyle. OCD is a more serious mental (anxiety) disorder and those suffering from it strongly dislike what they are doing. OCD clients are often great hoarders, whereas OC Personality Disorder clients are not. This is also a differentiating feature.

Incidence is about one percent of the population and is twice as common in males compared with females.

Therapy issues include careful planning, letting the client think they remain in control, redirect personality traits into better channels, give clear and precise information and instructions, use stress management methods such as relaxation, use cognitive behaviour therapy.

3. The Personality Disorders

Dr Bruce Stevens, PhD
Clinical Psychologist, Canberra

Exercise: Think about a person you have found difficult. Describe them using only the metaphor of a house.

The term personality disorder (PD) refers to enduring quality (personality traits) that a person displays in a wide variety of circumstances. Features of personality make an individual more prone to an emotional disorder when experiencing stress. For example an anxious person who is stressed may develop an Anxiety or Panic Disorder. Usually a **mental disorder** has a sudden onset and is of a shorter duration. A PD describes traits that have long been part of personality (therefore there is a need for reliable accounts of past behaviour extending back to adolescence). The traits are inflexible and dysfunctional causing significant functional impairment or subjective distress. The impairment is in two of the following: cognition, emotion, interpersonal relationships, and impulse control. As it was noted in the *Oxford Textbook of Psychiatry* an "individual suffers from his personality or that others suffer from it." People with a PD will have strengths as well and these should be noted.

Overall we can make a distinction between:

1. **Psychosis** when you feel "odd' with the person (trust your gut feeling)
2. **Personality disorder** when you feel that the person is "difficult"
3. **Neurotic** when the person is "distressed" usually with depression, anxiety, stress or panic symptoms.

I will introduce to you four preschool children:

1. Bryce 'The little fortress'

Bryce's mother left his father a few months after his birth and never returned. Her father was somewhat depressed before the separation. After she left he was often withdrawn. However, IT WAS not always. Bryce sometimes played happily and his father would pounce on him with rough and tumble games, then hugging and telling him how much he loved his 'little boy'. Unfortunately even positive interactions tended to be somewhat insensitive since the father could not read the needs of his son. When the father was depressed he would reject any overtures from his son. When he sought help from his father he was pushed away. Once Bryce fell and cut his knee. The rebuke, 'Why can't you be more careful!'

Bryce learned that he could not depend upon his needs being reliably met. At some level he would feel, 'I want to be close to my dad.' Sometimes he would get a hug but often he was pushed away. Nor could he read the mood of his father. Bryce was also periodically neglected and had to find food if hungry or to put himself to bed. It is a case of parenting being too much, too little and too intermittent.

Bryce also learned early that his father would not tolerate any display of genuine emotion countering either with hostility or 'You should be ashamed of yourself!'

Bryce seemed to cope very well. He became very independent. He would play happily on his own and make almost no demands upon his father. Often adults, who came to the house, would comment on his maturity and his ability to happily amuse himself. Bryce did not seem as interested in people but would play for hours constructing things with Lego. He would happily remain in a room with his father, not too close but then not straying far. It was odd that he would not get distressed if the father left him alone in the room. As Bryce gets a little older he rarely displayed anything resembling a strong emotion, almost as if he does not give himself permission to feel.

This child has developed a way to cope with a difficult home situation, a defence to minimize pain. Bryce has learned to not trust emotional signals. The messages from his father are contradictory, at times very inviting of closeness – though he can be smothering – while at other times angry and rejecting. Nor can Bryce trust his own emotions. He blocks out all feelings including anger. He does not allow himself to feel needs such as a desire for loving care. It is safest to ignore all interpersonal needs and to focus on toys or objects in his environment. Bryce may have given up asking, but he will happily take what his father has to give and manage the best he can on those emotional supplies. He is as emotionally neutral as he can be.

As Bryce gets older he will learn to respond to other adults. He will find that avoiding eye contact is considered rude. However, he will not make emotional contact. Because he so consistently avoids people, it will limit his ability to ask for and to use emotional assistance. His emotional insulation will also hinder his ability to be empathic. He will perfect his 'false self' of a self-contained happy child. He may find that he does well at school, especially in mathematics and science, perhaps one day becoming a computer engineer. He will value his ability to think and continue to be highly distrusting of emotions. Although it is not obvious he uses his developed ability to reason to manage his own emotions.

We can see that Bryce has worked out an effective survival strategy. He has experienced very confusing emotional signals from his father and it is not surprising that he has no confidence of anyone meeting his emotional needs. It is less painful to close down emotionally using things to distract himself. He does not want to be reminded of his own natural needs for care and attention. He over-develops his ability to think eventually employing it as a kind of executive function managing his emotions. He generally succeeds in blocking out emotional reality: past (painful memories), present (needs) and future (looking for what he does not expect to receive). He is an actor who has developed a false self, presenting as happy and content with himself. Behaviour is highly organized. It is a costly defence. Many facets of reality are excluded including sources of positive support.

We can recognize that Bryce has an overly simplified model of relationships and is unduly pessimistic about what comfort he may gain through future relationships. He may be content with very little. However, it is efficient in allowing him to adjust to a painful reality with a minimum of suffering.

2. Charlotte 'Normal as can Be'

Charlotte is three years old and happy. Her mother divorced but remarried reasonably soon after. Charlotte likes her stepfather but does not mistake him for her 'real' father whom she sees every second weekend. She is an easy child and mostly in a good mood. Initially she was upset about her father moving out of the house but managed to adjust to the new situation. Her mother was very sensitive to the initial turmoil of her emotions, and helped Charlotte to express her sadness in appropriate ways.

When Charlotte comes into a new room, for example when her mother visits a friend, she explores quite freely occasionally returning to 'touch base' with her mother. She is contented to play on her own but will also bring a toy to show her mother – inviting her to join her in a game. It is obvious to everyone that mother and daughter share a mutual affection. Charlotte has enough social confidence to approach strangers, but is not overly friendly or unguarded. If she is faced with a frustrating and difficult task, she tends to stick with it trying to solve the problem on her own, but if unsuccessful will eventually ask her mother for help.

Sometimes Charlotte is distressed. Her mother reads her emotions like an open book and will affirm that she is feeling sad, angry, frustrated, or ashamed. The mother can tolerate Charlotte's anger when she limits her daughter's behaviour. She delights when her daughter feels joy and recognizes when she is proud of some achievement. She is able to use language appropriate for a three year old and to stay within her realm of understanding when explaining something. Her mother is appropriately protective, 'Honey, don't watch that swing.' Communication is open and natural.

Charlotte has learned that her mother is dependable, what Winnicott called a 'good enough mother'. Unlike Bryce she can trust her mother's emotional signals and her own emotional needs. She can trust reality including how she sees it and thinks about it. In this way she is open to new information and has no need for constricting defences. Charlotte is 'securely attached' to her mother with both her father and stepfather emotionally important to her. Her behaviour is flexible, responsive and appropriate to a variety of situations.

She will have an easier time growing up. It is unlikely that she will be either a bully or a victim in the playground. In relationships she will find it easier to trust, to be tolerant of others, finding intimacy and satisfaction with fewer storms of negative emotions. Life will seem just a little easier.

3. Alison 'The Drama Queen'

Alison has been raised by a single mother who is a binge drinker. She is rarely sensitive to her daughter's emotional needs. At times she tries to be caring and loving, but will quickly lose her patience. When she can remain calm, she is quite responsive to her daughter. Naturally she is a better parent when she is not drinking. In a bout of drinking the mother can be bad tempered and on the rare occasion physically abusive. When her mother becomes sober again she is often plagued by guilt and remorse, 'What have I done to you darling?'

Alison is very clingy, ever watchful of her mother and careful not to let her out of her sight. When she tried to return to part-time work and leave Alison at child-care, her daughter screamed so much that she quit the job. It is not all a one-way street of demand. Sometimes her mother wants contact but Alison pushes her away. The most obvious quality of the relationship is the dynamic of push-pull. Unlike Bryce, Alison shows no avoidance.

Alison is often frustrated by her mother's emotional variability and general lack of being responsive. She shows this with tantrums, screaming in supermarkets when something is refused, pouting after any disappointment, and being disruptive in social settings, hitting at her mother if she attempts to leave even for a moment.

Once her mother having a cup of coffee with a friend. Alison was playing with blocks making a tower, and saw that her mother is not paying attention to her. Alison asked for attention, then screamed and finally threw a block at her mother. Her mother then made a gushy apology for neglecting her daughter, took her into her lap for a cuddle and effectively managed to reinforces the bad behaviour.

It is obvious that Alison does not have much confidence in her mother, but clings to her as if she is the source of all strength. She stays around her and is unwilling to explore new situations – even if there are interesting toys or friends her age to play with. She has limited competence in exploring and adapting to new situations.

Alison has a strength. She can accurately read the emotional fluctuations of adults. She understands the meaning of nonverbal cues, but finds it impossible to predict a reaction. She has no way of knowing whether the response will be supportive or hostile and rejecting. She becomes frustrated and remains either anxious or angry much of the time. Yes, there is parental inconsistency, but the real problem is a profound inability to predict behaviour. Alison has learned that she is unable to depend upon her thoughts – reason remains undeveloped.

However she can use her emotions. Anger is often effective. She can resist, punish and bully her mother - even as a three year old! If this fails Alison has a second strategy in coy behaviour. This includes smiling in an inviting way, displaying helplessness, need and dependency. It is a form of mock surrender, but purposeful in gaining predictable ends. Being coy also has the advantage of disarming aggression and inviting nurture. If Alison was shouted at and smacked when she interrupted her mother talking with a friend, the next move would have been to become cute and sweet. This almost always ends the aggression and moves the mother to comfort her. It is manipulative but effective.

Alison and her mother are enmeshed in cycles of crying and soothing interactions. It is a wonderful strategy to keep an inattentive parent highly involved. It guarantees at least attention and sometimes affection. Attachment is at a high intensity. This strategy depends upon an accurate reading of the parent's emotions. It is also necessary to be able to effectively use a range of emotional display, though in an instrumental and manipulative way.

There are costs. This child fails to develop important cognitive skills. Alison will have conflicting internal models about 'how her mother ticks'. Not only does it lack coherence,

fundamentally not making sense, but it adds to her lack of confidence in trying to understand. She does not learn to mature in emotional terms, for example in gaining better emotional regulation and limiting bad behaviour. She finds it very difficult to balance her needs with the needs of her mother or others around her. She will be very demanding and seem very selfish.

The mother will often feel very frustrated and victimized by Alison's manipulative behaviour. Unfortunately she will often submit to unreasonable demands, which reinforces Alison's 'acting out'. Her mother may resort to 'dirty tactics' such as responding with threats or physical abuse that only adds to problems.

As Alison grows up she will tend to be very volatile and manipulative. She may have problems keeping friends who find it hard to tolerate immature behaviour, taunting her as a 'mummy's girl', and excluding her from popular groups. She will be impulsive, sometimes disruptive in class. It will not be easy for her to face cognitive challenges, such as solving a maths problem, instead she will react emotionally. She can perceptively read adult emotions but has problems managing her own. It is not hard to predict a turbulent adolescence with frequent conflict with parents and authority figures. Emotional displays will be common. All the behaviours described with a three year old can become more exaggerated with adolescence.

4. Rocky 'Chaotic Lad'

Rocky did not have much luck in the 'choice' of parents. His mother was a heroin addict who supported her habit by working in the sex industry. His father suffered from a serious psychiatric illness and had to return to the hospital shortly before Rocky was born.

As Rocky became three years old he did not appear to rely on his mother but was easily frustrated. He had frequent temper tantrums. His emotions were hard to read, at times very detached, dazed or disoriented. There were moments when his face would appear blank. Occasionally he would stare off into space. When his father was discharged from hospital, Rocky was often hit without warning. It was not surprising that he showed fear in the presence of his father and mostly disinterest in his mother. Rocky eagerly approached strangers abandoning all caution.

Rocky does not seem to have a coherent strategy for getting his needs met. He will grow up with numerous problems including explosive anger and hostile behaviour. At times he will seem withdrawn and detached. If he reunited with a parent he may be care taking, disinterested, or punishing. He may become a bully in primary school and perhaps later have criminal convictions.

Bryce, Charlotte, Alison and Rocky represent four different patterns of how a child emotionally bonds to a parent. There has been extensive research about what is called 'attachment'. Mary Ainsworth and her team classified how children, mostly aged about 12-18 months, related to a parent. The categories are generally known as:

- Avoidant (A Type). This describes about 20-25% of children and includes Bryce.

- Secure (B Type). The estimate is 60-65% children including Charlotte.
- Resistant (C Type). The estimate is 10%. Alison is typical of this group.
- Disorganized (D Type). The estimate in a reasonably healthy or low risk group is about 10-15%, higher in a group of abused or neglected children. Rocky would be considered part of this group.

Attachment is quite specific, usually to a single person such as the mother, who is the source of security and protection. The A Type person trusts thinking but not emotions, the C Type trusts emotions but not thoughts and it is possible that D Type trusts neither.

While secure attachment is the foundation of healthy adult relationships, the other three patterns, A-C-D generally known as anxious attachment, are more characteristic of the way people with personality disorders tend to relate to others. The four patterns of relating can be conveyed with the categories of Transactional Analysis: A Type: I'm OK, You're not OK; B Type: I'm OK, You're OK; C Type: I'm not OK, You're OK; D Type: I'm not OK, You're not OK. I will spare you a lot of theoretical discussion and conclude that D Type may be foundational for some personality disorders (Antisocial and perhaps Schizotypal) but is not a pathway to narcissism.

SCHIZOID PERSONALITY

Cf. Albert Camus *The Stranger*

Impassive - Behaviour
Lack of expression, low energy and vitality. Speech slow and monotonous. Failure to grasp the emotional dimension of human communication, under responsive to all forms of stimulation. Feelings such as anger rarely expressed. Emotional deadness.

Interpersonal – Detached
Interpersonally indifferent and remote. Prefer solitary activities, (turn attention to things, objects, abstractions). Cf. a new generation of 'computer geeks'. There is little interest in people. He or she will fade in social background, they tend not to be able to read interpersonal signals or learn complex interpersonal manoeuvres. Retreat into the self.

Cognitive Style – Impoverished
Thought processes are also deficient, impoverished, especially in the area of social and personal life. Communications may be unfocused, tangential and off track. Words skim the surface of things. There is an inability to attend, select, and regulate perceptions of the environment.

Self image – Complacent
The Schizoid is self-satisfied. There is little interest in lives of others or self-reflection. Little inclination to look into personal feelings or attitudes. Others see such a person as bland. Self descriptions are vague and superficial.

Object Representations – Meager

The internal world is impoverished. Images are few and diffuse, memories devoid of clarity (little turbulence of drives, impulses and conflicts). Low arousal and low emotional reactivity. Inner life is like the external - dull.

Intellectualisation (as a kind of Defence)
This person will describe experiences in an impersonal and mechanical way. Abstract and matter of fact. Hardly feel emotional impact of events. Little need for defence since so little to defend.

Undifferentiated
Inner world barren, diffuse and inactive in dynamic terms.

Mood – Apathetic
There is little ability to experience affective states: pleasure, sadness, and anger to any appreciable degree.

Illustration: A funeral with <10 people.

AVOIDANT PERSONALITY

This is a new PD introduced by Million (1969)

This person is acutely sensitive to social judgment and humiliation. Unlike the Schizoid this person will experience their loneliness and isolation deeply, the 'out there' is painful. There is not the sense of emotional coldness. There is a strong need to relate but this person will fear being vulnerable in any way to others. Often will retreat to an inner world of fantasy and imagination.

Behaviour Fretful
Persuasive sense of unease. Very timid, over reacting to innocuous experiences. This person will over-read events as signifying ridicule or rejection. Frequent hesitations, fragmented thoughts, occasional confused and irrelevant digressions. Physical behaviour is controlled or guarded, but with bursts of fidgety and rapid staccato movements. This person is constantly on edge.

Interpersonal – Aversive
Distance is important from situations that might involve in close personal situations, uncertain whether he or she will be liked and fully accepted. It is safest to maintain distance to avoid being shamed and humiliated. Often there is a history of rejection – at least reported because it may be more *felt* than intended by others. This person will appear awkward and uncomfortable, he or she will tend to shrink from the 'give and take' of interpersonal interactions. This person will seem withdrawn and cold, but knowing this person better you will see him or her as very sensitive, touchy, evasive and untrustful. Actively detached.

Cognitive – Distracted
Avoidant people will scan the environment for potential threat; like a trauma survivor they tend to be hyper-vigilant. The preoccupation is with intrusive and disrupting inner thoughts.

This person is mentally flooded with excessive stimuli.

Self Image – Alienated
This person will see him or herself as inept and inferior. It is easy to find valid justifications for being isolated, rejected and empty. People are seen as critical, betraying and humiliating.

Object Representations – Attacking
There are intense, conflict-ridden memories of disturbed early relationships. The Avoidant is trapped in the worst of two worlds – seeking to avoid the distress around them and the emptiness of hurts within. Usually he or she will find no comfort or freedom to be. Inner Critic is negative and dominates the internal psyche!

Fantasy as a Defence
The Avoidant will try to break up or repress painful memories and emotions, block thoughts, prefer diffuse disharmony than focus on the sharp pain and anguish of being themselves. Fantasy is the only comfort. 'Day dreaming' is used to deal with frustrated needs for affection.

Fragile
There is a complex of torturous emotions, easily activated, and which tend to overwhelm the helpless individual. Psychological controls and weak. Internal conflicts are predictable such as the need for affection and comfort but mistrust sabotages this persons tentative efforts towards others.

Mood Anguished
There is a constant and confusing undercurrent of tension, sadness and anger. This can lead to general state of numbness. There is a constant anticipation of being criticized. The outlook is negative: to avoid pain, try not to need anything or to depend on anyone, - in effect to deny desire.

Illustration: Liz sought counselling with obesity and withdrawal into fantasy.

DEPENDENT PERSONALITY

Dependants are notably self-effacing, ever agreeable, docile, even 'crawling'. There is a clinging helplessness. He or she will feel inferior and run self down. The credo is to be submissive to avoid isolation. Cf. Freud's "Oral Character" type.

Expressive Behaviour: Incompetent
The lack of competence is seen in posture, voice, and mannerisms. Overly co-operative. Viewed by friends as generous and thoughtful. Humble, gracious, and soft. Always seeking approval. Obvious helplessness and clinging. No inner strength.

Submissive behaviour
This person will give up responsibility, leaving important matters to others, including placing own fate with authority figures. This person fits in to a religious cult (cf. Jonestown) or a

convent. Characteristics include attaching to others, submerge individuality, deny points of difference, and avoid expressions of power. Assume an attitude of helplessness, submission, and compliance. The goal is to elicit the nurture and protection needed.

Cognitive Naïve
Limit awareness of self and others to a narrow range. Minimally reflective, more like Pollyanna. Inclined to see only the good in things.

Self Image Inept
See self as weak an inadequate. Fragile when alone or abandoned. Incapable of doing things on own without support or guidance of another. Not only lack of confidence, but will actively denigrate themselves - running down own competencies! Tend to magnify faults and defects and idealize others.

Object Representations are Immature
Images of others as child-like in quality, if not infantile. Hold mixed images of the past – almost with a fixation. There is an emphasis on more youthful impressions. Only by internalising the role of being totally submissive and loyal can they be assured of consistent care and affection. This person is warm and can behave affectionately and admiringly. He or she has learned the inferior role well; and will readily provide the superior partner with feelings of being needed.

Introjection and Denial (Defence)
Introjection is to internalise the beliefs and values of another. It is natural to see this person as more powerful and nurturing. Denial – seen in Pollyanna quality of positive thinking, but denying unwelcome reality. May be saccharine sweet. Any hint of danger will release a torrent of contrition and self-debasement.

Self-Depreciation
This person will give up all responsibility. It is natural to evoke sympathy and attention from others. It is an intricate interpersonal dance in which the Dependent person is careful to restrain assertive impulses and deny own feelings.

Mood – Passive
Warm, tender, non-competitive, timid, conflict avoiding, with an underlying insecurity.

Illustrations:
1. Woman who withdrew to bed, suicidal gestures and relied on her teenage son to feed her.
2. Kathy McFee with John Conway, going along with his plans to murder his ex-wife.

HISTRIONIC PERSONALITY

Word hysteria – ancient Greeks – womb, which was then believed to travel through the body and settle in the brain during periods (early explanation of PMT). Histrionic personality, conveying excessive emotionality, began to be described in 19th C (sexuality, irritability, change in disposition etc.) Visual image – like an impressionist painting.

This person in a mild form is the 'life of the party' and can do well in the theatre. However, in the personality disorder is vain, inconsiderate, demanding and vain with considerable self-

deception.

Interpersonal attention seeking
Histrionics actively seek attention; market their 'appeal', often entertaining and sexually provocative ways. Affection and attention are the goals. Charming and coy behaviour. He or she will display a mixture of carefree and sophisticated, yet inhibited and naïve tactics. Mixed messages. Often a female will be seductive, at ease playing the game, but confused or apprehensive when male attention becomes too serious. The gestures are to draw attention, rather than self-expression. Such a person is very alert to signs of hostility or rejection.

Cognitive – Flighty
The Histrionic is inclined to avoid introspection. There is a lack an integrated sense of self. Will speak in impressionistic generalities, come to thoughtless judgments. However, because he or she is so other focused, there is no clear identity for themselves. The personality seems shallow, empty inside, with the person reacting more to external stimuli. Since there is scattered attention to details, this person tends to be distractible and flighty. Also, evasive of troublesome thoughts or intense feelings.

Self Image – Gregarious
See themselves as sociable, friendly, and agreeable people. Stimulating and charming. However, he or she will lack insight and fail to see personal insecurities, the need to draw attention to self and to be well liked.

Object Representations – Shallow
There is an insatiable starving for stimulation, attention and approval. He or she will feel empty of an inner self and seeks to fill that void. Lacking a core self, the Histrionic needs to draw nurture for from those around. The inner world is composed of a random collection of changeable and shifting emotions, shallow relationships, impulses and memories. (this is why there can be a problem of what psychoanalysts have identified as object constancy)

Defences: Dissociation and Repression
Characteristically, this person is attuned to the external world rather than inner. Therefore there is a lack of intra-psychic skills. Learn to seal off, repress or dissociate segments of memory. Often alter and recompose self-representations to create a succession of socially attractive but changing facades. There is a tendency to disconnect the true self from a theatrical role. Any unpleasant inner thought, memory or emotion is repressed to keep from intruding.

Disjointed
The inner world is loosely knit and carelessly united. Internal controls and regulation is scattered and not integrated – thus weak. Often Histrionics will depend on others. The sense of time is locked into present. Preoccupation is with external immediate stimuli, led to further impoverishment of inner depth.

Mood – Fickle
Often there is a high level of energy and activation. He or she will tend to be quick and responsive, especially with expression of emotions. Feelings are expressed with extreme ease.

Illustration: A 35 year old member of a therapy group who consciously tried to tone down sexual appeal but many of the males fell in love. Intense feelings but difficulty focus in individual therapy.

ANTISOCIAL PERSONALITY

This personality type has a long history. Theophrastus, a student of Aristotle, described the Unscrupulous Man. There has been centuries of interest in criminal personality, what Prichard (about 1835) called "moral insanity". However it is easy to over emphasize criminal type, when only small percentage come into conflict with the law. In TA terms this is the position "I'm okay; you're not okay."

Many have a low tolerance for frustration, act impulsively and cannot delay immediate pleasure. Often there is minimal planning, which leads to the accurate perception of the stupidity of criminals. (cf. Bank robber with note with address on the back) This person is easily bored and restless. When things are going their way may be gracious, cheerful, clever. However, he or she more often are brash, arrogant and resentful.

Interpersonal : Irresponsible
Most Antisocials are untrustworthy and unreliable in relationships. Fail to meet obligations of a marital, parental, employment or financial nature. There may be some pleasure in transgressing established social codes, in deceit or illegal behaviours. Forbidden fruits taste sweeter. Tend to exploit, bleed, and cast aside. People are used as a means to an end. Search for power or material gain to undo resentments of childhood. However, despite disrespect, may present a socially conforming mask. Untroubled by guilt and loyalty, this kind of person develops a talent for pathological lying. This kind of person is alert to weakness in others (cf. Irving Yalom, *Lying on the couch*, psychoanalyst who is conned by a patient)

Cognitive Deviant
Many Antisocials interpret events and actions in line with socially unorthodox beliefs and odd morality. They are disdainful of traditional ideals, but with some clarity in cognitive processes and logic. Rarely exhibit foresight. Right and wrong are irrelevant abstractions. Often present as innocent "victim", and seek to avoid blame.

Self Image – Autonomous
Since the Antisocial will reject social norms, the more dissimilar they can be from "ordinary people" the better. Hence to be clever, cunning, disrespectful and deviant are valued self-images. Such a person will tend to be unrestrained by personal attachments and responsibilities to others. Unconfined by persons, places, obligations and routines. They do what they believe is right for them – usually in the immediate moment.

Object Representations Debased
Internal images of people are malevolent and cruel. They will abuse, exploit, strip you of all that is valuable, dominate and brutalize if they can. To avoid this, the Antisocial needs to claim all the power possible. Alert to the perceived malice of others. Threats are omni-present. Memories are of a degraded and corrupt nature.

Acting out, Projection as Defences
Inner tensions are not constrained, but directly expressed. Acted out without guilt or remorse. Even socially repugnant impulses or feelings are openly expressed. Projection is also used. They are fully justified is how they act because of the evil of others. The antisocial will portray themselves as the victim. In this way, the person will not only disown impulses but attribute evil to others.

Unruly
Psychological structure poorly developed. Controls are easily by-passed. There is little capacity for delay of gratification. Little of value within. So self-aggrandizing. Often there is an obvious hedonistic need for immediate pleasure.

Mood – Callous
Emotional disposition tends to be irritable and aggressive. Deficit in social charity, human compassion, personal remorse or sensitivity. There may be a "lust for life" chasing excitement and pleasure. Impulsive to explore the forbidden.

One of the surprising things about assessing criminals is that they will find it hard to even fake remorse. You would think this would be easy enough if you were facing a jail term!

Illustrations:
1. A mild form was the builder who had been convicted of 7 DUI offences.
2. John Conway and the murder of his wife, instructs solicitor to blame Kathy McPhee.

OBSESSIVE – COMPULSIVE PERSONALITY

Freud and Abrahams described the "anal character" – carefully dressed, correct, scrupulous, constricted, financially stingy, - in the language of today a "control freak." The essential features are a pre-occupation with order, perfectionism, mental and interpersonal control at the expense of flexibility and openness. Illustration: Jack Nicholson's character in *As Good as it gets.*

Behaviour Disciplined
Grim controlled appearance. Air of austerity and serious minded. Posture and movement reflect an underlying tightness, with a tense control of emotions. Emotions controlled by a regulated, highly structured, carefully organized life. Speech is precise. Clothing formal and proper. (The kind of person who gardens in a tie). Perfectionism interferes with ability to make choices.

Interpersonal Respectful
There is a marked adherence to social convention and what is proper. Scrupulous about morality and ethics. This person will relate to others in terms of rank or status and tend to be authoritarian in outlook. Deferential to superiors; autocratic with inferiors. Usually appearing quite pompous and self-righteous.

This person is careful to be respectful, punctual, meticulous, even submerging own individuality to become extension of powerful person. This allows the OC to become

powerful, especially in bureaucratic structures and this power allows a sanctioned outlet to vent hostility. Tend to be very judgmental.

Cognitive – Constricted
The mind is organized in terms of conventional rules and regulations. Such people tend to be rigid and stubborn in adhering to formal guidelines to structure their life. Easily upset by unfamiliar events and novel ideas. When unsure of proper course of action, can end up immobile and indecisive. Are contemptuous of those who behave frivolously and impulsively.

Self Image – Conscientious
See themselves as devoted to work, industrious, reliable, meticulous, and efficient. Are "good organization men (usually)". Can be harsh in self-judgments. A strong sense of duty to others.

Object Representations Concealed
Only internalised representations that are socially acceptable are allowed into conscious awareness or given expression. Memories are highly regulated and tightly bound. Forbidden impulses are left unconscious. Self-exploration is resisted as the opposite to efficient behaviour.

Reaction Formations and Identifications (Defences)
It is important to be socially acceptable and to hide forbidden impulses. Tend to display a mature reasonableness. Identify with authority and give vent to hostility to inferior who transgress the rules. In this way Reaction Formation (eg. sickly sweet person who is really angry) is a defence that is ideal. May engage in ritualistic acts (eg. religious ceremonies) to "undo" the evil they have done.

Compartmentalized
Inner world is rigidly compartmentalized and tightly sealed. The OC sits on this tightly constrained but internal powder keg, beset by deep ambivalences and conflicts. The greatest task is to controlling own impulses and emotions. There is a pervasive fear of disapproval and being punished. This is a constant threat and the risk is that true feelings will be revealed.

Mood – Solemn
Compulsives are tense, joyless and grim. Warm and affectionate feelings are restrained. All constraint and inhibition. Tend to have somatic disorders. There is an internal conflict of intense fear and deep anger. Clearly there is a poorly developed capacity to enjoy life or even pleasure.

It is appropriate to distinguish the Axis I psychological disorder, Obsessive Compulsive Disorder that is related to controlling anxiety. Classic types are hand-washing or checking. This person will know it is irrational but can not stop the behaviour. The PD has traits woven into the fabric of personality and is barely aware that it causes problems for others.

Illustration: High-church Anglican clergy are humorous examples of what Freud described as religion as neurotic. George at St Paul's Millis and the order of lighting the candles.

SCHIZOTYPAL PERSONALITY

Analyst Dr Otto Kernberg saw last three PD's as having problems with structural aspects of personality. Consider the architecture of the psychic interior.

Historical

Kraeplin (1896) and Bleuler (1911) described schizophrenia. However, not all odd people are overtly psychotic. S. Rado (1950) coined term schizotypal. DSMIV links this disorder to schizophrenia and other forms of mental illness. Often there are genetic links with family members with schizophrenia.

Behaviour Eccentric
This kind of person is socially inept with peculiar mannerisms. May dress in unusual ways, often preferring a 'personal uniform' (Cf. Robin Williams in *Mork and Mandy* was in street clothes). Some are aloof and very withdrawn. It is socially isolation to protect the self.

Interpersonal Secretive
Schizotypals have learned to prefer privacy and isolation. Never high functioning, and tend to be marginal in work. He or she will frequently drop out and drift from one menial job to another. There is a restlessness (listless) with a lack of spontaneity, ambition and interest in life. Talk often digresses into odd or metaphysical topics.

Cognitive Style – Disorganized
There is an inability to organize thoughts, especially about interpersonal understanding. He or she will have different interpretations. Idiosyncratic conceptions regarding thoughts, feelings and actions of others. May withdraw to becoming highly ruminative, self absorbed, lost in daydreams. Ideas may include magical thinking, bodily illusions, odd beliefs, peculiar suspicions, cognitive blurring of fantasy and reality. Can have superstitious beliefs. Some New Age ideologies fit in well with such beliefs.

Self Image Estranged
Schizotypals see themselves as alienated from world around. Often ruminate about how empty is life. Millon observed "a sense of vapidness in a world of puzzling and washed out objects." Many see themselves as more dead than alive, insubstantial, foreign, and disembodied - detached observers of the passing scene.

Object Representations Chaotic
There is a jumble of early memories, perceptions and feelings. Almost random. Ineffective and uncoordinated frameworks for regulating tensions, needs and goals. Lost in personal irrelevancies and tangential asides.

Undoing as a Defence
Many of the bizarre mannerisms or idiosyncratic thoughts of the Schizotypal reflect a retraction or reversal of previous acts or ideas. The undoing process is seen in magical beliefs and ritualistic behaviours.

Fragmented

Inadequate and poorly constructed defensive operations, primitive thoughts and impulses tend to be discharged in random way. He or she may be overwhelmed by excessive stimulations. May react by "blanking out" drifting off into fantasy. If there is too much stress, the Schizotypal's coping capacity may overflow with primitive impulses, delusional thoughts, and bizarre behaviour.

Mood
Some Schizotypals are very drab and sluggish (a little Schizoid). Others are more like the Avoidant and become excessively
apprehensive and uneasy in social encounters.

Illustration: Chess playing client, had to visit his home, but it was not agoraphobia. Later he was diagnosed with paranoid schizophrenia after an abortive attempt to rob a newsagent.

BORDERLINE PERSONALITY

C. Hughes (1884) referred to "the borderland of insanity". Psychoanalysts have focused on the problem of identifying the "borderline" between neurotic characters (psychological disorders) and more severe forms of mental illness. Hospital based psychiatrists sought to distinguish schizophrenia from the borderline variants (which eventually led to Schizotypal Personality). Otto Kernberg investigated impaired ego functions.

This instability is generally obvious in adolescence. However, one of my clients described a BL four year old child! (whose mother was clearly BL) Illustration *Good will Hunting* the gifted adolescent who sees the psychiatrist.

Behaviour Erratic
There are high levels of inconsistency and irregularity. Dress and voice show rapid changes eg. from spirited to apathetic. Highly impulsive. There are outbursts of temper and emotional reactions. The brittle, volatile and unpredictable quality is unsettling and causes considerable 'wear and tear' on those around.

Interpersonal Paradoxical
Although there is a great need for attention and affection, the Borderline will act in unpredictably contrary, manipulative and volatile manner in their interpersonal relationships. These frequently elicit rejection rather than the support desperately need. He or she has a frantic reaction to fears of abandonment and the fear leads to explosions of anger and rage. This person is paradoxically exceedingly dependent upon others and vulnerable to separation. Some will play act submissive devotion, but this passivity leads to periodic outbursts. Usually there are excessive complaints, sour moods, irritability and tension in the atmosphere. Suicidal threats, self-injury or destructive impulses may function as instruments of blackmail. *Illustration* Ht in first group, opening with a 'joke', eventual N injury and rejection.

Cognitive Unstable
This kind of person will experience rapidly changing, fluctuating, polarized perceptions and thoughts, concerning persons and events. Have ambivalent attitudes towards themselves and

others. Evoke in others confusing and conflicting feedback. Few anchors or guideposts.

Self – Image Uncertain
Experience confusion of an immature, nebulous or wavering sense of identity, often with an underlying feeling of emptiness. Considerable difficulty maintaining a sense of self, because of contradictory self-representations, lack of inner cohesion and splitting.

Object Representations Incompatible
Conflicting images, discordant attitudes, contradictory needs, erratic impulses, clashing strategies for conflict resolution. It is hard to think clearly when there are so many inner conflicts. Sharply divided into polar extremes (eg. people: all good or all bad) then swing between idealizing and devaluing others. There is a fear of being engulfed by others or be abandoned with out warning.

Regression (Defence)
Under stress the BL will regress to earlier levels of functioning. Some aggressive impulses are turned against self (Inner Critic), but most are expressed towards others in destructive ways. Splitting is the other common, but primitive defence. This at least keeps the warring inner factions separate.

Split
Inner structures are split, sharply segmented across boundaries that divide contrasting perceptions, memories and affects. A lack of control can result in transient stress related psychotic episodes (usually with a paranoid flavour). The BL has the terrible dilemma of never fully trusting others in order to gain the security of affection needed. They feel intense anger towards those who they depend, not only because it shames them and exposes weaknesses, but because of the envy of the power over them.

Mood Labile
Intense and changeable affect. Most fail to relate unstable mood levels with external reality. Often episodes of inappropriate and intense anger. Rapid shifts from one mood to another are not inevitable, but do characterize extended periods when there has been a break in control. There are real problems with the internal regulation of emotions.

Illustrations:
1. When I was slow to diagnose until self-mutilation and then visiting two of my clients in the hospital in adjacent beds.
2. The difficult parishioner at Holy Covenant.

BL is often linked to childhood abuse and neglect. See Judith Herman's book *Trauma and Recovery* and her understanding of complex PTSD. Dr James Masterson used the illustration of the BL being manipulative and using immature strategies. It is like growing up in a 'concentration camp'. The guards have all the power. He said that for the BL the world is a hostile place and the self is always under attack. He talked about the need to work through an 'abandonment depression' in therapy.

PARANOID PERSONALITY

This was seen in medical literature, before even Hippocrates. It means to "think beside oneself." Kraepelin (1895) narrowed the meaning of paranoia, restricting it to highly systematized and contained delusions. He thought it would deteriorate to schizophrenia.

Behaviour Defensive
Paranoids appear tense and guarded. Eyes tend to be fixed, sharply focused. They are vigilant of their environment in order to anticipate any potential malice, deception or criticism of themselves. Tenaciously resistant of any external control or influence. He or she will exhibit an edgy tension, alert vigilance, abrasive irritability and be highly guarded. They rarely relax or let down their guard.

Interpersonal Provocative
Paranoids bear grudges and are likely to be quarrelsome and argumentative. They provoke others to become exasperated, frustrated and angry. The Paranoid has deep resentment and envy towards those who have 'made it." Every trivial rebuff is a reminder of past injustice. Fantasy of doom, underlying dread and fury.

Cognitive – Suspicious
There is a pervasive suspiciousness. Also sceptical, cynical and mistrustful of motives of others. Innocuous events are interpreted as signifying hidden or conspiratorial intent, and they will search for hidden meanings. He or she is willing to explore every detail to find some justification for their beliefs. They will create an atmosphere that provokes others. The result is that they act as the Paranoid anticipates.

Self Image Inviolable
Paranoids have persistent ideas of self-reference and self-importance. Often there is grandiosity. They perceive attacks on their character not apparent to others. Intense fear of losing identity and the power of self-determination. Tend to assume an attitude of invincibility and pride.

Object Representations Fixed
Internalised representations of early relationships are limited and fixed. – firmly held. Inner template of objects has idiosyncratic character. The confidence and pride of the Paranoid is an empty shell, extremely vulnerable to challenge, the defensive façade is constantly weakened by threats – both real and fantasy.

Projection, Fantasy (Defence)
Projection is a very characteristic defence. The Paranoid will disown undesirable traits, then attributing them to others. There is a profound lack of insight. They are hyper-alert, spotting the most trifling deficiencies in others. There is also the defence of projective identification.

Inelastic
Highly controlled with systematically arranged images. The defective nature of the Paranoid's structural organization is not its lack of cohesion, but rather its overly constrained and rigid character.

Mood Irritable
Paranoids tend to be cold, sullen and humourless. Tend to be unemotional and objective in outlook, but also typically edgy, envious, jealous, and quick to take personal offence. There is a dissociation of their tender affectionate feelings. Hard, unyielding immune and insensitive to suffering of others. Hostility is a means not of countering threats but it helps them to restore their image of self-determination and autonomy. Experiences of prior humiliation are brought to the surface and discharged into a stream of current hostility.

Conclusion

There has been little research on the long-term prognosis of PD's with the exception of the Antisocial. It seems that there may be some mellowing with time, for example after age 45. Medication is not seen as very effective with the exception of short-term assistance with stress or anxiety or anti-depressants for BL (preferably SNRI such as *Efexor*). Psychotherapy may help but gains are small and take years. A case management approach is less intensive but can provide some support. With any character pathology I think that a Christian conversion can help but by no means will faith remove all the problems.

To Read Further

Theodore Millon with Roger Davis, *Disorders of Personality: DSMIV and Beyond*, 2nd Edition, John Wiley and Sons, New York, 1996. Comprehensive. Extensively used in this lecture. Expensive but highly recommended.

4. Narcissistic Personality Disorder

Dr Bruce Stevens has studied the Narcissistic Personality as it affects Christians.[48]

Mapping the Fall: Understanding Narcissism

Dr Bruce Stevens, PhD

Greet those in the Lord who belong to the family of Narcissus (Romans 16:11).

Introduction

In the recent film The Apostle (1998) Robert Duval plays a southern preacher who is genuinely zealous for God. He has a gift of evangelism. In a scene, early in the picture, he bypasses a police cordon to speak to a dying man in a car accident - and brings him to faith. Yet the film is not like the story of Billy Graham, this southern preacher has some character flaws as well. In a fit of passion, he strikes out with a baseball bat and hits his wife's lover - the youth worker in his successful church. The young man goes into a coma and eventually dies. The film is a wonderful study of a very flawed man who is deeply devoted to God. This raises a dilemma known to anyone with experience in pastoral ministry: Sometimes the most committed Christians are the most psychologically disturbed. It is possible to combine a lively faith and yet be almost totally blind about personal limitations - even glaringly obvious defects. Psychologists call this a lack of insight. I would like to introduce and then explore the area of what I call 'unconscious sin.'

Theologians have worked out a language to describe the nature of humanity especially in the moral realm. It is highly realistic. The key words are 'original sin' and 'sins.'

St. Augustine was a good psychologist but he used theological words. He noted that humanity, cut off from God and not seeking redemption in Christ, tends to turn inward and look for a self-sufficiency in the self. This results in being self-absorbed or self-centred.1 The curious fact is that a person, cut off from grace, is rarely aware of the extent of the problem or the nature of the affliction. You could of course ask family, friends or any close acquaintance and generally get a clear picture. It is like making the observation that few of us know exactly why we are hard to live with! I want to explore this part of the territory of the fall.[2] I would like to change language games - word from psychology: Narcissism.[3]

1. C. S. Lewis made a distinction between self-centredness and selfishness. 'One of the happiest and most pleasing companions I have every met was intensely selfish. On the other hand I have known people capable of real sacrifice whose lives were nevertheless a misery to themselves and to others because self-concern and self-pity filled all their thoughts. Either condition will destroy the soul in the end. But till the end, give me the man who takes the best of everything (even at my expense) and then talks of other things, rather than the man who serves and talks of himself, and whose very kindnesses are a continual reproach, a continual demand for pity, gratitude and admiration'. C. S. Lewis, *Surprised by Joy*, Collins Fount, Glasgow, 1988, p. 117. Without using the word narcissism this is exactly what Lewis is talking about.

2. An excellent book on sin is Cornelius Plantinga, Jnr, *Not the Way it is Supposed to Be.' A Breviary of Sin*, Eerdmans, Grand Rapids, Michigan, 1995.

3. Sigmund Freud, 'On Narcissism: An Introduction', (1914) in Andrew P. Morrison, *Essential Papers on Narcissism*, New York Universities Press, New York, 1986, pp. 17-43. See the rest of this book for important essays by leading psychoanalytic writers.

A Classical and Modern Theme

This comes from the classical story of Narcissus. The most well known version was written by the Latin poet Ovid (died 17 C.E.). Briefly:

Narcissus was the son of Cephissus, the river god, and the nymph Leiriope. By the time he was sixteen everyone recognised his ravishing beauty, but he scorned all lovers -- of both sexes -- because of his pride. The nymph Echo was hopelessly in love but she was hindered by her inability to initiate a conversation . Eventually Narcissus rejected her. She wasted away in her grief to a mere voice. The young man, similarly spurned, prayed that he would love himself unremittingly. The goddess Nemesis answered this prayer by arranging that Narcissus would stop to drink at a spring on the heights of Mount Helicon. As he looked in the water he saw his own reflection and instantly fell in love with the image. He could not embrace his reflection in the pool. Unable to tear himself away he remained until he died of starvation. But no body remained - in its place was a flower. (Metamorphoses, Book 3)[4]

I will try to distil some common traits of narcissism. These include:

- an obvious self-focus in interpersonal exchanges;
- problems in sustaining satisfying relationships;
- a lack of psychological awareness;
- difficulty with empathy;
- problems distinguishing the self from others;
- hypersensitivity to any slights or imagined insults;
- a lack of emotional depth and ability to feel sadness; and
- vulnerability to shame rather than guilt?[5]

4. *The Metamorphoses of Ovid*, Trans. Allen Mandelbaum, Harcourt Brace and Co, 1993. A clear and readable version.

5. The psychoanalyst Otto Kernberg described the dynamics of narcissism. His clinical description is insightful and comprehensive. These clients have an 'unusual degree of serf reference in their interactions with other people, a great need to be loved and admired by others, and a curious apparent contradiction between a very inflated concept of themselves and an inordinate need for tribute from others... Very often such patients are considered to be dependent because they need so much tribute and adoration from others, but on a deeper level they are completely unable really to depend upon anybody because of their deep distrust and depreciation of others.' He added, 'The main characteristics of these narcissistic personalities are grandiosity, extreme self-centredness, and a remarkable absence of interest in and empathy for others in spite of the fact that they are so very eager to obtain admiration and approval from other people. These patients experience a remarkably intense envy of other people who seem to have things they do not have or who simply seem to enjoy their lives. These patients not only lack emotional depth and fail to understand complex emotions in other people, but their own feelings lack differentiation, with quick flare-ups and subsequent dispersal of emotion. They are especially deficient in genuine feelings of sadness and mournful longing; their incapacity for experiencing depressive reactions is a basic feature of their personalities. When abandoned or disappointed by other people they may show what looks on the surface like depression, but which on further examination emerges as anger and resentment, loaded with revengeful wishes, rather than real sadness for the loss of a person whom they appreciated. Otto Kernberg, 'Factors in the Psychoanalytic Treatment of Narcissistic Personalities', in Andrew P. Morrison, *Essential Papers on Narcissism*, New York Universities Press, New York, 1986, p. 213-15.

Naturally the great authors have portrayed narcissism, usually in ways far more vivid than any psychological writer. A lawyer, in one of Camus' novels indulged, in a prolonged 'confession'

in an Amsterdam bar. He reflected on his attitude to himself and to others, 'It is not true, after all, that I never loved. I conceived at least one great love in my life, of which I was always the object... I looked merely for objects of pleasure and conquest.' He continued, 'On my own admission, I could live happily only on condition that all the individuals on earth, or the greatest possible number, were turned towards me, eternally in suspense, devoid of any independent life and ready to answer my call at any moment, doomed in short to sterility until the day I should deign to favour them. In short, for me to live happily it was essential, for the creatures I chose not to live at all. They must receive their life, sporadically, only at my bidding. 6

This chilling portrayal is a vivid example of a personality completely dominated by narcissism. Narcissism is here expressed in 'neon' lights.

Diagnostic criteria for 301.81 Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy.

The person must have five or more of the following:
- has a grandiose sense of self-importance;
- is preoccupied with fantasies of unlimited success, power brilliance, beauty, or ideal love;
- believes that he or she is 'special' and unique and can only be understood by or should associate with, other special or high status people or institutions;
- requires excessive admiration;
- has a sense of entitlement;
- is interpersonally exploitive;
- lacks empathy;
- is often envious of others or believes that others are envious of him or her; and
- shows arrogant, haughty behaviour or attitudes.[7]

In classical mythology the serpent Hydra had nine heads. Every time Hercules cut off a head two new heads appeared. In a similar way narcissism is one disorder but with different types. I have identified nine "heads" of narcissism:[8]

6. Albert Camus, *The Fall,* Vintage Books, New York, 1956. See also Neville Symington, *Narcissism: A New Theory,* Karnac, London, 1993. An English psychoanalyst now living in Australia. He looks closely at the novel *Anna Karenina* by Tolstoy.

7. DSMIV, American Psychiatric Association, 1994, (see pp. 658-661)

8. Ben Bursten, 'some Narcissistic Personality Types', in Andrew P. Morrison, *Essential Papers on Narcissism,* New York Universities Press, New York, 1986, p. 381. Ben Bursten made a significant contribution in his conception of four types of narcissistic personality: Craving, Paranoid, Manipulative, and Phallic.

(i) Craver

Cravers are a bottomless well of need. It is experienced as an aching hunger. This overwhelming need places insistent demands on others - which can never be fully satisfied. Unfortunately the Craver is rarely aware of just how transparent they are with this need for nurture.

A Craver may have a haunting sense of anxiety and a terrible fear of abandonment. There is a habitual 'one down' position in relationships. This can lead to an apologetic, 'I am sorry for existing.' Another indicator of a Craver is the extravagant way they will idealise anyone in authority.

Vera dressed in a way one of her friends called 'loud'. She was certainly attractive and had no difficulties getting 'a date' but keeping a partner was another matter. There was something intense about her that led to relationships ending suddenly. She was usually surprised and somewhat mystified

Usually what is most obvious 'behind the facade' is a clinging dependence in relationships. Partners may experience endless frustration trying to meet escalating demands. Giving is like pouring sand into a sieve. In addition, the needs can be so overwhelming that the Craver will resort to manipulative and even exploitive ways to derive emotional sustenance.

There is at least one Craver in every church. You will know this person by how exhausted you feel alter even a brief conversation. In addition, if you fail to respond to their impossible demands, watch out!

(ii) Special Lover

The Special Lover is a 'pure' romantic.[9] This person may be exciting, stimulating, expansive and fun. However, the veneer may be quite thin and transparent. What is under the surface is a hidden grandiosity or an inflated sense of self. Private fantasies of uniqueness or unrivalled beauty may be savoured. However, perhaps more obvious will be idealised relationships: 'Our love is special.'

Stan was a 'hopeless romantic.' He went on the TV show Perfect Match and genuinely believed that fate was at work. He described himself quite realistically as a genuine sort of person who was always faithful. He could also be amazingly selfless in a relationship, always forgiving, and yet his romances were brittle. Something would 'snap' after the quiet dinners,

9. R. A. Johnson, *The Psychology of Romantic Love,* Arkana, London, 1983. The author is a Jungian analyst and this readable book explores the theme of romantic love through various stories in our culture. I also address this theme in *Regaining Intimacy: Dealing with the pain of a broken relationship,* Random. House, Sydney, 1995.

romantic walks and the poetry he wrote. He was almost addicted to ecstasy. However, eventually reality would intrude. In addition, it was a reality that he could not control

The inner self of a Special Lover is often highly vulnerable to any slights - real or imagined - and bleeding wounds persist from past experiences.

Some Special Lovers are very successful and widely admired. Naturally if he or she becomes a celebrity it adds to the sense of being special because of the admiring feedback of others.[10] The Christian community has many idealists, while some may be visionaries in the best sense of the word, others are grandiose and lack any sense of reality. Sometimes it is hard to tell the difference, but it is dangerous to lack discernment in this area. I think that another Christian type of Special Lover is the person addicted to intense spiritual experiences - a kind of junkie for the ecstatic or the latest wave that swamps the church.

(iii) Fantasy Maker

Fantasy Maker creates an elaborate inner world. The real world intrudes, naturally, but it is exactly that - an intrusion and often resented. All the excitement is in the realm of fantasy. Often it is inner richness, outer poverty. Because of this the Fantasy Maker may have an external appearance of superficiality, mightiness, and emptiness. There may be considerable social anxiety and awkwardness.

The allegiance of the person caught up in fantasy is always to that inner world. The external impression may not be self-centred, but the I within is always a hero in some role or other. Grandiosity is located in the inner life. If you believe the illusion it is to be significant, beautiful, admired, loved, and everything wonderful. It is an inflated self

The inner world is the realm of gratification. Reality is cold and harsh - to be avoided as long as possible. Usually there is a pervasive distrust of outer reality, which is often experienced as frustrating and withholding. Often such needs are so powerful that the retreat is necessary. Rather than enhancing personal growth fantasy feeds the illusion of independence.

Derek was an isolated teenager. He was involved in Dungeons and Dragons. He had a couple friends but it was based only on involvement in the games.

It is easier to be a Fantasy Maker in isolation. People tend to intrude and potentially mess things up.

10. H. Hendrix, *Getting the love you want: A guide for couples,* Schwartz and Wilkinson, Melbourne, 1988. A self-help book that explores the unconscious factors that infuses romantic love. There are helpful exercises for couples to work through as well. Also H. Hendrix, *Keeping the love you find.' A guide for singles,* Pocket Books, New York, 1992. In this later book he has an interesting developmental perspective and there are some exercises to help the reader to determine the stage at which they were wounded: attachment, exploration, identity, competence, concern, or intimacy.

Christians can be caught up in elaborate fantasy, equating faith with a denial of reality.

Alternatively such an attitude can be visionary and it may be hard to distinguish. However, humility is a mark of the spiritual life, not grandiosity. Perhaps it is best to pray for discernment and be sensible enough to heed, Y*ou shall know them by their fruits*. (Matt 7:16)

(iv) Power Broker

The Power Broker is in love with power, perhaps *in lust* with it and enjoys using it. Power may be expressed in angry, explosive ways - humiliating and even terrorising staff. Alternatively, it may be cold and bureaucratic. However, power is the currency of relationships and used in an instrumental fashion.

Perhaps the most obvious quality of a Power Broker is arrogance. There is a characteristic attitude of contempt for 'inferiors'. Empathy is in short supply. This kind of boss does not worry about how his or her decisions affect others.

Grandiosity also lurks beneath the surface. People are used in exploitive ways. There is a sense of entitlement, '*Why shouldn't I do this? I deserve...*'

Malcolm was the supreme organization man. He was the youngest senior executive in the history of a large computer company. Naturally he was competent. The highest level of management loved the results he produced, but the cost was less obvious. Gradually his reputation was tarnished with escalating numbers of employee resignations and stress claims.

Success, status and power can be attractive. Unfortunately relationships are usually very troubled. The Power Broker has an impoverished inner life with little to give in any emotional sense. Relationships based on power can easily become abusive.

I would image that some of you might be asking your self whether high profile pastors, evangelists or leaders of parachurch ministries might be Power Brokers? Perhaps. Look for the signs of narcissism - a trail of disillusioned and exploited staff.

(v) Rager

The Rager is a common and narcissistic type of personality. What is most characteristic is hypersensitivity to any perceived insult - whether intended or not. It is always taken personally and usually interpreted as an attack. This may be accompanied by highly irrational interpretations of malignant intent. A barely controlled rage simmers below the surface and often lashes out to injure anyone who is nearby. Violence may be part of this picture.

For years Betty ruled her family with her unpredictable explosions of anger. Gradually she alienated everyone. After 16 years of marriage Eric left. It was his 'bid for a new life' but he then instituted a custody fight for the three teenage children.

Perhaps it was surprising to no one but Betty - the children expressed a unanimous desire to live with their father.

A relationship with a Rager is always exciting if only for the fluctuations in mood and unpredictable behaviour. Members of the family will feel like they are 'walking on egg shells'. In this way the Rager can be highly controlling. The tendency to project blame is almost a 'knee jerk' reaction. The world may be seen in 'black and white' terms with a hint of paranoia.

In 15 years of pastoral ministry I have had to deal with a few Ragers. In the last church it was a good fight but I think the Rager won. I remember asking the previous rector of the parish how he dealt with this woman and he said, 'Move out of town!' Actually as Christians we are vulnerable to unpleasant, even nasty people. There are verses like 'turn the other cheek' which we can interpret as an encouragement to be chronically nice. Passivity will never work, it is always a challenge but we must find effective ways to limit the damage in the body of Christ. Some Ragers are best exposed as the wolves that they are!

(iv) Trickster

The Trickster is usually very charming and may have many social graces. He or she is engaging, smooth and inviting. Unfortunately the attractiveness is a thin veneer on a disturbed personality. Behind the 'trust me' messages there are a malicious intent. This is the personality of the 'con-artist'. There are motives of exploitation, blind entitlement and a cruel twist when the victim realises the script of betrayal.

Twenty-five years ago I was converted through the ministry of another denomination. The flagship church of that denomination had a large missions budget. It was even larger than it appeared because the treasurer skimmed off over $100,000 in two years. He was the son of a respected pastor in the movement and there was a crushing sense of betrayal.

The Trickster is ruthless in relationships. He or she delights in fooling the lover with such betrayals as sexual infidelity, fraud, or criminal conspiracy. Eventually trust is shattered. This is an elaborate way to justify the Trickster's contempt of victims. The theme of manipulation is always central and the excitement is in setting up the 'con'. Unfortunately the Trickster comes in many guises and almost all hard to recognise (until too late!).

Tricksters are predators and they may see Christians as naive and 'easy pickings'. After you find out, usually too late, watch out for 'repentance' because it is usually just another ploy.

(vii) Body Shaper

The Body Shaper looks good! The values are: image, fashion, glamour, youth and beauty. This form of narcissism is so much part of our culture that it is hardly

obvious.[11] However, what I am identifying is not just an office worker on the way to the gym for a regular workout but a disturbance in personality. It is important to be seen and admired. The exhibition of self is all-important.

There is an exaggerated need for admiration and a restless search for new worshippers. There may be a nagging perfectionism and an obsession with the perfect body.

Brent spent hours each day 'working out'. He 'sculpted' his body following the advice of his trainer. He was not interested in body building competitions; instead he would revel in admiring glances at the disco. He had what he considered a shameful secrete. He used steroids.

Many Body Shapers are beautiful people. However, it is only 'skin deep' and the inner world can be empty and bleak. The need for constant admiration which does not diminish but can intensify to a frightening degree. It may be surprising but this can lead to both 'throw away' relationships and a deep dependency on selected partners.

I am not sure about the Christian versions of this. One of my teenagers used to bounce to Praise Aerobics, but I lacked sufficient interest to consider whether it was in any way a monument to narcissism. In all seriousness this is an area of accommodation to the narcissism of our times and as Christians we do need to think through our response. As Christian we have had conflicting attitudes about the physical body, owing more to Plato than the Old Testament. Perhaps we could develop more insightful theological reflection and speak to what is thoroughly idolatrous in our society.

(viii) Martyr

The Martyr is in glorious pain. Suffering is all. Personal identity is constructed around being in pain... or being a victim... or a survivor. Pain justifies a pervasive self-focus, parasitic demands and potentially exploitive relationships with others. It is only natural to trade in sympathy especially if it is the only commodity going.

However, this pain is not ordinary pain. It is narcissistic pain, which takes on grandiose aspects; *No one has suffered as I have suffered*. Such are the building blocks of identity.

Denise had a pain disorder following a car accident. Medical opinion supported a mild condition but Denise exaggerated the symptoms until she found it almost impossible to leave her house. She joined a New Age Internet group that had odd views on healing.

The Martyr most easily forms relationships with someone who 'needs to be needed'. However, very quickly becomes unbalanced. This leads to deeply alienating friends and family who eventually feel manipulated and resentful. This frequently leaves the Martyr very much alone.

11. Christopher Lasch, *The Culture of Narcissism*, W. W. Norton, New York, 1979. Classic book on modern culture. A psychoanalytic perspective.

The Martyr has many Christian images that feel right. There is Christ on the cross suffering for

the redemption of humankind. This identification with the Saviour feels right and has grandiose aspects; *My suffering is redemptive for others.* There is theological emphasis, *Always carrying in the body the death of Jesus* (2 Cor. 4:10) and of course the Christian history in rich in examples of martyrs.

(ix) Rescuer

The Rescuer is usually seen as virtuous. Such people inhabit the 'high moral ground' of relationships. They are always helpful, considerate, and nice. This attitude may be expressed in terms of spiritual ideals such as 'also go the second mile' (Matt 5:4 1).

Just how is this narcissistic? After all some people are just helpful. The Rescuer has a hidden grandiosity: 'It is only me that can really change things.' This may be hidden in a helping profession including psychology, social work, medicine, and counselling or pastoral ministry.

Vince was working in a free legal service in an impoverished inner city area. He had an unusual zeal in his work. However, as a zealot he could be scathing of other members of the legal profession who were not as motivated by his high ideals. He often worked seven-day weeks and taking calls late into the night. He found it impossible to take holidays since 'My people need me.'

On a more mundane level Rescuers are drawn to unbalanced relationships perhaps with one of the other narcissistic types. Usually they will over-function in the relationship and will often feel exhaustion and resentment. The question is eventually asked, 'Why aren't *my* needs being met?'

In the church Rescuers are drawn to pastoral care - especially pastoral counselling and prayer ministry. Again this can be a genuine vocation and the exercise of spiritual gifts, but sometimes there is more in it for the carer than the cared for. Watch for the telltale signs of pride and grandiosity.

Additional Comments on the Nature of Narcissism

Rarely are the nine types pure. Narcissism, like coffee beans, usually comes in blends. For example a Craver who becomes a Rager when needs are blocked. Some types may be linked such as the Power Broker - Rager, or Craver - Special Lover. Each of the types becomes more understandable when you realise what underlies the disorder. Nine heads but one Hydra.

Once the types of narcissism are more clearly identified it is important to distinguish what I see as warm from cold narcissism. The cold unempathic, arrogant and distant narcissist is implied in DSM-IV and has been well described by psychoanalyst Otto Kernberg, 'Their emotional life is shallow. They experience little empathy for the feelings of others, they obtain little enjoyment form life other than from the tributes they receive from others or from their own

grandiose fantasies, and they feel restless and bored when the external glitter wears off and no new sources feed their self-regard They envy others, tend to idealise some people from whom they expect narcissistic supplies and to depreciate and treat with contempt those from whom they do not expect anything (often their former idols). In general, their relationships with other people are clearly exploitive and sometimes parasitic. It is as if they feel that they have the right to control and possess others and to exploit them without guilt feelings - and, behind a surface which is very often charming and engaging, one senses coldness and ruthlessness.[12] However, some narcissistic types are highly focused on human relationships, can be empathic, usually in a patchy way and are certainly emotionally needy - most characteristic of this are the Craver and Special Lover. The coldest type is the Power Broker and possibly the Trickster.[13]

Since narcissism is a structure of personality, any understanding in psychological terms must look back to developmental themes. How do such traits of personality develop? I have an image that is simplistic but may help: imagine a two-year-old infant inhabiting a bleak interpersonal world, possibly with episodes of abuse but more likely emotional neglect. How does this child comfort himself or herself? Think about the child curling up in bed, in a foetal position, thinking 'I can only trust myself. No one will look after me.' And then wrapping the vulnerable frightened self in a blanket of grandiosity, *I am special even if no one can recognise it*. The two themes of pre-conscious withdrawal into the self and the compensation of grandiose fantasy are what are most characteristic of narcissism.[14]

Allow me to add another dimension. I have said that the childhood environment may have been neglectful or even abusive, but ironically, childhood may be 'too good' and the child is the exclusive focus of the intrusive parent. This will lead to the same narcissistic themes in a life.

Simon described his 'perfect mother' who was always there for him, 'Yes, she may have had high expectations, but she had them most of all about herself. She had to be the perfect parent. I think that she shielded me from pain - almost as if when I hurt she hurt. We were very CLOSE, I think in ways that other children would know nothing about.

Now to a theological note, I think that the real origins of narcissism are in the fall -original sin - the inherent tendency of fallen humanity to be self-centred and to turn away from God in guilt and shame.

12. Otto Kernberg, 'Factors in the Psychoanalytic Treatment of Narcissistic Personalities,' in Andrew P. Morrison, *Essential Papers on Narcissism,* New York Universities Press, New York, 1986, p. 213-15.

13. It is possible that there are some gender differences at this point, perhaps males tend more towards the cold types of narcissism, and females the warmer7 This is of course speculation and there are many exceptions.

14. One of the great analysts who has both described narcissism and pioneered in the treatment of this disorder is Heinz Kohut. See H. Kohut and E. S. Woff, "The disorders of the serf and their treatment: An outline", *International Journal of Psychoanalysis,* Vo1.59, 1978, p.415. E. S. Wolf, '*Treating the self.' Elements of a clinical self psychology,* The Guildford Press, New York, 1988, p. 39.

A Narrative approach to Counselling

The philosopher Descartes thought before the fire and came up with his famous axiom*: I think therefore I am.* An expression of abstraction and pure truth. The essence of at least one stream of later modernism. Did he get it right? I think not. The answer should be not *I think* but *I have a story, therefore I am.*

All human experience has a narrative quality. Not only do stories shape our experience of life, but also it is through story that we make sense of the world. MacIntyre noted, *'The concept of a self, whose unity resides in the unity of a narrative which links birth to death as a narrative beginning to middle to end.* 16

Perhaps what is most central to who we are is our personal story. Think about the way we introduce ourselves or others, the importance of intimate sharing in friendship, and the role of testimony when lives change. This is also central to a satisfying sense of belonging in a community or a church. These are people who not only care for us but also have heard our story.

We all have stories about ourselves. Such stories can be positive and life giving or negative and destructive. How would you categorise the following?

Mary said, 'I know I am a Christian. There have been some dark times when my faith is all that has kept me from ending my life. However, I don't think anyone could possibly understand how lonely I have felt, especially when my addiction to binge eating and purging has been out of control. I hate my body. My uncle sexually abused me when I was a child; I can't get over feeling like a victim. Maybe that is why I treat myself so badly?'

Clearly there are life stories, which are still imprisoning Mary. It is a combination of how she was treated when she was young and felt powerless, and how she now understands herself as an adult. There is also a refrain of hope, but that seems to be a minor theme.

Narrative therapy, which has been pioneered by Australian social worker Michael White, pays close attention to the way language structures our understanding of reality. There is an influence by French philosophers Michel Foucault and Jacques Derrida. White has made an enormous contribution to therapeutic practice and understanding with concepts such as: deconstructing problems, externalising psychopathology, paying attention to unique out-comes, and building a preferred story.17 For example he understands presenting problems as 'stories' (which) are dominant to the extent that they allow insufficient space for the performance of the

15. Stephen Crites, 'The Narrative Quality of Experience', *Journal of the American Academy of Religion,* (September 1971), 39/3, 291-311.
16. A. Maclntyre, *After Virtue,* University of Notre Dame, Notre Dame, 1981, pp. 190-209.
17. See G. Monk, J. Winslade, K. Crocket, and D. Epston, *Narrative Therapy in Practice: The Archaeology of Hope,* Jossey-Bass, San Francisco, 1997; and I. Freedman and G. Combs, *Narrative Therapy: The Social Construction of Preferred Realities,* W. W. Norton, New York, 1996.

person's preferred stories.[18] I think that it can be argued that the recovery of narrative is an important post-modern step beyond the limits of modernism.[19]

Michael White is one of the most important international figures in individual and family psychotherapy. Australia is on the map in this area largely because of his creative thinking. However, what he has proposed is not the only form that a narrative therapy might take. First of all some limitations:

- He has a very narrow philosophical base in French deconstructionism and social construction.[20] He gives up any objective notion of truth. [21]
- An over reliance on the use of questions in therapy, which become like a method of intrusive interrogation. I would question whether this is at the cost of empathy.
- Externalising is an important technique and it is very helpful for problems such as a specific phobia, *depression* and perhaps alcoholism. However, what about problems for which a person needs to take personal responsibility such as domestic violence and sexual abuse? It may also be of limited application with personality disorders where psychopathology is ingrained in the personality.
- I find the attitude towards the therapist's use of power confusing. Is it really possible to shed the expert role and have *'possibility conversations'* (H. Anderson)? I think that an empowered therapist is more able to help a client move from *pathological victim to courageous victor*. [22]
- I have reservations about the loss of a systems perspective, which was one of the great gains in family therapy.

This emphasis on story is a natural point of integration for Biblical and therapeutic concepts. We are the people of the story of what God has done and will finally accomplish in Christ. Theologians call it a 'sacred story' (the German word is Heilsgeschichte). One of the central themes of the apostle Paul in Romans is the way we, as believers, are incorporated into Christ and share his story (see Romans especially chapters 5-8). All this is recognised and explored in contemporary theological circles in narrative theology.[23]

I have argued that the essence of narcissism is grandiosity. On the other hand, expressing it in a narrative form: narcissism is an expanded story about the self. A story in which the self is special or the hero in a fantasy drama.[24] Fundamentally, it is a distorted narrative. There is a stark contrast to the example of Christ as seen in the Philippian hymn, *Christ Jesus, who though he was in the form of God...* (Phil. 2:5-1 l)

18. M. White and D. Epston, *Narrative Means to Therapeutic Ends,* W. W. Norton, New York, 1990, p.14.
19. Also see K. J. Gergen, *The Saturated Self,* Basic Books, New York, 1991.
20. See Peter Berger and T. Luckman, *The Social Construction of Reality,* Doubleday, New York, 1966.
21. H. Anderson, 'Truth is constructed through interaction of the participants and it is constructed,' Conversations Language and Possibilities, Basic Books, New York, 1997.
22. G. Monk, Narrative Therapy in Practice, Jossey-Bass, San Francisco, 1997.
23. See Stanley Hauerwas, *Why Narrative?* W. B. Eerdmans, Grand Rapids, 1989.
24. Paul said, 'Knowledge puffs up' (1Cor. 8:2).

Once we can recognise that narcissism is a distorted story, this can be the locus of pathology. It is possible to reconstruct the expansive narrative and develop a preferred story - one more connected to reality?[25]

Steve is a 35-year-old single man. Both of his parents were alcoholic. They had a turbulent relationship and 'took a holiday in the bottle' every night. Steve developed a rich fantasy life to compensate for the lack of *nurture* in his family. He survived as an adapting child - it was safest to be invisible.

As an adult, he was left with an abiding sense of pain and inner defect. He had an intense relationship with Amanda, but after three years, she left him for another man. However Amanda rarely left anyone, in a complete sense, and they remained friends, in fact have shared the same house ever since. Steve reluctantly accepted the enforced nature of their Platonic relationship. He remained 'faithful' to the ideal of their special relationship because of mutual pain, which he enshrined with celibate waiting. I spelled out the dynamics of his narcissistic investment, 'Steve when you were a child you had to survive in the only way possible. You developed a fantasy world to escape and this makes a lot of sense. However, as an adult your loyalty is still to the fantasy rather than what is real.

I used the analogy of counterfeit money to explain the attraction of grandiosity, *In the fantasy realm you can create your own money and spend it. You can be a millionaire and there is no Bank Manager to challenge your extravagance. But in the real world it is a different story*. Steve thought about this and said, *In my family I didn't get even a $1, but now I expect to spend $1000*. I said, 'Exactly!' He was able to see the narrative *dimensions* when he said later in therapy, *Harvest in the real world is slow, harvest in the inner world is instant*.

I think that it is important to use gentle humour in counselling. It helps client own aspects of their unconscious sin, which is always painful, when it comes to awareness. This understanding of the 'influence of the problem' is important. Empathy is 'experience near' and makes the painful realisations less alienating. It is important to articulate and understand the old story. I encourage people to use journal techniques such as writing an autobiography, which encourages work between sessions. I see myself helping to question the old story, especially the narcissistic pay-offs, and consider my role to be a 'narrative editor' in this process. What is the preferred story? What would be a 'story in Christ' for this person? What would need to happen for this person to achieve greater spiritual maturity? It is a wonderful privilege to witness the re-authoring of a new story - one with Christ writing the 'unique outcomes' as well!

Once we recognise how pervasive narcissism is in our culture and even in our lives and intimate relationships, we understand that narcissism is not 'out there,' but inside. Appreciate that it is 'us' not 'them'. I will say again my fundamental axiom of narcissists: It is easy

24. There has been some thinking about how to recognise and correct a distorted narrative. Some factors may include 'alertness to limits', personal experience, searching for the ideals of both truth and intelligibility, appreciating that narrative requires an evaluation of character, understanding the link of narrative and tradition, and understanding the nature of an epistemological crisis in a story when schemata fail to explain and consequently the birth of a new narrative.

to recognise it in another person, but not in ourselves. Narcissism is mostly *unconscious.* Perhaps this is easier to accept when we realise that narcissism does not always dominate a personality. I have had to come to terms with areas where narcissism has an undue influence, and yet I do not think that my life is completely dominated by self-focus unconscious or otherwise. However to get the definitive opinion - ask my wife.

A Biblical Afterthought

In closing I would like to briefly use a Biblical example of a profound change in character - that of Jacob. He was born clutching the heel of his twin brother Esau. His story is one of trickery and supplanting his older brother, using hunger to rob him of his birthright and then later beguiling Isaac into giving him Esau's rightful blessing. Although we do not fully understand patristic culture this would have meant position in a large extended family, perhaps more property (cf. Deut. 21: 16-17), status and honour. However in God's economy there are laws of 'sowing and reaping' and Jacob is tricked into marrying Leah before gaining Rachel his wife of choice. Clearly Jacob is not a personality dominated by narcissism, as say King Herod, but there are themes of mild grandiosity and trickery. Jacob had a sense of entitlement, as if he deserved what was not his by right. But this changes. There is a vivid incident in which he wrestled with God and there is a transformation of narcissism.

Jacob was left alone; and a man wrestled with him until daybreak. When the man saw that he did not prevail against Jacob, he struck him on the hip socket; and Jacob's hip was put out of joint as he wrestled with him. Then he said, 'Let me go, for the day is breaking.' But Jacob said, 'I will not let you go, unless you bless me.' So he said to him, 'What is your name?' And he said, 'Jacob,' then the man said, 'You shall no longer be called Jacob, but Israel, for you have striven with God and with humans, and have prevailed.' Then Jacob asked him, 'Please tell me your name.' But he said, 'Why is it that you ask my name?' And there he blessed him. So Jacob called the place Penile, saying, 'For I have seen God face to face, and yet my life is preserved.' The sun rose upon him as he passed Penal, limping because of his hip. Therefore, to this day the Israelites do not eat the thigh muscle that is on the hip socket, because he struck Jacob on the hip socket at the thigh muscle. (Genesis 32:24-32, NRSV).

There is some ambiguity in the reading. Did Jacob wrestle with a man, an angel or was it God? It was a struggle that took everything of Jacob's strength and then some. Some of you know that feeling of exhaustion. It is like running an emotional marathon.

It was all night long. Is not it true that our hardest struggles are though the night when sleep is impossible? Sometimes tears. Certainly unbroken anguish. Is there anytime more lonely when everyone is sleeping in the long hours before dawn? Maybe you thought that you were wrestling with difficult people or a lack or resources but like Jacob you were wrestling with God.

As Christians, we have no special privileges. We face hard things just like everyone else. However, I believe that there is a difference. God is interested in forming our character. You may find this surprising but I think that God is even more interested in shaping us than the success or failure of our ministry. Think of Jeremiah. Think of Job. Think of St Peter. I think that it is in failure that our narcissism is most exposed and potentially transformed. Sometimes

God not only allows it but engineers it!

Jacob wrestled all night and his opponent did not prevail. The most important principle is DO NOT LET GO! Jacob held on in the struggle until he received a blessing. That is a good marker of the end of the struggle. When you struggled it was with God, whether you recognised it or not, but did you hang on for the blessing.7 Only you know that.

In the midst of the struggle Jacob was wounded. The divine figure 'struck him on the hip socket; and Jacob's hip was put out of joint.' And later he limped from the encounter. I get the impression that Jacob had that wound for life because it was commemorated in the Israelite practice not to eat the meat on that part of the bone.

How true of us. We emerge from the darkest of trials and may have held on for a blessing but we remain wounded. Our wounds may be hidden like internal bleeding. However, we know the hidden pain and the wounds that last. Like Jacob, we limp away.

Fortunately, our wounds are not where God would leave us. There is a higher purpose. I think that this is beautifully expressed in Henri Nouwen's sermon. The *Wounded Healer.*[26] He saw that genuine ministry was born out of woundedness.

I will illustrate from the experience of a client who saw me a number of years ago. I have called her Sandy[27] and have her permission to tell her story. She is a devout Pentecostal Christian. She was married to a GP who did not come to church with her. She could not understand why she was so depressed, since things were 'never better' in her marriage. She kept asking Jesus to take away her pain but it didn't seem to work. Naturally, she blamed herself for lack of faith.

She was a 'chronically nice' person who was something of a Martyr in the narcissistic typology. She told me about a time when her husband had an affair with her best friend. She had no feelings of anger just 'disappointment' and remarkably maintained the friendship in spite of the betrayal.

She told me about a frightening dream. *I was in a room with no windows. There were two bland walls. On one, there was a plaque with a picture of a bunny on it and an inscription. Then I turned around and saw a real rabbit sitting there. It said, "Go on do it." "What? .... Pick up the knife." I turned in horror and the rabbit on the plaque said, "Go on. Commit suicide." There I ran outside. I was in a green playing field. There was a freshly dug grave with a tombstone; "Here lies a holy sister."* I explained something of the Jungian method of the analysis of dreams and she came to realise that her 'niceness,' symbolised by the rabbits would end up killing her.

26. See his book by this name. Also *The Living Reminder,* Seabury Press, New York, 1977.
27. See Chapter 14 of my first book, *Setting Captives Free: Models for Individual, Marital and Group Counselling,* Harper Collins, London, 1994.

Gradually she gave herself permission to feel. She became angry with her husband and gradually worked that through to appreciate more of the texture of her relationship with him.

She was able to see both the good and bad.

She also went on a spiritual journey. A few months later, she went down to the coast for a personal retreat. She had the impression, *Don't forgive people, forgive instances*. She then wrote pages in her journal. One night she went through a *dark night of the soul* in which she experienced Satan's accusations. She couldn't sleep but had a vision of the risen Christ in the garden. He came to her. Three times, he called her name Sandy. He asked her *Do you love the Father?* Then he asked, *Do you love yourself?* She couldn't answer. Then Jesus put his hands on her face, *God made you in my image and likeness, you are his work of art. Now do you love yourself?* I was amazed at this experience. Never was I more convinced of the *genuineness* of such an experience.

There were many confirmations of her change and growth. However, the one that illustrated the 'wounded healer' was when she began to notice people at church coming to her to share their problems. They noticed that she was becoming more real. As her wounds began to heal - there was healing for others.

Jacob's opponent said, *You shall no longer be called Jacob, but Israel, for you have striven with God and with humans, and have prevailed.* In the Bible names have profound significance. The prophet's children were often named with a message for Israel. Moreover, names carry significance: Peter means rock. And he became the foundation for the church. However, the change of a name is also common. Jacob becomes Israel. Saul becomes Paul. It is the result of a spiritual encounter.

In our culture, names have nothing of this significance. We may decide to call a child Carrie, Zac, Annie, Molly or Garth - but it is for fashion or sound or whatever. In the wonderful film *Dances with Wolves* Kevin Costner receives his name from the Indians. It reflected more than what they observed, but something of his awakened spirit in the wilderness. Have we have lost something?

I would like to suggest a kind of meditation exercise. In prayer ask God if, after your experience of a struggle, if he has a new name for you. I mean this quite literally. After an experience of what I felt was a failure in ministry I asked God what name was on the other side of that experience? In some pessimism I feared it might have been Icabod (God has departed!) but I finally arrived at *You shall not strive*. I could not find the Hebrew or Greek for it, but it has a meaning for me in terms of my ambitious striving. Something changed and it was of spiritual significance.

Conclusion

C. S. Lewis in his children's book, *The Lion the Witch and the Wardrobe*[28] had a wonderful image for the fall. The land of Narnia, while under the reign of the Witch, was in 'perpetual winter' - a land covered by snow. I have tried to look at the same landscape and ask what is the nature of fallen humanity? What is it about us that still bears the imago dei, but is distorted into a parody of what God intended? I have used the psychological language of narcissism to describe styles of personality and ways of interacting in our fallen world. In addition, I have introduced the concept of 'unconscious sin', which is a universal. In this rather meandering

journey through classical mythology, psychoanalytic theory, post-modern philosophy, contemporary therapy, Biblical and narrative theology - I hope I have taken you to some of the edges in pastoral care and counselling. It is an exciting field with the possibility of finding some points of integration for very different disciplines.

The degree of spiritual insight and awareness of unconscious sin is one in which we will all differ. Ultimately it is a very personal issue, one that touches who we are and our relationship with God. It is in intimate and hidden places that we struggle with this but never fully resolve it short of the new creation. But we can recognise the need for God to show us through the Holy Spirit what we cannot see (John 16). We can listen to our friends, who if they are good friends will occasionally say something spiritually relevant. If you have a spouse, you can give thanks to God, for he or she will usually point out your faults - perhaps not in ways you will want to hear! Above all, I think that we can take ourselves less seriously, to allow insight into our failures and to invite God to transform our narcissism. This 'light touch' is beautifully captured by the cartoonist Michael Leunig in his *Common Prayers*. I will conclude with one of my favourites, though I am not even sure why it speaks so deeply to me:

When the heart
Is cut or cracked or broken
Do not clutch it
Let the wound lie open

Let the wind
From the good old sea blow in
To bathe the wound with salt
And let it sting

Let a stray dog lick it
Let a bird lean in the hole and sing
A simple song like a tiny bell
And let it ring.[29]

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28. Fontana Lions, London, 1956.
29. *Common Prayers Collection,* CollinsDove, North Blackburn, 1993.

5. Glossary of DSM-IV Terms

Abstracting, Abstracting Ability - Refers to one's ability to use abstract, symbolic thought, as differentiated from concrete or literal thought.
Acute - Current; currently visible; related to the present or recent past; not *chronic*.
Aetiology - Cause.
Affect - The outward, often facial, manifestation of subjective inklings or emotions.
Agnosia - An inability to recognise and name objects.
Agoraphobia - A morbid fear, and intolerance of, unfamiliar surroundings or open spaces.
Akinesia - Lack of movement.
Alogia - Lack of thought content, inferred from lack of verbal productions.
Ambivalence - vacillation between or among two or more thoughts or things; indecision, perhaps to a pathological extent; also, coexistence of contradictory feelings or impulses toward something.
Amenorrhoea - Absence of menses.
Anergia - Loss of strength or energy; feeling a loss of strength.
Anhedonia - An inability to experience pleasure.
Anorexia - Absence of appetite or eating; refusal to eat.
Anxiety - A feeling of apprehension or uneasiness, similar to fear, due to the anticipation of internal or external danger. The source of the danger, in some definitions, is unknown. In psychoanalytic theory, the danger stems from threats (usually unconscious) to the ego.
Anxiolytic - Refers to the amelioration of anxiety; as a noun, a class of medications that alleviate anxiety.
Apathy - Marked lack of interest or motivation.
Aphasia - An inability to understand or produce language, not related to sensory (e.g., deafness) or motor (e.g., dysarthria) deficit.
Aphonia - Inability to speak or produce normal speech sounds.
Apraxia - Loss of a motor skill not explained by simple weakness or previously existing incoordination.
Arylcyclohexylamine - Any of a class of psychoactive substances, which includes phencyclidine (PCP).
Associations - With respect to thought process, the relationship (normal or abnormal) between one idea or thought and the next (see also Tangential, Loose Circumstantial, Clang).
Asterixis - A neurological sign characterised by flapping of the hands, associated with toxic or metabolic encephalopathy.
Ataxia - Muscle incoordination, especially affecting gait.
Athetoid - Refers to slow, regular, twisting motion of limbs.
Autistic - Refers to autism (q.v., in text); refers to marked disturbances in relating to, and apparent unawareness of, others and one's environment.
Autonomic - Refers to normally involuntary innervation of cardiac and smooth muscle tissue (e.g., internal organs).
Avolition - Lack of initiative, especially for goal-directed activity.

Belle Indifference - An apparent indifference to symptoms that would be expected to elicit worry or distress (also La Belle Indifference).
Benzodiazepine - A class of antianxiety and hypnotic medications.
Bereavement - Grief over a loss.

Bestiality - See Zoophilia; also, the practice of sexual activity with non-human animals.
Biopsychosocial - Refers to the multideterminate nature of psychiatric syndromes and disorders, and to multideterminate approaches to their understanding and treatment.
Blocking - An interruption of communication before a thought or idea has been completed, caused by psychological factors that are unconscious or unknown to the individual.
Blunting - With respect to affect, marked reduction in normal intensity.
Bulimia - Episodic, usually uncontrollable eating hinges, sometimes accompanied by ingestion of large amounts of foods. Self-induced vomiting or diarrhoea is characteristic.
Butyrophenone - A class of antipsychotic medications.

Cannabis - Marijuana**.**
Cardiac Neurosis - The fear or erroneous belief that one has heart disease; also a feeling of physical incapacity related to past heart disease, out of proportion to one's actual disability, or to fear of having a heart attack.
Catalepsy - Diminished responsiveness, often trance-like; may be related to organic or functional disorders or to hypnosis. Includes waxy flexibility.
Cataplexy - Episodic loss of muscle tone, often to the extent of falling and often triggered by strong emotions.
Catatonic - Refers to any of several striking motor anomalies, generally described as related to a psychosis, including extreme excitement, stupor, negativism, rigidity, or posturing.
Cerea Flexibilltas - Waxy flexibility**.**
Choreiform - Writhing.
Chronic - Long persisting; not acute or limited to the present.
Circadian - Refers to 24-hour biological rhythms.
Circumstantial - When referring to thought process, describes conversation or a train of thought that wanders from the point but eventually returns to it.
Clairvoyance - The experience or feeling of being able to sense others' thoughts (not usually considered psychotic).
Clang - With respect to associations or thought process, speech or train of thought largely governed by sound or rhyme rather than logic (e.g., "Turn on the light, tight, bright; bright enough to bite. Watch out for biting dogs.").
CNS Depressant - In pharmacology, refers generally to central nervous system sedation (does not refer to depression of the mood).
Complex Tics - Tics that involve more extensive behaviours than simple motor tics (e.g., grooming behaviours, coprolalia).
Compulsion - A powerful impulse toward a specific purposeful behaviour, which is often repetitive and unwanted, and often in response to an obsession.
Concordant - In genetics, refers to a characteristic or trait found in two genetically related especially twin) animals or people.
Concrete - Refers to literal thought, as differentiated from abstract, symbolic thought.
Confabulation - Creation of inaccurate memories or fabrications, unconsciously, to substitute for unrecalled events.
Congenital - Present at birth, but not necessarily implying genetic or familial transmission.
Conjugal - Refers to marital, especially sexual, relationships.
Constricted - With respect to affect, a reduction or circumscribing of range and/or intensity.
Constructional Apraxia - Loss of the ability to produce or copy drawings, shapes, or designs.
Continence - The ability to control voluntarily one's urination or defecation.
Conversion - Refers to a physical symptom or dysfunction that unconsciously expresses an

emotional conflict or need (cf., conversion reaction).
Coprolalia - Pathological use of obscene or unacceptable words.
Coprophilia - Reliance on faeces as a primary source of sexual gratification.
Covert - Hidden.

Defence Mechanism - See Neurotic Defence Mechanism.
Delirium - An acute, organically caused brain disorder characterised by confusion and altered consciousness.
Delirium Tremens - A severe, life-threatening delirium caused by withdrawal from alcohol.
Delusion - A fixed, false belief not ordinarily accepted by other members of an individual's culture. In DSM-IV, a bizarre delusion is one that involves very unusual or completely implausible elements. A delusion of **reference** is one in which elements in the environment, such as comments from the news media, have particular significance and/or refer to oneself.
Dementia - An organically caused mental disorder characterised by loss of previously held mental abilities, including intellect, memory, and judgement.
Depersonalisation - A strong feeling of not being oneself or of being detached from oneself or the environment.
Depression - A sad, despairing, or discouraged mood; such a mood or feeling sufficient to be a symptom or a mental disorder; a syndrome (e.g., Major Depression) characterised by depressed mood.
Derailment - A disorder of thought process in which one's thoughts unexpectedly and appropriately leave the topic. Similar to loose associations.
Derealisation - A strong feeling of strangeness or detachment from the environment or from reality.
Dereistic - Refers to feelings or thoughts that are grossly illogical, not in accordance with reality.
Diplopia - Double vision.
Diurnal - Daily.
Dizygotic - Refers to multiple foetuses (e.g., fraternal twins) developed from more than one zygote.
Dysarthria - Difficulty in speech production related to anatomical or co-ordination deficit.
Dysfluency - A disturbance of language fluency.
Dyskinesia - A movement disorder involving involuntary muscle contractions; may be mild (e.g., benign orofacial dyskinesia) or severe (e.g., hemiballismus).
Dyslexia - Difficulty understanding or manipulating words (e.g., in reading) that is not related to education or intelligence.
Dysmenorrhoea - Irregularity or other abnormality of menses.
Dysmorphophobia - Preoccupation with an imagined defect in appearance. Body Dysmorphic Disorder.
Dysphonia - An impaired ability to create or understand sounds.
Dysphoric - Uncomfortable, painful.
Dyssomnia - A disorder of sleep, whether organic or functional.
Dystonic - With respect to movement, refers to involuntary, often painful or disfiguring muscle contractions; also, not in agreement with (see also Ego-dystonic).

Echokinesis - Pathological imitation of another's movements.
Echolalia - Pathological imitation of a just-heard word or sound.

Ego - Literally, the self, refers to one's inner self or personality; in psychoanalytic theory, a major part of the (largely unconscious) psychic apparatus, which is primarily responsible for defence mechanisms.
Ego-alien - Foreign to one's view of oneself.
Ego Boundary - The conceptual delineation between oneself (especially one's perception of oneself) and tile external world.
Ego-dystonic - Inconsistent with an acceptable view of oneself.
Ego-syntonic - Consistent with an acceptable view of oneself.
Empathy - Being aware of another's feelings as if through that person's eyes (e.g., putting oneself in another's shoes).
Encapsulated - Circumscribed, well delineated (e.g., referring to delusions; see also Fragmented).
Endogenous - Arising from intrapsychic causes (see also Reactive)
Erotomania - A delusion of idealised, secret romantic love, usually involving a famous or highly visible person.
Etiology (Aetiology)- Cause.
Euphoria - A feeling of extraordinary happiness or well-being.
Exacerbate - Make worse.
Expressive - In language, refers to the construction, production, and expression of communication, largely words.

Factitious - Refers to symptoms or disorders voluntarily produced by the patient for unconscious reasons (separate from Malingering).
Familial - Transmitted within families, not necessarily genetically (see also Hereditary, Congenital).
Fetish - A body part or nonliving object not ordinarily associated with sexual excitement that nevertheless causes inordinate sexual arousal in an individual; the condition of being attracted to such an object.
First-degree Relative - In genetics, a parent, full sibling, daughter, or son.
Flagellation - Beating, usually whipping, with a sexual, religious (e.g., absolving), or self-punitive context; slang for masturbation.
Flashback - An intense, dissociative experiencing of a past event or feeling; may be reality based or substance induced.
Flight of Ideas - Rapid movement from topic to topic, out of proportion for ordinary conversation, usually verbal.
Florid - Highly visible, unmistakable; "in full bloom."
Folie a Deux - A condition in which two people, usually living together, affect each other's psychotic syndromes in such a way that when one is symptomatic, the other improves.
Fragmented - Not whole; poorly circumscribed (e.g., referring to delusions;
see also Encapsulated).
Functional - Usable; able to function; with respect to psychiatric disorders, refers to those not associated with known or presumed anatomical, physiological, or other "organic" causes.
Gamma Alcoholism - An alcohol abuse syndrome characterised by the inability to stop drinking once one begins.
Ganser Syndrome - A dissociative syndrome occasionally seen under conditions of isolation or incarceration.
Gender Identity - One's personal assumption of, or identification with, his or her maleness or femaleness.

Globus Hystericus - Emotional feeling of a "lump in the throat." Grandiose - Refers to size or importance greatly out of proportion to reality.
Gran Mal - A form of seizure including both loss of consciousness and generalised movements (also Grand Mal).

Hallucination - A sensory experience in the absence of external stimulation of the relevant sensory organ. Hallucinations are separate from thoughts, feelings, obsessions, and illusions, and are experienced as if they were real.
Hallucinogen - A substance that induces hallucinations.
Hallucinosis - Hallucinations during clear consciousness.
Hebephrenic Schizophrenia - A non-DSM-IV term for Schizophrenia, Disorganised Type; *Hebephrenia* connotes inappropriate, shallow, silly affect and behaviour.
Hemiballismic - Refers to gross, irregular movements of large parts of the body.
Hereditary - Having to do with genes and/or chromosomes; genetically transmitted (see also Familial, Congenital).
Homosexuality - Persistent adult sexual preference for members of one's own gender, whether or not accompanied by a homosexual lifestyle. Persistent homosexual preference should be differentiated from occasional homosexual or bisexual fantasies or behaviour among adults, and from ordinary, transient sexual play or experimentation among children and adolescents.
Hostile-Dependent - A situation in which one's dependence on someone or something engenders guilt, irritation, or inconvenience in the dependent individual, leading to anger against the other person or tile object. As a personality trait, refers to a person who is routinely dependent on others but also hostile toward them because of the feelings and conflicts associated with that dependency.
Hyperacusis - Overarousal; hypersensitivity to sensory stimulation, especially sounds.
Hypervigilance. A condition of emotional and physiological preparedness, to an unnecessary extent, in anticipation of an anxiety-producing stimulus.
Hypnagogic - Refers to the semiconscious state just before sleep.
Hynopompic - Refers to the state just as one awakens from sleep.
Hypnotic - In pharmacology, a medication to induce sleep.
Hypoxyphilia - The practice of strangling or suffocating oneself, almost to the point of unconsciousness, for sexual stimulation.
Hysterical - Histrionic; also, refers to a Conversion Disorder (Briquet's syndrome); having flamboyant, superficially stereotypic gender characteristics; frightened or panicked to the point of being out of control. (Note: The many meanings of this disorder in clinical and lay settings often make it's understanding in any one context difficult.)

Ideas of Reference - Ideation, often short of a delusion, that occurrences or objects in the environment have particular, special meaning for oneself.
Identity - The sense of self, providing a unity of personality over time.
Idiosyncratic - Characteristic of one individual; limited to one person.
Illusion - The misperception or misinterpretation of an external stimulus, differentiated from hallucinations by the presence of some form of sensory stimulation.
Immediate Memory - In the mental status examination, the portion of memory that exists a few seconds after an event (e.g., repetition of words or numbers immediately after they are spoken by the examiner).
Incidence - In epideminology, the number of new cases that occur over a given period of time

(see also Prevalence).
Incontinence - Inability to control urination or defecation.
Infibulation - Piercing the skin, especially for sexual reasons
Insufflation - "Snorting" or sniffing, as with powdered cocaine.
lnvolutional - Refers to the menopausal or postmenopausal period of life, especially depressive disorders arising at that time.

Jacksonian - In epilepsy, seizures with. localised convulsive movements without loss of consciousness.

Kleine-Levin Syndrome - Episodic hypersomnia, beginning in adolescence and associated with bulimia.
Klistnaphilia - Reliance on enemas as a primary source of sexual gratification
Kluver-Bucy Syndrome - Primitive impulse-control symptoms associated with memory defect and other changes, caused by loss of both temporal lobes.
Korsakoff's Psychosis - A psychosis characterised by confabulation, often related to chronic alcoholism (see also Wernicke's Encephalopathy).

La Belle lndifference - See Belle Indifference.
Labile - Rapidly shifting; unstable.
Lacrimation - Tearing.
Lesch-Nyhan Syndrome - A metabolic defect associated with Mental Retardation.
Limited Symptom Attack - In Anxiety Disorders, a single or small number of symptoms of anxiety that do not meet DSM-IV criteria for Panic Attacks.
Loose; Loose Associations - With respect to associations or thought process, lack of logical connection between one's thoughts or ideas, usually expressed in confusing conversation. Similar to Derailment.

Macropsia - The illusion that objects appear larger than they actually are.
Magical Thinking - The belief that one's thoughts or behaviour will affect the environment in some way separate frown natural cause and effect.
Malingering - Symptoms or disorders that are voluntarily produced for conscious reasons of personal gain (separate froth factitious).
Melancholia - Severe, anhedonic depression (implies an endogenous source).
Metaphorical Language - Idiosyncratic communication meaningful only to those familiar with the speaker's (e.g., a child's) past experience.
Micropsia - The illusion that objects are smaller than they actually are.
Milestones - The significant accomplishments of human growth and development (e.g. walking unassisted, speaking in sentences), especially the ages at which they occur.
Monoamine Oxidase Inhibitors (MAOI) - In Psychopharmacology, a class of antidepressant medications.
Monozygotic - Refers to multiple foetuses (e.g., identical twins) developed from a single zygote.
Mood - Breadth of sustained emotion (e.g., sadness, euphoria); a pervasive and sustained emotion.
Mood Congruent - Apparently consistent with the mood being exhibited (eg. mood-congruent behaviour, mood-congruent delusion).
Mood Incongruent - Not consistent with the mood being exhibited.

Morbid - Occurs during or after an exacerbation of a disease; severe, predisposing to serious illness or other problems (e.g., morbid obesity).
Multiaxial - Refers to several classes of information used in psychiatric evaluation. DSM-IV uses five axes, the first three of which constitute the official diagnostic assessment.
Munchausen's Syndrome - A factitious (i.e., voluntary but unconsciously motivated) disorder or set of symptoms.
Myoclonic - Refers to irregular, brief, usually generalised muscle contractions.

Narcissism - Focus on and regard for oneself, to either a healthy or abnormal extent.
Narcotic Antagonist - A drug that counteracts the physiological effect of a narcotic.
Necrophilia - Reliance on dead sexual objects (in reality or fantasy) as a primary source of sexual stimulation.
Negative Symptoms - With respect to Schizophrenia, often subtle but pervasive absence of normal thought or behaviour, as differentiated from presence of abnormal symptoms. Negative symptoms include absence of normal affect or social interaction, as differentiated froth presence of hallucinations or delusions.
Negativism - Active or passive resistance, for example, to movement (as in catatonia) or to verbal responsiveness (as in autism).
Neologism - A "word" invented by an individual, often having an idiosyncratic meaning.
Neuroleptic - In common usage, refers to antipsychotic medication; also, a neuroleptic medication.
Neurotic - Refers to internal, unconscious conflict; also refers to a neurosis (e.g. a neurotic disorder or conflict characterised by unconscious defence mechanisms).
Neurotic Defence Mechanism - An unconscious pattern of feelings, thoughts, or behaviours designed to prevent or alleviate anxiety that stems from internal conflict. The presence of this pattern - in combinations called defensive systems - is generally normal and adaptive, but in many people, it reaches maladaptive proportions. Examples include denial, displacement, intellectualisation, projection, rationalisation, reaction formation, and undoing. All defence mechanisms involve repression, which is the mechanism by which the person prevents unconscious material from reaching awareness. Some writers describe some defence mechanisms as voluntary. Lists of defence mechanisms vary from text to text.
Nihilistic - Refers to non-existence or lack of existence (e.g., of oneself).
Nonrestorative Sleep - Sleep that does not satisfy one's need for sleep.
Nystagmus - A specific, rhythmic motion of the eyeballs, sometimes in response to certain neurological tests.

Obsession - A persistent, intrusive thought.
Opioid - In pharmacology, any class of drugs or other substances with actions similar to opium (e.g. heroin, meperidine).
Overt - Open, easily seen.

Palilalia - Pathological repeating of one's own sounds or words.
Parallel Play - In young children, play with another child, but not involving interpersonal interaction.
Paranoia - A condition of over-suspiciousness, sometimes to a grossly unrealistic, even psychotic extent; old term (usually *paranoia Vera)* for Delusional Disorder.
Paraphilia - Any of a class of recurrent, intense, pervasive sexual urges or fantasies that are associated with psychosocial dysfunction and/or arc not socially acceptable; commonly

synonymous with sexual deviation.
Paresthesia - Numbness or tingling, usually of the extremities.
Partialism - In Paraphilias, focus on specific nonsexual parts of the body as a primary source of sexual stimulation.
Passive-Aggressive - Unconscious aggressive impulses manifested in passive ways (e.g., by obstructing progress or purposeful inefficiency).
Pathognonomic - Refers to a symptom or sign that is found in only one disease or disorder, and in no other.
Pathological Intoxication - Intoxication, generally from alcohol, in response to only a small amount of intoxicant, and out of proportion to that amount.
Pathophysiology - Organic abnormality related to disease.
Pavor Nocturnus - Sleep terrors.
Perseveration - Persistent, often rhythmic repetition of words or ideas, not generally controllable by the individual.
Personality Trait - Enduring patterns of perceiving, relating to, and thinking about the environment and oneself, exhibited in a wide range of social and personal contexts.
Pervasive - Broadly and comprehensively found; involving all or almost all things.
Petit Mal - A form of seizure that involves loss of consciousness with impulsive movements (also Petite Mal.
Phenomenologic - Refers to descriptions or descriptive characteristics. DSM-IV descriptions of disorders are often phenomenological (i.e., based on observations) rather than etiological (based on cause).
Phenothiazine - In psychopharmacology, a class of antipsychotic medications.
Phobia - A persistent, irrational, morbid fear of an object or an activity, recognised by the individual as unreasonable but nevertheless leading to significant avoidance of the phobic object.
Piloerection - Stiffening or raising of the hair on one's body.
Postpartum - After delivery of one's child.
Poverty of Speech - Restricted quantity of speech. Differentiated from poverty of speech content, which implies adequate quantity but little information.
Premorbid - Before the onset of illness.
Preoccupation - A repetitive, often continuous thought or focus of one's thoughts (see also Obsessive).
Presenium - The period just before old age.
Pressure of Speech/Pressured Speech - Accelerated, often loud and emphatic speech, which is difficult to stop and may continue even in the absence of a listener.
Prevalence - In epideminology, the number of cases present in a population at or during a particular time (see also Incidence).
Primary Gain - The unconscious gratification, from alleviation of neurotic conflict, that motivates neurotic behaviours (e.g., somatoform symptoms) (see also Secondary Gain).
Prodromal - Premonitory; preparatory.
Prognosis - A prediction of the outcome of an illness or disorder, based on clinical experience with similar cases.
Pseudodementia - A dementia-like syndrome not actually related to organic illness.
Pseudologia Fantastica - Telling of elaborate, intriguing lies. Psychoactive - In pharmacology, having some effect on the psyche, emotions, or psychiatric/psychological symptoms.
Psychogenic - Caused by the emotions or psyche.

Psychomotor - A combination of physical and mental functions.
Psychomotor Agitation - Continuous activity (often with pacing, wringing of the hands, or inability to sit still) related to emotional distress.
Psychomotor Retardation - General slowing of emotional and physical responses.
Psychosocial - Refers to a combination of psychological and social factors or interventions.
Psychosomatic - Refers to the interaction between the mind and body, especially illnesses in which emotional disorder or conflict gives rise to, or significantly affects, physical signs or symptoms. Closely related or identical to psychophysiological, in which physiological mechanisms are affected by emotional factors.
Psychotic - Refers to serious impairment in reality testing, with inaccurate perceptions and/or thoughts about external reality (implying the creation of a new, internal reality).

Querulous Paranoia - A delusion of injustice that one feels must be remedied by legal action.

Reactive - Refers to symptoms associated with, or exacerbated by, one's external environment (as opposed to the intrapsychic environment); more especially, emotional symptoms that change (e.g., get better or worse) with changes in the external environment (see also Endogenous).
Recent Memory - In the mental status examination, memory for items or names 3 to 5 minutes after hearing them.
Receptive - In language, refers to tile taking in, processing, and interpretation of sensory input, generally words.
Reciprocal Play - In children, play that involves interacting with another child (see also Parallel Play).
Reflex Memory - See Immediate Memory.
Remission - Abatement of symptoms, commonly to the point at which an. indication of disease is present (but it is not considered cured).
Remote Memory - In the mental status examination, memory for items or events that occurred in the distant past.
Residual Phase - When referring to psychiatric illness, the part of the course in which acute or florid symptoms is no longer present.
Rhinorrhoea - Nasal discharge.
Ritualistic - Refers to an activity, usually repetitive, employed for a magical or anxiety-relieving, often idiosyncratic purpose.
"Ruin Fits" - Seizures precipitated by alcohol withdrawal.
Rumination - Obsessive repeating of a thought or idea; in infants, regurgitation and re-swallowing of food.

Scanning - A condition, often associated with hypervigilance, in which a person tries intensively to be aware of his or her environment, in fear or anticipation of an anxiety-producing event.
Scapegoating - In families or groups, the involuntary appointing of one member to represent the pathological characteristics of tile group.
Scatologia - Lewd or obscene speech.
Seasonal Depression - Depression whose symptoms arc regularly associated with a particular time of year, usually winter (cf., Seasonal Affective Disorder).
Secondary Gain - Indirect gratification or reward, not consciously sought, from illness or symptoms. Easily confused with Primary Gain and with direct rewards for malingered

symptoms.
Seizure Equivalent - Motor, sensory, autonomic, or emotional feelings or behaviour that are ictal in nature. Also called Epileptic Equivalent.
Self-esteem - Regard for oneself.
Self-image - -One's mental picture of oneself, particularly with regard to strengths, weaknesses, expectations, and ethics.
Senium - Old age.
Sensory - Related to the senses (eg., sight, smell, touch); differentiated from motor.
Sign - A manifestation of a pathological condition observed (directly or indirectly) by an examiner rather than subjectively experienced by the individual. Separate from symptoms.
Simple Schizophrenia - A non-DSM-IV classification that refers to a form of schizophrenia without florid symptoms.
Simple Tic - Reasonably delimited tics, *such* as eye blinking, grimacing (see also Complex Tic).
Sleep Apnoea - Any of several physiologically based conditions in which one stops breathing while asleep.
Sleep Paralysis - Inability to move just before falling asleep, or just after awakening.
Sleep-related Myoclonus - Myoclonus that *occurs* exclusively during, or is related to, sleep.
Sleeptalking - A non-REM Parasomnia similar to, and probably related to, sleepwalking.
Somatic - Refers to the body or human biology.
Somatopsychic - Refers to psychological symptoms caused or exacerbated by somatic illness or injury.
Speech Melody - The intonation or inflection of one's speech.
"Speedball" - Any of several combinations of abusable drugs, especially cocaine and heroin mixed in a syringe.
Stammering - An impairment in speech fluency similar to stuttering.
Startle Response - A condition, often related to hypervigilance, in which an individual reacts abruptly, and out of proportion, to a minor physical stimulus.
Stereotyped/Stereotypic - Refers to movements or verbalisations repeated mechanically, without apparent purpose (see also Ritualistic).
Stressor - An object or situation, real or symbolic, that gives rise to stress.
Stuporous - Physically and verbally unresponsive, especially because of an illness, intoxication, injury, or altered state of consciousness.
Subacute - Having the potential to become acute; likely to become acute.
Superego - In common usage, the *conscience;* in psychoanalytic theory, that portion of the psyche formed by identification with and introjection of parental characteristics that foster ethics, empathy, and self-criticism.
Surrogate - Substitute.
Symbolic - Substituting for a real feeling, memory, object, or event. In a psychodynamic context, the thing symbolised is unconscious, and the symbol may bear only an indirect relationship to it.
Sympathomimetic - Refers to a substance whose action mimics that of the sympathetic nervous system.
Symptom - The outward manifestation of pathological condition, perceived by the patient, especially subjective complaint.
Syndrome - A group of symptoms and/or signs associated with each other (but not necessarily occurring at the same time), sometimes suggesting a particular disorder or diagnosis.

Tangential - Refers to thoughts or words that depart from the current train of thought in an oblique or irrelevant way.
Terminal Insomnia - Awakening significantly earlier than planned, with an inability to return to sleep.
Thought Broadcasting - The delusion that one's thoughts can be heard by others.
Thought Insertion - The delusion that others have placed thoughts in one's mind.
Thought Withdrawal - The delusion that thoughts have been removed from one's mind.
Tic - An involuntary, rapid, recurrent, non-rhythmic, stereotyped motor movement or vocalisation.
Tolerance - In pharmacology, physical habituation to a drug (prescribed or not), leading to loss of its effect unless the dose is increased (not synonymous with addiction); generally, loss of effectiveness of a particular treatment or stimulus at its current level.
Toucherism - Frotteurism, but sometimes distinguished from Frotteurism by its fondling characteristics.
"Trailing" - The auditory illusion that sounds echo or persist.
Trance - A non-organic alteration of consciousness, produced voluntarily (e.g., during hypnosis) or involuntarily (e.g., during a dissociative disorder).
Transsexualism - One's deep and persistent belief that one's physical gender is inappropriate, and that he (or, more rarely, she) should be of the opposite sex. It is accompanied by marked gender dysphoria and a near-constant wish to change one's gender. Transsexualism should be differentiated from transvestism and ordinary homosexuality.
Transvestic Fetishism (Transvestism) - A paraphilia in which cross-dressing (e.g., a male wearing typically female clothing) is prominent; should be differentiated from transsexualism and homosexuality.
Trichophagy - The mouthing or eating of one's hair.
Tricyclic - In psychopharmacology, a class of antidepressant meditations.

Unconscious - Out of awareness; not under voluntary control; that part of the psyche not available to voluntary control or awareness.
Urophilia - Reliance on urine as a primary source of sexual gratification.

Vertigo - A feeling of dizziness, usually including the sensation that one's environment or oneself is spinning.
Visual Tracking - Following objects with one's eyes.
Voluntary - Under conscious control.
Vorbeireden - A psychological symptom involving giving approximate answers or talking past the point, done consciously in Factitious Disorder and unconsciously in Ganser's syndrome.

Waxy Flexibility - A symptom of catatonia characterised by the ability of an examiner to move the patient's body or limbs into different positions, which are then held indefinitely by the patient (also Cerea Flexibilitas).

Wernicke's Encephalopathy - Central nervous system dysfunction due to thiamine deficiency, as in chronic alcoholism (part of the Wernicke-Korsakoff syndrome).

Zoophilia - Reliance on sexual activity with non-human animals (in reality or fantasy) as one's primary source of sexual stimulation.

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STRESS MANAGEMENT AND GRIEF THERAPY

1. Stress Management

Introduction

You have freed me when I was hemmed in and enlarged me when I was in distress (Psalm 4:1 Amp). (*In pressure, Thou has enlarged me* - Darby)

O Lord by these things people live; and in all these is the life of my spirit (Isaiah 38:16 NRSV).

We glory in tribulations, knowing that tribulation produces perseverance; and perseverance, character; and character, hope (Romans 5:3,4).

Count it all joy when you fall into various trials, knowing that the testing of your faith produces patience. But let patience have its perfect work, that you may be perfect and complete, lacking nothing (James 1:2-4).

When Jesus heard it (beheading of John Baptist), he departed from there by boat to a deserted place by Himself (Matthew 14:13).

Our light affliction, which is but for a moment, is working for us a far more exceeding and eternal weight of glory (2 Corinthians 4:17).

Come to Me, all you who labour and are heavy laden, and I will give you rest (Matthew 11:28).

Your body is the temple of the Holy Spirit who is in you, who you have from God, and you are not your own? For you were bought at a price; therefore glorify God in your body (1 Corinthians 6:19,20).

The cares of this world, the deceitfulness of riches, and the desires for other things entering in choke... (Mark 4:19).

Godliness with contentment is great gain...the love of money is the root of all kinds of evil, for which some have strayed from the faith in their greediness, and pierced themselves through with many sorrows (1 Timothy 6:6,10).

Add...to knowledge temperance (self-control, moderation); and to temperance patience; and to patience godliness (2 Peter 1:6).

The management of stress is a problem area for most people. The Christian counsellor will spend a good deal of his or her time helping people, as well as themselves, in stress management.[49]

The world is becoming an increasingly stressful place to live in. An August 1999 report[50] indicated that in Australia, in the year 1998, almost four billion dollars was spent on prescription drugs. A record amount of 250 million dollars was spent on drugs to fight stress. These drugs were used to deal with problems that were previously dealt with by counselling or not treated at all. Antidepressant medication has been steadily increasing at about 20 percent a year to an all-time high in 1998 (186 million dollars). It is estimated that one in five Australians will suffer some time in their lives from major depression. In addition to the antidepressants, there is also a marked increase in anti-psychotic anti-obesity drugs. People are clearly showing a growing reliance on drugs to cope.

Reasons why people are finding it harder to cope with living would include the following.

- Disruption in family relationships and the high divorce rate.
- High rate of occupational problems (retrenchments, competition, etc.)
- Decline in country town numbers and facilities (Australia).
- Longer work hours.
- The increased pace of life generally.
- Rapid increase in technology and difficulty keeping up with it.
- Avoidance of pain and suffering.
- Uncertainty and fear about the future.

Stress in workplace, another report has shown, is now one of the major causes of suicide.[51] The study showed that out of 142 cases of suicide studied in Northern Ireland that the biggest single group of people who took their own lives were business executives because of stress (45 percent of the total). It is well known that "executive suicides" are very high in Japan.

Signs to look for in a person (employee) contemplating suicide include:

- Behaviour changes (sleeping habits, drinking, etc.)
- Increased interactions with colleagues (settling debts and disputes).
- Depression (even in mild form and withdrawal).
- Change in work habits (working harder in certain areas).
- Displays of inadequacy, but a refusal to talk about problems.

It is also well known that there is a very high suicide rate among young people in most developed countries. This is no doubt because of family problems, poor job opportunities and fear of the future.

Many stressed people do not communicate their stress problems and anxieties because of fear that they will be seen as a failure.

Definition of Stress

Stress is something everybody experiences but nobody can clearly define. Stress causes muscle spasms (headaches, neck pain, lower back pain, chronic diarrhoea, palpitations, chest

and stomach pain, jaw problems), heart disease, cancer, skin ailments, emotional problems (anxiety, depression, hostility) and addictions.

Stress could be defined as a non-specific response of the body to any demand placed upon it. The demands placed upon it are called stressors. Generally, the stressors are not the problems but rather the response of the body to them.

Stress is not all bad. It is a prime motivator. We can profit from stress. We can grow through stress, as the Psalmist states, *In pressure Thou hast enlarged me* (Psalm 4:1 Darby).

Stress has always been there but as technology and the pace of life increases so does stress.

Stress has been extensively researched in recent times with the work of Dr Hans Selye, from the University of Montreal, being one of the pioneers. He described the general and local adaptation syndromes (GAS, LAS), in his classic, *The Stress of Life*. He defined stress as simply the *wear and tear of life*. He also emphasised that without some stress we would die, and maintained that it is excessive stress, what he calls distress, is what we need to eliminate. The research continues, especially in the area of occupational stress.

Burnout is a commonly used expression to vaguely describe a condition of stress exhaustion, which is really an inability to manage stress. It is common among Christian workers.

In the DSM-IV, the word *stress* only appears in clinical conditions as Post-traumatic Stress Disorder and Acute Stress Disorder.[52] However, it is inferred as a major factor in many conditions, especially the Anxiety Disorders and Somatoform Disorders. In fact, we can assume that the majority of diseases are psychosomatic - or have to do with psychological, spiritual or sociological stress factors.

Stress, is anxiety out of proportion. Anxiety - the distress caused by life's pressures - is the emotion which research has connected mostly with the onset of disease. The immune system becomes weakened and exposes one to a high disease risk.

The management of stress is a topic, which comes up under many different headings addressed in these manuals.

For example, anxiety conditions have largely to do with poor management of stress; depression is a often a consequence of poor stress management; addictions are primarily due to poor stress management; rejection, hostility and overachieving are the result of poor responses to stress; low self-esteem, perfectionism, resentment, anger and guilt are major causes of stress.

Causes of Stress

The two main causes of stress are crises (major stress) and the smaller everyday nagging things.

Major Stressors (Crises)

Crisis stressors, which none of us can avoid relate mainly to major stress associated with changes in life such as a death in the family, divorce, loss of job, serious illness, accidents, natural disasters, war, abuse and violence, and the like. These are severe at the time but most get over them. Any blockages in the healing process do need to be addressed. These major stressors produce **Acute Stress Disorder** and **Post-Traumatic Stress Disorder.** (See *Vol. 2*)

Some interesting research was done in 1974 by Dr Thomas Holmes on common life-changing events that produce stress in which he called the Holmes-Rahe Scale. He gave a stress value to each life-changing event. This was slightly modified by Keith Sehnert in 1981.[53] (Fig. 11)

Figure 11

HOLMES-RAHE SCALE
(Revised by Sehnert)

	EVENT	VALUE
1.	Death of spouse	100
2.	Divorce	73
3.	Marital separation	65
4.	Jail term	63
5.	Death of close family member	63
6.	Personal injury or illness	53
7.	Marriage	50
8.	Fired at work	47
9.	Marital reconciliation	45
10.	Retirement	45
11.	Change in health of family member	44
12.	Pregnancy	40
13.	Sex difficulties	39
14.	Gain of new family member	39
15.	Business readjustment	39
16.	Change in financial state	38
17.	Death of close friend	37
18.	Change to a different line of work	36
19.	Change in number of arguments with spouse	35
20.	Large mortgage	31
21.	Foreclosure of mortgage or loan	30
22.	Change in responsibilities at work	29
23.	Son or daughter leaving home	29
24.	Trouble with in-laws	29
25.	Outstanding personal achievement	28
26.	Spouse begins or stops work	26
27.	Begin or end school	26
28.	Change in living conditions	25
29.	Revision in personal habits	24
30.	Trouble with the boss	23
31.	Change in work hours or conditions	20
32.	Change in residence	20
33.	Change in schools	20
34.	Change in recreation	19

35. Change in church activities 19
36. Change in social activities 18
37. Smaller mortgage 17
38. Change in number of family get-togethers 15
39. Change in sleeping habits 15
40. Change in eating habits 15
41. Single person living alone 15
42. Other (describe)……
43. Other (describe)……

TOTAL…….

If your score is 150 or less you have a one in three chance of an emotional or physical breakdown during the next two years. This is lessened if you do not have a negative attitude to the normal pressures of life.

If your score is 150-300, you have a fifty-fifty chance of emotional or physical difficulty during the next two years.

If your score is 300 or more, you have a 80 percent chance of emotional or physical difficulty during the next two years. It is suggest that you take it easy for a year or so and avoid major decisions.

Everyday Stressors

The everyday smaller nagging things often cause the more serious prolonged stress. We cannot avoid either. Stressors can be classified as either physical, chemical, disease, emotional, and spiritual.

A list of the many causes of prolonged stress are as follows.

- Frustration (inability to meet goals).
- Anxiety (fear or worry - especially of the future).
- Change (especially the rapid changes in technology – techno-stress).
- Monotony.
- Unresolved family of origin issues.
- Low self-esteem.
- General pressures of life.
- Family and relationship pressures.
- Chronic pain.
- Chronic illness.
- Occupational pressures (Workaholism, wrong notions about *success).*
- Environmental pressures (climate, noise, pace, etc.).
- Sexual pressures (unfulfilled, dysfunctions, compulsive).
- Life transitions (each transition has its own set of pressures).
- Spiritual (resentment, repressed anger, guilt, perfectionism, greed, worry, etc.).
- Prolonged effects of crises (see above).

Spiritual Stressors

Not operating within the call of God

Ministering outside of the specific call of God on your life, and simply meeting needs, etc. is a major cause of burnout in Christian workers. (See section on *Vision, Calling, Ministry)*

Unforgiveness, resentment and bitterness

These are common and major cause of stress. In the parable in Matthew 18:34, Jesus states that the unforgiving servant was delivered to the torturers. Forgiveness releases both the offender and the offended.

Guilt

Guilt gnaws and cripples the inner being, and again is a major cause of stress. Scripture states:

> *The way of transgressors is hard* (Proverbs 13:15 KJV).
>
> *The wicked are like the troubled sea, when it cannot rest, whose waters cast up mire and dirt. 'There is no peace' says my God 'for the wicked'* (Isaiah 57:20,21).
>
> *The wicked writhe with pain all their days* (Job 15:20 NRSV).
>
> *The wicked flee when no one pursues, but the righteous is as bold as a lion* (Proverbs 28:1).
>
> *The wages of sin is death* (Romans 6:23).

Perfectionism

Perfectionism, so common in the church, is due to false belief systems, is also a major cause of stress. It is the high cost one pays for aiming too high. Overachieving is closely associated with it (the *Competitive Christian* of the *Plumbline* model). Such are constantly striving seeking the approval of an authority figure, or seeking to prove that they are not a failure, with wrong motives.

Greed

Greed is also a major cause of stress. Materialism, affluence, idolatry, *Keeping up with the Jones*, are characteristic of the age. In our city, Canberra, we have many public servants and the typical pattern is climbing the public service ladder with all the associated things that go with it - a bigger house, car, holiday home and the like. This generates much stress as people seek to manage their finances. God's answer to it all is contentment.

Worry

Worry and stress are interwoven. Worry is a spiritual issue. Jesus stated on several occasions, *Do not worry* (Matthew 6:25,26,28,31). Worry is also associated with the cardinal sin of unbelief.

Symptoms of Stress Overload

Symptoms and warning signs of stress overload are as follows.

- Muscle spasm, in the form of:
  - Headaches.
  - Migraine.
  - Neck pain.
  - Temporo-Mandibular Joint (jaw joint) pain.
  - Lower back pain.
  - Bowel spasm (colitis, irritable bowel, chronic diarrhoea).
  - Palpitations.
  - Chest pain.
  - Stomach pain (especially in children).

- Skin ailments (many itches and rashes).

- Overachieving (time urgency - too much to do and not enough time to do it).

- Hostility (uncontrolled aggression).

- Negativism.

- Proneness to sickness, as a result of a weakening of the immune system (commencing with the common cold, asthma, herpes and to much more serious diseases).

- An increase in:
  - Caffeine.
  - Alcohol.
  - Tobacco.
  - Other drugs.
  - Refined sugar.

- Addictions – which not only have their roots in family shame, but also in poor stress management.

- Major stress produces the Acute and Post-Traumatic Stress Disorders.

Burnout

Burnout is a vague term describing a range of symptoms similar to stress overload and depression. The word *burnout* does not appear in the DSM-IV.

Burnout is not uncommon among Christian workers, and several writers have addressed the issue.[54] We know, for example, of several Baptist pastors who recently suffered from it. Many Christian workers suffer from the irrational belief and thinking that they cannot say no when called upon to help others. They have great difficulty in setting their boundaries. They believe their calling involves carrying the burdens of all who wish to hand them over to them!

Burnout has a gradual onset, and symptoms include the following.

- Fatigue.
- Lack of motivation.
- Loss of joy.
- Loss of enthusiasm.
- Withdrawal.
- Loss of appetite.
- Sleep disorders.
- Poor decision-making.
- Physical stress related conditions (see above).
- indulgence in addictive substances (alcohol, drugs, food, sex).

Responses to Pressure

Selye referred to three stages of the stress response in the general adaptation syndrome - the alarm reaction, stage of resistance and the stage of exhaustion.[55]

It is not the pressure that is the problem it is how we react to it. Stress is not outside, but rather it is inside. People vary greatly in the way they handle pressure.

The body's response to stress is extensive and includes the following responses.

- Hypothalamus of the brain sends signals of stress to the body.
- Pupils dilate.
- Muscles tighten.
- Blood vessels constrict.
- Heart rate increases.
- Breathing increases.
- Blood pressure rises.
- Adrenal glands release hormones into blood stream (especially adrenaline).
- Stomach and intestines affected, etc.

Our response to pressure largely relates to the following.

- Our personality type.
- Belief systems.

Personality Type and Stress

Type A and B personality types were first described by Friedman and Rosenman in 1974.[56] They found that everybody is born into one of these two categories.

The Type A person is fast moving, ambitious, aggressive, self-demanding, competitive and tend to be successful. The type B person is more casual and laid back, less competitive and less concerned about achievement. In the general population, the two types occur in about equal numbers but in urban populations, the number of Type A personalities markedly increases.

Type A personalities tend to be addicted to the adrenaline rush of the body's emergency system to carry out normal duties, which subjects the person to a lifestyle of continuous stress.[57]

Research also found that Type A personalities are more prone to heart attack than those of Type B. Unless a Type A person changes his lifestyle by reducing his external pressures, he is more likely to experience heart disease with each passing year.

However, recent studies indicate that it is the anger (hostility) component of Type A personalities rather than their hurried, high-pressure lifestyle that puts them at risk of heart disease.

Further recent studies have found there is a subtype of Type B, called Type C personality. This personality represses feelings and internalises problems. This is also a major cause of heart disease and other internal diseases related to the immune system, such as cancer.

Myers Briggs temperaments react under pressure as follows.

NF - non-conformity, rebellion, guilt, discouragement.
NT - compulsive self-doubt, argumentative, bored/frustrated, will fight.
SP - boredom, constraint, recoil, avoidance, delay.
SJ - exclusion, rejection, fix it or leave it, frustration, criticism.

The temperaments of Hippocrates react to pressure as follows:

SANGUINE	-	Tends to produce stress in others.
	-	Stress from being disorganised and unpunctual.
	-	Women sanguines tend to be screamers.
	-	Tend to run away from problems.
	-	Difficulty managing pressure leading to explosive outbursts.
CHOLERIC	-	They produce the most pressure of all temperaments.
	-	They refuse to give up.
	-	Impatience and criticism.
	-	Relationships suffer.
MELANCHOLY	-	Because of their sensitive nature and perfectionism they tend to internalise stress.
	-	Negativism and criticism.

- Inability to relax.
- Tendency to emotional, mental or physical breakdown.

PHLEGMATIC
- Tends to avoid pressure.
- Their procrastination tends to increase stress.
- Tend to blame others.
- Resorts to fantasy.

Belief Systems

The other primary factor, which affects how we react to pressure relates to our belief systems. Stress is really an attitude. You can choose to be stressed or not.

Negative people will react adversely to pressure, whereas positive people thrive under pressure.

Low self-esteem, fear of failure, worry, over-achieving, striving to please others, inability to set boundaries, irrational zeal, and the like all relate to false beliefs.

Stress Management

It is not the pressure that is the concern, but rather how we manage it. The following Stress Management Test will help us access this.

Stress Management Test

The following simple self-assessment will help you understand better how you cope under pressure.

Answer yes (Y) or no (N) to the following questions.

_____During the last 3 days, have you done some real exercise for at least 2 of the days (20 minutes of walking, swimming, cycling, etc)?

_____During the last 3 days, have you eaten more plant foods than non-plant foods (red meat, milk products, eggs)?

_____During the last 3 days, has your diet been low in sugar, salt, refined and quick foods?

_____Have you not drunk more than three cups of coffee/tea during any of the past 3 days?

_____Have you not smoked during the last 3 days?

_____Have you had no more than ten standard drinks (men, 7 for women) during the past

3 days (one standard drink is 200 ml of beer - 4 to the bottle, 120 ml of wine - 6 to the bottle, 75 ml of fortified wine - 10 to the bottle, 30 ml of spirits - 23 to the 700 ml bottle)?

_____During the last 3 days, have you done something good for yourself (movie, book, garden)?

_____During the last 3 days, have you spent at least 20 minutes in meditation each day?

_____During the last 3 days, have you laughed at life, at yourself?

_____Do you have a support system - someone to hug and talk to?

_____Do you have just a few hassles and handle them well, rather than a life full of hassles?

_____During the last 3 days, have you been in control, rather than having blown it?

_____During the last 3 days, have you used deep relaxation (switched off, taken deep breaths, and done a relaxation technique)?

_____During the last 3 days, have you had mainly positive thoughts?

_____Do you have regular medical checks (blood pressure, women - breast check, cervical smear, etc.)?

_____During the past 3 days, have you done something nice for somebody else (affirmed, encouraged, served, helped)?

SCORE: Number of (Y)_____ Number of (N)_____

If you scored less (Ys) than 6, you need to radically alter your attitude to life and your lifestyle. If you scored more than 12, you are in good shape. If you scored about the middle, you should check your score regularly and aim to improve.

Cognitive Restructuring

As one's belief system plays a major role in how they react to pressure, careful attention needs to be given to this in stress management. Cognitive restructuring will be necessary. Instead of allowing yourself to become weighed down by something, learn to laugh at it. We can do something about it. This involves determined and significant choices being made.

The overriding biblical principle to consider in all stress management is that of moderation. With *Type As,* it is usually all or nothing.

Dr John Tickell comments that in stress management it is a question of everything in moderation except.[58]

- Laughter (stress cycle breaker number one).
- Sex, with spouse of course (extramarital sex is a major cause of increased stress) however, compulsive sex in marriage produces marital stress.
- Vegetables (used to excess by races that live the longest and feel the best).
- Fish (fish oils protect arteries, also used by races that live the longest).

Type A personalities need not be locked into their type, but move over to Type B characteristics on a regular basis.

A change from negative thinking to positive thinking is essential. For the Christian this will mean renouncing unbelief, fear and worry and embracing the all-sufficient grace of God and the power of the Holy Spirit.

Positive thinking people act in the following ways.

- Learn to like pressure.
- Realise that success is ultimately measured by performance under pressure (when times are easy, success is easy, but rarely long lasting).
- Know when times are tough, only the strong succeed and this success is long-lasting. *When the going gets tough the tough get going!*

Changing irrational *What Ifs* and *If Onlys* and *Shoulds*, *Musts* and *Oughts* and dealing with perfectionism will be necessary to minimise stress. (See Chapter 1)

Assertiveness training and setting boundaries are also very important cognitive-behaviour change that will probably be necessary.

As much irrational thinking has its roots in one's family of origin, it will be necessary to help clients work through family of origin issues. (See *Volume 3*)

Pressure leads to either corridor restricted rigid thinking or to lateral thinking. Lateral thinking means creative thinking to find ways to reduce stress.

Finding the Will of God for Your Life

The only place of real fulfilment is being in the centre of God's will. This helps to produce a positive attitude. However, many seek to do God's will with irrational zeal in an unbalanced manner. We are responsible to care for ourselves physically, emotionally and spiritually as we labour in the Lord's work.

This will include the following.

- Committing oneself to basic values and sticking to them.
- Setting clearly defined and realistic goals (short-term and long-term).
- Making oneself accountable to others in authority.
- Establish proper priorities for daily living.
- Observing the principle of Sabbath.
- Serving, giving to and affirming others.

Vision, Calling, Ministry

Let each one remain within the calling they have been called (1 Corinthians 7:20, 24).

Following from the previous section of *Finding the Will of God for your Life* is the important matter of knowing what is our vision, calling and ministry and remaining within it. A good deal of burnout in Christian workers occurs because the worker does not understand his or her calling, or if they do, they do not remain within it. They simply continue to fulfil needs as they arise. The following is intended to help us find out what our vision, calling and ministry are and remain within them.

Vision

Habakkuk received a vision from the Lord, whilst he stood on his *watch* and was waiting *To watch and see what He will say to me* (Habakkuk 2: 1). He was then told, after he had received the vision, *To write the vision, and make it plain on tablets*. It is important to write down our vision, calling and ministry and our natural and spiritual giftings.

The word of the Lord was rare in those days; there was no widespread revelation (vision) (1 Samuel 3:1)

Where there is no vision the people perish (cast off restraint) (Proverbs 29: 18).

I was no disobedient to the heavenly vision (Acts 26: 19).

Vision is a revelation from God to you personally, usually comes in relation to a burden you have for some people group, etc.

It is important to share the vision with others and seek confirmation. *In the multitude of counsellors there is safety (or wisdom)* (Proverbs 11:14, 15:22, 24:6).

After it is confirmed it is then necessary to set objectives, goals and strategies. It may be a short term or long term vision. Sharing the vision also enables others to *buy into* the vision.

Calling

There are two main types of calling. There is the general high calling of God on your life (Philippians 3:14), and there is a specific call of God upon your life for a distinct assignment.

The high call of God relates to being called out of the world into the fellowship of his Son (1 Corinthians l:9 and being called to be conformed to the image of his son (Romans 8:28,29).

The specific call of God is like what Abraham was called to (Genesis 12, Hebrews 1l:8, and Paul (Romans 1: 1), and us to the fulfilment of the Great Commission, and especially to a

special area of need (people group, area of society, etc.).

We are exhorted to remain with God in that calling (1 Cot. 7:20, 24), and to fulfil it (1 Corinthians 9: 16). Failure to do this is a major cause of frustration, lack of fulfilment and burnout.

Ministry

Ministry relates more to the kind of work, or the tools, God has sovereignly endowed me with, to serve him in his Kingdom. There are my natural giftings and my spiritual giftings (Romans 12:4-8, 1 Corinthians 12:28-31, Ephesians 4:11) which are often connected, and both of which he uses in his service.

Various tests help us to understand our giftings. We need this assistance because of negativism and the fact that most of us underrate what God has given to us, and do not rise to the height of our potential in Him. Some valuable tests are Myers Briggs and Wagner-Hout Spiritual Gifting Test. (See *Personality and Other Tests* in *Volume 6*)

Exercise

Complete the following questionnaire (Figure 12).

Figure 12

VISION, CALLING AND MINISTRY QUESTIONNAIRE

Do I have a vision?_____

If so, what is it?_____

Have I written it down and shared it?_____

Have I prayed for and sought others to buy into it?_____

If I do not have a clear vision, have l sought to buy into another's vision?_____

What is the high call of God on my life?_____

What is the specific call of God on my life?_____

Am I remaining with God in that calling (1 Corinthians 7:20,24)?_____

Am I fulfilling that call (1 Corinthians 9:16)?_____

What is my ministry (my giftings)?_____

What do I like doing?_____

What has God's obvious blessing on what I do?_____

Am I fulfilling my ministry and my calling?_____

If not, what is preventing its fulfilment?_____

Am I doing anything which not a clear call from God?_____

If so, why?_____

Is it the fear of man?_____

Wanting the approval of man?_____

Failure to involve others?_____

Do I recognise and make room for others in the realm of my calling?_____

Other comments_____

Physical Exercise

Moderation is what is called upon here, not fanaticism. Dr John Tickell recommends simply a minimum of one percent of your time being devoted to exercise, which must be sufficient to make you lightly puff.[59] This means 100 minutes per week, which can be done in three lots of 30 minutes, four lots of 25 minutes or seven lots of 14 minutes.

When lightly puffing the arteries get flushed out, joints lubricated, and there is increased oxygen in the brain. Lightly puffing will mean the pulse rate rises from a resting pulse of about 60 per minute to about 130 per minute. Your maximum pulse rate is about 220 minus your age. Lightly puffing is about 70 percent of maximum pulse rate. Therefore, if you are 60 years of age, your maximum pulse rate is 220, less 60, which is 160. Seventy percent of this is 112.

Suitable exercises are brisk walking (the best exercise), climbing steps, running, swimming, cycling, beginner and intermediate aerobics, etc. Anaerobic muscle exercises are also useful.

Lower back pain is a very common problem in people over 50. Much of it is caused by stress, overweight and flabby stomach muscles. The majority of back pain can be controlled by strengthening the stomach muscles and by stretching the hamstring muscles (muscles on back of thigh) regularly. This is done by exercises that involve lying on one's back flat on the floor and raising and flexing the legs.

Dietary Adjustment

Good diet, or sensible eating, is very important in stress management and for health generally. It has been well said, *We are what we eat.* Medical research is proving that what we eat has a powerful effect on our mental, as well as our physical, well-being. What we eat can determine whether we are anxious or relaxed, happy or depressed, and alert or dull-headed.

It is becoming increasingly clear that poor diet plays a significant role in the cause of many disorders such as anxiety, burnout, depression, chronic tiredness, various immune system maladies, and many cancers.

Greater care needs to be exercised by most of us as to what we put into our mouths. We so often abuse our body temple, and then wonder why certain complaints arise. Christians need to give a lead to the world in sensible and right diet.

Many are turning to vegetarianism, or to semi-vegetarianism. However, the biblical principle of moderation is the key. Fanaticism needs to be avoided.

The current dietary emphasis is that a good diet is one low in fat and high in fibre. This means increasing plant foods and reducing non-plant foods. John Tickell recommends a diet of at least two-thirds plant food and one-third non-plant food. He refers to the plant foods as basic foods and the non-plant foods as bonus foods (red meat, milk products, eggs, chocolate, and the like).[60] We recommend this as a good policy to follow. Better still, the ratio could even be higher with say 80 percent or even higher in plant foods.

The main points being currently emphasised for good diet are:

- Low fat.
- High fibre.
- Low, or no, red meats.
- Low, or no, chicken.
- Lean meats.
- Low, or no, milk products (low fat milk or soy milk can be substituted).
- Low eggs.
- Low, or no, refined sugar.
- Low salt.
- Low fast foods.
- Low refined foods.
- High water intake (ten glasses per day and two before each meal).
- Low, or no, alcohol.
- Low butter or margarine.
- High fish.
- High dark green vegetables (cabbage, cauliflower, Brussels sprouts, broccoli).
- High vegetable and fruit juices.
- A good high fibre/fruit breakfast.

Avoid Stimulants

Smoking is absolutely out. As Dr John Tickell comments, *It is impossible to be intelligent and smoke at the same time*.[61]

Alcohol can be useful. It reduces fat levels in the blood, dilates blood vessels, it is a good sedative, dry wine stimulates the appetite, stout is good for those convalescing. However, it is as Scripture states, *a mocker*, and becomes easily abused and self-destructive. Many cannot handle alcohol, and therefore must not touch it at all.

It needs to be kept in mind that alcohol is a major producer of fat. The amount of weight increase from 50 drinks per week over 12 months, which you need to burn off just to stay the same weight, is 24 kilograms.

If you can handle alcohol, again the biblical principal of moderation is called for. If you want to drink, it is strongly recommended that you do not exceed the following amounts:

A maximum of 20-25 standard drinks a week for men, and little less for women is in order providing everything else in your life is in place. Some say a lot less but Dr John Tickell believes this amount is acceptable.[62] One standard drink is 200 ml of beer - 4 to the large bottle and just less than two in a *stubbie*, 120 ml of wine - 6 to the bottle, 75 ml of fortified wine - 10 to the bottle, 30 ml of spirits - 23 to the 700 ml bottle.

Caffeine, in coffee, tea and other drinks has to be watched. It is the most common drug of addiction in the world. It is recommended to either give it up or have no more than three cups a day.

Many also resort to drugs to help them cope with stress (illegal, over-counter and prescription drugs). The typical picture in Australia over the years is that the men drank alcohol and the women took pills (*I'll have a Bex and a cup of tea and a lie down)* to manage stress. Many teenage girls today take *Panadeine* regularly to manage their stress.

Sugar, in refined and processed form (refined sugar, sweets, biscuits, cakes, drinks, starchy foods), are also stimulants and fattening. It is recommended that they be ingested only on special occasions.

Dealing with Guilt, Anger and Resentment

Guilt, resentment and anger are common causes of stress and stress-related illness. They must be addressed in the whole process of stress management. (See *Volume 2*).

Leisure

Time must be taken to ease the pace and switch off. This can be done by resorting to such things as reading a good light book, looking at a good movie, walking and working in the garden, going to exhibitions, going for a casual drive.

Breaking away from the routine is essential. There is nothing wrong about having the following breaks:

- To regenerate yourself away from anybody else (say every quarter).
- Just with your spouse (say every six months).
- With the whole family (say every year).

It is recommended that specific days be crossed off your schedule well ahead of the time to have these breaks and not allow anything to interfere with them.

Sleep

To be able to have 6-8 hours of good sleep and waking fresh in the morning is essential to stress reduction and good health.

Using alcohol or drugs to assist this is not recommended as they interfere with the better non-rapid eye movement (REM) sleep.

Support System

It is very difficult to cope with stress without a good support system. This means an emotional and physical supportive spouse and family.

Relaxation

Many progressive relaxation exercises are available and are highly recommended, ranging from simply switching off and taking deep breaths regularly, to a structured progressive relaxation procedure. Stress dissipates and blood pressure reduces as this is done. (See *Volume 2* for a sample relaxation exercise)

Meditation

Many authorities recommend the value of a time of meditation each day either at the beginning of the day or at the end. Type A personalities have real difficulties with this. The great Christian Swiss psychologist, Paul Tournier, recommended 45 minutes each morning for meditation to evaluate the previous day and plan the coming day.[63]

The Christian has a big advantage here. If he or she has a regular quality and meaningful quiet time each day, especially in the morning, it will do must to reduce stress and help the person get things into proper perspective.

Scripture also strongly supports this.

> *They that wait on the Lord shall renew their strength; they shall mount up with wings like eagles, they shall run and not be weary, they shall walk and not be faint* (Isaiah

40:31).

In quietness and confidence shall be your strength (Isaiah 30:15).

Meditation on the Word of God particularly will be beneficial. Psalm 1, the first and most important of all the Psalms, emphasises this (Psalm 1:2,3):

> *Their delight is in the law of the Lord, and on his law they meditate day and night. They are like trees planted by streams of water, which yield their fruit in its season, and their leaves do not wither. In all that they do, they shall prosper* (NRSV).

Serving Others

Scripture tells us that it is more blessed to give than to receive (Acts 20:35b). This is an important principle. Type A personalities tend to be very selfish. A significant reducer of stress is to be engaged in reaching out to others in service, ministry, giving, affirmation, encouragement, and time to listen and care. It is recommended that an important aspect of stress management is to commit oneself to do at least one thing of this nature each day.

Stressor Management

Some major changes may be necessary in stress management to reduce the number of stressors. This may have to be radical rather than just minor changes. In major stress situations radical changes are necessary.

This is often difficult. The following will help.

- Identify the problem stressor.
- Accept the possibility of change.
- Analyse the situation and consider what could be changed.
- Choose a strategy and begin to implement it.

Some Practical Daily Tips

The following are some practical daily tips to help reduce stress during the workday:

- Take time to be quiet and meditate each morning.
- While your car is warming up take a minute take some deep breaths.
- While driving be aware of body tension, and take steps to reduce it.
- Keep to the speed limit.
- After parking at your work-place pause a moment and orient yourself for the day.
- While at work often pause and take some deep breaths to relax.
- Use your breaks to really relax (not coffee but relaxation, walks, etc.).
- At lunch change your environment, eat quietly, or close your door and consciously relax.
- Stop work every hour for one to three minutes to do something different and relax.
- When relaxing at lunch talk about non-work related topics.
- Take on one task at a time and complete it. Attempting less in this way enables you to

achieve more.
- Be assertive and say "no" when your workload is too full.
- Smile and maintain a sense of humour.
- Leave work on time.
- At end of day spend time to evaluate the day.
- Relax and unwind on way home.
- When arriving at home take a minute to re-orientate and prepare to be with your family.
- Change your work clothes and take five to ten minutes to be quiet before mixing with family.

Chronic Pain Management

Perhaps the most uniform form of stress is pain, whether it is physical or emotional. Pain accounts for over 80 percent of physician visits and affects over 50 million Americans, and is a major drain on the economy. Pain can be acute or chronic, and certainly can have psychogenic causes.

Chronic pain is defined as pain persisting for over six months, and it can be somatogenic (physiologic) or psychogenic (psychologic).[64]

Chronic pain is a major cause of stress and produces many problems in its management.[65]

Chronic pain takes many forms. The following are an example of a few types of chronic pain:
- Chronic back pain.
- Chronic headaches (eg. Migraine).
- Facial pain (Temporo-Mandibular Joint Pain – TMJ, Tragedian Neuralgia, Fibromyalgia, etc.)[66]
- Cancer pain.
- Intestinal obstruction.
- Visceral pain in paraplegics.

Much that has already been stated has to do with pain management, but the following are factors to be considered particularly in its management:
- Medical consultation and perhaps medication.
- Cognitive-behaviour therapy.
- Family of origin work.
- Relaxation techniques.
- Group therapy.
- Family therapy.

Debriefing following Major Stress

Debreifing counselling is necessary following major crisis stress situations such as natural diasters, war, major loss, serious abuse and violence and major losses.

This would include talking about and discussing the following phases:

- Fact phase (what actually happened?)
- Thought phase (what were the client's initial and following thoughts?)
- Feeling reaction phase (the client is encouraged to fully share their feelings).
- Stress response (signs and symptoms – depression, grief, anger, etc. - immediately after and long term).
- Teaching phase (explaining normal reactions, stress management).
- Re-entry phase (reassurance, referrals, etc.)

2. Grief Therapy

Introduction

Blessed are those that mourn, for they shall be comforted (Matthew 5:4).

Surely He has born our griefs and carried our sorrows...(Isaiah 53:4).

Though I walk through the valley of the shadow of death, I will fear no evil; for You are with me (Psalm 23:4).

Grief is the response to the loss of any significant object or person in our lives. The process of grief follows such losses as a death, divorce, other broken relationships, financial loss, lost job, an amputation, loss of health, ageing, abandonment of significant life goals or dreams. It also includes the many subtle losses that affect us. Grief therapy is in current vogue and an understanding of it is necessary.[67]

Life is a blending of loss and gain. In creation loss is the ingredient of growth. A bud is lost when it turns into a beautiful rose, and a seed when it germinates, when a caterpillar turns into a butterfly, when deciduous teeth are shed to make way for permanent teeth, when leaving high school to go to university, when immigrants leave their country, and when missionaries move to new fields. Losses provide opportunities for growth.

Grief can take three different courses.

- A normal grief response.
- A difficult and long-term (2-4 years) process of healing and readjustment.
- A pathological response when it is denied, delayed or distorted.

Each grief, because it is personal, is very individual in nature. This is why people find it hard to relate well to grieving persons. It can be very isolating.

Stages of Grief

The stages of grief, or recovery after a loss, were first described by Elizabeth Kubler-Ross. [68] These stages normally proceed spontaneously over the course of time. However, there can be blockages, interruptions and delaying of the process. The following stages of grief are a simplification of Kubler-Ross's work.

Shock

This manifests itself in numbness, violent expressions of intense feelings, and distortion of perceptions.

Denial

This is a protective device, which dilutes the reality while we muster our emotional forces to cope.

Anger and bargaining

These alternate. Anger is associated with resentment and bitterness (against parents, others, God) and a deep sense of injustice. Anger helps us to separate.

Depression

This helps us explore the full impact of the loss. It slows us down so we can eventually let go of the pain of the loss without burying its memory. It manifests itself in pain, yearning for the lost person, and mourning for self and the deceased (in case of death), guilt, remorse, loneliness, panic and fear of the future, physical distress, sleeplessness, loss of appetite, listlessness and sometimes hyperactivity.

Acceptance

This is a time of refocusing and exploring new options with new energy. New strengths are mustered, new relationships are developed, and a new pattern of life begins. Ultimately the grieving person can help and minister to others who may be grieving. The person coming out of grief can look back and see the healing process.

Recovery from Loss

Recovery from loss involves the normal process through the stages of grief, especially the acceptance phase. This includes rebuilding one's life by developing new strengths, new relationships and new patterns. The grief curve illustrates the recovery process (Figure 13).

Blockages in the Grieving Process

It is possible to have a blockage in the recovery process at any of the points on the diagram. This indicates a need for counselling.

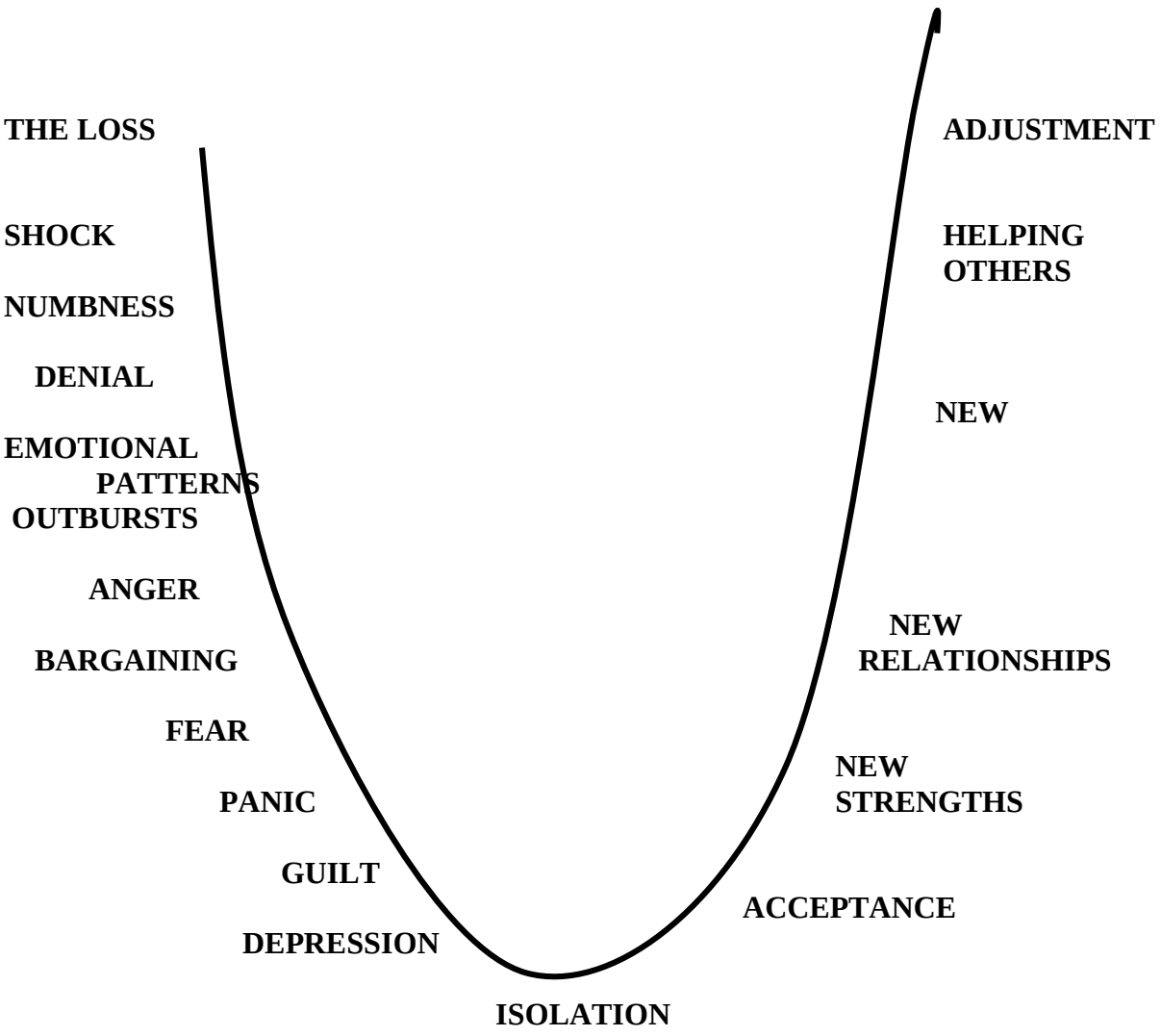
The main blockages that can occur are as follows.

- Resentment and bitterness.
- Anger against God.
- A refusal to come to terms with one's feelings.
- Blocking feelings with drugs, addictions, etc.
- A grieving spirit.
- A refusal to hand the grief over to the Lord (Isaiah 53:4).
- A refusal to readjust one's circumstances and one's life.

Those involved in a major loss need to give themselves permission to grieve.

Figure 13

GRIEF CURVE



The Lord supports and sympathises with those who grieve. The following passages referring to the manner in which God intervenes in the grieving process are helpful.

- The God who grieves (John 11:33-36, Luke 13:34).
- The God who sees our losses - this helps us in facing reality (Mark 5:21-34).
- The God who hears us when we are depressed - this helps us in our identity, self-esteem and gives us hope (Psalm 42:1-4,7-11).
- The God who loves us when we feel afraid - he helps us deal with fear (Mark 16:1-8).

- The God who is with us when we feel alone - he helps us face loneliness and the embarrassment of others (Psalm 142).
- The God who offers healing - Jesus bore our griefs so we do not have to have prolonged grief (Isaiah 53:4).
- The God who helps us reinvest in life (Psalm 30).

Jesus took our griefs and sorrows at the cross and bore them so that we do not have to (Isaiah 53:4). How sad it is that people are so naturally reluctant to go to the cross, and to the one whom has promised to take our burden upon him. *Come unto Me all you who labour and are heavy burdened and I will give you rest...* (Matthew 11:28).

The beautiful old hymn of Joseph Scriven puts it so well:

What a friend we have in Jesus
All our sins and griefs to bear!
What a privilege to carry
Everything to God in prayer.
Oh, what peace we often forfeit,
Oh, what needless pain we bear -
All because we do not carry
Everything to God in prayer.

Have we trials and temptations?
Is there trouble anywhere?
We should never be discouraged,
Take it to the Lord in prayer.
Can we find a friend so faithful,
Who will all our sorrows share?
Jesus knows our every weakness,
Take it to the Lord in prayer.

Guidelines for Counselling those Grieving

As most are uncomfortable and awkward in seeking to help those grieving the following are some useful guidelines.

- Start with general conversation.
- Emphasise that you care for them and would like to help them.
- Encourage then to express their deep feelings of anger, fear, loneliness. disappointment, confusion, despair, etc.
- Reassure them it is good to cry.
- Tell them there is light at the end of the tunnel.
- Actively listen as they share their grief.
- Don't say, *I know how you feel.*
- Don't avoid them because of your own discomfort.
- Don't be afraid to mention the deceased's name.
- Avoid trite answers and cliché statements such as *God knows best.*
- Don't make decisions for them.

- Minister the comfort of the Holy Spirit.
- Be available for the long haul of the grieving process.

Facilitating the Grieving Process

The following are some useful practical tips the therapist can suggest to those grieving to help them facilitate the grieving process:

- Nurture your relationship with God.
- Accept the grief.
- Talk about the loss.
- Keep busy.
- Take care of yourself.
- Eat well.
- Exercise regularly.
- Get rid of imaginary guilt.
- Accept your understanding of the loss.
- Join a small group.
- Associate with old friends.
- Postpone major decisions.
- Put your thoughts into a journal.
- Turn grief into creative energy.
- If necessary get professional help.

3. Grief Therapy

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MSc. (Fam. Life Min) (Concordia)

I. DEFINITIONS

Simply, *grief* is the pain of loss. It is the emotional/spiritual/physical response to the loss of a person, significant object or situation in life. Although in this material I generally refer to loss through death, grief is a normal human response for many losses. Such losses may include divorce, job, status, financial loss, incapacitating illness, broken relationships and ageing, among others.

The *grieving process,* or *mourning*, is the process by which we acknowledge and work through the pain of loss over a period of time until we begin to live again, and learn to love again, and the loss has become a healthy memory.

I prefer to use the terms, *pastoral care and counselling* of the bereaved to include all informal and more formal pastoral care (by a pastor or lay person) exercised to facilitate the normal grieving process. I use the term grief therapy for specific therapeutic intervention in situations where grief has not been resolved, usually many years after the loss was sustained.

II. A THEOLOGICAL REFLECTION ON GRIEF

1. Loss and grief are inescapable - To be human is to Grieve

Since the Garden of Eden, humanity has lived with the pain of loss: loss through fractured relationships (sin) and loss through death. All relationships have been affected by sin: relationships between ourselves and God, between ourselves and each other, and between ourselves and creation. (Genesis 3: 14-19). St Paul sums up the situation in Romans 5:12: *Therefore, just as sin came into the world by one man, and death came through sin, so death spread to all because all have sinned.*

We love, we attach ourselves to things and people. Grief is inescapable when loss is experienced. Even Jesus was not immune from grief. We will hurt because someone we love dies, or because a relationship is broken and in spite of our best efforts we cannot be reconciled. Changes overwhelm us that are beyond our control. We may protest that it should not have happened; that death came too soon, it isn't fair; it is so final. We grieve for what we have lost. We feel so very vulnerable. We wonder how life can go on. And yet it does. We begin to live again. As American Lutheran pastor Herbert Anderson once wisely remarked, *We learn to live as we learn to grieve*.

2. God is present with us, he suffers with us, he comforts us

One of the great truths of Scripture and of God's activity among us is that he is present with us, no matter what, and that in fact he suffers with us. Isaiah's words in chapter 43 are a great reassurance of God's presence: *When you pass through the waters, I will be with you* and *Do not fear, for I am with you.* The much-loved Psalm 23 expresses the confidence of God's presence. Isaiah also describes the God who suffers with us, and for us, in his Suffering Servant song. (Isaiah 53:4) Surely, the greatest act of presence among us and suffering with us is to be seen in the incarnation. God in human form, who lived our life, experienced loss and grief, and was put to death on a cross. That God would choose to identify with us in this way is surely amazing love – and amazing vulnerability. God was willing to enter the darkness of our human life to be present with us, and to us.

God's presence among us is also as a God of comfort, to comfort all who mourn, to provide for *those who mourn in Zion to give them a garland instead of ashes, the oil of gladness instead of mourning*. (Isaiah 61:3a) Matthew 5:4 also expresses this*: Blessed are those who mourn, for they will be comforted*. St Paul knew that all too well in the difficulties that he experienced: …*the God of all consolation who consoles us in our affliction*…(2 Corinthians 1:3-4). In speaking of the coming of the Holy Spirit, the presence of Jesus among us, Jesus promises his disciples that they will not be left as orphans. (John 14:18) They need not be troubled, because they will be given a comforter. Anderson sums it up with poignant simplicity: *Learning to grieve is a lesson in faith*. We find our limits and begin to see that we are sustained by God's gracious care.

3. God is a God of resurrection, of transformation

The account in Luke's Gospel of the disciples walking along the road to Emmaus (Luke 24:13-35) demonstrates most beautifully the way the presence of Jesus to the disciples, sad and full of grief for the loss of their Lord, led to a transformation of their perception of what had happened. Their eyes were opened to see that the Lord has risen indeed, and nothing was quite the same again.

Death and loss are inevitable, it is true. Yet, when our lives are in God's hands we find that loss can become a time for growth, for transformation of ourselves, for healing. We should not try to block the pain of grief in ourselves or others. Henri Nouwen, in a *Letter of Consolation* observed that we could face our loss and grief with open minds and hearts because consolation is to be found where our wounds hurt the most. It is in that place where our wounds hurt the most that God is truly present performing his transforming work of making all things new (Revelation 21:5).

III. NORMAL GRIEF REACTIONS IN UNCOMPLICATED MOURNING

It is important for us to understand that there is a wide range of feelings and behaviours that are part of the normal grieving process. (I am not referring here to Kuebler Ross' Stages of Grief. In *A Grief Observed* (Lewis, 1961) C. S. Lewis wrote: *No one ever told me that grief felt so much like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the same yawning. I keep on swallowing*. These words were a great reassurance to me during a time of intense grief. Identifying and

naming feelings in the surge of confused and unexplained emotions, and knowing they are normal and will eventually pass, is a considerable help.

1. Feelings

Sadness, anger, guilt and self-reproach (*Couldn't I have done more*?), anxiety, loneliness, fatigue, helplessness, shock, yearning, emancipation, relief, numbness may all be present at different times and in different sequence. Sometimes people feel like they are going crazy. We can be reassured, and better reassure others, when we appreciate this.

2. The body

These sensations are often overlooked, but they play quite a role in acute grief reactions. The following sensations are not uncommon: hollowness in the stomach, tightness in the chest or throat, oversensitivity to noise and light, a sense of being disconnected from things and people, breathlessness, muscle weakness, lack of energy, dry mouth.

3. The mind

Disbelief, confusion, preoccupation, sense of presence, hallucinations are quite common, particularly in acute grief.

4. Behaviours

There may be sleep and appetite disturbances, absent-minded behaviour, social withdrawal, dreams of the deceased, the avoidance of reminders of the deceased (particularly if the relationship was ambivalent), calling out, searching, sighing, overactivity/restlessness, crying, visiting places connected with the deceased, treasuring objects.

Recognition and acknowledgement of many normal grief reactions enables us to reassure a grieving person that the strange things happening to them are normal, and that they are not going crazy. Accepting the uniqueness of each person's grief is important, and helps the bereaved person to get on with grieving. I believe it is important not to pathologise a person's behaviour during this time. This can hinder, rather than help, the grieving process.

A note about depression

Depression may be present in a grieving person, but this sort of depression does not normally involve a loss of self-esteem. It usually comes and goes. Clinical depression, on the other hand, is prolonged, and involves loss of self-esteem. It does not respond to human warmth and comfort in the way grief related depression usually does. Clinical depression may appear as a symptom of *unresolved* grief.

IV. THE TASKS OF MOURNING

In 1969 Elisabeth Kuebler Ross wrote her significant work *On Death and Dying* which deals with stages of grief in the anticipation of death as the result of a terminal illness. Kuebler

Ross' work was important in raising popular awareness that grief is a process, which has many, phases, or stages. Although she was dealing with anticipatory grief in her study, her 'stages of grief' have been applied to the grieving process (mourning) that a person goes through after a significant loss. Kuebler Ross lists the stages as Shock, Denial, Anger/Bargaining, Depression, and Acceptance.

One cannot deny the importance of Kuebler Ross work in raising awareness of the issues. One of the difficulties with it has been that people have tended to see the order of stages as fixed, rather than as a fluid, unique, multi-faceted process in which people move in and out of stages as they work towards a resolution of the grieving process. Stages also implies a certain *passivity*, rather than the concept of grief *work*, something which can be done, that has an end point. For these reasons I find Worden's (1992) concept of the *Tasks of Mourning* a useful one.

The tasks are as follows:

1. To accept the reality of the loss

Accepting the reality of the loss involves the acceptance that the person has really died (or the relationship has irretrievably broken down) and that reunion (in this life at least) is impossible. I clearly remember Dr Bruce Stevens (in Pastoral Care and Counselling lectures at St Marks National Theological Centre, Canberra) making us aware of the way in which spiritualists would sometimes prey on parents who had lost a child to offer them 'contact' with their dead child. One of the results was that parents would continue to deny that their child was really dead. A bizarre example of the denial of the reality of the loss was the case of the fatal exorcism of a woman in north-western Victoria some years ago. The deluded husband was convinced that his wife would rise from the dead within a few days.

2. To work through the pain of grief

The pain of grief is physical, emotional and spiritual. It should not be minimised; it cannot be avoided (except to reappear later in some other form). We cannot take away another's grief, nor can we truly understand another's grief. (One of the most unhelpful, yet common responses to a grieving person is to say*: I know how you feel*.) Sometimes people attempt to escape their pain by moving geographically from the place of loss. Unfortunately the pain goes with them. Dr Bruce Stevens noted in his lectures: We need to let people go crazy for a while. Sometimes Christians deny the pain of others' grief by such statements as: *He's gone to a better place* or *You can always have another baby*. Sometimes people try very hard not to feel.

3. To adjust to an environment in which the deceased is missing

The adjustment may not just be an emotional one; it may call for the development of new skills to deal with life. My mother-in-law made a wonderful adjustment to handling the complex financial dealings that her husband had undertaken with sole responsibility during their fifty years of marriage. I have seen a number of older men and women make difficult but successful adjustments in very practical matters after the death of a spouse, where role expectations had formerly been very clearly defined and separated. Sometimes spouses retreat

into a sort of helplessness, or loss of identity, which may require some outside assistance.

4. To emotionally relocate the deceased person and move on with life

This can be the most difficult of the tasks to accomplish because of (among other things) the notion that if I move on with life I will forget the dead person, and by my forgetting the dead person will somehow cease to exist even as a memory. The most important task of grieving writes Anderson (1995) is in making a memory, preparing *an emotional scrapbook*. A creative, interesting resolution of this task in a woman's life is described by narrative therapist Michael White in, *Saying Hullo Again.* (*Selected Papers*, 1989) Worden (1991) summarises this task thus: *The counsellor's task then becomes not to help the bereaved give up their relationship with the deceased, but to help them find an appropriate place for the deceased in their emotional lives – a place that will allow them to go on living effectively in the world.*

I would suggest that one of the marks of the successful resolution of mourning is the freedom to love again, to be there to serve others and to comfort others with the comfort, which we ourselves have received. (2 Corinthians 1:4-6) In a wonderful way this loving is both the end of our healing and the means. Tolstoy, the great Russian writer, expressed it this way: *Only people who are capable of loving strongly can also suffer great sorrow, but this same necessity of loving serves to counteract their grief and heals them.*

V. HELPING PEOPLE MOURN

In this section, I want to look at ways in which the pastor or pastoral counsellor (in particular) can help people mourn in a healthy way, so that the grieving process is both encouraged and facilitated.

1. The Funeral

Since time immemorial, humanity has acknowledged rites of passage by the enactment of ritual. Funeral rites of one sort or another have been practised long before the Christian minister came to have (almost) the monopoly on conducting funerals in our Western culture. In the funeral, the movement from Separation to Transition and Reincorporation is acknowledged and facilitated by ritual means.

The funeral service gives permission to mourn, and in the Christian funeral service, this mourning can take place in the context of the sure hope of the Resurrection.

What a funeral can do:

a. It can help make the fact of the loss real. (Task One) It is usually a good idea for family members to view the body before the coffin is closed. There is also something starkly real about seeing the coffin at the church or crematorium that helps to acknowledge death. Even if there is no body (loss at sea, war, or some other reason) it is generally a good idea to have some sort of service to facilitate mourning.

b. It is an opportunity to express thoughts about the deceased. Sometimes members of the congregation are invited to share their memories of the deceased during the service. Often this will allow the expression of realistic memories, in contrast to idealised ones, which sometimes happens in a more formal obituary. People can be asked to reflect in silence on their relationship with the deceased. There is also a spontaneous opportunity to share thoughts as people gather outside the church, crematorium or at the graveside.

c. It is an opportunity to give expression to the life of the person who has died. Often this will be done through a formal obituary. One powerful way to give expression to a person's life is through the use of symbols. At a funeral for a much loved and respected Catholic priest whom I knew, his Bible and other items of his life and office were laid one by one on his coffin.

d. The funeral service is an opportunity to draw together a support network for the bereaved. Family, friends, workmates, congregation members, those who have been involved in the care of the deceased may all in some way be involved in follow-up care of the bereaved.

e. For the Christian funeral, there is the added dimension that we grieve, not as those who have no hope (1 Thessalonians 4:13), but as those who share with Martha in John 11 the conviction that Jesus Christ is indeed *the resurrection and the life.*

Family members can actually be more involved in the preparations for the funeral than most people realise. For example, by arrangement with the funeral director, family members can wash and dress the body, if they so choose. Before the funeral of Dylan in Gundaroo, NSW (Canberra Times, 21 December, 1997) his father made the coffin and children from the school wrote their messages on the coffin. The funeral involved the family and the community in a special way.

Death is really the only loss that is widely ritualised through a funeral service. I would suggest that it might be helpful to prepare some sort of ritual for the ending of a marriage for those who want it. In her book, *Praying our Goodbyes* Joyce Rupp acknowledges the need for endings through loss of one sort or another to be ritualised. She offers some helpful ways for doing this. Dr Bruce Stevens offers *A Liturgy for a Person Experiencing the End of a Marriage* in his book *Regaining Intimacy* (1995)

2. Help the Bereaved Person to Actualise the Loss

A thoughtfully planned and sensitively conducted funeral can go a long way towards helping this to happen. It is also helpful to encourage the bereaved person to talk. There seems to be an almost insatiable need for someone who has sustained a significant loss to talk, to go over events surrounding the loss again and again. Each grief is unique, however, and not everybody may wish to talk. Encouragement to share memories of the deceased, both happy and sad, can help a person actualise the loss. I cannot emphasise too strongly the place of *active listening*. It is probably the greatest gift of care and presence that a person can give. It may be helpful to accompany the bereaved to view the body before the funeral if there is hesitation in the face of death. Sometimes a visit to the hospital where the person has died is helpful. Visits to the grave, over time, also reinforce that death has actually occurred.

3. Help the Bereaved Person to Identify and Express Feelings

Active listening is vital here also. As I have already noted, anger is a common emotion, though not always recognised or acknowledged. If this is the case, it may well be displaced onto the pastor, or the doctor, or the funeral director. Sometimes it is directed inward, with resultant depression, or even suicidal thoughts/behaviour. A helpful pastor/counsellor will encourage the acknowledgement of anger, with focus, so that over time there is a healthy resolution of intense feeling. Sadness, too, is normal, as are anxiety and helplessness. Guilt should also be mentioned here, as it often accompanies a death. However, reality testing will assist in removing any false guilt that may be present. Focusing on what has been lost, and the significance of these losses, will help in gaining perspective over time, and prevent a wallowing in self-pity.

A grieving person will often be overwhelmed by the intensity of emotions. As I have mentioned before, reassurance is important. However, we cannot take away a bereaved person's pain. Nor should we. A pastor/counsellor/friend has the role of paraclete, one who is called in to help, one who 'walks beside' as Jesus did on the Emmaus road. (Luke 24)

4. Assist in Living without the Deceased (or Other Loss)

Several points should be noted here:

It may be necessary to help the bereaved person with some practical decision making skills. A problem solving approach is needed in what decisions need to be made, and what considerations/options are there? Often among older people, where a spouse dies who have been the main decision maker, there is a need for such skills to be practised.

However, it is important to discourage *major* decision making too soon after a significant loss. For example, a decision to sell the family home and move away should not be made too soon.

A sensitive area in which the pastor/counsellor can play a role is finding appropriate ways to discuss a person's sexual needs and feelings, if the deceased person has been the sexual partner. In the case of loss through divorce, in particular, there may the desire to jump into another relationship too soon, because the person believes they cannot live without a sexual relationship.

Help to relocate the deceased person

Reminiscing is an important way in which this happens. It gradually divests the bereaved person of the emotional energy that has been tied up with the deceased person. It helps in finding a place for the deceased person as a memory, so that the survivor can move on and form new relationships and is integrated into the community through work or other social relationships. (Raphael, 1983) Sometimes people need to be reassured that making a memory does not mean dishonouring the dead person, nor does it mean forgetting.

Allow time to grieve and provide continuing support

The grieving process cannot be hurried. Grief takes as long as it takes. As mentioned before, each person's journey of mourning is unique. The depth of relationship, personality factors, and the nature of the loss will influence the time it takes to resolve a loss. Anniversaries and holidays can be hard times for the bereaved person. Remembering these with a phone call, a card, or a visit can be a great help. In Canberra, one of the Funeral Directors has for several years now offered an evening late in the year for bereaved people called *Coping with Christmas*. It has been of benefit to many.

Be aware of unhealthy coping (i.e. drugs) and pathology

The pastor or counsellor can be aware of the use of drugs or alcohol to mask grief. It may be necessary to refer such a person to a professional counsellor, although I believe that in many cases the Christian community is the ideal place for dealing with such difficulties. Again, I would urge that caution be exercised about pathologising people.

Be open to listen to faith issues in relation to loss and grief

Each of us has a need to find meaning in what has happened. A bereaved person will often struggle with questions of faith and meaning at such a time. A pastor, counsellor or friend who has ready answers about God's will, or going to a better place or even this must have been for a purpose will stick knives into the wounds. Rather, good active listening over time and an openness *not* to have easy answers will facilitate finding meaning eventually. Pointing people to the Psalms of Lament can be helpful for some.

Encourage a good diet and healthy lifestyle

There can be a tendency in grief to neglect to take adequate food, hydration and exercise. This can be a particular risk for people living alone.

5. Some Practical Suggestions

Some practical ideas that have proven helpful to people working through the grieving process.

Keeping a journal

For many people writing down their thoughts and feelings is most therapeutic. C.S. Lewis' *A Grief Observed*, written after the death of his wife from cancer, does just this. It also helps to chart the ups and downs, and to observe progress over time.

Writing a letter to the deceased

If death was sudden and there is unfinished business of some sort (e.g. unforgiveness) this can be most helpful. The pastor or counsellor can play a valuable role here, particularly if there are issues of confession and forgiveness to be dealt with.

Preparing a scrapbook

The preparation of a memory book is a special way in which family members can participate in a shared activity, particularly if there are children who have lost a parent or sibling through death. The exercise will give a focus for grief, as each family member will grieve differently. Photos and accounts of family events can be used in this, as well as the children's drawings.

Dealing with irrational thinking

Sometimes after a significant loss the bereaved person succumbs to such irrational thoughts as I'll never be loved again. The pastor or counsellor can help a person deal with such thoughts, although timing is important here. In the acute stage of grief, cognitive behaviour therapy is *not* appropriate.

Joining a support group

Groups such as Compassionate Friends (loss of a child), Solace (widowhood) SANDS, SIDS can be very helpful with specific losses through death. Support groups offer participants the opportunity to know they are not alone; they can identify with those who have had a similar experience. Other benefits of a support group are: emotional outlet, guidance, hope, the development of trust, helping others and an opportunity to deal with issues of meaning.

VI. GRIEF THERAPY

There are times when people fail to grieve, or to grieve appropriately. Whether grief is delayed, or becomes pathological, the resolution of the grieving process is hindered and the person is unable to get on with life in a healthy way. In such a situation, therapeutic intervention is called for; it may be an outside referral to a professional counsellor. The pastor or pastoral counsellor requires wisdom to assess whether their skills are in fact adequate for the situation.

1. Poor Resolution

Factors that may be associated with poor resolution of the grieving process. (Raphael 1983, Worden 1991 and others)

1. The particular circumstances of the death. (e.g. suicide, missing presumed dead).
1. Patterns in the pre-existing relationship with the deceased. (eg. ambivalence, overdependence).
3. The ability of the family and social networks to facilitate mourning.
4. Other crises at the time of loss. (e.g. multiple losses, the need to cope).
5. Unresolved childhood loss/bereavement.
1. Personality factors. (e.g. inability to tolerate emotional distress leading to withdrawal, difficulty tolerating dependency feelings, the need to be 'the strong one').
7. Anger against God.
8. Refusal to readjust.

2. Types of Unresolved (Pathological) Grief

Chronic grief

Chronic grief is not to be confused with anniversary reactions, which are not uncommon ten years or more after a death. Chronic grief goes on for years as unfinished; the person feels unable to get on with life. The person may have had ambivalent feelings towards the deceased (a love/hate relationship), or have been sexually abused, or have been overdependent on the deceased.

Delayed grief (postponed grief)

Something is unresolved from a previous loss. At the time of the original loss the feelings may have been so overwhelming that they were not dealt with. This is not uncommon in suicide and abortion.

Masked grief

The reactions which the person is experiencing are not recognised as relating to the loss. There is the development of non-affective symptoms, which are a substitute for the affective symptoms of grief. I have seen this particularly in older people following the death of a sibling. Sometimes the symptoms are physical, such as chest pains, particularly if the person has died of a heart attack. Sometimes the consequence is maladaptive behaviour. This is not uncommon in children. (Acting out)

Exaggerated grief reactions

The person is aware of the loss, but resorts to maladaptive behaviour, such as clinical depression, anxiety, or substance abuse.

2. The Resolution of Pathological Grief (Raphael and Worden)

Grief therapy will often be taken some years after the original loss. Different circumstances will suggest varying approaches and emphases; however, grief therapy will probably consider the following:

- The setting will usually be controlled (e.g. the pastor's office). Sometimes a therapy group will be appropriate.

- The pastor or counsellor should exclude a physical cause for the problem. If there is any doubt, a physical examination should be suggested.

- Active listening.

- Set a goal with the person.

- Explore the circumstances of the death.

- Talk about memories and the relationship. As time goes on the counsellor may need to move to *negative* experiences of the deceased, and explore *ambivalent* feelings. *Idealisation* may have occurred. A death wish, or anger, resentment and unforgiveness that are unacknowledged will leave unfinished business. Lack of affect may indicate anger at the deceased. Guilt may be an issue. It should always be reality tested. If it is real, confession and forgiveness will provide great release. It is helpful to assess at which of the Tasks of Mourning a person is stuck, then intervention appropriate to the task can be applied.

- Explore any 'linking objects'. these are not the same as mementoes. Linking objects, like children's transitional objects, are needed all the time. People cannot be without them. Somewhat akin to this is leaving a room untouched, as a 'shrine,' many years after the death.

- Explore with the person the ending of the grief. The person has been so used to being this way that it may be helpful to ask *What would you lose by giving up this grief?*

- Saying goodbye. It is important to realise that saying goodbye does not mean forgetting. Rather, it is goodbye to the wish for the deceased to be alive. The counsellor needs to be sensitive to the timing for this. I have found a symbolic ritual act to be helpful here, such as planting a rosebush in memory of a child who has been aborted.

- Acknowledge the finality of the loss.

A consideration

There is a certain awkwardness for the person dealing with delayed grief many years after the event. Affect is every bit as powerful as it would have been at the time of the loss, so sensitivity from family and friends is called for.

VII. SPECIAL AREAS OF GRIEF

There are a number of situations, which require special consideration, and some knowledge of the particular issues involved. The following is only an outline of these areas, and the pastor or counsellor will benefit from specialised reading.

1. Sudden Death (e.g. heart attack, homicide, accidental death)

There is a sense of unreality about the loss. There may be guilt feelings that will need to be

reality tested. Scapegoating may occur. If there is medical and/or legal involvement following the death, there may be a sense that there is no end in sight. Helplessness and agitation may accompany such a death. Unfinished business is common, and there may be a deep need to understand.

2. Suicide

This is also a sudden death, but a unique experience. Invariably, shame and stigma are attached to such a death, and there is often guilt, particularly if conflict preceded the death. Anger and fear are common, and may lead to self-destructive impulses. There is likely to be a sense of abandonment and, of course, many unanswered questions.

3. SIDS (Sudden Infant Death Syndrome)

There is no warning of such a death; there is no apparent cause.
The involvement of the legal system places a particular strain on the family, and often suspicion is placed on the parents. (Child abuse) Parents may grieve such a loss very differently, placing a great strain on the marriage relationship. Siblings need to be considered, as there may be guilt over the death, particularly if the new baby has been resented.

4. Miscarriage and Stillbirth

Miscarriage has been called 'the unspoken death,' although in recent years there has been a much greater awareness of the need to grieve such silent losses. In both cases, there is a sense of saying goodbye before hello has been said. Both involve the loss of a person, however tiny. Often there is self-blame, and fears about future pregnancies are common.

Stillbirth is a tragic, unexpected loss. Sometimes the parents are prevented from seeing the baby, although this happens less nowadays. It is usually important for parents to see, touch, name and photograph the baby, and be involved in arrangements for the burial. There may be intense longing – the relationship with the child goes back to the beginning of pregnancy. Sometimes marital and family difficulties follow. There are often different patterns and levels of grief in each parent.

5. Adoption

Although few babies are given up for adoption these days, there is sometimes unresolved grief in older women who have given up a child for adoption many years before. There may be sadness, doubt, ambivalence, fantasy about the child. Where there is a lack of resolution of the grief, there may be difficulties such as preoccupation with maternity, anger and disillusionment towards men and a protective attachment towards subsequent children.

6. Death of a Child

There is something 'unnatural' about the death of a child; parents expect to die first. A child is an extension of our biological and psychological past, present and future. (Past: the grandchild of a lost parent; present: proof of maturity or worth; future: our immortality. The age of the child is irrelevant. The guilt, anger and separation pain is agonising. There may be many what ifs? Milestones with peers are painful. There may be a loss of social support, because people don't know what to say. Sometimes expectations are placed on other children, or a subsequent child is expected to take the dead child's place. Often there is idealisation of the child, and comparisons made.

In providing support, speak of the child by name, and help the family *remember.*

Avoid bad theology such as *God took your child* etc., and don't tell the parents to be grateful for their other children.

7. Abortion

Grief is often denied. There may be stigma, shame and secrecy. Both guilt and ambivalence (relief and sadness) towards the baby may coexist. There may be anger towards self or those who pressed for termination. Grief may be felt when the baby would be born. There may be acting out: repeated unwanted pregnancies in an attempt to rework the experience satisfactorily. Unresolved grief and guilt for an abortion may underlie later problems, such as depression or other reactions. It can be helpful to provide an opportunity for confession and forgiveness, and give permission to grieve.

8. AIDS

This is an area we will need to face more and more, as deaths from AIDS increase. In such deaths, there is often guilt, stigma, and the loss of family and social support for survivors. Death from AIDS is invariably untimely death, and people often suffer multiple losses. There is likely to be anticipatory grief as the survivors face the loss of a person well before the death occurs. Bryce Courtney's book *April Fool's Day*, which deals with the life and death of his haemophiliac son, is a powerful compassionate account that I would recommend.

9. Anticipatory Grief

Both the dying person and family members begin to grieve in the face of terminal illness. Denial and reality may alternate, even in the face of visual evidence. There may be emotional withdrawal by the carer(s), or smothering over involvement leading to exhaustion. Survivors' sense of their own mortality is heightened. The time leading to death can become a time for growth, as families deal with unfinished business: practical, emotional and spiritual. There is a difference for the dying person and the survivors: the survivor is losing only one relationship, whereas the dying person is losing many.

9. Divorce

Divorce can be one of the most painful losses. Some have described it as a loss worse than death. Yet there is no funeral, and no ritual ending for a broken marriage. The grieving process even in emotionally reasonable healthy people may take from 2-4 years. Separation and divorce often bring roller coaster emotions, even in the person who has made the decision to leave. Disillusionment, despair, anger, self-blame, despondency, elation, rejection may all occur. Many people describe the loss of a dream and a vision for the future. Grief work may be difficult and painful, but necessary. Sometimes people want to jump into a new relationship too soon. The support system of the extended family is very important, but often the first reactions may not be helpful. Don't forget that grandparents grieve too. It is important that both parents work at healthy grieving, so that they can help their children.

11. Infertility

In Australia, one in ten couples of childbearing age have infertility problems. Infertility can be a major life crisis, yet the wounds cannot be seen. There is a paradox about this loss, because there is no one to mourn. Infertility occurs as primary infertility, where the woman is unable to conceive; as secondary infertility, where one child is born, then the woman is unable to conceive again; and repeated miscarriages, where a woman is unable to carry a baby to live birth. Infertility calls forth a particular type of grief, because grief and hope occur *together*, making it difficult to come to a resolution of the grief. Depression and anger are often present. A common perception is that people get what they deserve (i.e. the myth of a just world) and infertility is seen as a punishment. Many emotional issues need to be worked through for the couple relationship to survive and be healthy. They may blame one another. There may be guilt, if one party is infertile due to a prior abortion, or a sexually transmitted disease. For the woman her self-esteem and self-concept are often linked to motherhood, while the man's self-image may be threatened, because he does not have a 'son and heir.' For both, children may reflect important aspects of themselves. The whole issue is complex as with medical advances there are moral, ethical and emotional issues, not to mention the costs involved.

VIII. GRIEF AND THE FAMILY SYSTEM (Worden and others)

As most significant losses occur within the context of the family unit, it is helpful to consider the impact of the loss on the family system. It is not sufficient to treat each individual in relation to the deceased; rather, each individual's grief needs to be related to the functioning of the family system as a whole. Each death in the family leaves a gap and brings the whole family system out of balance for a time.

The successful resolution of the family's grief allows a family to establish a new family with new boundaries, from the old.

Some Considerations

1. How well does the family express and tolerate feelings? Families have rules about the expression of feelings. Those that cope best are open to discussion about the deceased, and able to process feelings about the death, including feelings of vulnerability. The members of these families help each other to cope. Families where openly expressed feelings are not tolerated may express their members' grief as acting out behaviour.

2. Unresolved grief may serve as a key factor in pathological relationships over generations. A three-generation genogram will help to bring these issues out into the open.

3. What is the functional position or role the deceased played in the family? If the deceased had a significant position (e.g. sickly one, value setter, scapegoat, nurturer, patriarchal clan head) there will be considerable disequilibrium. Sometimes another family member will be sought to fill the vacancy.

Children's Grief

Some points to bear in mind:

1. Children do mourn, but differences are determined by the cognitive and emotional development of the child.

2. Children between five and seven are particularly vulnerable. They have some understanding of the permanent ramifications of death, but little coping capacity.

3. The work of mourning may not end in quite the same way for a child as for an adult. Mourning may be activated and the grief reworked as the child matures through adolescence and adulthood, particularly at important life events. This is quite normal.

Note: An excellent practical resource on children's grief can be found on the Internet: www.parenting.sa.gov.au.

Grief and the Elderly

With increasing numbers of people living into their seventies and eighties in our population, there are a growing number of elderly people who have experienced bereavement.

Some considerations:

1. Interdependence

In lengthy marriages, many spouses have been highly dependent upon one another. This may make for a more difficult adjustment after the loss.

2. Multiple losses

Not only does the number of losses through death increase, there are many other losses that the ageing person may experience (e.g. loss of health, move into hostel or nursing home, loss of

familiar community etc.). It is possible to be so overwhelmed by the many losses that grieving is not done adequately. A further complication is the absence of hope in a future for the very old. Younger people usually cope better with grief because they can look to a future in which to start over.

3. Personal death awareness

A heightened sense of the elderly person's own mortality may cause some existential anxiety. A pastor, counsellor or friend needs to be comfortable discussing this.

4. Loneliness

Many bereaved elderly persons live alone.

5. Touch

Many of the elderly living alone after the death of a spouse have a strong need to be touched. The pastor, counsellor or friend who is comfortable with using therapeutic touch can use this in an appropriate way.

6. Reminiscence

This is a helpful intervention technique, also called life review. It can help a bereaved person bring up unresolved conflicts, and to integrate all of their life's experiences.

7. Discussing relocation

The pastor, counsellor or friend can help the elderly person decide whether to move from their home. However, this decision should not be made too soon after the death, provided the bereaved person is able to care for herself. Do not, however, underestimate the importance of the home. Increasingly our communities are providing services that assist the elderly to stay in their own home.

IX. RESOURCES ON GRIEF

General books on Grief

Alexander, Helen. *The Experience of Bereavement*. Lion, 1993.

Bright, Ruth. *Grieving. A Handbook for Those Who Care*. MMB, St Louis, 1986.

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Raphael, Beverley. *The Anatomy of Bereavement*. Basic Books, New York, 1983.

Westberg, Grainger. *Good Grief*. Church Education Press, Melbourne, 1966.

Worden, J. William. *Grief Counseling and Grief Therapy*. Routledge, London, 1991.

Books on Special Areas to offer Grieving People

Arnott, Paul. *No time to say Goodbye*. Albatross Books, Sutherland, 1992. (Death of a child)

Chilstrom, Corinne. *Andrew, you died too soon*. Augsburg, 1993. (Death of a child by suicide)

Giulano, Barbara (Ed.). *Survival and Beyond. An Anthology of Stories by Victims of Crime.* Available from NALAG, ACT. (02) 6260 5442

Helm, John. *Through the Valley. Encouragement for those nearing life's end.* Openbook Publishers, Adelaide. (Anticipatory grieving)

Helm, John. *Beyond Grief.* Openbook Publishers, Adelaide.

Hickman, Martha. *I will not leave you desolate. Some thoughts for grieving parents*. Abingdon, 1982. (Death of a child)

Lewis, C. S. *A Grief Observed*. Faber and Faber, London and Boston, 1961. (Lewis' diary written after the death of his wife from cancer)

Nicol, Margaret. *Loss of a Baby. Understanding Maternal Grief.* Bantam Books, Sydney, 1990. (Stillbirth, neonatal death, cot death, handicap, miscarriage, adoption/termination, infertility.)

Riols, Noreen. *My Unknown Child. A personal story of abortion*. Hodder and Stoughton, 1986.

Rupp, Joyce. *Praying our Goodbyes*. Ave Maria Press, Notre Dame, Indiana, 1988. (Ideas for ways to find closure for losses other than death)

Stevens, Dr Bruce. *Regaining Intimacy. Dealing with the pain of a broken relationship*. Random House, 1995. (Help for working through the tasks of mourning after a broken

relationship)

For Children 8-12 and their Parents

Coleman, William. *When Someone you Love Dies*. Augsburg, 1994.

For Young Children

Warland, Jane. *Our Baby Died*. JBCE, 1994. (A picture storybook written by a mother from the point of view of a child whose baby sister died.)

An Excellent Christian Resource for a Bereavement Support Group

Smith, Harold Ivan. *Death and Grief. Healing through Group Support*. Intersections Small Group Series. Augsburg Fortress, Minneapolis, 1995. (Available through the Open Book)

4. Soul Therapy

Introduction

The Lord God formed man of the dust of the ground, and breathed into his nostrils the breath of life; and man became a living soul (Genesis 2:7).

As her soul was departing (for she died)... (Genesis 35:18).

Why are you cast down, O my soul? And why are you disquieted within me? (Psalm 42:5,11, 43:5).

And Mary said: 'My soul magnifies the Lord, and my spirit has rejoiced in God my Saviour (Luke 1:46,47).

For what will it profit them if they gain the whole world, and forfeit their life? Indeed, what can they give in return for their life? (Mark 8:36,37 NRSV).

My soul is exceedingly sorrowful even to death (Matthew 26:38).

I gather the flowers by the wayside, by the brooks and in the meadows, and only the string with which I bind them together is my own (Montaigne).

Soul therapy, also known as soul care, has become a current fashion in seminaries, bookshops, and counselling conferences. Expressions such as shapers of the soul, nourishing the soul, balm for the soul, soulfulness, soul work and windows of the soul are appearing. Much of this is attributable to the publication of Thomas Moore, *Care of the Soul* in 1992.[70] This fits in with the increasingly popular New Age - post-modern world view. Moore believes in a kind of pantheism and psychological polytheism, a view that the human personality, or soul, is divided into many character traits or gods. There is no recognition of the God of the Bible nor of the need of the Bible.

Christians could dismiss all this as another fad or New Age craze, but soul is a biblical term that was used by Jesus, and worthy of close examination.[71] Christian soul care is the core of what Christian counsellors are called to do.[72] Soul therapy, or soul care, therefore simply includes the whole range of Christian counselling.

The theme for the American Association of Christian Counsellors national convention at Nashville in 1999, attended by 3200 Christian counsellors, was the soul and it is commonly referred to as the *Soul Conference.*

The word soul, like the word spiritual, is gaining popular currency. This is good as at least people are thinking about that dimension of humanity. It also gives the Christian excellent opportunities to discuss spiritual issues and present the gospel of Jesus Christ.

Definition

Many different and confusing definitions of soul are being submitted. The soul is not something that is tangible and easily defined. It refers to something like life or the whole person. We can see its evidence but it cannot be weighed, seen on a computer screen or chemically analysed. However, despite its many connotations, the word soul has two distinct meanings in the Bible. It refers to one's life (including the body), and one's personality (the immaterial abiding inner self). Soul could be said to be the hidden person of the heart (1 Peter 3:4). Your soul is the real "you." You don't have one, you are one. The soul is made up of the many mysterious aspects that go together to make up identity. It involves the infinite depths of a person's being. Soul is not mind, logic or ego. It has to do with being rather than doing. It is connected with the unconscious.

Soul in this context is different to the generally accepted definition which states it includes the mind, will and emotions.

Soul Therapy

It must always be kept in mind that true soul care is found in turning away from self and entrusting the soul to the grace of God shown in the life, death, resurrection and ascension of Jesus Christ. He is the one who gives rest to our souls (Matthew 11:28-30). The Holy Spirit is also closely linked with our soul. The sensitivity of the dove would indicate this. The Holy Spirit is the means to assist us in the realm of our soul.

Soul therapy, or becoming soulful, means getting in touch with our inner life, apart from what is merely head. It will necessitate slowing down to get to those inner depths. It is getting out of the head world into the soul world. It is more difficult for males. It is achieving and functioning from a state of inner spiritual grace, so, as there is a oneness between the outer and inner man.

As persons become more in touch with their soul, the shaming voices from the past become subdued and have less control over the person.[73]

It is really getting in touch with the feminine in us. Leanne Payne addresses this question well, commenting that the feminine symbolises responsiveness, creativeness, surrender, and power in her love and feminine virtue to *civilise the male*. Many men have lost the feminine, which is the capacity to 'know' (be impregnated or penetrated) by meaning at all. The result she comments is a *flight from women, the flight that has resulted in a Western world filled with unaffirmed men and women*.[74] Healing of the masculine soul must mean attending to these issues. It is ultimately found at the Cross in the contemplation of the perfect manhood of Jesus.[75]

It will also mean engaging the real self, and discarding the false self, which the ego erects.

Soulwork will also involve experiencing the deeper spiritual life through spiritual reading, meditation, moving closer to God and deeper in our relationship with Him. The writings of the

mystics help in this regard (for example, Mme Guyon - *Experiencing the Depths of Jesus Christ* and Brother Lawrence - *Practising the Presence of God*.)

Soul therapy has to do particularly with the experiential side of therapy. It is entirely apart from the cognitive approach. It is therefore not the full picture. The mind, and living by faith, are very important in the Christian walk, and are to be in no way minimised in the emphasis on soul.

Soul therapy, or becoming more soulful, will mean an increased interest in such things as:

- The reality of the Holy Spirit.
- The deeper spiritual life.
- Reflection.
- Intimacy.
- Sensitivity.
- Deeper appreciation of the beauty and detail of creation.
- Passion.
- Poetry.
- Metaphor.
- Stories.
- Music.
- Art.
- Imagination.
- Dreaming and paying more attention to dreams.
- Longings.
- Depth of feelings, such as grieving.
- Meditation.
- Tranquillity.
- Gentleness.
- Deep peace within.
- Acceptance of human frailty.
- Acceptance of disturbed feelings.
- Deepening relationships.
- Transcendence.
- Praise and worship.
- Creativity.
- Shades of colour, texture, etc.
- Nostalgia.

Recommended Reading

Albers, Gregg R. 1988. *Counselling the Sick and Terminally Ill.* Dallas: Word.

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Friedman, M and Rosenman, R. 1974. *Type A: Behaviour and Your Heart.* New York: Knopf.

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Hawkins, Don. 1996. *Overworked: Successfully Managing Stress in the Workplace.* Chicago: Moody.

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Kubler-Ross, Elisabeth. 1970 *On Death and Dying.* London: Tavistock.

LaHaye, Tim. 1983. *How to Manage Pressure before Pressure Manages You.* Grand Rapids: Zondervan.

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Worden, William. 1996. *Children and Grief.* New York: Routledge.

Wright, Norman. 1991. *Recovering from the Losses of Life.* Tarrytown, NY: Flemming H Revell.

APPENDIX – Sample Handouts

Some sample handouts, which the authors use in therapy, are included here. **These may be copied and used by students as long as their source is acknowledged.**

- Initial history sheet (Confidential basic information).
- Therapy agreement.
- Father God.
- Assertiveness.
- Five levels of communication.
- Active listening.
- Ground Rules of communication and conflict resolution.
- Feeling word list.
- Seven great truths of Christian identity.
- Self-acceptance.
- PO Chart.
- List of irrational thinking.
- Marriage false beliefs.
- Basic needs of husband and wife.
- Four components of a relationship.
- Family Chronology
- How to forgive.
- Resentment/Forgiveness List.
- Trauma List.
- Guilt List.
- Perfectionism and excellence.
- Revitalising marriage.
- Consequences of divorce on children.
- Occult list.
- Abuse Questionnaire.
- Anger self-assessment.
- Alcohol self-assessment.
- Codependency self-assessment.
- Obsession self-assessment.
- Compulsion self-assessment.
- Food Addiction self-assessment.
- Sexual Addiction self-assessment.
- Sexual Addiction Screening Test (SAST).
- Stress self-assessment.
- Compulsive Gambling self-assessment.
- Workaholism self-assessment.
- Religious Addiction self-assessment.
- Money Addiction self-assessment.
- Shopaholism self-assessment.
- Internet Addiction self-assessment.
- Exercise/Sport Addiction self-assessment.
- Power Addiction self-assessment.

- Thrill-Seeking Addiction self-assessment.
- Client therapy feedback assessment.

CONFIDENTIAL BASIC INFORMATION

(Block letters please)

DATE_____

NAME (Mr, Mrs, Ms, Miss,)_____
(Couples please fill in separate information forms)

ADDRESS_____

PHONE: HOME_____**BUSINESS**_____

YEAR OF BIRTH_____

OCCUPATION_____

EMPLOYED BY_____

MARITAL STATUS (Circle): ***SINGLE, DE FACTO, MARRIED, SEPARATED, DIVORCED***

RELIGIOUS AFFILIATION_____

HAVE YOU HAD PREVIOUS COUNSELLING? (Circle) ***YES / NO***

IF YES, WHAT FOR?_____

ARE YOU UNDER CURRENT MEDICAL TREATMENT?_____

ARE YOU TAKING ANY MEDICINES, DRUGS?_____

WHO REFERRED YOU TO THIS PRACTICE?_____

WHAT IS THE MAIN PROBLEM THAT BRINGS YOU HERE?

_____

THERAPY AGREEMENT

I understand that my therapist will help me to understand myself, assist me in clarifying my problems, goals and objectives, and help me look at alternative solutions to my problems. This will involve homework, which I am prepared to commit myself to, as requested. I further understand that I am fully responsible for the decisions I make concerning my life and behaviour.

I understand that the model of therapy used looks at the past and the present. It considers my family of origin, feelings, thought patterns and communication skills, all having in view personal and family restoration to wholeness. It is designed to help me focus on achieving optimum health, encouraging me to seek and find an enriching and fulfilling life.

I understand that I am personally responsible to pay for all therapy provided for me and my minor children (if applicable) at the time of the service. I also understand that arrangements with insurance companies, employers and the like for reimbursement of fees is my responsibility.

SIGNATURE_____

DATE_____

FATHERHOOD OF GOD

GOD IS A PERFECT FATHER who:

Has taken me into his family – I'm a child of God
Loves me unconditionally
Non-judgementally accepts me
Gives me:

- **Forgiveness of sins**
- **Eternal life**
- **The Comforter (the Holy Spirit)**
- **All good gifts (wisdom)**
- **Every spiritual blessing**
- **Whatever I ask in Jesus' name**

Wants my company and to be known by me
Wants to speak to me and guide me
Wants to affirm and encourage me
Cares and provides for me
Protects me
Wants to set me free from worry
Heal me through Christ
Lovingly disciplines me so I can be more fruitful.

N. B. Litchfield

MY FATHER GOD

He is supreme in authority, dazzling in his beauty, flawless in his character, ingenious in his creativity, calmness in his existence, he is the most exciting person in the universe, unswerving in his faithfulness, matchless in his grace, blazing in his glory, unparalleled in his greatness, awesome in his holiness, incomprehensible in his humility, the author of humour, the ultimate in intensity, absolute in his justice, infinite in his knowledge and wisdom, unfathomable in his love, the fountain of life, unending in his mercy, has totality of ownership, limitless in his power, fascinating in his personality, majestic in his splendour, unquestionable in his sovereignty, indescribable in his tenderness, the personification of truth, unsearchable in understanding, terrible in his wrath, he has an eternal indestructible kingdom, he is the ruling reigning monarch of the universe, he is King God, the lover of my soul, the one who has totally captivated me, the only one who can totally fulfil me, and has ruined me for the ordinary.

Joy Dawson

ASSERTIVENESS

FOUR BEHAVIOUR PATTERNS

1. **Passive - a doormat - letting others ride over your Feelings.**

2. **Aggressive - lashing out verbally or physically.**

2. **Passive-aggressive - outwardly passive but inwardly aggressive - getting back at the other person by indirect devious means (eg. being difficult, procrastinating, etc.).**

4. **Assertive - the right and honest behaviour pattern.**

BECOMING ASSERTIVE

- **Being honest about your feelings.**
- **Stating opinions firmly and expressing feelings appropriately, particularly when not previously heard.**
- **Getting free of people-pleasing.**
- **Setting boundaries, and not letting others invade them.**
- **Saying "no" and "yes" when necessary.**
- **Setting time limits on events that are not mutually enjoyed.**
- **Requesting legitimate favours.**
- **Addressing problems in the open.**
- **Asking questions when confused.**

N. B. Litchfield

THE FIVE LEVELS OF COMMUNICATION

1. CLICHE

Eg. "It's a nice day" - very superficial but necessary.

2. FACTS AND INFORMATION

Very safe, as it is talking about something else other than oneself.

3. OPINIONS AND IDEAS

Goes a little deeper but communicates thoughts not feelings.

These three are all cognitive: we must get below the line!

---

4. FEELINGS

This is where intimacy and meaningful communication really begins.

5. PEAK EXPERIENCE

This is sharing the real me in openness and transparency. There is no holding back whatever the risk. While it is impossible to be on this level constantly, the more one gets to it the richer the relationship will be.

COMMUNICATION AND CONFLICT RESOLUTION

GROUND RULES

Right timing
Active listening
Share on deep feeling level (Assertiveness)
No interruptions except for clarification
Equal time to each for sharing
No stomping out in anger
No withdrawing in silence
Use "I" not "you" or "we" statements
No global statements (always, never)
Keep in the here and now
No quick advice
No jumping conclusions
No quick judgements
No judging motives
Be patient and quick to forgive.

ADDITIONAL FOR CONFLICT RESOLUTION

Define the problem
How do each contribute to the problem?
Brainstorm
Agree on one solution to try and persist
Discuss progress
Affirm each other.

COMMUNICATION EXERCISE

Select weekly mutually acceptable time of 90 mins.
Agree to a short agenda two days beforehand
Read Ground Rules first and check each other if violated
Do this for twelve weeks running.

N. B. Litchfield

ACTIVE LISTENING

The most important communication skill is active (or reflective, responsive) listening. This means fully hearing the other person out and reflecting back to them what you think you have heard. It is not easy.

Active listening is the clear demonstration to the other person of **unconditional love** and **non-judgemental acceptance.** It involves attending, respect and empathy.

ATTENDING (Warmth, Non-verbal communication)

- Facial expression
- No distracting mannerisms
- Grunts and nods
- Reassuring appropriate touch
- Tone of voice
- SOLER acronym:
  - S - Squarely seated facing the other person, about one and a half metres apart
  - O - Open posture (arms not folded)
  - L - Lean forward (a little)
  - E - Eye contact
  - R - Relaxed posture.

RESPECT

- Treat the other person as an equal
- Respect his/her views even if you don't agree
- No quick advice
- Stay on the topic

EMPATHY

Empathy is accurately perceiving the content and FEELINGS of what the other person is saying and reflecting it back to them in your own words. This is done by summarising content and paraphrasing feelings. Feelings must be validated.
(It is standing in the other person's shoes and trying to understand why they think and feel the way they do)

Typical **empathy responses** that can be made after the other person has shared are:

If I hear you correctly you are saying...and you feel...Am I correct?
It sounds as though you feel...because of...Is that right?
From your point of view, you think...and you feel...Have I got it right?
Excuse me interrupting, I want to make sure I am hearing you correctly...

When the person sharing feels they have been properly heard and their feelings validated, then the roles are reversed. Therefore, the communication goes from one to the other until resolution.

N. B. Litchfield

FEELING WORD LIST

HAPPY / COMFORTABLE
Airy, blissful, bright, bubbly, buoyant, charmed, cheerful, cheery, ecstatic, elated, enchanted, expectant, free, giddy, glad, delighted, happy, hilarious, jolly, jovial, joyful, jubilant, 1ight, 1ight-hearted, merry, overjoyed, amused, jolly, pleased, thankful, grateful, sparkling, surprised, thri11ed, enthusiastic, gay, content, peaceful, warm.

UNEASY
Awkward, baffled, embarrassed, frustrated, nauseated, out-of-sorts, restless, edgy, wound-up, trepidation, unsettled, cautious, apprehensive, cynical, disturbed, discomfort, restless, anxious.

ANGRY
Annoyed, boiling, cantankerous, enraged, frustrated, furious, infuriated, antagonistic, grouchy, grumpy, irritated, peeved, provoked, repulsed, incensed, repulsed, dislike, bitter, resentful, enmity, abhor, seething, sulky, touchy, furious, indignant, upset, hurt.

SECURE / CONFIDENT
Adventurous, at ease, at home, attracted, bold, calm, comforted, confident, cool, courageous, brave, composed, dashing, determined, easygoing, fearless, free-and-easy, heroic, loose, pleased, poised, relaxed, secure, snug, spontaneous, strong, unbridled, unhindered, unrestrained, venturous, zealous, optimistic.

UNHAPPY / UNCOMFORTABLE
Aching, agonised, cheerless, cold, crushed, hurt, dark, dejected, depressed, despondent, disconcerted, dismal, disillusioned, distressed, disappointed, dissatisfied, dejected, disconsolate, dismal, down, down in the dumps, down in the mouth, downcast, downhearted, frowny, forlorn, gloomy, glum, grief-stricken, grieved, heartbroken, heavy, heavy-hearted, joyless, lonely, long-faced, pessimistic, dreadful, mournful, miserable, cynical, murky, pained, sad, sullen, amazed, unhappy, weepy, shocked, indignant, annoyed, alarmed, bewildered.

AFRAID
Alarmed, anxious, apprehensive, fearful, frightened, scared, petrified, frozen, bewildered, boxed-in, butterflies-in-the-stomach, coming unglued, confused, distressed, fearful, frightened, terrified, embarrassed, guarded, hard-pressed, horrified, horror-stricken, jittery, locked-in, nervous, overwhelmed, panic stricken, panicky, paralysed, queasy, quivery, shaky, shocked, squeamish, tense, tight-in-the-neck, timid, threatened, trembly, uptight, worried, mixed-up, hopeless.

AFFECTIONATE
Amorous, cosy, cuddly, grateful, loving, moved, passionate, ardour, drawn towards, attracted to, benevolent, dote, enchanted, fond, infatuated, romantic, sensitive, sexy, tender, touched, warm, friendly.

LOW ENERGY
Bashful, beat, down, done-out, flaked out, drained, bushed, cool, dull, exhausted, feeble, indifferent, listless, lukewarm, pensive, shy, tired, unlively, washed-out, waterlogged, weak, apathetic, passive, negative, slothful, lazy, resigned, fatigued, weary, disconsolate, bored, slack, forlorn, lonely, dejected, isolated.

HIGH ENERGY
Alert, all alive, attentive, awake, eager, energetic, enthusiastic, excited, elated, exhilarated, exuberant, fidgety, frisky, lively, peppy, playful, refreshed, rejuvenated, revived, spirited, spry, talkative, vibrant, vivacious, optimistic, positive, hyperactive.

N. B.Litchfield

NAME_____

1. I AM CREATED IN GOD'S IMAGE (Genesis l:26,28)

2. I AM LOVED BY GOD UNCONDITIONALLY FOR WHO I AM (John 3:16, Romans 5:8)

3. I AM PRECIOUS, I AM PRICELESS
I am saved by the precious blood of Christ (Psalm 49:7,8, 1 Peter 1:8)

4. I AM A SAINT OF GOD
I am justified (Romans 5:I),
I am sanctified (Hebrews 10:10, 1 Corinthians 1:2, 6:11)

5. I AM A PRINCE (PRINCESS) IN GOD'S KINGDOM
(Psalm 113:7,8, 1 Peter 2:9)

6. I AM A CHILD OF GOD
I belong to God's family and household, (John 1:12, Ephesians 1:l -7)

7. I AM A SON OF GOD
Adopted into his eternal family (Galatians 3:26, Ephesians l:3,5)

LORD, I BELIEVE YOU

SIGNED_____DATE_____

N. B. Litchfield

SELF - ACCEPTANCE

- **All have both depravity and dignity.**
- **God planned us before birth.**
- **God has not finished making us yet.**
- **Outward beauty is not related to inward beauty.**
- **God's plan for us is conformity to Christ.**
- **We are all different and unique.**
- **Accept unchangeable features.**
- **Avoid odious and carnal comparisons.**

THE TEN UNCHANGEABLES

- **Parents.**
- **Gender.**
- **Birth order.**
- **Siblings.**
- **Physical features.**
- **Mental capacity and temperament.**
- **Race.**
- **Time in history.**
- **Ageing.**
- **Death.**

Accept them and thank God for them

BUILDING SELF-ACCEPTANCE

- **Correct defects if possible.**
- **Resort to the prayer of faith for incurable sickness.**
- **Glory in unchangeable defects, attach new meaning to them, use it as a motivation to build inward character.**
- **Confess ungratefulness.**
- **Thank God for all the positive things about you.**

N. B. Litchfield

PO CHART

THE EVENT

ACKNOWLEDGE THE OLD

- Painful feelings

- Inappropriate actions

- Old belief/thoughts

DISPUTE OLD BELIEF

(If three are answered in the negative it is irrational)

- Is it fact? (reality, truth) Yes/No Why?

- Is it nurturing me? Yes/No Why?

- Is it helping me meet my goals? Yes/No Why?

- Is it helping me in my interpersonal relationships? Yes/No Why?

ACKNOWLEDGE RENEWED BELIEF

- Reality, truth

PUT OFF THE OLD

PUT ON THE NEW

- Right beliefs/thoughts

- Right behaviour

- Right feelings

N. B. Litchfield

IRRATIONAL THINKING

THREE COMMON FALSE BEL/EFS

1. **I must do well at all times.**
2. **You have to treat me well and kindly.**
3. **Conditions must be exactly the way I want them to be.**

THE DIRTY DOZEN **(Guaranteed to make your life miserable)**

1. **I must be loved and approved by all significant others.**
2. **Everyone should think the way I do.**
3. **I should never make mistakes or fail.**
4. **I should never let anyone down.**
5. **My life must be conflict free (especially with those closest).**
6. **I must be accepted by others.**
7. **My life should a/ways be happy.**
8. **Everyone needs to understand me.**
9. **Everyone needs to agree with me, especially those who love me.**
10. **I need to perform to be loved.**
11. **No one can dislike (or hate) me.**
12. **I can't change the way I am.**

These false beliefs can be summarised in the following equation:

MY SELF-WORTH = MY PERFORMANCE + 0THER PEOPLE'S 0PINIONS 0F ME

N. B. Litchfield

CHANGING MARITAL FALSE BELIEFS

FALSE BELIEF	TRUTH
It's really awful having a husband like Bob.	***Bob is my God-given husband and although I would prefer him to act differently, I can live with him without making continued demands that only go unmet.***
It's impossible to be happy with Bob as he is.	***It would be nice if he would change, but it is not essential for my personal happiness.***
I can't stand it any longer.	***I can live a satisfactory and happy life even if Bob doesn't treat me, as I want him to. My life can be fulfilling and enjoyable even if he never changes.***
I'm wasting my life living with Bob.	***I'm not wasting my life. I'm believing in God to work in Bob's heart to make him the person he wants him to be. I also believe God is working in my heart.***

N.B. Litchfield

BASIC NEEDS OF HUSBAND AND WIFE

HER GREATEST NEEDS

(In order of importance)

Affection (non-sexual)
Conversation
Honesty and openness
Financial support
Family commitment

HIS GREATEST NEEDS

(In order of importance)

Sexual fulfilment
Recreational companionship
An attractive spouse
Domestic support
Admiration

Willard Harley, Jr.

RELATIONSHIPS

THE FOUR COMPONENTS

LOVE - The most enduring.
(includes care, commitment, kindness, affection, service, generosity, compassion).

TRUST - The most fragile, and once damaged takes a long while to rebuild (includes confidence, loyalty, honesty, faithfulness, reliability, consistency).

RESPECT - The most neglected.
(includes honour, regard, recognition, acknowledgement of a person's worth).

INTIMACY (UNDERSTANDING) – The longest to build.
(includes knowledge, empathy, listening, openness, sharing of feelings, self-disclosure, insight, no secrets).

Tom Marshall

FORGIVENESS

WHY DO WE NEED TO FORGIVE?

Jesus said so (Matt.6:12,14,15, Eph.4:32, Co1.3:13).
Because God has forgiven us (Eph.4:32, Col.3:13).
So as God can forgive us (Matt.6:14,15).
So that we do not torment ourselves (Matt.18:34-35).
To release the other person (Matt. 18:34-35).
It is the only answer to resentment, bitterness and hatred - and helps with anger.
It is the key to our inner healing.

HOW TO FORGIVE

1. **Ask God to reveal areas where we need to forgive. Make a list. Be specific and thorough.**

2. **Go down the list, name the person and the hurt, and how it affected you, and pray genuinely, *Father, I forgive. ……..... for ...…….....***

3. **Confess resentment, bitterness, greed and unforgiveness.**

4. **Hand the hurt over to the Lord and receive his comfort (Is.53:4, Matt. ll:28).**

5. **Ask for his grace to work through the process, bringing the emotions into accord with the choice made, so it is from the heart (Matt.18:35).**

6. **Keep speaking out the forgiveness.**

7. **Expect nothing in return.**

8. **Do not insist on them changing.**

9. **Act out forgiveness (Matt.5:38-48, Rom.12:14-21).**

I0. **Bless them and pray for their prosperity.**

11. **Release the person from saying *I'm sorry*.**

12. **Overcome evil with good.**

(The last six indicate heart forgiveness)

N. B. Litchfield

FAMILY CHRONOLOGY

(OF JONES FAMILY)

1900 Grandfather Jones came to Sydney from Denmark to live.
1903 Grandfather Jones married Elizabeth from Sydney, and settled in Newcastle.
1922 Father was born following a very difficult birth. Elizabeth nearly died.
1925 Mother was born in Adelaide (youngest of five children) into a poor struggling family.
1930 Father's family of three moved to Townsville.
1931 Father nearly died from pneumonia.
1934 Father sent to boarding school in Brisbane.
1937 Father expelled from boarding school, causing major upset in family.
1938 Mother's family developed a successful boating business in Townsville.
1940 Father joined the army and went to Egypt – suffered serious war injuries.
1943 Uncle Bill shot down over Bremen in a Lancaster, causing major upset in the family.
1946 Father married mother and lived in Adelaide. Marriage was very difficult due to his war injuries and other reasons.
1947 I (Tom) was born into a family with a difficult marriage.
1948 Family moved to Alice Springs. Being cut-off from the extended family produced additional tensions.
1949 Joan, the third child, was born with Down's Syndrome.
1953 Uncle Arthur admitted to mental hospital with chronic alcoholism, where he remained for the rest of his life..
1956 Dad had an affair, which lasted 18 months. Mom separated from him for a year, and took the four children with her.
1957 Mum and family returned to dad but problems in the marriage continued.
1960 I was sent to boarding school in Adelaide, where I stayed for five years.
1966 I went to university and completed an engineering degree.
1972 I married Susan and settled in Adelaide.
1976 Our second child died at childbirth.
1977 Dad was admitted to a recovery centre for alcoholism.
1978 Dad died at 56 years of age from the effects of the war, stress and alcohol.
1979 Mom had a nervous breakdown, and was admitted to hospital with depression.
1980 I developed social phobia, which produced serious tensions in our marriage.
1984 I began psychotherapy and my wife and I commenced marriage therapy.

N. B. Litchfield

TRAUMA LIST

AGE	TRAUMA
5	**The first day at school was very painful. I remember leaving my mother and crying most of the day.**
6	**At school, my teacher made me stand in the corner for the whole afternoon.**
8	**My teacher ridiculed and embarrassed me in front of the class.**
9	**A bully at school hit me and made my nose bleed.**
12	**My family moved to Bathurst and I had to start a new school and make new friends.**
13	**My dad belted me severely with a stick and I was badly bruised for two weeks.**
14	**My dad belted me again with a stick and was again bruised.**
17	**I left home and stayed at a friend's home because I couldn't take any more of the abusive language of my dad**
19	**I got sacked from work, which shocked me as I thought I was doing a good job.**
20	**My girlfriend left me for another boy after a 12-month relationship.**
24	**My father refused to come to my wedding.**
26	**My wife and I had a nasty argument over finances, and she threatened to leave me.**
27	**My wife separated from me for six months.**
29	**We (my wife and I) had a big argument, again over finances, which I thought was very unfair.**
30	**My wife left a second time and proceeded with property settlement and divorce.**

N. B. Litchfield

RESENTMENT/FORGIVENESS LIST

THE HURT	THOUGHTS/FEELINGS	DATE FORGIVEN
Dad called me stupid in front of two of my friends when I was 9.	**I wanted to disappear and die. and die. I felt so humiliated. I thought I was worthless. I was angry with him for being so insensitive towards me in front of my close friends. They were also very embarrassed. I felt I couldn't invite my friends home again. . My dad was often insensitive like that.**	**3/5/00**
My uncle trapped me in a corner on Christmas when I was 12 and rubbed me between the legs and kissed me on the lips.	**I felt so dirty and ashamed. I also felt guilty because I let him do it, and even liked it. I knew it was wrong, but was unable to do anything about it. I couldn't tell my mum. I've had problems with my sexuality ever since, and wonder whether I will ever become "normal." I feel everything to do with sex is unclean. In my marriage, I find no real satisfaction in having sex. I felt I could never trust my uncle and other older people again.**	**10/5/00**
My husband left me and four children for another woman after twelve years of marriage.	**I felt deeply hurt, angry, totally rejected and abandoned. I also believed that I was inadequate sexually. I was left with a sense of worthlessness and helplessness. I was particularly angry about his self-centredness and heartlessness. I never thought he would do such a thing. I often wondered why he did it, and what that other woman had that I didn't have. I know I'm far from perfect but I have done my best to be a good wife.**	**17/5/00**

N. B. Litchfield

GUILT LIST

DATE	SIN
July 1985	**I was very abusive and disrespectful to my mother.**
December 1988	**I stole some stamps from my boss's office.**
February 1990	**I bought a Playboy magazine and indulged in its pornography and masturbated.**
February 1990	**I lied to my wife about it (the Playboy magazine).**
April 1995	**I strongly criticised my boss behind his back.**
June 1998	**I was very insensitive and unkind to my daughter.**
July 1999	**I got drunk at a pub.**
March 2000	**I looked at some pornography on the Internet.**

PERFECTIONISM VERSUS EXCELLENCE

PERFECTIONISTS	PURSUERS OF EXCELLENCE
Reach for impossible goals.	**Enjoy meeting high standards that are within reach.**
Value themselves by what they do (human doings).	**Value themselves by what they are (human beings).**
Are devastated by failure.	**Learn from failure.**
Can only live with being number one.	**Are happy with being number two, if they know they have tried their hardest.**
Hate criticism.	**Welcome criticism.**

N. B. Litchfield

REVITALISING MARRIAGE

DAILY

Start and finish day with kiss and a hug.
Share your daily worries.
What would make your spouse's day?
Make time to be together more.
Don't retire with unresolved conflict.
Say, *I'm sorry* or *I forgive you.*

WEEKLY

Have a special night out by yourselves (or fortnightly).
Find out how each other feels – listen!
Give small pleasant surprises (love note, flowers, etc.) with *I love you* on them.
Set aside time for sex.
Avoid sexual boredom.

MONTHLY

Share new adventures.
Have short time of separateness.
Cheerfully do things you don't prefer, just for your spouse.

ANNUALLY

Mutual evaluation time.
Set goals.
Learn something new.

N. B. Litchfield

EFFECTS OF DIVORCE ON CHILDREN

(Legal and emotional divorce)

- **Stress related illness.**
- **Guilt.**
- **Anxiety/depression.**
- **Bargaining – fantasy/unreality.**
- **Low self-esteem.**
- **Confusion – emotional, identity, gender.**
- **Father hunger.**
- **Grandparent confusion.**
- **Resentment of parents – love/hate.**
- **Divided loyalties.**
- **Schoolwork affected.**
- **Promiscuity very likely.**
- **Greater proneness to drugs/alcohol.**
- **Leave home early.**
- **Higher delinquency/crime.**
- **Twice as likely to suffer adult depression.**
- **Likely to become divorced themselves.**
  (deficient trust, intimacy, sexuality).

N. B. Litchfield

THE OCCULT

Circle any of the following in which you have been involved:

Witchcraft, magic, sorcery, astrology, divination, necromancy, idolatry, spiritism (spiritualism), seance, psychic healing, TM, Yoga, fortune telling, Ouija boards, palm reading, crystal ball reading, tea-cup reading, iridology, numerology, ESP, EST, hypnotism, demonic art forms (artefacts, souvenirs, Balinese carvings etc., visiting heathen temples and ceremonies etc.,) Freemasonry, Oddfellows, Druids, Manchester Unity and other lodges, some rock music and abstract paintings, pendulum diagnosis, colour therapy, charms and amulets, curses placed on families, superstitions, deja vu, premonitions, games such as Dungeons and Dragons, demonic symbols (frogs, owls, snakes, dragons, unicorns), demonic jewellery, levitation, astral travel, automatic writing, martial arts, chain letters, others.…….....

N. B. Litchfield

ABUSE QUESTIONNAIRE

The following abuse questionnaire will help you identify abuse you have suffered.

Think about any time(s) in your life that you have been a victim of physical, sexual, emotional, intellectual or spiritual abuse.

Examine each type of abuse. For each type of abuse you have been a victim of, indicate your age(s) when the abuse occurred. Next indicate overall frequency of the abuse using the following scale: 1 = once; 2 = occasionally; 3 = periodically; 4 = often; 5 = very often. Then in the final column, indicate the relationship and name of the abuser(s) (eg. father, mother, brother, sister, stepfather, stepmother, spouse/partner, uncle, aunt, minister, counsellor, stranger, neighbour, etc.).

TYPE OF ABUSE	AGE	FREQUENCY	ABUSING PERSON
Physical Abuse			
Example: Shoving	8,18-30	5	mother, stepfather
Shoving, pushing	____	___	_____
Slapping or hitting	____	___	_____
Scratches or bruises	____	___	_____
Burns	____	___	_____
Cuts or wounds	____	___	_____
Broken bones or fractures	____	___	_____
Damage to internal organs	____	___	_____
Permanent injury	____	___	_____
Beatings or whippings	____	___	_____
Pulling hair, ears, etc.	____	___	_____
Inadequate medical care, etc.	____	___	_____
Inadequate food, clothes, etc.	____	___	_____

Other	____	__	_____

Sexual Abuse

Flirtatious/suggestive language	____	___	_____
Inappropriate holding/kissing	____	___	_____
Sexual fondling	____	___	_____
Masturbation	____	___	_____
Oral sex	____	___	_____
Forced sexual activity	____	___	_____
Household voyeurism	____	___	_____
Exhibitionism (inappropriate nudity)	____	___	_____
Allowed to watch parent's lovemaking	____	___	_____
Barging into bedroom/bathroom	____	___	_____
Sexual hugs	____	___	_____
Jokes about your body	____	___	_____
Use of sexualising language	____	___	_____
Penetration with objects	____	___	_____
Bestiality (forced sex with animals)	____	___	_____
Criticism of your physical or sexual development	____	___	_____
Other's preoccupation with your sexual development	____	___	_____
Other forms	____	___	_____

Emotional Abuse

Emotional neglect	____	___	_____
Harassment or malicious tricks	____	___	_____
Being screamed or shouted at	____	___	_____
Unfair punishments	____	___	_____
Cruel or degrading tasks	____	___	_____
Cruel confinement (locked in closet, long-term grounding)	____	___	_____
Abandonment, no supervision, being left or deserted	____	___	_____
Touch deprivation	____	___	_____
Overly strict dress rules	____	___	_____
No privacy	____	___	_____
Having to hide injuries from others	____	___	_____
Forced to keep secrets	____	___	_____
Having to take on adult responsibilities as a child	____	___	_____
Having to watch beating of other family members	____	___	_____
Being caught in the middle of parents' fights	____	___	_____
Being blamed for family problems	____	___	_____
Other forms	____	___	_____

Intellectual Abuse

You were forced to think the same as your parents	____	___	_____
You were not allowed to think or express opinions	____	___	_____
Your thinking was ridiculed	____	___	_____
You were not taught decision-making or problem-solving	____	___	_____
Parent's did not share their doubts with you	____	___	_____
Other forms	____	___	_____

Spiritual Abuse

Sect leader/Parent takes the place of God in your life	____	___	_____
Parent(s) worshipped	____	___	_____
Demanding perfection	____	___	_____
Forced to conform to a legalistic set of rules	____	___	_____
Forced to perform religiously	____	___	_____
Fear of church leader	____	___	_____
Lack of guidance	____	___	_____
No information given about true spirituality	____	___	_____
Parents addicted to religion	____	___	_____
God taught as punishing	____	___	_____
True character of Father God not taught nor demonstrated	____	___	_____
Rigid insistence on separation from others	____	___	_____
Not able to do many of the			

normal things others can do	____	___	_____
Other forms	____	___	_____

_____

N. B. Litchfield

ANGER SELF-ASSESSMENT

Place a Y (yes) in front of any of the following symptoms that apply to you (be honest):

……You procrastinate in completing imposed tasks.
……You tend to be difficult and unco-operative in doings things required of you.
……You have a preference for sadistic, barbed or ironic humour.
……You tend to be flippant, sarcastic or cynical in conversation.
……You sigh a good deal.
……You resort to affected politeness and cheerfulness.
……You tend to smile while hurting deep down.
……You laugh when nothing is funny.
……You have frequent nightmares or disturbing dreams.
……You have difficulty sleeping.
……You suffer from boredom, apathy and loss of interest in things which once interested you.
……You noticing a definite slowing of your movements.
……You get irritable over trivialities.
……You sleep more than usual as an escape.
……You find that you get drowsy at inappropriate times.
……You have Temporo-Mandibular Joint Pain Syndrome.
……Do you feel depressed much of the time.
……You tend to over-work and over-achieve.
……You suffer from other stress-related physical symptoms - back and neck problems, facial tics, spasmodic foot movements, habitual fist clenching, stomach ulcers, vague pains, high blood pressure.

If answered (Y) to ten or more of the above questions you have a problem with repressed anger, due to deep hurt.

N. B. Litchfield

ALCOHOLISM SELF-ASSESSMENT

It is not. easy for people to face up to an alcohol problem due to denial and shame. Honesty is needed. The following simple test will assist persons determine how dependent they are on alcohol. Mark "yes" (Y) or "no" (N) before the following questions:

…….Has someone close to you sometimes expressed concern about your drinking?

…….When faced with a problem, do you often turn to alcohol for relief?

…….Are you sometimes unable to meet work or home responsibilities because of your drinking?

…….Do you sometimes feel guilty about your drinking?

…….Have you ever felt you ought to cut down on your drinking?

…….Have you, or anybody else, required medical attention because of your drinking2

…….Have you sometimes experienced a blackout - a total loss of memory while still awake when drinking?

…….Have you ever been in conflict with the law in connection with your drinking?

…….Have you often failed to keep the promises you have made to yourself about controlling or cutting down your drinking?

…….Do you ever lie about how much you have been drinking?

If you have answered "yes" to three or more of the above questions alcohol is probably creating problems in your life and alcoholism is present at least in its early stages. Alcoholism is a progressive disease and the more advanced it is the serious it becomes.

N. B. Litchfield

CAGE QUESTIONNAIRE

…….Have you ever felt you ought to CUT down on your drinking?

…….Have people ANNOYED you by criticising your drinking?

…….Have you every felt GUILTY about your drinking?

…….Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover ("EYE opener")?

If you answered "yes" to one of the above there is the suspicion of alcohol abuse, if you answered "yes" to two or more there is alcohol abuse, and if you answered "yes" to all four it indicates alcoholism.

CODEPENDENCY SELF-ASSESSMENT

To help determine your degree of codependency check the following which apply most of the time (be honest):

….....I have difficulty identifying or expressing my feelings most of the time.

…....I try to manage other people, or control their lives.

….....I have unrealistic expectations for myself and others.

….....I am concerned about what others think of me.

….....I feel responsible for the behaviour or feelings of others.

….....I need approval from someone to feel good about myself.

…....I don't trust my own opinions or views.

….....I have lied in order to protect another person.

…….I need to take care of someone to feel useful.

..…...I try to avoid conflict.

….....I experience pain or illness.

…..…I feel powerless to change my life.

..…...I have difficulty making decisions.

….....I have low self-esteem.

….....I involve myself in relationships that are not good for me.

….....I confuse my thoughts and feelings with those of another.

..…...I try to read the mind of loved ones or analyse them.

….....I feel someone should be punished for letting me down.

….....I have tried without success to end an unhealthy relationship.

….....I must be strong, good or perfect to be accepted.

If you checked 0-5 times you are probably a well-rounded, happy person who can make choices about relationships.
If you checked 6-10 times you are preoccupied with another person, loosing yourself in the relationship (mildly codependent).
If you checked 11-15 times you are codependent, focussed on the problems or concerns of another person to avoid your own feelings (moderately codependent).
If you checked 16-20 times you are addicted to someone else who is an addict or compulsive (highly codependent).

N. B. Litchfield

OBSESSION SELF-ASSESSMENT

The following test measures your tendency to engage in obsessive thinking. Check if the statement is mostly true for you.

…..When I am sitting in a hall, church, etc. I tend to count objects, such as lamps, bricks, people, etc..

…..I have recurring thoughts that I cannot control.

…..I fantasise or visualise images or behaviours that disturb me, but I cannot seem to put them out of my mind.

…..I have difficulty falling asleep at night because my mind is too active and will not let me rest.

…...I have thoughts of violence (like killing or hurting somebody).

…...When I shake hands with someone, or touch a tap or doorknob, I worry about whether I have become infected

…...I am full of doubts and have difficulty making up my mind whether I believe something or not

…..I worry about whether I have unknowingly done some harm such as hurting someone in an accident, or receiving too much change at the shop.

…..The more I try to stop thinking something unpleasant, the more it forces itself into my mind.

…..I am often preoccupied with details about a project or something else I must do.

…..I like to keep to a set daily routine and am upset when the routine is exchanged.

…..I have to turn things over and over again in my mind before deciding what to do

…..Generally, I have difficulty making up my mind about almost everything.

…..I have many thoughts that are repugnant or senseless, and the more I try to eliminate them, the stronger they become.

…..I often feel as if my mind is an "enemy within," controlling me, rather than me controlling it.

Score as follows:

1-2: Normal obsessiveness, which is present in all.

3-5: Moderate obsessiveness, but with a tendency to become overly obsessive in times of anxiety and stress.

6-15: Severe obsessiveness. You tend to be controlled by your obsessions, and you need help.

N. B. Litchfield

COMPULSION SELF-ASSESSMENT

The following test measures your tendency to be compulsive. Check if the statement is mostly true for you.

……Even when I know I've done something correctly (such as locking the door) I have a need to go back and check it.

……I often do things I do not really want to do because I have a strong urge to do them.

……I cannot leave a task partly finished, but continue until it is done.

……I prefer to have a routine and do the same things the same way every time.

……I have rules I follow whether it is for doing something or going somewhere.

……I am strongly controlled by the belief that unless I do something (such as touch a doorknob or say an expression) something unpleasant will happen.

……I do several things that I consider to be meaningless, yet I feel compelled to do them even against my better judgement.

…….When I have completed something or have performed some behaviour I have resisted, I feel a great relief from tension.

……I have a strong need to be organised, neat and tidy.

……I am fairly rigid when it comes to keeping to time schedules and planned activity.

……I often have to things over because I don't think they have been done right (by myself or others).

……I am very careful about how I fold my clothes when I take them off at night.

……I have a place for everything and carefully put everything back into its place.

……I am a detail person and like to pay attention to detail because it makes me more feel more comfortable

……Having left something undone makes me feel very uncomfortable and uneasy.

Score as follows:

1-2: Normal compulsiveness, which is present in all.
3-5: Moderate compulsiveness, but with a tendency to become compulsive in times of stress.
6-15: Severe compulsiveness. Your behaviour is working against you, and you need help.

N. B. Litchfield

FOOD ADDICTION SELF-ASSESSMENT

Check any of the following seven questions that apply to you (be honest):

……Do you often stuff yourself with a lot of food in a short period of time?

……Do you often crave and consume large amounts of high-calorie or junk foods?

……Do you hide food - or hide from others while you are eating?

……Do you eat until someone interrupts you, you fee/abdominal pain, you fall asleep, or you start vomiting?

……Have you ever tried to lose weight by chronic fasting, severely restricted diets, induced vomiting, laxatives or diuretics?

……Are you afraid of not being able to stop eating voluntarily, or have you not been able to stop eating voluntarily?.

……Do you frequently experience depression, guilt or harsh thoughts, about yourself after an eating binge?

If you answered Yes to any of the questions, you have a food addiction and need help.

COMPULSIVE OVEREATING QUIZ

Check any of the following questions that apply to you (be honest):

……Do you eat when you are angry?

……Do you eat to comfort yourself in times of stress and tension?

……Do you eat to stave off boredom?

……Do you lie to yourself and to others about how much you have eaten and when you ate?

……Do you hide food away from yourself?

……Are you embarrassed about your physical appearance?

……Are you 20 percent or more over your medically recommended weight?

…...Have significant people in your life expressed concern about your eating patterns?

…....Has your weight fluctuated by more than ten pounds in the past six_months?

……Do you fear your eating is out of control?

If you answer Yes to three or more of these questions you are a compulsive overeater.

N. B. Litchfield

SEXUAL COMPULSIVITY/ADDICTION SELF-ASSESSMENT

Check any of the following questions that apply to you (be honest):

…..You take part in sexual behaviour despite your better judgement.

…..You set strict rules concerning sexual behaviour only to repeatedly violate these rules.

…..You have a history of negative consequences related to your sexual behaviour (financial, social, emotional, physical or legal).

…..Your sexual behaviour appears ritualised.

…..Other than tension release, there is a lack of pleasure during or following sex.

…..You are preoccupied with and are obsessed with sex.

If you identify with two or more of the above questions you have a problem with sexual addiction.

N. B. Litchfield

Sexual Addiction Screening Test (SAST)

Another clinically useful screening test is the Sexual Addiction Screening Test (SAST). This is designed to assist in the assessment of sexually addictive behaviour. The test was developed in co-operation with hospitals, treatment programs, private therapists and community groups. The test provides a profile of responses, which helps to discriminate between addictive and non-addictive sexual behaviour.

To complete the SAST test answer each question by placing a check in the appropriate **Yes** and **No** columns.

YES	NO	
_	_	1. Were you sexually abused as a child?
_	_	2. Have you subscribed or regularly purchased explicit magazines as Playboy or Penthouse?
_	_	3. Did your parents have trouble with sexual behaviour?
_	_	4. Do you often find yourself preoccupied with sexual thoughts?
_	_	5. Do you feel that your sexual behaviour is not normal?
_	_	6. Does your spouse (or significant other/s) ever complain about your sexual behaviour?
_	_	7. Do you have trouble stopping your sexual behaviour when you know it is inappropriate?
_	_	8. Do you ever feel bad about your sexual behaviour?
_	_	9. Has your sexual behaviour ever created problems for you or your family?
_	_	10. Have you ever sought help for your sexual behaviour?
_	_	11. Have you ever worried about people finding out about your sexual activities?
_	_	12. Has anyone been hurt emotionally because of your sexual behaviour?
_	_	13. Are any of your sexual activities against the law?
_	_	14. Have you made promises to yourself to quit some aspect of your sexual behaviour?
_	_	15. Have you made efforts to quit some type of sexual behaviour and failed?

_ _ 16. Do you have to hide some of your sexual behaviour from others?

_ _ 17. Have you attempted to stop some parts of your sexual behaviour?

_ _ 18. Have you ever felt degraded by your sexual behaviour?

_ _ 19. Has sex been a way for you to escape your problems?

_ _ 20. When you have sex, do you feel depressed afterwards?

_ _ 21. Have you felt the need to discontinue a certain form of sexual activity?

_ _ 22. Has your sexuality interfered with your family life?

_ _ 23. Have you been sexual with minors?

_ _ 24. Do you feel controlled by your sexual desire?

_ _ 25. Do you ever think your sexual desire is stronger than you are?

SAST SCORE RANGE	**NON-ADDICT**	**ADDICT**
0 - 4	89.3%	10.7%
5 - 8	89.6%	10.4%
9 - 12	77.2%	22.8%
13+	3.5%	96.5%

This means that if you scored 13 or more Yes the likelihood of your being a sexual addict is 96.5 percent.

Patrick Carnes

STRESS SELF-ASSESSMENT

Answer yes (Y) or no (N) to the following questions.

_____During the last three days, have you done some real exercise for at least two of the days (20 minutes of walking, swimming, cycling, etc)?

_____During the last three days, have you eaten more plant foods than non-plant foods (red meat, milk products, eggs)?

_____During the last three days, has your diet been low in sugar, salt, refined, fast foods.

_____Have you not drunk more than three cups of coffee/tea during any of the past 3 days?

_____Have you not smoked during the last three days?

_____Have you not had more than nine standard drinks (for men, 7 for women) during the past three days (one standard drink is 200 ml of beer - 4 to the bottle, 120 ml of wine 6 to the bottle, 75 ml of fortified wine - 10 to the bottle, 30 ml of spirits - 23 to the 700 ml bottle)?

_____During the last three days, have you done something good for yourself (movie, book, garden)?

_____During the last three days, have you spent at least 20 minutes in meditation each day?

_____During the last three days, have you laughed at life, at yourself?

_____Do you have a support system - someone to hug and talk to?

_____Do you have just a few hassles and handle them well, rather than a life full of hassles?

_____During the last three days, have you been in control, rather than having blown it?

_____During the last three days, have you used deep relaxation (switched off, taken deep breaths, and done a relaxation technique)?

_____During the last three days, have you had mainly positive thoughts?

_____Do you have regular medical check-ups (blood pressure, breast check, cervical smear)

_____During the past three days, have you done something nice for somebody else?

SCORE: Number of (Y)_____ Number of (N)_____

If you scored less Yes than 6, you need to radically alter your attitude to life and your lifestyle. If you scored more than 12, you are in good shape. If you scored about the middle, you should check your score regularly and aim to improve.

N. B. Litchfield

COMPULSIVE GAMBLING SELF-ASSESSMENT

Answer yes (Y) or no (N) to the following questions:

…..Do you lose time from work due to gambling?
…..Does gambling make your home life unhappy?
…..Does gambling affect your reputation?
…..Do you ever feel remorse after gambling?
…..Do you ever gamble to get money to pay debts?
…..Does gambling cause a decrease in your ambition and efficiency?
…..After losing, do you feel you must return as soon as possible to win back your losses?
…..After a win, do you have a strong urge to return and win more?
…..Do you often gamble until your last dollar is gone?
…..Do you ever borrow to finance your gambling?
…..Do you ever sell anything to finance gambling?
…..Are you reluctant to use gambling money for normal expenditures?
…..Does gambling make you careless about the welfare of your family?
…..Do you ever gamble longer that you planned?
…..Do you ever gamble to escape worry or trouble?
…..Do you ever commit, or consider committing, an illegal act to finance your gambling?
…..Does gambling ever cause you to have difficulty sleeping?
…..Do arguments, disappointments and frustrations create in you an urge to gamble?
…..Do you have an urge to celebrate good fortune by a few hours of gambling?
…..Do you ever consider self-destruction as a result of your gambling?

Compulsive Gamblers usually answer Yes to at least seven of the questions.

N. B. Litchfield

WORKAHOLISM SELF-ASSESSMENT

Answer *Yes* or *No* to the following questions (be honest):

…..I am highly task-oriented (or performance-oriented).
…..Once I start a job I have to finish it.
…..I prefer to do most things by myself rather than ask others for help.
…..I feel guilty if I don't complete a job I've commenced.
…..I feel guilty if I haven't completed something correctly.
…..Most of the time I have to be doing something.
…..I sometimes become so preoccupied by a thought that I cannot get it out of my mind.
…..I get very impatient when I have to wait.
…..I get irritated when I am interrupted.
…..I stay busy and have many *irons in the fire.*
…..I over commit myself.
…..I get irritated when I see another person's messy desk or cluttered room.
…..I prefer a neat, clean, and orderly room rather than in a messy one.
…..I use schedules and lists of jobs a lot.
…..I believe that the person who works the hardest deserves to be rewarded.
…..My job/housework is more important than leisure activities.
…..I am more interested in facts than feelings.
…..I think talking about feelings to others is a waste of time.
…..I frequently feel angry without knowing what or who is bothering me.
…..I like always to be in control and what's happening around me.
…..I like to plan well for the future.
…..I often put demands on myself beyond what others normally do.
…..I tend to be a perfectionist.

A score of 5 or less, reflects a fairly relaxed person. A score of 6-10 is average. A score of 10 or more reflects a definite tendency toward Workaholism.

N. B. Litchfield

RELIGIOUS ADDICTION

Self-Assessment Questionnaire

Place a *Yes* in front of any of the following questions that apply to you (be honest):

…..Are you easily led by a strong charismatic personality?
…..Are you compulsively fascinated by religious topics, ceremony and rituals?
…..Have you any other addictions?
…..Have you been involved in the past with extreme or fanatical sects or cults?
…..Are you involved currently with an extreme or fanatical sect or cult?
…..Do you feel guilty if you do not attend most of the services of your church?
…..Are you dogmatic kind of person?
…..Do you tend to force your views upon others?
…..Are you generally intolerant of others who do not share your religious views?
…..Do you tend to respond with strong emotion to religious events and situations?
…..Are you largely closed to the input of others?
…..Are you preoccupied about religious things?
…..Do you give large amounts financially to a religious organization?
…..Do you change churches readily if your views are not readily accepted?
…..In spite of your religious commitment you still feel unfulfilled and unhappy?
…..Has significant person's in your life complained about your religious activities?
…..Have your religious activities caused physical symptoms such as headaches, back pain, upset stomach, sleeping or eating problems, anxiety or depression?
…..Have you experienced major problems with relationships as a result of your religious activities?

If you answered Yes to five or more questions, you probably have Religious Addiction

N. B. Litchfield

MONEY ADDICTION

Self-Assessment Questionnaire

Place a *Yes* in front of any of the following questions that apply to you (be honest):

……Is being affluent a driving necessity for you?
……Do you strongly feel that you need to *Keep up with the Jones* to feel good.
……Do you believe that you need to have an expensive car or home, etc. as a symbol of success?
……Do you have a driving ambition to amass a large amount of money by a certain time, which is causing you to work excessively hard and for long hours.
……Do you obsessively and compulsively spend large amounts of money investing?
……Are you a compulsive hoarder?
……Do you compulsively collect valuables for investment purposes?
……Do you spend large amounts of money on hobbies or sports?
……Would you be considered by others to be miserly and stingy with your money?
……Do you compulsively seek out the best deal and bargain?
……Do you frequent garage sales looking for bargains and buy them even if you don't really need the item.
……Does your mind spend a good deal of time thinking about money?
……Does your conversation centre a good deal on money?
……Do you sense that others get irritated when you speak so much about money issues?
……Is your preoccupation with money issues causing a rift in your relationships?
……Has somebody close to you complained about your preoccupation about money issues?

If you answered Yes to three or more of the above questions, you have a problem with Money Addiction.

N. B. Litchfield

SHOPAHOLISM

Self Assessment Questionnaire

Place a *Yes* in front of any of the following questions that apply to you (be honest):

…..Is shopping a major activity with you?
…..Do you feel you need to go window-shopping to get relief and a *high* after times of hurt and stress?
…..Do you tend to buy things on the spur of the moment?
…..Do you buy new clothes, tools, craft materials, decorations, etc. that sit in the closet for weeks or months before you wear them?
…..Do you spend more than 20 percent of your income on loans and credit cards?
…..Do you pay only the minimum balance on your charge accounts each month?
…..Do you hide purchases or lie about them so your spouse and family doesn't know you were shopping?
…..Do you ever lie about how much something cost so others think you just got a bargain?
…..Do you buy something just because it's on sale even though you have no real use for it?
…..Have you intentionally gone shopping to life your spirits or help deal with depression, rather than because you needed something?
…..Do you feel nervous and guilty after a shopping spree?
…..Is your weekly pay often gone on Tuesday when the next pay day isn't until Friday?
…..Do you borrow money from friends, even though you know it will be hard to pay it back?
…..Do you often have to put on credit small purchases because you do not have enough cash?
…..Do you spend large amounts of time on computer shopping?
…..Do you often feel hopeless and depressed after spending money?

If you answered Yes to 5 or more of these questions, you have a Shopping/Spending Addiction problem and should seek help.

N. B. Litchfield

INTERNET ADDICTION

Self-Assessment Questionnaire

Place a *Yes* in front of any of the following questions that apply to you (Be honest):

…..You neglect important family activities and social events, work responsibilities, academic projects, or health concern to spend hours on the Net.

…..A significant person, such as a spouse, boss or close friend complained that you are spending too much time or money on the Internet.

…..You are constantly anticipating your next *On Line* session.

…..You are determined to spend a brief time *On Line*, only to discover to your shame that several hours have passed.

…..You feel guilty about the amount of time you spend on the Internet.

…..You check your email compulsively.

…..You compulsively *surf the net* for pornography.

….. You compulsively *surf the net* for private chat sessions to have cybersex.

…..You develop cravings and withdrawal symptoms when you are away from the computer.

…..You often skip meals, classes, or appointments to get on the Internet.

…..You would rather talk to people *On Line* than face to face.

…..You often sleep less than five hours a night so you can spend more time on the Internet.

…..You are constantly and compulsively seeking out the latest hardware and software and upgrading your computer.

If you answered Yes to any of these questions, you probably have a problem with Computer and Internet Addiction.

N. B. Litchfield

EXERCISE/SPORT ADDICTION

Self-Assessment Questionnaire

Place a *Yes* in front of the following questions that apply to you (be honest):

…..You get so used to your exercise routine that even very important events are considered as intrusions.

…..What you eat, or don't eat, depends on whether you are exercising or not.

…..You don't feel right unless you exercise.

…..You feel depressed if you don't exercise.

…..You exercise even if you feel sick or tired.

…...Is exercise (or sport) the main topic of your conversation?

…..Do you spend a lot of time thinking about your health and fitness?

…..Is your commitment to exercise (or sport) causing personal, relationship, work and other problems?

…..Is it possible that your exercise (sporting) activity is a means of escape from personal or relationship problems.

…..Do you get depressed over minor injuries?

…..Have you been criticised because of your exercising?

…..It's beginning to be hard to drag yourself to exercise - you think of ways to get out of it, but you can't stop it.

If you answered Yes to two or more of the above questions you probably have a problem with Exercise or Sport Addiction.

N. B. Litchfield

POWER ADDICTION

Self-Assessment Questionnaire

Place a *Yes* in front of any of the following questions that apply to you (be honest):

…..Are you highly competitive?
…..Do you always like to win?
…..Are you a perfectionist?
…..Do you have strong opinions about most things?
…..Are you highly confrontive?
…..Do you find it hard to say, I'm sorry?
…..Are you largely black and white?
…..Do you have problems with your temper?
…..Have you lost your temper or had anger outbursts more than twice in the past two weeks?
…..Does your language tend to be abusive?
…..Do you use sarcasm or barbed humour?
…..Do you resort to passive/aggressive behaviour (being difficult and uncooperative)?
…..Do you suppress your feelings then suddenly let them all out?
…..Do you like mostly to be in charge of what's going on?
…..Do you resort to such statements as, The Lord has told me? to convince others?

If you answered Yes to more than five of the above, you probably have a problem with Power Addiction.

N. B. Litchfield

COMPULSIVE THRILL SEEKING

Self-Assessment Questionnaire

Place a *Yes* in front of any of the following questions that apply to you (be honest):

…..Are you impatient with dull or boring people?

…..Do you get easily bored with high structure and sameness?

…..Do you prefer art that jolts the senses rather than that which provides calm and peace?

…..Would you like to ride a motorcycle?

…..Do you do things that are risky and frightening?

…..Would you like to try hang-gliding, parachute jumping or bungee jumping?

…..Do you believe that you need thrilling experiences to help cope with the stresses of life?

…..Are you one who often wants to try something unconventional or new?

If you answered Yes to two or more of the above questions, you are at least a candidate for Thrill-Seeking Addiction.

If you answer *Yes* to the following, you have a Thrill-Seeking Addiction

…..Has your thrill-seeking activities caused any problems - in relationships, injury, health or financially?

…..Has a significant person in your life complained about your thrill seeking activities?

N. B. Litchfield

THERAPY ASSESSMENT FORM

Please take a few minutes to fill out this exit form. This will help us know how helpful (or not) we were to you and how to improve our services in the future. We will maintain your strict confidence about this form. Thank you.

Name_____**Date**_____

Overall, were you satisfied with the help you received from counselling/therapy?

☐ Highly satisfied ☐ Somewhat satisfied ☐ Mixed feelings
☐ Somewhat dissatisfied ☐ Highly dissatisfied

Compared with the start of therapy, how would you rate your level of improvement?

☐ Greatly improved ☐ Much improved ☐ Slightly improved
☐ About the same ☐ Slightly worse ☐ Much worse

List one or two things that reflect your satisfaction or dissatisfaction with the therapy

_____

_____

_____

_____

Did you feel that your problem was understood?

☐ Yes, great understanding ☐ Yes, mostly understood
☐ Not sure if understood ☐ No, didn't understand

Were your views and values respected?

☐ Yes, greatly respected ☐ Yes, mostly respected
☐ Not sure ☐ No, didn't respect

Were you, in therapy, guided to action and resources that helped resolve your problem?

☐ Yes, clear direction ☐ Yes, guidance OK
☐ Not sure ☐ No, poor guidance

Were there any problems during therapy with any of the following issues?

☐ Fees ☐ Confidentiality ☐ Sexual actions or communications ☐ Too passive ☐ Too controlling
☐ Not enough listening or support ☐ Lack of or inaccurate knowledge ☐ Improper or incompetent therapy
☐ Late/poor preparation for sessions ☐ Response to emergencies ☐ Poor referral or consultation with others

Explain the above

_____

_____

_____

_____

_____

NOTES

[1] We are indebted to Peter Toth and other former Diploma students for the wheel concept.

[2] Ellis, Albert. 2000. "Can Rational Emotive Behaviour Therapy (REBT) be Effectively Used With People Who Have Devout Beliefs in God and Religion?" Washington: APS, *Professional Psychology: Research and Practice.* Vol. 31. No. 1. 29-33. Washington: Amer. Psychological Assn.

[3] Stinnett, N and DeFrain, John. 1985. *Secrets of Strong Families.* Boston: Little Brown and Company. Referred to by George Reikers in *Counselling Families.* p.102-121. Used by permission of the publisher.

[4] This is also referred to by McMinn, Mark. *Psychology, Theology and Spirituality in Christian Counselling.* p.10,26.

[5] Nouwen, Henri. *The Wounded Healer,* and *The Living Reminder.* New York: Seabury Press. 1977.

[6] Recommended reading:
Adams, Neil. 1995. "Spirituality, Science and Therapy." in *ANZ J. Fam. Ther. 1995. Vol. 16, No.4, p.201-208.*
McBride, J. leBron. 1998. *Spiritual Crisis. Surviving Trauma to the Soul.*
Vande Creek, Larry. 1999. *Spiritual Care for the Elderly.*
Miller, William. 1999. *Integrating Spirituality into Treatment.*
Emmons, Robert. 1999. *The Psychology of Ultimate Concerns.*
Crapuchettes, Bruce. 1997. "Spirituality and Relationships." In *Psychotherapy in Australia.*Vol. 4, No.1, November 1997.
Walsh, Froma. Ed. *Spiritual Resources in Family Therapy.*
Richards, P.S. and Bergin, A.E. *A Spiritual Strategy for Counselling and Psychotherapy.*
Shafranske, E.P. Ed. *Religion and the Clinical Practice of Psychology.*

[7] Paul Meier did some properly conducted research several years ago on Dallas Seminary students and found that students who regularly practised Scripture meditation were healthier, passed exams better and were better off in every way than those who did not. See: Meier, P. 1985. *Renewing Your Spiritual Mind.* Chicago: Moody.

[8] Darrell Furgason, who is completing his PhD in international studies at the ANU, is actively involved in lecturing on biblical worldview issues at Youth With A Mission and elsewhere. This chapter is a summary of lectures given by him to students completing the Diploma in Christian Counselling and Family Therapy, 2000.

[9] Used by permission of Darrell Furgason.

[10] From: Conn, Harry. 1978. *Four Trojan Horses.* New York: Parson Publishing.

[11] This material on *Foundations of Christian Ethics* is a modification of notes of lectures by Tom Marshall at the *Methods and Models of Biblical Counselling* School in Kona, Hawaii in 1990. Used by permission of Tom Marshall's widow.

[12] Darrell Furgason, who is completing his PhD in international studies at the ANU, is actively involved in lecturing on biblical worldview issues at University of the Nations and elsewhere. This chapter is a summary of lectures given by him to students completing the Diploma in Christian Counselling and Family Therapy, 2000.

[13] Used by permission of Darrell Furgason.

[14] See: Collins, Gary. *Excellence and Ethics in Counselling.* Dallas: Word.

[15] The Australian Board of Certified Counsellors can be contacted at PO Box, 226, Wilson, Queensland, 4051.

[16] See: Bond, Tim, Standards *and Ethics for Counselling in Action.*

[17] An excellent text on ethics is by Sanders, Randolph J. *Christian Counselling Ethics.*

[18] Recommended reading:
Bond, Tim. *Standards and Ethics for Counselling in Action.*
Tan, S.Y. *Ethical Considerations in Religious Psychotherapy. Potential Pitfalls and Unique Resources.*

[19] See: Rutter, Peter. *Sex in the Forbidden Zone.*

[20] See: Collins, Gary. *Christian Counselling.* p.34-35, 307.

[21] Highly recommended to assist in writing reports: Zuckerman, Edward. *Clinician's Thesaurus. The Guidebook for Writing Psychological Reports. Fourth Ed.*

[22] See: Hess, Allen and Weiner, Irving. *The Handbook of Forensic Psychology.*

[23] Based on a paper presented by Dr Rod Allen, Maitland.

[24] Good basic texts on this topic:
Davidson, G.C and Neale, J.M. *Abnormal Psychology.*
Meier, Paul et al. *Introduction to Psychology and Counselling.*
Barlow, D.H. and Durrand, V.M. *Abnormal Psychology*.
Barlow, D.H. *Clinical Handbook of Psychological Disorders.*
Goodwin, D.W. and Guze, S.B. *Psychiatric Diagnosis. Fifth Edition.*
Hogg, M and Vaughan, G. *Introduction to Social Psychology*.
Carlson, N.R. *Foundations of Physiological Psychology*. *3rd Ed.*
Appleby, Drew. *The Handbook of Psychology.*
L'Abate, Luciano. *Family Psychopathology.*

[25] For more details on these disorders see *DSM-IV.* Anyone serious about counselling needs to have this volume close at hand.
Other related books recommended are:
Morrison, James. *DSM-IV Made Easy. The Clinicians Guide to Diagnosis.* New York: Guilford, 1995.
Morrison, James. *The First Interview. Revised for DSM-IV.* New York: Guilford, 1995.
Reid, W.H. and Wise, M.G. *DSM-IV Training Guide*. New York: Brunner/Mazel, 1995.
Goodwyn, D.W. and Guze, S.B. *Psychiatric Diagnosis*. New York: Oxford, 1996.
WHO. *Management of Mental Disorders, Vols. I and. 2. 2nd Ed.* Darlinghurst: WHO, 1997. (These two widely used volumes are highly recommended, as they not only give diagnostic information but also management skills and therapy issues for each disorder. They are available from the Collaborating Centre for Mental Health and Substance Abuse, WHO, 299 Forbes Street, Darlinghurst, NSW, 2010. Fax. 612 9332 4316).
Jongsma, Arthur and Peterson, Mark. *The Complete Adult Psychotherapy Treatment Planner.*

[26] For a full explanation of the test see: Graham, John R. *MMPI -2. Assessing Personality and Psychology*.

[27] DSM-IV.

[28] Saunders, Randolf. *Christian Counselling Ethics.* Downer's Grove: IVP, 1996. P.192-193.

[29] See: Naughton, G and Laidler, T. *When I Grow Too Old to Dream. Coping with Alzheimer's Disease.*

[30] For more information on the management of Alzheimer's Disease see:
Alzheimer's Association of Australia.

NHMRC. *The Problem of Dementia in Australia.* Canberra: Social Psychiatry Research Unit, ANU.
VandeCreek, Larry. 1999. *Spiritual Care of Persons with Dementia.*
Clemmer, William M. 1997. *Victims of Dementia.*

[31] Saunders, R. *Christian Counselling Ethics.* P.193.

[32] For more information on Schizophrenia see:
DSM-IV and Reid, W and Wise, M. *DSM-IV Training Guide.*
WHO. *Management of Mental Disorders. Vol.2.* p. 345-461.
Fowler, David, et al. 1998. *Cognitive Behaviour Therapy for Psychoses.*
Chadwick, Paul et al 1998. *Cognitive Therapy for Delusions, Voices and Paranoia.*
Backus, William. *Telling the Truth to Troubled People*. p.204-216.
Moate, M and Enoch, D. Schizophrenia: *Voices in the Dark.*

[33] See: Rogers, Richard. *Clinical Assessment of Malingering and Deception.*

[34] An excellent text on DID is, Spira, James L. Ed. *Treating Dissociative Identity Disorder.* San Francisco: Jossey-Bass, 1996.

[35] Recommended reading:
Chu, James. 1999. *Rebuilding Shattered Lives. The Responsible Treatment of Complex Post-Traumatic and Dissociative Disorders.*
Freisen, James G. *Uncovering the Mystery of MPD,* and *More than Survivors. Conversations With Multiple-Personality Clients.*
Spanos, Nicholas. 1996. *Multiple Identities and False Memories.*
McMinn, Mark. "Dissociative Identity Disorder" in *Christian Counselling Today.* 5:1, 1997. P.19.

[36] Martin, Grant. *Critical Problems in Children and Youth.* Used by permission of the publisher.

[37] See: Freeson, James. *More than Survivors. Conversations With Multiple-Personality Clients,* and *Uncovering the Mysteries of MPD.*
Martin, Grant. *Critical Problems in Children and Youth.*

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[48] Used by permission of Dr Bruce Stevens.
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[69] Helen Middelmann is a counsellor with the Lutheran church and a chaplain to Calvary Hospital, Canberra. This chapter contains the material she uses for her lectures to students completing the Diploma in Christian Counselling and Family Therapy course, 2000.

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[73] Highly recommended: Miller, Keith. *The Secret Life of the Soul.*

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