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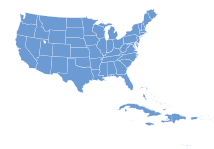
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Letter from the president

I am the scapegoat

As a young nurse, I attended an NCF conference about spiritual care. A mental health nurse told us a story about a patient who crawled on the floor and bleated like an animal. The staff tried to talk to her, but she did not respond, she just continued to crawl around. One day the young nurse had an idea and she asked the patient 'Who are you?' The patient looked at her and said, 'I am the scapegoat.' As the nurse knew the deep meaning of being the scapegoat (Leviticus 16), she understood the symbolic actions of her patient. When she explained her understanding of it's meaning to the patient, the woman rose up from the floor and was able to share her pain by talking with the nurse.

Research from mental health care in the western world shows that working with spiritual/existential care is very challenging, especially for patients with distortions and delusions. The attitude that forbids you to talk with patients about God or politics is still very much alive and may inhibit their recovery. This attitude is the case despite patients with mental illness often struggling with existential questions related to who they are. People who suffer from psychosis often express their struggle using religious concepts and there is benefit in being able to address their issues using the same language.

Patients and their families seek health care because they need our **knowledge**. As nurses, we have knowledge about both the illness and disease perspectives and we know about the fundamentals for a healthy life such as food, rest, activity, hygiene and sleep. In carrying out our care, **communication** is essential. How we listen and dialogue, talk and teach, tells the patient if we are interested and able to use our knowledge with good professional discernment. **To be seen as a person**, not just as a number or diagnosis matters much to patients.

A woman with schizophrenia struggled with severe hallucinations. She carried out many suicidal attempts and she self-harmed herself severely. She was treated with isolation and cohesive treatment. Only a few people were able to touch her life in her deepest misery. Years later, she tells how some staff showed her sincere interest, as a human being. She shared how they were able to support her and maintain her dignity. They were like an oasis in her desert-like life. These moments represented glimpses of light and hope in her darkness and helped her to endure her suffering. After some years, she had a therapist who could journey together with her as she uncovered some of the meanings of her hallucinations and symptoms, so she could deal with her life-pain in a healthier way. Today she is healed and works as a clinical psychologist helping others.

As you read this edition of CNI, I pray that you will see even more ways where you can live out your faith in your nursing practice so you can bring healing to patients' lives.

Dr Tove Giske
NCFI President



Letter from the editor

Mental Illness has traditionally been associated with stigma and discrimination. In the Christian world to own up to having mental health problems has often led to a label of being unspiritual or failing in our relationship with God. Yet mental health is an integral part of general health it is often neglected by health professionals and by individuals and denied by the church.

The World Health Organisation estimates that 400 million people suffer from some form of mental or neurological disorder or from psycho-social problems. Christians are not exempt and nurses are under greater pressure than many others because they try to maintain an appearance of health and of coping with any situation that arises for the sake of their patients. It is easy to deny that we suffer from mental health problems. Yet to do so is to fail to care for ourselves and so be equipped to serve as we should.

In this issue of CNJ we have a number of important articles that discuss issues around mental health as they impact on nurses and nursing practice. Pamela Cone shares stories of caring for mental health patients and how spiritual caring interventions can make a difference. Debra Schout offers a Bible Study that helps us reflect on caring for ourselves, while other articles included cover depression and stress experienced by nurses and finally, most importantly a reflection by Louise Younie on resilience. Resilience is the ability to withstand and spring back from the stresses that we experience.

I hope you find these articles helpful and if you have any comments or observations to make about your own experiences or those of others please don't hesitate to write to me about them so that we can share them with our colleagues.

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Facts and figures

(Mental Health Tackling the Challenges (2015) ICN, Geneva Switzerland)

- about one fifth of the world's youth suffer from mild to severe mental health disorders.
- 400 million people in the world suffer from mental or neurological disorders
- mental disorders represent more than 12% of the total burden of disease about 24% of patients who seek primary health care suffer from some form of mental disorder
- 69% of patients with mental disorders usually present to physicians with physical symptoms and many of them are often not correctly treated

Some myths about mental illness

The public may believe that people who suffer from mental illness:

- never recover enough to become contributing members to their communities
- are fundamentally unstable and unpredictable
- may be dangerous to those around them
- are possessed by evil spirits or curses
- are paying the price for some moral or spiritual wrongdoing



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Caring for the spirit: It takes all kinds

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Spiritual care is often entwined with or mistaken for psychological care. I was in my last year of nursing school when I had my first break “ah-ha” moment that led me toward psychiatric/family mental health nursing. At the time, I suddenly understood that spiritual care included caring for the spirit in ways not always recognized as spiritual. I was in an unusual nursing program that began in the first year with health and wellness care and ended the final year with severe illness, including intensive and cardiac care as well as the lock-down units of the state mental health institution. Two cases stand out in my memory as being tragic and needing a special touch to the inner spirit.

Calming the storm within

The first person was a 64 year-old woman who was institutionalized 50 years before for “teenage hysteria” and put on the strongest psychotropic drugs available in the 1920s. Her family had abandoned her (her file noted she was never visited during those 50 years), and she shuffled to where she was told to go with a sad and despairing expression on her face. At the time, I was horrified and angry that something that may have been hormonal in nature had resulted in her being shut away her entire life! I asked about changing and lowering medication dosages to recent (at the time) recommended doses. I also asked if we could use behavioural modification (then fairly new in nursing). Staff appreciated the time we student nurses spent with patients, so they agreed.

I focused on being with (providing mindful presence) this woman and talking kindly with her and actively listening to her at regular times each day. She began to look forward to our times together, and her face lit up when I came to meet her. I noticed that she liked her bed and room area to be very neat, and she grumbled a bit about the others in her room being “sloppy.” So

I got permission to guide her toward being an encourager of her roommate to have neat and clean sleeping areas. We made this a unit-wide initiative and gave a reward to the ones with the cleanest room. She began to engage with others, and with my continued encouragement, she took leadership in her unit, eventually becoming the “den mother” of the other women in her unit, which contained several rooms with 8–10 patients in each.

One might ask in what way this is spiritual care. While I used behaviour modification as well as the physical aspect of medication adjustment, I believe it was the touch of my spirit to hers that made the difference in her life. From being unknown and unwanted, she became the focus of my love and attention, and later, that of the staff. Loving and caring for her fed a need in her for love and belonging that lies within us all. She never left the hospital, but the staff reported that she became cheerful and encouraging to other patients, so she became part of the care-giving family at the institution.

“Loving and caring for her fed a need in her for love and belonging that lies within us all.”

Unlocking the heart and mind

The second patient was at the same institution, but I met her at a different time during a different semester and in the lock-down ward. Since we had some success with the use of music in school nursing, my nursing student partner and I decided that we would use music therapy (very newly recognized as therapy in 1974) with the severe cases where traditional approaches were not being successful to see if we could make a difference in any patient’s life. The staff assigned us about a dozen patients who were extreme cases that included psychotics as well as one catatonic patient. That catatonic patient placed in our care was a lovely African American woman

in her 30s who had a severe tragedy in her life that resulted in a psychotic break. She had just finished a doctoral degree when the family tragedy happened and her mental breakdown occurred, and for the last two years, she had sat rocking her body, knocking her head against the wall wherever she was placed. The woman was compliant but unresponsive to anyone.

Our music therapy consisted of an hour of music and activity (clapping, singing, dancing) three times a week with rewards for any type or amount of participation in the activity. We usually made a circle of chairs outside, since the spring weather was nice most of the time. Using an old-fashioned tape player, we tried different types of music and motion. We learned each one's name and helped them clap, or sing, or even dance, with a fair amount of success, and we made progress in helping several patients reorient toward healing. The catatonic one sat and rocked.



“When we nurses bring love to our patient encounters, we enhance the potential for healing and touch the inner spirit of our patient.”

After about six weeks of music sessions, I found some polka music, and the thought came to me that I should try it with the group. I told them I had some special music, and I would love to dance to the music but did not know how to polka. I started the music and encouraged clapping, then I asked, “Does anyone know how to polka? Maybe you can teach me!” Out of the blue, this young African American woman spoke, “I know how to polka. I can show you.” She got up and came to me, and of course, I took her hand with a frantically beating heart and said, “Okay, let’s go!” She taught me to polka, and soon, there were several others dancing with us. When the song ended, she laughed and said it had been a long time since she had danced the polka! Suddenly, she became aware of her surroundings and wondered where she was. Of course, the staff had started gathering as soon as they saw what was happening, so there was someone nearby to lead her to her doctor after the music session. As she was leaving, she smiled at me and thanked me for reaching out to her and connecting with her. She said she was drifting in a “foggy place” and was glad to

find her way out of it. I later learned that she recovered rapidly and was able to go back to her life after some time in therapy.

Again, one could ask if this is mental or spiritual care. I would argue they are intertwined and often support each other. It is true that I used behavioural therapy; however, I had somehow (with God’s guidance) found the key to unlock her mind through her love of music, particularly polka music. Music can be a bridge, especially when used with love, caring, and kindness.

Conclusion

Caring for the spirit of a patient can give energy to heal and can provide motivation to move forward. Human to human connections are critically important, as is a sense of love and belonging. In both of these cases, the love and belonging that is vital to us all had been compromised, and when love was freely shared in a way that reached the inner spirit of that person, a reconnection occurred. When we nurses bring love to our patient encounters, we enhance the potential for healing and touch the inner spirit of our patient, often in ways we had never envisioned and could never have imagined. God is always ready to speak to our hearts and show us how to reach others; we just need to be “tuned in” to hear, to listen, and to follow through on what He brings to our mind and heart.

Bible study on caring

Presented by Dr. Debra Schout, Pediatric Nurse Practitioner and Bible teacher. The study was originally presented at the SAME Regional conference in Bangladesh. November 2017. All Bible quotations are from the New International Readers Version.

Practice some self care

Nurses who want to stay healthy are often advised to practice some self-care. At first I thought this was perhaps a non-biblical concept. It focuses on me! But Parker Palmer reminded me “self-care is never a selfish act – it is simply good stewardship of the only gift I have, the gift I was put on earth to offer others.”¹,

As nurses we often carry grief, hurt and pain on behalf of other people. Perhaps your nursing training taught you to watch out for burn out, compassion fatigue, and secondary or vicarious trauma. Maintaining spiritual and mental health is an important part of being an effective support to patients. How can we do it? The Bible gives us some ideas on how we can support one another through listening, praying, storytelling, and rituals:

Listening to one another. Read the verses below and note the importance of listening:

“My dear brothers and sisters, take note of this: Everyone should be quick to listen, slow to speak and slow to become angry.” James 1:19

“If your brother or sister sins, go and point out their fault, just between the two of you. If they listen to you, you have won them over.” Matthew 18:15

Praying

We long for God to listen to us. The Psalmist said, “I love the Lord, for he heard my voice; he heard my cry for mercy. Because he turned his ear to me, I will call on him as long as I live.” Psalm 116:1–2. As we pray we praise the one who understands, say again what we believe, and pour out our emotions to the God who listens. I call on you, my God, for you will answer me; turn your ear to me and hear my prayer. Psalm 17:6

Story telling

In Old and New Testaments, stories are used to bring people's minds back to where they should be. Remember the story Nathan told in 2 Samuel 12? He stirred up David's emotion with the story, and then helped David to realize the story was about David himself. Jesus' parable stories include the Good Samaritan. Jesus used the story to help turn a religious man's mind toward caring for others. It is good to learn from stories, and also healthy to tell our own story.

Ritual

James 5:14–15 links prayer and ritual. “Is anyone among you sick? Let them call the elders of the church to pray over them and anoint them with oil in the name of the Lord. And the prayer offered in faith will make the sick person well; the Lord will raise them up. If they have sinned, they will be forgiven.” The oil likely had very few healing properties. But the ritual reassures us of something normal, reminds us of our faith, and returns us to rest. Other restoring rituals include foot washing ceremonies, lighting of candles, nailing a list of sins to a cross (or burning the list.)

Cast your care upon God and know for certain that God loves you

Self-care while important cannot heal us. Self-care can also be defined as opening your heart to God; it is care received.

First Peter 5:7 instructs us in “Casting all your anxieties on him, because he cares for you.” A review of the context is a bit surprising. Peter is teaching elders to take responsibility willingly and for the right reasons. When the Chief Shepherd appears, they will receive the unfading crown of glory. He tells younger people to listen to their elders. And to everyone he says, “all of you clothe yourselves with humility toward one another, because God resists the proud but gives grace to the humble.” The writer concludes in 1 Peter 5:6–7, “Humble yourselves therefore, under the mighty hand of God, so that he may exalt you at the proper time, casting all your cares on him, because he cares about you.”

“All of you clothe yourselves with humility” (1 Peter 1:5), this is the thing that causes stress! Why? Because we don’t like being little or pained or losing face or not being appreciated. It is anxiety producing.

So when the anxiety comes, how do we ‘cast’ it? Luke 19:35 uses the same word for “casting.” It is the story of Jesus’ triumphal entry into Jerusalem. As Jesus rides on a donkey people cast their garments on the colt. They literally gave the garment to the colt to carry. They are not carrying it any more. It is not like casting in fishing, where you throw out the bait only to reel it back to you again. Instead you give the burden to another to carry.

John Piper, well known pastor and author says, “One of the greatest things about the God of the Bible is that he commands us to let him work for us before commanding us to work for him.”² In Matthew 11:28, the Scriptures say, “come to me, all of you who are weary and burdened, and I will give you rest. Take up my yoke and learn from me, because I am lowly and humble in heart, and you will find rest for your souls.” And the psalm writer wrote in Psalm 55:22, “Cast your burden on the Lord, and he will sustain you; he will never allow the righteous to be shaken.”

When we believe something to be true we act like it is going to happen. Trust that he cares for you. It is a command with a promise. The command is to cast your cares. The promise is that God cares

for you. Piper says, “He’s not going to stand by without exerting influence. He’ll act... and He’s God.”³ He’s the Chief Shepherd! Speak your trust to God. Philippians 4:6 says, “Don’t worry about anything, but in everything through prayer and petition with thanksgiving, present your requests to God. And the peace of God, which surpasses all understanding, will guard your hearts and minds in Christ Jesus.” We can add the ‘thanksgiving’ because we know for sure God will act.

See the needs of others and become the healing presence of Christ to them

When you know that God cares for you, your compassion toward others will be possible. You will notice the need in others. Weil (1950) says, “The capacity to give one’s attention to a sufferer is a very rare and difficult thing; it is almost a miracle; it is a miracle.”⁴ Allow God to work that miracle in and through you.

Story of Mephibosheth

Second Samuel 4:4 introduces us to someone named Mephibosheth. He was a son of David’s friend, Jonathan. The friendship of David and Jonathan was unusual; Saul is Jonathan’s father and is king. It would be normal for the king’s son to be the next king. But David has already been anointed the king by the choice of God through the prophet Samuel. Still between Jonathan and



David there was a close friendship. The story tells how Jonathan saved David's life and they made a promise to one another to always be friends. The story goes forward to the time when Jonathan and his father Saul are killed in battle. In the culture of the day the king's family, if they were not to remain on the throne, would go into hiding. The new king would otherwise destroy them all in order to stop anyone from trying to take over the throne. 2 Samuel 4:4 tell us that Jonathan, the son of Saul, had a son who was crippled in his feet. He was five years old when the news about Saul and Jonathan [who had just been killed] came from Jezreel, and his nurse took him up and fled, and as she fled in her haste, he fell and became lame. And his name was Mephibosheth.

Further on in the story, after David had been established as the King, it seems David had time to think of something other than his enemies. So chapter 9 2 Samuel opens with David remembering his friend Jonathan.

And David said, "Is there still anyone left of the house of Saul, that I may show him kindness for Jonathan's sake?" David asks the question of a servant named Ziba. And Ziba said to the king, (2 Samuel :3), "there is still Jonathan's son who was injured in both feet." So the King had Mephibosheth brought to him. Mephibosheth of course may have had a lot of anxiety to cast at that point in time! Not only is he a commoner being called into the presence of the King, he is the son of the former king and therefore considered a threat to the throne. He may well have thought this was it for him – after all his years of hiding. Verse 6 tells us Mephibosheth

son of Jonathan son of Saul came to David, fell face-down, and paid homage. David said, "Mephibosheth!" "I am your servant," he replied. "Don't be afraid," David said to him, "Since I intend to show you kindness for the sake of your father Jonathan. I will restore to you all your grandfather Saul's fields, and you will always eat meals at my table."

Surely that was a surprise to Mephibosheth. David shows how much he cares by not only giving land and food to Mephibosheth, but he commanded Saul's servant Ziba, (verse 9) "I have given to your master's grandson all that belonged to Saul and his family. You, your sons, and your servants are to work the ground for him, and you are to bring in the crops so your master's grandson will have food to eat. But Mephibosheth, your master's grandson, is always to eat at my table."

I'm sure Mephibosheth was surprised by the grace and caring of David. Like David, we as nurses can be the caring presence of God for others. Many may come to us thinking, "who cares?" Some think people only go to hospitals to die! Some have no family who visit or only the person who has been assigned to be with them and provide their personal care. Hospitals can be frightening and lonely places. Caring nurses who extend the grace of God to people become the healing presence of Christ to others.

Practice some self-care. Cast your cares on God and know for certain that God cares for you. And then see the needs of others and become the healing presence of Christ to them.

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New perspectives on global mental health: The emerging role of the nurse

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Introduction

In 1948, in the first bullet of the preamble to its constitution, the World Health Organization (WHO) defined health as follows: “Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity”. Despite this early identification of mental health as integral to health, it was not until this century that mental health emerged as a global health priority. What is mental health? WHO describes mental health as, “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (WHO, 2016, para. 1). Contrast this to mental disorder or mental illness, “a diagnosable illness that affects a person’s thinking, emotional state, and behaviour and disrupts the person’s ability to work, carry out daily activities, and engage in satisfying relationships” (National Council for Behavioural Health, 2015, p.2). Promoting mental health, preventing mental illness and the early identification and treatment of mental illness are all needed. As WHO states “There is no health without mental health” (2005, p.11).

Nurses can have a key role in addressing the global mental health problem. Not only are nurses the most prevalent health care professionals worldwide, they constitute the largest group of professionals working in mental health and their numbers exceed those of all other mental health professionals combined (Maulik, Daniels, McBain, & Morris, 2014, p.177). For Christian nurses, who practice from a Christian world-view, the call to bring God’s healing includes mental health and emerges from deep within the spiritual life. This paper will identify the scope of the global mental health problem, identify the theological underpinnings

of mental health practice, and delineate ways in which nurses can move out of traditional roles of caring for the hospitalized mentally ill to promote mental health and prevent mental illness.

Scope of the problem

A strong case can be made for the significance of addressing mental health as part of global health. An estimated one in four people worldwide will have a mental health condition in their life time (WHO, 2010). Statistics are available from many countries; in the authors’ country, the United States of America (U.S.A.), one in five adults will have a mental health disorder in a given year (NIH, 2016). How disabling are mental and behavioural disorders compared to other health problems? The World Health Organization (WHO) uses a metric known as the “disability-adjusted life years (DALYs)” which represents the total number of years lost to illness, disability, or premature death within a given population. What is the number one cause of disability worldwide? Heart disease? Stroke? Diabetes? The answer is depression, which affected over 300 million people in 2015. In addition, anxiety disorders were ranked the sixth leading cause of disability (WHO, 2015). The DALYs measure is a reminder that mental illnesses take a tremendous toll on individuals, families, and communities. Mental illnesses are serious problems and cannot be minimized to having “emotional problems” or “a bad day”. They certainly cause suffering but what are often overlooked are consequences like the global economic cost: an estimated one trillion dollars per year in lost productivity (WHO, 2017).

The global mental health challenge is not just about how common and disabling mental health disorders can be but also about the “treatment gap.” Globally, less than 50% of those who need mental health treatment receive it. This gap climbs to over 90% in the least resourced countries in the world (Patel et al, 2010). To address this disturbing health inequity, new strategies have been developed. The new

strategies encompass a much broader approach including education, health promotion, prevention and “task shifting” of treatment approaches. This “task shifting” moves mental health treatment beyond traditional mental health professionals to primary care providers and community health workers. Task shifting opens up new opportunities for nurses worldwide to play a key role.

Theological underpinnings: But where is mental health in the Bible?

Although the term “mental illness” is a modern term not found in the Bible, it seems clear that helping people with the full realm of health issues, including mental health issues, is part of God’s desire for Christian health workers. In the Old Testament, the prophet Isaiah in chapter 65 paints a picture of the restoration of all creation that is at the core of God’s comprehensive redemptive plan. Good health is part of that plan as seen in verse 20 (NRSV) where both infant mortality – “No more shall there be in it an infant who lives but a few days” – and premature death adults – “an old person who does not live out a life time “ are mentioned. In addition, this new creation includes the absence of emotional pain (v. 19, “no more shall the sound of weeping be heard in it”). The absence of emotional pain is also seen in John’s picture of the New Jerusalem in Revelation 21 verse 4 it states that “He will wipe every tear from their eyes. Death will be no more; mourning and crying and pain will be no more.” The ministry of Jesus knits together the Biblical dimensions of this holistic vision and the actions that flow from it as described in Matthew 9: 35: “Then Jesus went about all the cities and villages, teaching in their synagogues, and proclaiming the good news of the kingdom, and curing every disease and every sickness.”

The biblical concept of *shalom* has been suggested as a key to understanding holistic mission (Campbell, 2005). Although *shalom* is frequently translated as peace, it is a rich concept. Plantinga (1995, p.10) writes about the concept of *shalom*:

“The webbing together of God, humans, and all creation in justice, fulfilment, and delight is what the Old Testament prophets called *shalom*. We call it peace, but it means far more than mere peace of mind or cease-fire among enemies. In

the Bible *shalom* means universal flourishing, wholeness, and delight – a rich state of affairs that inspires joyful wonder as its Creator and Saviour opens doors and welcomes the creatures in whom he delights.”

The concept of “holistic mission” flows from the idea of God’s *shalom*. The Holistic Mission Issue Group that met as part of the Lausanne movement’s 2004 Forum for World Evangelization addressed this. They explicitly included mental health as part of holistic mission: “From this perspective, holistic mission is mission oriented towards the satisfaction of basic human needs, including the need of God, but also the need of food, love, housing, clothes, physical and *mental health* and a sense of human dignity.” (Padilla, 2005, p. 16)

What about the nurse?

For Christian nurses, the Good Samaritan has been described as the model for the nurses’ care ethic (Benner, 1998). As Benner relates:

“The story of the Good Samaritan suggests that the starting point in health care ethics should be in recognition and in relationship to the universal human reality of vulnerability and suffering. Moral worth and respect is to be accorded to all fellow human beings. Therefore, we are to be compassionate strangers to those who fall outside our own communities and kinships. Suffering and vulnerability are the common fates of finite embodied human beings. We each might need a fellow human being to respond with compassion to our needs for protection and comfort.” (para 2)

It is easy to extrapolate the role of the nurse in mental health care as part of the compassionate stranger role of the nurse. Unfortunately, one of the results of basic nursing education is a flawed view of mental health. Nurses generally are trained in inpatient facilities caring for the most severely ill at the time of crises when they cannot function without 24/7 supportive nursing care. In non-hospitalized mental health care, nurses are trained in Western models, which focus on the “50 minute hour” of one to one counselling with the psychiatrist or psychologist and those with prescriptive authority manage medication. The standard answer to the treatment gap has been to call for more-licensed professionals, more degrees in counselling, more resources to

provide more “50 minute hours.” There is now an abundance of seminaries with “Christian counselling” masters degrees. One reason for the popularity of these degrees may be that they provide a legitimized role for women in denominations who do not ordain women for other ministries. The ways in which nurses have been trained have limited the care models that nurses’ have experienced. Western models have been applied across the globe without questioning their “goodness of fit”. Western models have failed to meet the pressing global needs for mental health care.

Time for a new paradigm

The need for care is great. It is time to transcend the narrow view provided by Western models and embrace the newer emerging approaches to mental health care. These new approaches start with three levels: self-care, family care and community care. These three levels focus on prevention; providing education is a key component. Professional care comes in at a fourth level and starts in the primary care setting, before moving on to higher levels of specialty mental health care. Hospitalization for a mental health condition is the highest level of care in these newer models.

In addition, there is room for more models from more cultures. What are the strengths of the community? At the third International Lausanne Congress, held in Cape Town South Africa in 2010, the “Care and Counsel as Mission” Track developed “The Cape Town Declaration” (available in English at <http://www.belhaven.edu/careandcounsel/declaration.htm>). That declaration takes an unmitigated Christian stance, questions Western psychology as the only model of human understanding, and supports models that use indigenous, Christian models of human functioning, wholeness and resiliency. An example is provided in the work of Dr. Gladys Mwititi, a leading clinical psychologist in Kenya. Although her PhD from Fuller Theological Seminary School of Psychology provided training in classical Western methods, in her practice she has moved beyond this. She describes how she has been able to embrace the strengths and natural resiliencies found in African culture and practice psychology in new ways (Mwititi & Dueck, 2006). Her work, built on the newer models, has become the standard in Africa for addressing mental health concerns after violent events. An

example is available in her own words, after the Garissa attack in Kenya, in a video from the Kenyan television program “Citizen Weekend”, available on you tube, <https://www.youtube.com/watch?v=plOp8Ruwx18>.

How can nurses help?

Nurses need to start addressing mental health within their own communities and spheres of influence. Nursing needs innovative thinkers to address the ways nurses can be used in these new approaches. Nurses come to the table highly skilled in patient education and health promotion. Nursing care finds innovative ways to make connections and provide patients with support. Nurses are also trained as patient advocates. This general nursing expertise can be applied to the three initial levels of the newer models – teaching mental health self-care, promoting healthy family functioning, and strengthening communities. Nurses can take on greater roles to support the three initial levels to promote good mental health.

Christian nurses have access to church, one of the most stable and most important community organizations in many cultures. The church is an essential community resource. Mental health can be incorporated into existing health miniseries and existing programs of care for congregants. Faith Community Nurses can address mental health. Encouraging pastors to speak openly about mental health from the pulpit aids in reducing stigma. When offers to pray are made at end of service, mental health conditions can be identified by name as appropriate issues to bring forward for prayer. Support groups for new parents or those caring for the ageing fit well into the church setting. Other action steps for the church and mental health have been develop by the second author (Smith, 2015) are available at <http://www.belhaven.edu/careandcounsel/pdfs/12-Recommendations-Future-Church-and-Global-Mental-Health.pdf>.

Conclusion

The time to address global mental health is now. The opportunities are obvious. The needs are pressing. Christian nurses can make a difference in addressing disparities, preventing pain and suffering, and becoming conduits of healing for the world. Let nurses not be afraid to embrace new roles. As the scripture encourages us to

take on new things in Isaiah 43: 18–19: “Do not remember the former things, or consider the things of old. I am about to do a new thing; now it springs forth, do you not perceive it? I will make a way in the wilderness and rivers in the desert. (NRSV)”

Going deeper: Additional resources

- a regular online journal on mental health in a developing world context, **Developing Mental Health**, is free and can be accessed at <http://www.developingmentalhealth.org>
- The **Mental Health Innovation Network** provides a community of mental health innovators and resources for effective mental health innovations. <http://www.mhinnovation.net/>
- The **World Health Organization** has been cited many times in this article and provides a comprehensive mental health action plan for 2013–2020 at http://www.who.int/mental_health/action_plan_2013/en/
- cited in this article and reviewed in this issue of *CNI: The Routledge Handbook* is **THE recognized nursing book** for global mental health:

Yearwood, E.L. & Hines-Martin, V.P. eds. (2017). *Routledge handbook of global mental health nursing: Evidence, practice, empowerment*. Abington, Oxon: Routledge, Taylor & Francis Group.

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Love, Relationships and the Mind

Swee Eng Goh, SRN, BN, PGdipNS, Bachelor of Theology Nurse Clinician, Homecare Services [Fei Yue Community Services]

My interest in mental health until recent years was dormant when insight and understanding erupted like a volcano. I realise how empowering the learning journey has been for me personally and professionally.

For many years, as a nurse I didn't recognize the symptoms of bipolar or chronic depression. Even the nurses around me did not recognize mental health issues. This was until 2013 when I was invited to help start a nursing home for mentally ill people, then my perspective changed. My interest in spirit, soul and body connection to health helped me to see the clients in the nursing home with a different pair of eye lens. However, my observation on the standard treatment of people with a mental conditions was rather unsettlingly as I was rather uncomfortable with the conventional way of managing them.

Notwithstanding the learning curve took flight when I took a break from work from mid-2016. The luxury of time allowed me to delve more into issues around mental health. The first book I stumbled on was "Cracked"(2014) by James Davies who gave me a view that I never heard of – the harm of the current mental health care model. The book 'Pills for the soul? (2005)' by Dr. Dieter K. Multze challenged the churches to rethink their views on mental health. He wrote that the church has adopted wrongly a syncretistic views of mental health services where rather the blending of drug therapy, prayer and deliverance is the way to go, although not all churches adopt a deliverance ministry. His Biblical and scientific views reflect a view of a recent UN Human Rights publication by Dainius Puas a professor of psychiatry who wrote "There is now unequivocal evidence of the

failures of a system that relies too heavily on the biomedical model of mental health services... New ways of thinking need to permeate the public sector, and mental health must be integrated into the whole of public policy."(2017)

In 2017 I took short online courses on mental conditions and listened to online lectures. My perspective, now widened, was further challenged when I have had personal encounters with people with a mental conditions. Connecting with a person's heart does more than any medication can do. Understanding, confidence, courage, unconditional love and giving hope to the person are vital ingredients for the helper. No medication can ever take away fear, guilt and the shame of an individual who is heavily laden with these feelings. Pastors have such an important and prominent role in the healing and recovery of people with mental conditions. Nurses who are empowered through practical knowledge and skills play a important role in supporting the pastoral ministry of the church.

One of the greatest obstacles I face is that very few people want to be involved in the care of people with mental health conditions. I don't just mean an occasional call or 'give a treat' kind of ministry. I mean committed care.

Susie Kim's book "Interpersonal Caring"(2012 p95) reiterates the importance of the cultivation of personal relationships with patients. She wrote that "interpersonal caring can be implemented on the basis of recovery principles and approaches for the people with serious mental illness" If this is the case, what can nurses do to help people to understand and cultivate loving interpersonal caring as part of nursing care in the recovery and wellbeing of such persons? To answer my own question, I am planning to launch a community of practice on mental health in church this March. What are you doing?

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Book review

Routledge Handbook of Global Mental Health Nursing: Evidence, practice, empowerment

Reviewed by Amy Rex Smith

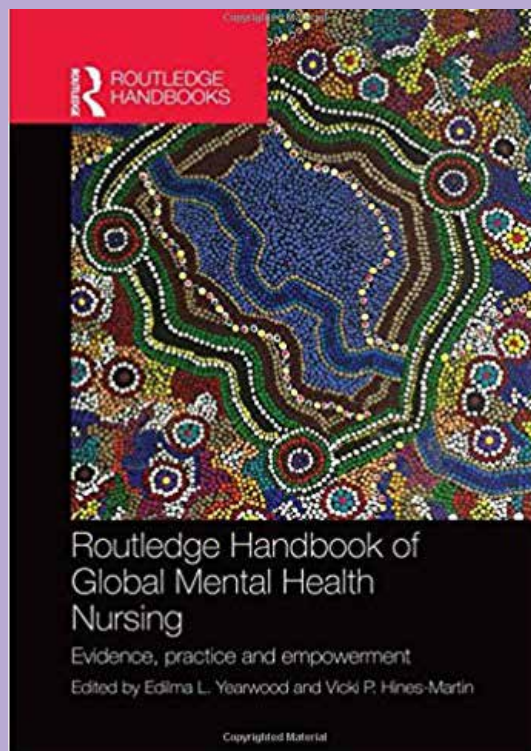
Abington, Oxon: Routledge, Taylor & Francis Group (2017), \$240 US, 492 pp ISBN-13: 978-1138017610 ,Kindle edition \$55.85 US ISBN-10: 1138017612 Edited by E.L Yearwood and V.P. Hines-Martin

Awarded second place in the 2017 American Journal of Nursing Book of the Year Awards in Psychiatric and Mental Health Nursing.

This massive book – almost 500 pages – was edited by two Americans and published in England. The size alone may explain the cost of \$240 U.S. dollars for the hard cover copy. I bought the Kindle version for about \$55 U.S. dollars. While using a Kindle version makes it harder to navigate, all of the information is present. The purpose of this book is to provide an international perspective on mental health nursing. The foreword is given by internationally renowned psychiatrist Vikram Patel, who lauds this book as first of its kind and acknowledges the importance of nurses in mental health care across the globe.

The book has thirty-three chapters is organized into four sections: (1) Historical and contemporary mental health nursing; (2) Promoting mental health nursing within social and cultural contexts: Best practices and clinical perspectives; (3) Cultural voices and human rights: Case exemplars; and (4) Empowerment strategies. While it suffers from the unevenness which is the weakness of any edited tome, it has much to offer. Its many chapters provide a smorgasbord of mental health nursing topics and everyone can find something of interest.

I was disappointed by the evidence-based health promotion strategies for major areas of practice internationally as I found the diagnosis by diagnosis approach too Western in orientation and too repetitious. The exemplars section represented a range of countries, reflecting different problems and approaches to mental health. This provided a wide scope of mental health nursing care internationally. The countries that were represented were Jamaica, Philippines South Africa, Australia, Malawi, Argentina, Japan, Canada and the United



Kingdom; there was also an exemplar on Korea Americans.

Because of my practice as a Faith Community Nurse and my resultant interests in health promotion and prevention, I was most taken with the entire section on Empowerment. This included two chapters, one on mental health literacy and one on models and frameworks of mental health care within community environments. These two chapters provided essential grounding for nurses practicing in faith communities who want to address mental health issues effectively.

This book would be a great resource to have in the library for a School of Nursing or at a central location for an agency or NGO. Because of the cost, I am certain that most nurses could not afford personal copies. If one needs this for personal practice, I would suggest the Kindle version as a good option. It contains valuable information and a single place to research the entire field of global mental health nursing.

Nursing students and depression: What can we do as nursing educators?

Susan Ludwick, DNP, MSN, RN, Sub-Editor CNI

Nursing students undergo a stressful academic program both in clinical and didactic settings. Stress can often lead to anxiety and depression. According to the Robert Wood Johnson Foundation, nurses experience clinical depression twice the rate of the general public (Lampert, 2016). Nursing students are also at high risk for depression compared to other students (Rezayat, 2014). The culture of survival in a nursing program which includes demanding lectures and clinical schedules, anxiety with simulation, increased stress with learning and applying new skills, high expectations and an obligation from faculty, family and peers to be successful leads students to feel overwhelmed which often leads to anxiety and depression. We as nursing educators need to better understand the strategies to identify those students who may be struggling with depression. We must also encourage peer support and encourage students to seek additional help if needed.

Several studies have been done to explore how nursing students deal with stress, anxiety and depression. For example, according to Chen et. al (2015), anxiety, sleep quality, and stress positively predicted depressive symptoms in junior college nursing students in a cross-sectional study in Taiwan. According to Ratanasiripong, Ratanasiripong, and Duangrat (2012), several interventions were utilized to help students prevent depression. These included stress management programs, relaxation workshops, humour, peer instructors, mentors, and mindfulness.

Based on evidence, peer support groups decrease anxiety and promote positive outcomes among nursing students. Some examples of peer support groups include mentoring, tutoring, and faith-based groups. Peer support groups also promote fellowship among the students, lessen depressive symptoms, increase satisfaction, increase confidence, and improve retention



(Smith, 2014). Several U.S. nursing programs have developed peer support groups. For example, nursing students at the University of Kentucky developed the Student Mentors Advantages for Student Health (SMASH). This group encourages nursing students to discuss their emotional needs, deal with the stress of grading expectations, and encourage each other to seek help if needed (Adams, 2016). Participants who had peer mentors scored lower on the State Trait and Anxiety Index compared to those without peer mentors (Walker and Verklan, 2015). According to Mollica & Mitchell (2013), peer mentoring decreased anxiety, increased self-confidence, increased retention, increased student satisfaction, and built leadership skills.

Faith-based peer support groups also serve as an encouraging way to support nursing students who are Christ followers and help lessen anxiety and depressive symptoms. Nurses Christian Fellowship International (NCFI) serves nursing students globally with peer support groups. National and local NCF groups offer students peer support, prayer, fellowship and friendship when students are feeling overwhelmed with the nursing program. Students often are able to reach out to one another and offer much needed encouragement to each other which maintains and sustains a positive student morale. NCF groups also offer Bible studies where students can study God's word and better understand God's love. Christian nurse faculty members who in some cases facilitate the

NCF peer support group, can also offer prayer, encouragement and support when needed.

As a nursing educator for over 20 years, I have observed many nursing students with depressive type symptoms. God is encouraging me to focus more on students' emotional and spiritual needs as they progress in a very demanding curriculum and stressful schedule. As nursing educators, we must recognize the signs that there may be issues with depression. Some of the students that give us concern include: a withdrawn student, one who is easily agitated, one who is overly perfectionist, one who communicates in confidence that she does not feel welcome in any of the study groups, and students who may be experiencing financial and personal issues while in the nursing program. So many nursing students are struggling with physical, emotional, familial, and personal issues which are affecting their learning, their academic and clinical performance and causing depression. Many of these personal issues may be related to their poor communication skills, not asking for help, and poor performance. As a nursing educator, I feel it is our responsibility to understand a student's individual story and try to better understand the personal struggles that may be hindering a student's learning.

God wants us to know that He loves us unconditionally, and students need to know about God's love. A student who is feeling overwhelmed with studying for tests, worrying about simulation, burdened with caring for an alcoholic father, feeling stressed because her car was towed due to not paying the bill or still feeling low from a boyfriend who ended a relationship will not be able to perform at her best. It is my goal to serve my students in love by recognizing the signs and symptoms that they may be experiencing depression, talk with them, encourage them to obtain peer support like the NCF group on campus, and encourage them to seek additional help if needed.

Psalm 139:14 reminds us: "I praise you because I am fearfully and wonderfully made; your works are wonderful and I know that full well." God loves us and we are all wonderfully made and so valuable to Him. As nursing educators, we must remember that we are called to love our students. Galatians 5:13, 14 .."rather, serve one another humbly in love. For the entire law is fulfilled in keeping this one command: Love your neighbour as yourself.

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Coping with stress in an unstable world

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Lessons from the elastic

Are you struggling with stress overload? Then you are not alone. This is a major issue in our societies at large, which invariably includes the world of Health Professionals.

Dr. Archibald Hart has observed and concluded that “we are entering an extraordinary new age in Medicine and the Health Sciences. On the one hand, we are making remarkable progress in curing illnesses and prolonging life. On the other hand, we are losing the battle against a very simple but elusive problem...stress. Despite medical sciences enormous studies in treating illnesses, the problems caused by stress are becoming more prevalent and difficult to treat. The time is rapidly approaching, if it hasn't already arrived, when we will be dying less and less from infections or evasive diseases, but more often from the ravaging effects of too much stress. And stress disease is different from most forms of illness...we bring it on ourselves” (1995, p 1).

What is stress and where does it originate? Dr. Hans Selye, the father of stress research, defines stress as a “non-specific response of the body to any demand” (1976, p 15) and Psychologist Archibald Hart indicates that it is a multifaceted response which includes perceptual, emotional, behavioural, and physical changes (1995). Is all stress negative? Not at all! Passmore & Chaleff (1988) describe stress as a generalized response to any demand whether joyful or painful. Selye (1976) had previously indicated that there are two types of stress; Distress and Eustress. Distress occurs when the stress or demands made upon the person have a negative impact. Eustress are the demands that challenge and provide opportunities ...that in fact keep life interesting, and leave the individual feeling energized in the long term. In fact, it has been observed that to have no stress is to not be living. What



then, determines the difference between feeling energized or eventually overwhelmed?

As human beings, made in the image of God, we have been endowed with the innate ability to respond to stress/demands, and to rise to the occasion. Imagine with me, the analogy of the Elastic. It has the capacity to expand; to respond to the demands that, in fact, reinforce its usefulness. It was made to stretch; to hold things together. But reflect on the elastic that has always been responding to demands...is continually stretched, with no “down time”. Its fibres begin to weaken, it loses its resiliency/elasticity, and eventually the ability to respond to demands. So it is with ourselves. We have a God-given capacity to respond and adapt to both normal and extenuating circumstances, through the stress response, known as the “fight or flight” syndrome. Adrenaline is released, which through a series of chemical reactions, allows us to respond; to rise to the occasion. However, if the demands are overwhelming or appear, *prima facie*, to be insignificant, or at least manageable but are ongoing, with no provision of rest or relaxation, then the ongoing release of Adrenaline begins to cause damage, both physically and psychologically. There are red flags that surface as an alert. These include, but are not limited to appetite changes, insomnia, frequent illnesses, anxiety, mood swings, irritability, forgetfulness, poor concentration, difficulty making decisions, withdrawing from relationships, cynicism, and apathy. If those are ignored, the consequences are inevitable. These are represented through both cardiac and mental health illness. These include Acute Myocardial Infarctions, CVA's,

Depression, and Anxiety. They are a direct consequence of stress or Adrenaline damage. How then can we prevent or at least slow down or reverse this pattern of deterioration in our current situation? It is by remembering and embracing the principle of Balance or healthy coping.

Our experience of stress needs to be balanced by relaxation and rest. There are primarily three categories that represent various coping strategies. These include (i) modifying the stressors, (ii) perceiving the stressors we cannot change in a healthy context, and (iii) building into our lives stress buffers.

This begins by coming to terms with the stressors that are within your capacity and healthy sphere of influence to change. This might include Stepping Back from the demands that are not high priority. i.e. by setting limits and saying “No”. It could also include ‘Letting go’ of responsibilities that belong to significant others. Time Management is another strategy that facilitates prioritizing and focusing on those tasks that are significant, and minimizing those that are not, without a sense of false guilt.

Stress Buffers promote an inner resilience to life’s demands. These include exercise, rest, and relaxation, time out including daily breaks, weekly Sabbath rest, and periodic vacations. Spending time in relationship with supportive, positive significant others, making time for fun and laughter, not only provide time away from stressors, but also serve to increase the release of positive chemicals classified as Endorphins. These, in turn, increase the sense of well-being and personal resilience in the presence of stress. As an example, research continues to reinforce the value of 30 minutes of vigorous walking, at least 4–5 times weekly, on the levels of Endorphins; their positive impact on the general well-being of that person. Finally, it is in recognizing, being mindful of, and coming

to terms with the places over which we are not intended to have control. Learning to let go of that perceived need, and seeing life in perspective, can be a life-long pursuit with immeasurable rewards. This includes an inner, deep-seated sense of well-being and peace of mind, accompanied by healthy relationships. Tapping into spiritual resources regularly, is an amazing, evidence-based source of strength and resilience.

In Psalm 46, we are reminded that even in places of natural disaster and turmoil i.e. earthquakes, war etc., there is a place of strength, refuge, and safety for those who choose to focus and meditate on the Awesomeness of God, Who both made and keeps all things together in this Universe. Remembering this Awesome God, in The Person of Jesus, Who for a time laid aside His right to be worshipped as God, so that we could have a relationship with Him, is very powerful. It is seeing Him in our places of struggle that allows us to put our experience of pain and stress into perspective. Finally, we are reminded in Philippians 4:4–8, to not get stuck in focusing on our challenges or struggles, but rather to talk to God, Who is in control of the Universe, about everything, and to focus on those things that are positive. The consequence is the gift of peace, independent of our circumstances.

Are you struggling in a specific situation, or just generally feeling overwhelmed? Perhaps the most helpful initial step is to breathe a prayer to God, the same prayer that was made long ago by St. Francis of Assisi’s: “God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference”.

Then find someone that you trust, who will walk with and support you on this part of your journey, towards Healthy Coping in this broken and unstable world.

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Reflexión sobre los deterioros de memoria en el adulto mayor desde la perspectiva Cristiana

Personal reflections on memory deterioration of the elderly from a Christian perspective

Por Ligia Mantilla, CECEC, Colombia, Enfermera Profesional egresada de la Facultad de Enfermería de la Universidad Nacional de Colombia Con experiencia en Salud Mental y en el cuidado del adulto mayor en un hogar geriátrico.

Ligia Mantilla, Professional Nurse, graduated from the National University School of Nursing in Bogotá, Colombia. and an active member of NCF Colombia, with experience in Mental Health Care and Caring for the Elderly in a Geriatric Home.

Relato de mi experiencia

Había pasado casi una hora y concluimos que esta actividad de tertuliar, hablar y escuchar nos servía para la memoria. “La memoria es muy importante para la vida, para ubicarnos” dijo una de ellas. “Ya que la memoria es una de las principales funciones del cerebro y además es un proceso activo, uno recuerda mejor lo que le interesa.” “Y a veces lo que le conviene” dijo otro.

Recordé en ese momento que había diferentes tipos de memoria, como la memoria declarativa y que ésta a su vez podría ser a corto plazo o a largo plazo y que dentro de la de largo plazo estaba la memoria episódica (autobiográfica y acontecimientos) como también una memoria semántica (lenguaje) y la memoria a corto plazo como la memoria de trabajo y ejecutiva.

Es prodigiosa la memoria cómo se gravan los recuerdos en la corteza cerebral de los lóbulos temporales, haciendo que sus surcos se hagan más profundos, más rugosos.

Había visto, durante mi vida laboral, pérdidas de memoria por lesiones cerebrovasculares, por problemas degenerativos, por problemas de sinapsis y neurotransmisores y por problemas emocionales. Muchas veces las personas dicen: “Tengo la palabra en la punta de la lengua” pero la palabra no llega, se evocan las imágenes. Y me acuerdo de Ursula en 100 años de Soledad del escritor Gabriel García Márquez cuando



empezaron a colocar letreros frente a cada objeto para recordar el nombre.

A la semana nos volvimos a reunir en el salón contiguo al patio rojo donde siempre está prendida la televisión, para continuar el conversatorio sobre la memoria. Pasa él con su bandeja repartiendo tinto, es un residente que colabora en la cocina. Pasa delante de la fila alineada de 4 personas, cada una en su silla de ruedas. Están muy cerca el uno del otro, no más de 15 centímetros los separan, pero sus pensamientos se alejan, no cruzan palabra, no cruzan mirada, ni un gesto. No hay la más mínima intención de acercamiento de un ser humano con el otro, sus ojos cerrados, ¿acaso duermen? , ¿acaso sueñan? ,¿acaso meditan?, ¿acaso añoran? Todos lucen gorros de lana que dejan ver cabellos lacios, cabellos canos, cabellos negros. Deben estar dentro del porcentaje de residentes con deterioro cognitivo, mental, social, físico que son los invitados especiales de los hogares geriátricos.

Entonces recuerdo la demencia senil del tipo Alzheimer, su proceso degenerativo, su pérdida de memoria, sobre todo la episódica reciente. Y a mi mente viene la tía Aura , su inhabilidad para adquirir nuevos aprendizajes y retener recuerdos, su desorientación, su pérdida de atención gradual, luego su confusión, su irritabilidad, su lenguaje pobre, repitiendo siempre lo mismo y el uso de “esa cosa” como palabra comodín. No podía leer ni escribir, su aislamiento le dolía, olvidó toda su historia, hasta el nombre de sus hijos, su pérdida paulatina de habilidades manuales. Ya no podía vestirse, cepillarse los dientes, ni usar los cubiertos, las apraxias.

Empezamos revisando un dibujo del cerebro, reconociendo las zonas de éste que tienen que ver con la memoria y el aprendizaje. Nos detuvimos en la neurona y sus conexiones y nos concentramos en la detección y aparición de síntomas sugestivos de alguna demencia. Todos empezaron a recordar historias de parientes

y conocidos; todos querían saber cómo los neurólogos podían hacer el diagnóstico.

Luego, de forma sencilla hablamos de los biomarcadores, como todo un equipo empezaba a examinar, a hacer test de memoria, a realizar exámenes como la resonancia,. miraban cómo funcionaba el metabolismo en el cerebro y a veces hasta hacían pruebas tomando muestras de líquido céfalo raquídeo para dar un diagnóstico acertado. Aunque siempre hay que tener presente que a medida que pasa el tiempo van apareciendo problemas vasculares, metabólicos degenerativos y ya a veces nos desconcentramos, nos elevamos.

Luego se continuó con un poco de actividad física, estiramientos muy sencillos. Luego cada uno recibió su hoja donde había un dibujo que miraron por unos minutos con mucha atención. En seguida se volteó la hoja y se empezó a hacer preguntas sobre detalles del dibujo y pasamos a la siguiente actividad. Cerramos por un instante los ojos para traer a nuestra mente la imagen de nuestra comida preferida recordando los más mínimos detalles y los recuerdos que nos traían. Uno a uno fueron hablando del famoso ajiaco de navidad, los ingredientes, los acompañamientos, el arroz con pollo, el famoso tamal con chocolate. Evocaron los momentos vividos con su familia y recordaron a sus padres, hermanos, compadres, vecinos. A mi mente vino la imagen de mi abuela con su pañolón gris, haciendo el famoso postre de natas, evidencia de esa memoria sensorial que nos hace recordar olores, evocar perfumes, saborear aromas, recordar texturas, volver a tener 20 años y recordar sus labios frescos, húmedos. Finalizamos el taller hablando de las actividades que debemos tener en cuenta para tener un envejecimiento activo, como son una dieta baja en grasa, comer frutos secos, dieta rica en vitamina E, dormir bien, no fumar, hacer ejercicio, hacer ejercicios de memoria, leer, hacer crucigramas, sopas de letras, socializar, participar en actividades recreativas, que no falte el vino rojo, el optimismo, para poder seguir disfrutando días de sol y días de lluvia.

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The Centre for Profound Education (CPE)

Positivity care of children for children with learning disabilities in Pakistan

Sana Mirza Ba (Hons) in Applied Social Sciences, MA in Criminology, University of Brighton, Program Coordinator at Center for Profound Education Trust

The Centre for Profound Education Trust; a non-profit organization established in March 2013 is the vision of Dr Shakil Malik; Emeritus Consultant Psychiatrist Senior Clinical Director Mental Health Services at Sussex Partnership NHS Trust (UK). This psychosocial welfare program was designed to cater to the special needs and learning disability/ies of children and young adults in the twin cities of Rawalpindi/ Islamabad located in the Punjab province of Pakistan.



The centre was built on the foundations and rationale that only four per cent of children with special needs have access to schools in Pakistan as shown in statistics provided by the Department of Education (2013); out of which 66 per cent of disabled people lived in rural areas and 34 per cent in urban areas. Dr. Malik; with the realization of this unfortunate truth and the dearth of services provided in his country of origin; envisioned and conceived the program as an individualistic effort to counter in his own personal capacity this gross violation of human rights of individuals with disability in Pakistan, which is also referenced as a mandate in the Sustainable Development Goals (2015).



CPE aims to promote learning, managing problems of behaviour and/ or health by imparting an explicit skills-set training in areas identified as being deficient or lacking in knowledge and ability.

The School provides an individualized structured program for just over fifty students' the majority of whom belong to a low socio-economic stratum.

The Centre aims to enable each student to reach his/ her optimum potential in a barrier-free and disability conducive environment.



The program offered at CPE specifically targets and focuses on teaching children with special needs 'life skills' to ensure independence, enabling students to meet the challenges of practical living. CPE facilitates their learning through the latest educational techniques backed by professional consultations, diagnosis, treatment, therapy and counselling where

needed by highly qualified psychiatrists and educationalists from the United Kingdom.

CPE's mission is to improve the quality of life and care of children/ young adults with special needs in a country, which is pervasively engrossed in explicit negative attitudes towards disabled people. To achieve equality and change public attitudes the Centre has adopted a systematic approach to ensure students are given utmost respect in terms of their capability and capacity and to wherever possible be reflective of their independence and productivity.

Part of the mission is to spread awareness and building an understanding on disability by extending support to families and sensitize community on special needs and the importance of special education.

Overtime, CPE has made significant gains by giving chances to life and opportunities to living for just a little over fifty children and their families. With the help of a dedicated team of twenty personnel who have through compassionate care, excellence in service-delivery and boundless patience stood on principals of de-stigmatization, non-discrimination and inclusion of differently-abled children in mainstream community. CPE generates funds from a pool of friends who donate generously however the school still suffers from a huge deficit of 1000 pounds every month, which is a mammoth impediment threatening its existence and sustainability.

Those at CPE have complete ownership and bear the onus of social responsibility as global citizens



of providing love and care to children with special needs. Please help join the CPE family and support us in exploring avenues of raising funds, transferring skills and expertise, volunteering time and ideas and enable us to carry our school to new levels of success.

With this fact in remembrance at all times that the repercussions of a disabling society can be equally far-fetched and crippling for those who are seemingly 'enabled' and 'empowered'.

CPE is not merely a structural intervention aimed at improving disabled children's living standards but also simultaneously tackles an attitudinal change to prepare Pakistani society as being aware and appreciative of the worth of human life and its diversity.



Resilience

Dr Louise Younie MBChB, DRCOG, DCH, MRCP, MSc, GP and Clinical Senior Lecturer, Barts and The London School of Medicine and Dentistry, QMUL (Queen Mary University of London)

At a time when health professionals may feel they are facing more pressures than ever, the concept of resilience has gained traction with increased writing, research and practice exploring how to develop resilience in our students and workforce (Dunn et al., 2008, McCann et al., 2013).

Resilience as a concept may be thought of as the capacity of an individual to withstand challenges and remain intact. This draws on the field of the physical sciences where resilience is described as the ability of materials to resume their original shape after being bent or stretched (Dong, 2016). However, resilience thus described might give us the impression it is about the individual capacity to be tough. Yet another competence or skill to master. Resilience, I would like to propose, is not purely individual (being affected by the health and resilience of the organisation (Balme et al., 2015)) and neither is it about toughening up.

Resilience is less about how much we can withstand and more about how we deal with our inherent vulnerability and weakness as human beings

Resilience is less about how much we can withstand and more about how we deal with our inherent vulnerability and weakness as human beings (and health professionals). A recent experience for me gave rise to the idea of the three S's: *Self-awareness*, *Seeking help* and *Solidarity*. My feeling of a lack of confidence in general practice after two years away with maternity leave and then cancer was brought to a head with an experience of excess anxiety in managing an unusual patient case of cauda equina in a 36 week pregnant lady. Everything was dealt with correctly, but my heightened anxiety was unfounded (*self-awareness*). I decided that I should seek help and saw my own wonderful GP who helped me realise that it would be useful to request mentoring or support from

my practice. This led to very warm and supportive conversations with a GP partner and the practice manager and reminded me that I am not alone (*solidarity*). I also asked for spiritual mentoring or support from my church which even after one meeting has begun to be restorative. This, no doubt is an ongoing journey for me rather than a fait accompli.



From my work with medical students over the years, seeking help and speaking up, especially within a competitive and macho environment, takes courage. Yet when medical students are given a safe and creative workshop space, self-doubt is a theme which often emerges, usually with a few students contributing.

Can you see the tiny black fish in the bottom left hand corner swimming amongst bright and brilliant other fish? This image was made by a medical student on a creative arts for health course as an assignment, to describe how she felt amongst her colleagues. On sharing this text in the room, a palpable sense of relief ensued. Two other students had also created images exploring their felt vulnerability. They explained their own images privately in their reflective journals. Through sharing, students realise they are not alone. Another year, on a similar arts for health course, one student produced an image of a grape on a chess board and wrote:

The photo I took to represent my time at med school so far was of a grape on a chess board, surrounded by beautifully carved, hard, honed, black chess pieces lining up for battle. Whatever else I have learned or failed to learn, over the last week, I certainly feel more like a grape among grapes now.

A paper well-loved by medical students which highlights the importance of community, of sharing difficulties and facing limitations has the title '*If Every Fifth Physician Is Affected by Burnout, What About the Other Four? Resilience Strategies of Experienced Physicians*' (Zwack and Schweitzer, 2013). This is a qualitative research paper exploring 'resilience fostering actions' identified in practicing clinicians. The three S's appear again. On the theme of *self-awareness*, they mention reflexivity, personal reflection and 'recognising when change is necessary'. Under *solidarity* was the 'quest for and cultivation of contact with colleagues'. Finally, the research promotes 'proactive engagement understanding the limits of our skills, Thus the importance of all three, of *self-awareness*, *solidarity* and *seeking help*.

The picture I am seeking to paint with these examples is that of engaging with our shadow

rather than running from it (to draw on Jungian imagery), or coming out from, rather than hiding behind our fig leaves. Chris Johnstone (2016), a doctor working in the field of resilience writes 'face what you face' as the first step. It seems we have been created with weakness which penetrates to the core of our being and we are tempted as humans to respond by giving an air of confidence and strength. Greater strength may, however, begin with acceptance of our weakness.

Paul writes in 2 Corinthians 12: 9–11

But he said to me, "My grace is sufficient for you, for my power is made perfect in weakness." Therefore I will boast all the more gladly about my weaknesses, so that Christ's power may rest on me. That is why, for Christ's sake, I delight in weaknesses, in insults, in hardships, in persecutions, in difficulties. For when I am weak, then I am strong.

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About NCFI

Doctrinal basis

The following are the basic beliefs which NCFI members hold and which encompass the basic beliefs of the Christian Faith:

- the unity of the Father, the Son and the Holy Spirit in the Godhead
- the Person of the Lord Jesus Christ as very God, of one substance with the Father, and very Man, born of the Virgin Mary
- the Divine Inspiration and supreme authority of the Holy Scriptures in all matters of faith and conduct
- the guilt and depravity of human nature in consequence of the Fall
- the substitutionary Death of our Lord Jesus Christ and His Resurrection, as the only way of salvation from sin through repentance and faith
- the necessity for the New Birth by the Holy Spirit and his indwelling in the believer

Aims

- encourage Christian nurses and nursing students to live out their faith in compassionate professional practice
- deepen the spiritual life and cultural awareness of Christian nurses and nursing students around the world
- promote friendship, communication, connection and collaboration among Christian nurses worldwide
- support Regional NCFI Councils (Committees) and National NCFI organisations in their ministry with nurses
- empower Christian nurses to examine and apply scripture as it relates to professional practice
- equip and support the development of Christian nurse leaders around the world
- represent Christian nursing in the global nursing and healthcare arena

Culture

- faith and prayer
- *this is the lifestyle by which we will be known*
- integrate Biblical principles into our professional nursing practice
- *this is the how we live out our calling*
- participate in healthcare to demonstrate Jesus' love through equipping, encouraging and empowering nurses to provide competent and compassionate care
- *this is our life of nursing as ministry*
- seek to respect and understand cultures, languages, local customs, and healthcare practices as we serve
- *this is our commitment to incarnation*
- work with, learn from and encourage those who share the same purpose
- *this is our commitment to local communities of believers and the global Body of Jesus Christ*

Strategic goals 2013–2021

1. establish a sustainable financial and administrative infrastructure to achieve the aims of the organisation
2. establish an effective worldwide communication and collaboration network
3. develop an International Institute of Christian Nursing to equip nurses in professional practice, education and collaborative research
4. expand a network of prayer and praise across the organisation
5. initiate and develop key partnerships across like-minded organisations and institutions
6. organise international conferences normally every 4 years
7. expand the organisation through increased membership including students, active practitioners and retired members

Announcements

NCFI regional conferences

Full details of the upcoming Regional Conferences will be found on the web site www.ncfi.org

PACEA: June 7th–10th 2018, Chientan Youth Activity Centre, Taipei Taiwan

Africa: October 7th–12th 2018, Jos Plateau State, Nigeria

CANA: July 18th–22nd 2018 Azusa Pacific University, Azusa California USA

South America: October 2018 Argentina, Please refer to the website for further details

Europe: Please refer to the website for details

SAME: November 15th–19th 2017, Lamb Hospital, Dinajpur, Bangladesh

Editorial notes

CNI accepts a wide range of submissions including

- letters to the editor
- research manuscripts and literature reviews
- opinion pieces
- reports and book reviews
- educational articles
- spiritual teaching
- experience manuscripts

All submissions should be forwarded to the editor for consideration (babsparfitt@hotmail.co.uk). The editorial committee will review submissions to ensure that they adhere to the aims and scope of CNI.

Research papers should follow the accepted format of reporting including an abstract, introduction, design, method, results or conclusions and discussion. They **should not be more than 2000 words in length** and must indicate the ethical approval process has been undertaken.

Manuscripts addressing topics of interest, educational approaches and spiritual teaching should **normally be no more than 1500 words** or less. Letters, reports and opinion statements should normally be **500 words** or less. If you are uncertain regarding the length or type of your submission please contact the editor.

All manuscripts should be word processed using Microsoft Word, Times Roman, spacing normally

1.15. Grammar and English should be checked as far as possible before submission. Avoid complex formatting, as this is sometimes difficult to transfer into the main document. British English spelling is preferred and should comply with the Concise Oxford Dictionary.

Articles written in Spanish or French will be considered.

References should be presented normally using the Harvard style, author names followed by year of publication. e.g. (Jones 2015). When a web page is cited the date when it was accessed should be noted. DOI's should be included when possible for Internet accessed publications.

Photographs and tables etc. should be submitted of the highest possible quality to allow for printing and titles should always be given. No pictures or tables should be submitted without permission from the copyright holder.

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NCFI Congress 2020

The next NCFI World Congress will be held in Denver, Colorado, USA at the Colorado Christian University.

- THEME: Opportunities and Challenges in Nursing Today: A Christ-centered Response.
- Venue for the 2020 NCFI World Congress: Yetter Hall, Colorado Christian University, Denver.
- Pre Congress Training Courses will be held – July 10–13, 2020



Denver is in the heart of the beautiful Rocky Mountains of Colorado

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