"And when they [Job's three friends] raised their eyes from afar, and did not recognize him, they lifted their voices and wept; and each one tore his robe and sprinkled dust on his head toward heaven. So they sat down with him on the ground seven days and seven nights, and no one spoke a word to him, for they saw that his grief was very great." (Job 2:12-13)

✣ Lecture II: Emotional Expression ✣

✣ What is Your Definition of Stress?

We are all familiar with the word '*stress*'. Stress is when you are worried about getting laid off from your job, or worried about having enough money to pay your bills, or worried about your mother whom the doctor said she needs an operation. In fact, to most of us, stress is synonymous with worry, but stress is actually a result of many different kinds of circumstances: happy and sad. Therefore, if you are used to thinking that stress is only something that makes you worry, you have the wrong idea of stress. Consequently, many people carry enormous stress loads and they do not even realize it. To your body, stress is synonymous with change. Anything that causes a change in your life causes stress. It does not matter if it is a 'good' change or a 'bad' change, they are both stress. When you find your dream apartment and get ready to move, that is stress. If you break your leg, that is stress. Good or bad, if it is change in your life, it is stress as far as your body is concerned. Moreover, imagine change in your life is also stress. Now with this broad definition of stress in mind, let us evaluate some emotional responses to stressors.

✣ Suicide:

a) Suicide Facts & Figures: (From the National Institute of Mental Health)

- In 1999, suicide was the 8th leading cause of death for males, and 19th leading cause of death for females. Suicide is the 3rd leading cause of death for young adults 15 to 24, following homicide and unintentional injuries.
- More men than women die by suicide. Males are four times more likely to die from suicide than females, but females are more likely to attempt suicide than males.
- In 1999, the total number of suicide deaths was 29,199.
- In 1999, more people died from suicide than from homicide. The ratio was 5:3.
- In 1999, there were twice as many deaths due to suicide than deaths due to HIV/AIDS.
- The strongest risk factors for attempted suicide in adults are depression, alcohol abuse, cocaine use, and separation or divorce.
- The strongest risk factors for attempted suicide in youth are depression, alcohol or other drug use disorder, and aggressive or disruptive behaviors.

b) Suicide From a Christian Perspective: (Adapted from an article by H.G. Bishop Youssef)

- Those who commit suicide will be judged as murderers of themselves. Suicide prevents the possibility of repentance thereby jeopardizing salvation.
- Our body is the temple of the Holy Spirit **(1 Cor 6:19-20)** and damaging this temple is a sin.
- A mentally ill person who is responding to hallucinations, delusional thoughts, or other bizarre thought process is an exception and cannot assume responsibility for his/her suicide.
- Suicide could be a means of manipulating others or a way of causing pain to the family.
- Suicide is a violent act against God's sovereignty.
- With this blatant disregard of life, and the lack of repentance associated with suicide the Orthodox Church cannot pray over the body of a person who has induced his/her own death because St. John said, "there is sin leading to death. I do not say that he should pray about that" **(1 Jn 5:16).**

c) What Can You Do to Help?

Suicide is increasingly becoming a fatal antidote to the problems of emptiness, pain and depression that seem to be reaching epidemic proportions in our culture. But suicide is preventable. Most suicidal persons desperately want to live. They are just unable to see alternatives to their problems. Suicidal thinking and destructive behavior is a result of a pain-filled life. Long-term pain causes stress. Over time, stress (emotional, psychological and/or spiritual) can lead to depression. It is at this point that suicidal thinking often enters the depressed person's thought processes. Escape from pain provides the necessary motivation. Relief becomes the primary objective. Most suicidal people give definite warning signs to their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them. If you suspect someone of suicidal tendencies, trust your suspicions. Take the danger seriously. Your intuition is probably right. Be attentive to these common warning signs:

- Suicide Speech – Listen carefully. Take all suicidal statements seriously, including indirect statements, such as, "My family would be better off without me."
- Prior Suicide Attempts – People with previous attempts are at greater risk.
- Surviving family members not only suffer the trauma of losing a loved one to suicide, but also are themselves at higher risk for suicide.
- Sudden Behavioral Changes – Extended periods of crying, sleeplessness and loss of appetite can be warning signs. Also, drastic changes of behavior, withdrawal from friends and/or social activities, taking unnecessary risks and/or an increase in use of alcohol or drugs are all indicators of suicidal intent.
- Depression – People who have experienced a recent loss or a person who is depressed is 500 times more at risk than one who is not depressed. Individuals who are depressed often lose interest in their personal appearance and previously pleasant activities such as hobbies, work, or school.
- Making Final Arrangements – For example, giving away possessions to family members and friends, or preparing for death by making out a will and final arrangements.
- Isolation and Withdrawal – Almost all suicides can be traced to one or more broken relationships. When relationships fail, people often isolate themselves.
- Extremely Aggressive Behavior – This reveals the amount of pent-up emotion inside a person. If large amount of guilt also are present, aggression may be inward.

d) Care-giving Principles:

- Never promise to maintain secrecy when suicide is a concern. Bringing the situation out into the open with those who can help may prevent an attempt.
- Talking about suicide does not cause someone to be suicidal. Inquire about suicidal thoughts and feelings, and be willing to discuss them in detail.
- Determine how far along he/she is in making plans for suicide. Use the acronym, S.L.A.P., to gain information:
  1. **S –** What are the *specific* details?
  2. **L –** How *lethal* is the plan? Firearms are the most commonly used method of suicide.
  3. **A –** How *available* is the method of choice?
  4. **P –** What is the *proximity* of help? Who will find him/her? How long will it take to be found?

  If the person can answer each of these questions clearly, then the risk of suicide is extremely high.
- Ask the person to repeat a promise not to hurt himself/herself for a specific period of time, and to give you possession of the means by which he/she intends to commit suicide.

- Be sure that the person can reach you or another responsible person if the desire to commit suicide becomes strong or if he/she feels the need to talk to someone.
- Insist that he/she does have a choice. Almost always, there are healthy ways to alleviate pain. Your primary job is to provide those alternatives. Remember that the person threatening suicide really does not want to die. He/she wants to end the pain.
- Listen. A depressed person's present need to be heard far outweighs the need to be taught.
- Surround the one in pain with support. Point and physically lead the person to other sources of help. Arrange professional help if at all possible.

Hundreds of thousands of suicides have been prevented by caring people who listened well and gave wise counsel. Our lives must continually echo St. Paul's words, "Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and God of all comfort, who comforts us in all our tribulation, that we may be able to comfort those who are in any trouble, with the comfort with which we ourselves are comforted by God" **(2 Cor 1:3-5).**

✣ **Chemical Dependency:**

For every ten people who consume alcohol or drugs in this country, at least one becomes chemically dependent. Addiction has an exponential impact beyond the life of the individual addict; adversely affecting three to five other lives of people related to the substance user. The implication of this fact upon the future of our society is enormous. Conservative estimates reveal that some 15 million people are addicted to alcohol alone. As prices drop and availability increases, the number of people becoming addicted to illegal drugs is also climbing steadily.

With an estimated one in three families ravaged by alcohol and drugs and 87% of adults in a recent survey calling drug abuse among teens a very serious problem, preventative action is now necessary within every home. And the earlier the better!

Surveys report that one in every three forth graders feels pressure to drink. Research indicates that the average age at which children first experiment with alcohol or marijuana is 12. And according to a recent Gallup poll, more than 4 million children age 13-17 said they had been offered illegal drugs within the previous 30 days.

Availability is only one of the many drug-related threats among teens; another is physical maturity. Teenage bodies are three times more susceptible to alcohol addiction than adults. Many become alcoholics within six months of their first drink.

a) Why Do People Abuse Alcohol/Drugs?

Chemical dependency typically evolves from abusing alcohol and/or drugs in an illusive attempt to meet one's emotional needs for comfort and esteem. The "quick fix" brought on by alcohol and/or drug consumption is often a way to self-medicate, thereby temporarily masking emotional pain. Getting drunk or high begins as a mood-altering experiment that progresses as a repetitious coping mechanism for "getting along" with life.

Chemical substances produce real feeling of euphoria or relief, especially in the early stages of use. As the pleasure centers of the brain "learn" this effect, impulses to use or drink, even when consumption causes negative consequences, gradually exceed the rationale for appropriate restrain. Defense mechanisms such as denial and repression sabotage decision to quit. Finally, addiction takes over when the substance actually alters brain chemistry so that the drug becomes vital to the brain's normal functioning.

b) Stages of Addiction:

- **Experimenting and Learning –** The user is encouraged to try alcohol or drugs by peers or other significant others. Attracted by the prospect of an escape from pain (emotional and/or physical) the user experiences the desired effects of the substance, often with few identifiable consequences. With time, the user learns to trust the substance and its effects and learns that the effects are controlled by the amount of intake.
- **Seeking –** In this stage the user often engages in social consumption and establishes limits for intake. Occasionally the user may consume to excess and experience hangovers, blackouts or other physical manifestations of overdoing. During this stage a person may continue to control the amount of drugs/alcohol consumed. Disruption in school or work may result; however, the user generally feels no emotional pain for drinking/using.
- **Obsessing –** Alcohol and drugs become increasingly important. The user becomes preoccupied with getting drunk or high, developing a compulsive approach to drinking or using. During this stage the user begins to experience a periodic loss of control over alcohol and/or drug use – often breaking self-imposed rules about substance use – and increase consumption. A sense of self-worth declines, and the abuser begins to feel guilt and experience a sense of shame. The abuser often projects self-hatred onto others, as personal health, relationships with others and fellowship with God are adversely affected, while he/she begins to rationalize, justify and minimize negative feelings toward self.
- **Consuming –** The substance "has" the user, and now he/she must consume the alcohol/drugs just to feel "normal". The addict believes that other people and circumstances are the roots of his/her problems. At this point, the addict may entertain thoughts of escape such as suicide, leaving the family or moving. Feeling of guilt, shame, remorse, anxiety, paranoia and anger escalates, and the addict experiences a further deterioration of physical, mental, spiritual and emotional health. Additionally, the addict experiences symptoms of withdrawal.

✣ **Obsessive Compulsive Disorder:**

Obsessive Compulsive Disorder, commonly called OCD, is characterized by obsessive thoughts and/or compulsions that have great power over a person. The sufferer simply cannot get rid of debilitating fears and unwanted thoughts. Obsessions can be so strong that the mind is consumed with doubt. This is why OCD is sometimes called the "doubting disease". OCD often produces a profound fear that something terrible will happen unless the sufferer carries out certain rituals, such as washing of the hands, checking and re-checking electrical appliances or locks, hoarding objects, etc. After performing the ritual a certain number of times, the sufferer finally starts to feel that "everything is OK now". Then the ritual can be discontinued – until the obsession occurs again. It is estimated that 3% of the population in the United States – about 5 million people – have this debilitating condition. Approximately 80% of sufferers experience both obsessions and compulsions.

a) Symptoms of OCD:

- Obsessions are unwanted, recurrent, and persistent thoughts or images that are extremely difficult to suppress and cause overwhelming anxiety. These thoughts may be frightening or embarrassing.
- Compulsions are repetitive, ritualized behaviors one feels driven to perform to alleviate anxiety or to keep something terrible from happening.
- People with OCD make up their own rules that must be followed each time the ritual is carried out. The OCD sufferer knows that the compulsion does not make sense, but once the ritual is completed the person feels better for a short period of time. The compulsions are never pleasurable.

b) Common Obsessions:

- "Something has to be placed in a certain order or arrangement."
- "I must do [something] very slowly in order to get it right."
- "I have to do [something] over and over again to make sure that it is right."
- "I am very concerned with [certain word, numbers, sounds or images]."
- "I am very superstitious that some numbers are lucky [or unlucky]."
- "I can't throw out useless or old things because I might need them in the future."
- "I am afraid of getting dirty or infected with germs."
- "I am afraid of being violent or hurting others."
- "I am afraid that disaster might occur."
- "I feel guilty about blasphemous religious thoughts."
- "I feel guilty and ashamed of perverse sexual thoughts."

c) Common Compulsions:

- "I have to [clean or wash my hands, shower, bathe, brush my teeth] over and over."
- "I have to clean [curtains, house, car] over and over."
- "I have to put things in a certain order over and over."
- "I have to check [door locks, light switches, stove] to be sure they are correct."
- "I have to [climb up and down stairs, go through doorways, or do things] over and over again."
- "I have to count up to a certain number over and over again."
- "I just can't throw out things, such as old newspapers, magazines, mail, or containers."
- "I have to read the newspaper or listen to the news to make sure that I have not caused a disaster."
- "I ask other people for reassurance that something has or has not happened."

d) What is the OCD sufferer's greatest fear?

The greatest fear of many people with OCD is that other people will find out and think that they are crazy. This is why OCD sufferers often attempt to hide their pain and their symptoms. They know that their symptoms don't make sense and waste massive amounts of time but feel helpless because they simply can't get those thoughts out of their mind or stop doing the compulsive rituals.

✣ **Anorexia:**

A life-threatening condition has increased to epidemic proportions in America during the 1990s. Thousands of adolescent girls and young adult women have fallen prey to anorexia nervosa. Anorexics are obsessed with thoughts of becoming thin even when they are already so thin their body hardly casts a shadow. So they pursue "thinness" by a severely restricted diet and overly vigorous activity. In the process they often become anxious, fixated, guilt-ridden and dangerously underweight.

The high-risk population for anorexia nervosa includes adolescent females between 12 and 18 years of age. Within this age group, as many as one girl in every 250 may develop this debilitating disorder. Mortality rates now exceed 5%, and women account for 95% of the cases.

The majority of anorexics come from middle to upper-middle class families. Their fathers frequently hold professional positions, and they enjoy all the conveniences of modern living. They usually attend the very best schools. Often, their families value physical fitness, and one or both parents will generally be on a diet. Mothers and sisters of anorexics frequently suffer from related eating disorders and place value on a slim appearance for family members.

During childhood the anorexic is typically described as a model daughter who accepts all the family values and attempts to fulfill everyone's expectations. She is usually highly intelligent, but may be self-critical toward her school performance. Anorexics tend toward extreme perfectionism. She is competitive, yet somehow socially reserved, at times even shy. Although she usually relates well to her friends, these relationships are often superficial.

The anorexic's initial decision to diet to improve her appearance is consistent with the family's value of a slim appearance. Over time she begins to demonstrate a subtle, sick preoccupation with dieting. She begins to develop a distorted body image and sees herself as heavier than she really is. Paranoia about gaining weight is common. She develops anxiety about eating and becomes obsessed with an overly strict and strenuous exercise program. Often sleeplessness may develop.

Once the anorexic begins to fall below a healthy weight she will enter a sustained battle with her family. She may begin to limit the effect of meals by vomiting or consuming laxatives. She experiences the cessation of menstruation. When the anorexia becomes acute there are myriad of psychological and physiological consequences, often serious enough to threaten mental balance and physical well being. Anorexia nervosa can be a life and death matter and hospitalization may be indicated.

✣ **Phobias:**

Phobias are inordinate fears, which vary in degree from mild situational discomfort to an overwhelming fear that can disrupt a person's life. Phobias are divided into three major classes:

- **Agoraphobia –** Excessive fear of being in places or situations from which escape might be difficult or at least embarrassing, or fear of situations in which help might not be available should the person become incapacitated.
- **Social Phobia –** Excessive fear of being observed by others, fear of being unable to talk without faltering, fear that something embarrassing might happen, or hands shaking while trying to eat or write. This fear centers around social situations where the person is observable. He is afraid that he will embarrass himself in some way.
- **Simple Phobia –** Excessive fear of a particular object or situation such as fear of an animal, of heights, of closed spaces, of blood, or of physical injury. Animal phobias are very common in childhood and usually disappear without treatment. Phobias of blood or injury often begin in adolescence or young adulthood. Most of the specific phobias begin in the third or fourth decade. Treatment may not be necessary, but if it is required, therapy for phobias can be very successful.

The cause of phobias is uncertain, but there is mounting evidence that a person who develops these inordinate fears has inherited an overactive nervous system. Whatever the cause, phobias tend to become self-perpetuating through three major mechanisms:

- A stressful or phobic situation causes an outpouring of adrenaline that provokes very unpleasant physical and emotional reactions. The person's heart rate may accelerate; the mouth may become dry and the hands sweaty; there may be tremors; breathing can be shallow, rapid and feel impaired. The person may become pale, feel nauseated and have an urge to go to the bathroom.
- The secondary reaction is a compounding of these symptoms because he feels others can see that something is wrong with him, adding more to his embarrassment and fear.
- The third mechanism is called anticipatory anxiety, which means the person is so fearful of the anxiety reaction and its presumed consequence that anxiety develops simply over the thought of

being in a fear-producing situation. This causes further nervous system arousal and increases the likelihood of having an anxiety reaction in the situation.

The hallmark of a successful treatment centers on the concept of desensitizing or de-conditioning.

Social phobias are best treated with a combination of psychotherapy and medications called:

- Beta-blockers, which block the adrenaline-type physical reactions.
- Tranquillizers, which block the subjective symptoms of fear.

Once the physical and emotional reactions are under control, the person then needs to confront the situation from the mildest example of what would trigger the phobia until he can eventually engage in the most severe form of the situation. Repeated success results in desensitization so the person loses the anticipatory fear and his entire nervous system settles down. Finally, he can stop his medications and continue to have success in the situations that formerly aroused incapacitating anxiety.

Simple phobias and in some cases social phobias, can be treated strictly through behavioral techniques that result in desensitization. All of these techniques are highly successful. The Christian has additional resources. By claiming on a moment to moment God's promise that He will never leave or forsake us, we have assurance that He will go "through the water and the fire" with us and that we will not be "swept away or burned up".

By focusing on God's unconditional love and forgiveness, believers will be less vulnerable to what others happen to think. Queen Esther said, "If I perish, I perish!" **(Esther 4:16)** and the apostle St. Paul said, "We have been made a spectacle to the world, both to angels and men. We are fools for Christ's sake" **(1 Cor 4: 9-10).** These two individuals did not have anticipatory anxiety because they were not intimidated by real or imagined consequences.

Christians are better able to claim or stand on the promises when they are not overwhelmed by physical and emotional symptoms of anxiety. Medications and therapy can help reduce these symptoms so that they are better able to appropriate the powerful, healing, protective Christian principles that are so numerous throughout the Holy Scripture.

---

* Most of this lecture is extracted from www.raphacare.com