UNIT 5

Chapter 7

Contemporary Social Issues

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Table of Contents

Contemporary Social Issues

As healthcare Chaplains, we will increasingly confront a number of crucial, sometimes controversial, social issues that will force us to address them in some way or another. It is essential, therefore, for us to have a good understanding of these issues, to have thought through our position on each of them, and to be able to communicate our understanding of the issue clearly and effectively to others.

Chaplains who come from a church ministry background will discover an entirely different environment in the healthcare setting. The faith community accepts, supports and values mutually held beliefs. The pluralistic healthcare setting brings together people from all different walks of life, religious beliefs and worldviews. The Chaplain needs to be respectful of these various positions, even though s/he may not agree with all of them. The Chaplain's ability to do this with gentleness will be tested when it comes to dealing with people facing some of these contemporary social issues.

This chapter will discuss abortion, addictions, AIDS, alcoholism, euthanasia, and suicide. The resources section will list other issues: eating disorders, homosexuality, and surrogate motherhood. After reading this chapter, the Trainee will be asked to write essays on some of these subjects. In researching a subject, use the resources at the end of this chapter, other resources available in a library or on-line, and refer to one's own experience and knowledge of the Scriptures in presenting one's viewpoint.

Abortion

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If we accept that a mother can kill even her own child,
how can we tell other people to not kill each other?
Any country that accepts abortion is not teaching its people to love,
but to use any violence to get what they want.

— Mother Teresa (1910-1997), Roman Catholic Nun

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An abortion is the termination of a pregnancy by loss or destruction of the fetus before birth. An abortion may be spontaneous or induced. The latter is an act with ethical and legal ramifications.

Medical Aspects

Spontaneous abortion, or miscarriage, occurs when the embryo fails to develop, when there is complete or incomplete expulsion of the products of conception — the embryo or fetus, and placenta — or when the fetus dies prior to 20 weeks from the woman's last menstrual period (LMP). If fetal death occurs at 20 weeks or more after the LMP, it is termed a late fetal death or a stillbirth. As many as three-fourths of conceptions probably result in a spontaneous abortion. Most occur before the woman's pregnancy can even be confirmed — prior to 6 weeks after her LMP. They constitute about one-fifth of confirmed pregnancies and about one-tenth of all hospitalizations for pregnancy in the United States. The woman may experience cramping and blood loss, or pains closely resembling those of childbirth.

Induced abortion is a procedure intended to terminate a suspected or known pregnancy and to produce a nonviable fetus at any gestational age. Most induced abortions in the United States are performed in the first trimester—within 12 weeks of the LMP. The technique for most first-trimester pregnancy terminations utilizes a procedure called vacuum aspiration or vacuum curettage. After dilation of the cervix, a hollow

plastic tube with a hole near its end is inserted into the uterus. The embryo or fetus and placenta are drawn into the tube through vacuum pressure.

Second-trimester induced abortion involves a more complicated procedure. If the pregnancy has progressed to no more than 16 weeks since the LMP, the most common technique is dilation and evacuation, a method that is similar to vacuum aspiration. The next most common procedure, injection of fluid into the amniotic sac, is usually postponed until after the 16th week in order to reduce the risk of injection outside the amniotic cavity. Fluid injected into the cavity may be either a saline solution or hormones called prostaglandins. Comparative studies of abortion techniques have determined that surgical evacuation techniques, especially up to 17 weeks' gestation, are safer than instillation techniques.

Hysterotomy (surgical incision of the uterus) and Hysterectomy may be used when medically indicated. In France, during the 1980s, an abortion-inducing drug call RU 486 (mifepristone) was proved 85 percent effective during the first six weeks after LMP, especially when used with prostaglandins. On September 28, 2000, the United States Food and Drug Administration approved RU 486 for sale in the United States for use to end early pregnancies (up to seven weeks after a missed menstrual period). In the approval notice, it was described as a "safe, effective, and non-invasive way" of ending a pregnancy.

While many women are quick to celebrate the legality of RU-486 as a means of getting women "out of the stirrups" and "into their own homes," it does not change the fact that both surgical and non-surgical procedures end a baby's life. Whether by pill or curette, innocent lives are being extinguished.

Legal Aspects

Although discouraged by most major religions, induced abortion has been practiced in every culture since ancient times. During the 19th century, several countries passed laws prohibiting abortion to protect women from the dangerous methods then in use. Between 1920 and 1967 the USSR, most Eastern European and Scandinavian countries, Japan and Great Britain legalized abortion. About half of the world's people live in countries where abortion is available on request. Another one-fourth lives in areas where abortion is permitted to protect the woman's health. The most restrictive policies tend to be found in fundamentalist Islamic countries and countries of sub-Saharan African and Latin America. In several of these countries, however, medical practitioners provide abortions without being prosecuted. In the 1980s, about 40 to 60 million induced abortions occurred each year; about 33 million of them were legal.

In the United States, legal induced abortion was generally unavailable until 1970, when a few states liberalized their abortion laws. Early in 1973 the U.S. Supreme Court declared most restrictive abortion laws unconstitutional because they violated the woman's right of privacy. Since then, abortion has been generally available throughout the United States. The 1973 Supreme Court cases Roe v. Wade and Doe v. Bolton left the decision to have a first-trimester abortion to the woman and her physician. States could pass regulations to ensure the safety of second-trimester abortions and could prohibit third-trimester abortions. Since then, further restrictions have been legalized. In the 1989 case of Webster v. Reproductive Services, the Supreme Court upheld a Missouri law that prevented the performance of abortions by public employees or in taxpayer-supported facilities. In 1990 the Court ruled that states may require teenage girls to notify both parents before obtaining an abortion or else request a judicial hearing. A 1991 administrative decision barred federally funded clinics from mentioning abortion as an option, but this restriction has been somewhat eased.

Several state legislatures have voted on bills that would outlaw abortion except in cases of rape, incest, or to save the mother's life, but most have not passed or have been vetoed by the governor. Severely restrictive laws have been passed in several states as part of an effort to produce a Supreme Court decision reversing Roe v. Wade. In 1992 the Court upheld the 1973 ruling but permitted states to place further restrictions on abortions, such as parental or spousal notification and a 24-hour waiting period before the procedure. The Hyde Amendment passed by Congress in 1976 severely restricted federal funds for abortions, although many states continue to fund abortions for indigent women. In 1988 the Reagan

administration banned federal funding of research using fetal tissue obtained from induced abortions, a ban extended by the Bush administration in 1989.

Impact of legalization: Deaths from illegal abortions amounted to one-fifth of all deaths related to pregnancy and childbirth in the United States. After the 1973 decision, mortality and hospitalizations dropped dramatically, in part due to improved training and the use of safer techniques among abortion providers. Legalization also stimulated development of more convenient and lower-cost service. By the 1980s most abortions were in freestanding clinics, and about one-half were outpatient procedures. About 27 per 1,000 U.S. women of childbearing age had induced abortions each year, a rate higher than in other industrialized Western nations but about half the worldwide rate. Studies of long-term consequences of abortion show that risks of spontaneous abortion, preterm delivery, and low birth weight for a second pregnancy following vacuum aspiration are no greater than risks for a first pregnancy. These same studies have also been unable to link abortion with long-term psychological problems.

Ethical Aspects

Opponents of legalized abortion believe that human life begins at conception and that abortion is the intentional killing of a human being. Members of the "Right to Life" movement have lobbied for a constitutional amendment on the rights of the unborn. Opposing this position is the "pro-choice" stance, which stresses the woman's right to choose to continue or terminate a pregnancy. "Pro-choice" supporters also argue that legal abortion is safer than illegal abortion and relieves the psychological and social problems associated with bearing an unwanted child.

If a person shoots a bald eagle—the symbol of the United States—the judicial system will throw him in prison and toss away the key. That same system will stop a multi-million-dollar dam in the state of Tennessee to save an inch-long snail-darter fish or fly the President of the United States to the northwest sector of America to discuss the fate of a spotted owl. Yet should someone wish to destroy a human baby growing inside a mother's womb, such an act will be looked upon not only as entirely within that person's rights as an American citizen, but as perfectly legal.

While the U.S. Supreme Court outlawed the death penalty for hardened criminals, it simultaneously imposed that same penalty upon multiplied millions who never had committed a single crime. Their only "crime" was that they were not "perfect," or that they threatened to arrive at an "inconvenient" time. Abortion is a violation of biblical morality and should be opposed by every faithful child of God. The Proverbs writer stated: "These six things the Lord hates, yes, seven are an abomination unto Him: a proud look, a lying tongue, *hands that shed innocent blood*, a heart that devises wicked plans, feet that are swift in running to evil, a false witness who speaks lies, and one who sows discord among brethren" (6:16-19, emphasis added). What blood could be more innocent than that of a tiny infant not yet fresh from the womb?

Biblical Aspects

What does the Bible have to say about abortion? The Bible forbids the killing of innocent people (Exodus 20:13). The Israeli midwives were commended by God for refusing to obey Pharaoh's command to kill all male babies at birth (Exodus 1:16-21). God told Jeremiah, "I knew you in the womb" (Jeremiah 1:5). In Luke 1:41, 44 there are references to the unborn John the Baptist, who was at the end of his second trimester in the womb. The word translated "baby" is the Greek word "*brephos*" which is the same word used for the already-born Jesus (Luke 2:12, 16) and for the babies brought to Jesus to receive his blessing (Luke 18:15-17). Exodus 21:22-25 indicates that the life of the unborn baby is equal to the mothers.

"For you created my inmost being you knit me together in my mother's womb. I praise you because I am fearfully and wonderfully made; your works are wonderful; I know that full well. My frame was not hidden from you when I was made in the secret place. When I was woven together in the depths of the earth, your eyes saw my unformed body" (Psalm 139:13).

Addictions

Every form of addiction is bad,
no matter whether the narcotic be alcohol or morphine or idealism.

— Carl Jung (1875-1961), founder of analytical psychology[1]

We may have "overdosed" on the term *addiction*. The word pops up repeatedly and is used to describe people who cannot control their dependence on drugs, alcohol, sex, pornography, and various kinds of foods. People talk, as well, about addictions to work, television, shopping, sports, the Internet, and computer games. Addictions are mentioned so often and so casually that it can be easy to forget their ability to strangle a life.

But genuine addictions are too painful to be treated lightly. We know addictions can destroy bodies, marriages, families, vocations, and even Pastors and Chaplains. These people need accountability, assistance from caring brothers and sisters, and the help that comes from God in bringing freedom from the addictive ties that are so binding.

When people hear so much about addictions, they tend to accept them as something that is a part of life. In time, they even begin to overlook obvious addictions in their midst and convince themselves that demonstrated addictive behaviors can be good. The best example is gambling. It has become a socially sanctioned addiction. Across the country, legislatures and communities are encouraging gambling to stimulate the economy, provide funds for schools, and attract tourist dollars. Missing from this discussion about casino windfalls are reports about gambling's proven potential to harm individuals and hurt communities. It is deceptive in its promises, made to look attractive, advertised without restriction, and lauded as the financial savior for cash-strapped communities or school districts. But gambling exploits human weakness, stimulates greed, spawns street crime (sixty percent of pathological gamblers engage in crime to promote their habit), corrupts governments, and undermines lives. The director of Harvard Medical School Center for Addiction Studies predicts that in the coming decade there will be more problems with gambling addiction among youth than currently exists with teenage drug addiction.

The Problem[2]

Everyone is deeply addicted to his or her favorite sins, whether it is gossip, petty criticism of others, or self-centeredness. Paul described the condition perfectly in Romans 7, as he described himself as a sinner addicted and attached to sin, doing the very things he did not want to do, and not doing the things he should. Sin addiction is so powerful that it even captured Paul, a man who had met Christ face-to-face. Paul's experiences and his ongoing struggles are evidence that spiritual experiences do not immunize anyone from the addictive power of sin.

[1] HCMA may not agree with everything Carl Jung said, but this statement is worth reflecting on as you think about this subject.

[2] The following is adapted from Stephen Arterburn, radio talk-show host of *New Life Live* and founder of New Life Ministries, in his article, "The Addiction Challenge: Helping Our Clients Break Through Denial and Enter the Reality of Life," *Christian Counseling Today* 4.4 (1996): 10-11.

The key difference between common sin and sin in addictive proportions is that in common sin, the *person* has a problem; in addictive sin, the *problem* has the person and has consumed the person in the futile fight for control over the addiction. With sin, the struggler repents and heads in the other direction. With addiction, the turn cannot be made until the person recognizes the futility of the addiction. No amount of willpower, spiritual insight, or emotional strength will pull addicts from the grips of the addiction. No matter how "good" they get or "strong" they grow or "insightful" they become (the three reasons they seek counsel), their addiction and the recovery from it (or failure to recover), will be a part of their lives forever. Therein lays the challenge for the counselor. Since no one wants to be labeled an addict or go through the long process of recovery, denial becomes the counselor's biggest adversary. The addiction challenge starts with assisting people in breaking through their denial and entering the reality of life beyond their limited power to fix themselves.

The Solution

1. *See it.* Lamentations 3:40 says, "Let us examine our ways." It is the counselor's job to help clients see the full dimensions of their problems and their inability to fix them on their own. Probing into the various areas of blindness will help them see that what they are experiencing is not the norm.

Though it may have been years since they experienced the initial euphoria, addicts continue trying to repeat it with more of the addictive behavior or substance. Whether the addiction is to drugs, sex or gambling, the addict has an insatiable tolerance for the mood-altering act. More stimulation eventually produces less satiation for the addict.

It is important to help the addict see how much s/he consumes or participates in the problem behavior. It is also important to help them see that their efforts to fix their problems on their own have failed. Ask the addicts to contrast who they were, what they did and how they felt when they began their addictive behavior to what their life is like now. Continue to probe into the areas where the addiction has produced undeniable consequences and altered behavioral patterns. Finally, help them to see that they have proven they have no power over the addiction. Then invite them to see God's power as sufficient to help them overcome it.

2. *Say it.* In James 5:16, Christians are told to confess their sins to each other and to pray for one another so that they might be healed. In Psalm 32, David explains that in his silence his bones grew old. Bringing the person to a point of open confession about the reality of his/her problem, who s/he has hurt, and how s/he feels is perhaps the greatest gift a counselor can give to an addict. It also prepares the person for spiritual renewal.

3. *Own it.* Owning the problem means being able to admit that what was once a problem has grown into an addiction. It requires a willingness to participate in groups with others who have the same problem. Owning it means taking the label of addiction and wearing it without shame, knowing that it is a sign of strength to survive its deadly progression.

The process of owning it also involves experiencing and acknowledging the pain, rather than running from it. In his *Confessions*, St. Augustine said, "In my deepest wound I saw Your glory and it dazzled me." Owning the problem is seeing God through the pain rather than being blinded by the pain.

4. *Release it.* When people are released from their pasts, they have come to understand, accept and forgive in every way. They understand and accept the forgiveness God has provided for them and they live accordingly. They also begin the process of forgiving those who have hurt them. Finally, they are able to forgive themselves.

The counselor's role is to help them, according to Hebrews 12:15, remove all areas of bitterness and resentment so that anger will decrease and serenity will increase. Once addicts release the grudges they have against others, they can experience the grace of God and live in it freely. This can take years to accomplish (and some never do).

5. *Reverse it.* When people in A.A. take the message of recovery to other strugglers, they are reversing the addiction. They are reaching out to comfort others with the same comfort that God has provided for them (2 Corinthians 1:3-4). People in this phase survive, recover and then go out to assist other people. They get out of themselves and into other people. What was very evil and shameful in the past now becomes something that God can use to benefit others. This reversal process is what brings the most fulfillment to addicts. It is the phase of recovery that provides the best hedge against relapse.

AIDS

AIDS destroys families, decimates communities and, particularly in the poorest areas of the world, threatens to destabilize the social, cultural, and economic fabric of entire nations...Where pain and suffering exist, we must provide comfort and solace. Where neglect and inequity prevail, we must bring compassion and justice.

— Rabbi David Saperstein, director of the Religious Action Center of Reform Judaism

Acquired Immune-Deficiency Syndrome (AIDS) is a serious illness. The virus that causes AIDS (called HIV—Human Immunodeficiency Virus) attacks a person's immune system, the body's natural defense against disease. Damage to the immune system leaves the body vulnerable to secondary illnesses that can be fatal. There is still no known cure for AIDS, but research continues in the hope of developing treatments and a vaccine.

HIV is mainly spread (1) through sexual intercourse with an HIV-infected person; (2) by reusing a needle used by an HIV-infected person to inject illegal drugs; and (3) from HIV-infected mothers to their infants before, during or after birth (through breast-feeding). HIV may also spread through blood and blood products, though this is very unlikely now because all donors are carefully screened and all donor's blood and blood products are tested before being used. Current research shows that HIV is *not* spread by casual contact. For example, it is not spread by nonsexual, everyday contact such as touching, hugging, shaking hands, breathing, coughing, using toilets, telephones, drinking fountains, etc.

So far, most AIDS cases have occurred among (1) homosexual and bisexual men who contracted HIV through sexual activity with an infected person; (2) heterosexuals who contracted HIV from sexual activity with an infected person; (3) intravenous drug abusers who share infected needles to inject drugs; (4) hemophiliacs who apparently contracted HIV through the use of donated blood and blood products; and (5) children who contracted HIV from an infected mother. In 2007, it was estimated that 33.2 million people lived with the disease worldwide, and that AIDS had killed an estimated 2.1 million people, including 330,000 children. Over three-quarters of these deaths occurred in sub-Saharan Africa.[3]

Although treatments for AIDS and HIV can slow the course of the disease, there is currently no vaccine or cure. Antiretroviral treatment reduces both the mortality and the morbidity of HIV infection, but these drugs are expensive and routine access to antiretroviral medication is not available in all countries.[4] Due to the difficulty in treating HIV infection, preventing infection is a key aim in controlling the AIDS epidemic,

[3] "2007 AIDS Epidemic Update," UNAIDS, WHO (December, 2007).

[4] F. J. Palella, Jr, K. M. Delaney, A. C. Moorman, et al, "Declining Morbidity and Mortality Among Patients with Advanced Human Immunodeficiency Virus Infection. HIV Outpatient Study Investigators," *New England Journal of Medicine* 338.13 (1998): 853–860.

with health organizations promoting safe sex and needle-exchange programs in attempts to slow the spread of the virus.

To protect ourselves from any risks we may face in a healthcare facility, follow these recommendations for "universal precautions":

- Do not make assumptions about who is infected. Take appropriate precautions with all patients.
- Wear gloves anytime we might come in contact with blood, potentially infectious body fluids, any body fluid containing visible blood, and items and surfaces that may be contaminated.
- Wear masks, eye protection and gowns if there is a chance of blood or other body fluids splashing on us.
- Prevent wounds from sharp instruments and needles.
- Protect open wounds from contact with potentially infected materials. Properly cover any broken skin surfaces.
- Wash hands and other skin surfaces immediately after direct contact with blood or other body fluids (without gloves, masks, etc.), after removing gloves and other protective gear, and after handling potentially contaminated items.
- Take care of contaminated articles and infectious waste, according to the facility's policies for reprocessing or disposing of such items.
- Stay informed about our healthcare facility's policies. Follow all recommended procedures exactly.

As a Chaplain, we need to reject the myths about the illness. Misinformation has caused a great deal of unnecessary panic. We need to respond without fear to the needs of all people who require our spiritual help. It is common to have some fears about AIDS. However, it is our responsibility to give quality chaplaincy care to everyone. Discuss any concerns we may have about HIV/AIDS with the Teaching Chaplain.

Keep our knowledge of HIV/AIDS patients confidential. (Confidentiality should be a regular part of our chaplaincy care with all patients we visit.) Be supportive of them. Treat the HIV/AIDS patient with the same compassionate care with which we minister to all persons.

Our role as a Chaplain is to facilitate an environment where patients can articulate their spirituality as a resource for living and dying with HIV/AIDS. Support their need for confidentiality. Help them differentiate between those things over which they can have some control and those things that they cannot control. Listen to them. Be empathetic. Examine and deal with our own biases and judgmental attitudes.

Alcoholism

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For most normal folks,
drinking means conviviality, companionship and colorful imagination.
It means release from care, boredom and worry.
It is joyous intimacy with friends and a feeling that life is good.
But not so with us in those last days of heavy drinking.

— Alcoholics Anonymous, *The Big Book*

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As we became subjects of King Alcohol,

shivering denizens of his mad realm,
the chilling vapor that is loneliness settled down.
It thickened, ever becoming blacker.
Some of us sought out sordid places,
hoping to find understanding companionship and approval.
Momentarily we did —
then would come oblivion
and the awful awakening to face the hideous Four Horsemen —
Terror, Bewilderment, Frustration, Despair.

— Alcoholics Anonymous, *The Big Book*

Alcoholism refers to the drinking of alcoholic beverages to such a degree that it seriously and repeatedly interferes with major aspects of an individual's life — such as work, school, family relationships, or personal safety and health. Alcoholism is considered a disease, meaning that it follows a characteristic course with known physical, psychological and social symptoms. The alcoholic continues to consume alcohol despite the destructive consequences. It is generally thought that once the disease has developed, the alcoholic will not drink normally again. An alcoholic who abstains from drinking can regain control over the aspects of life with which alcohol interfered. The alcoholic is then said to be "recovering," not "cured," from the disease. It is important to note that the symptoms and pattern of drinking problems may vary with the individual. This variability has led some researchers to question the accuracy of the disease concept of alcoholism.

A person does not have to drink every day to be an alcoholic. Moreover, someone who drinks frequently, or sometimes gets drunk, is not necessarily an alcoholic. It is possible to abuse alcohol for a short or contained period without developing alcoholism. For example, some people may drink abusively during a personal crisis and then resume normal drinking habits. College-age people tend to drink more heavily than other age groups. It is often difficult to distinguish such heavy and abusive drinking from the early stages of alcoholism.

Nearly 14 million American adults, or 7.4 percent of the population, are estimated to be alcoholic. Alcoholism is found among all age, socio-cultural and economic groups. An estimated seventy-five percent of alcoholics are male, with twenty-five percent female. Alcoholism is a worldwide phenomenon, but it is most widespread in France, Poland, the Scandinavian countries, the United States, and Russia.

Symptoms and Causes

Some common signs of alcoholism in the early stages are constant drinking for relief of personal problems, an increase in a person's tolerance for alcohol, onset of memory lapses while drinking ("blackouts"), surreptitious drinking, and an urgent "craving" for the first drink. Dependence on drinking gradually increases and memory blackouts become more frequent. A physical dependence first appears with early morning tremors and agitation that require a drink for relief. In the late stage, drinking bouts are usually very frequent. There is an acute withdrawal syndrome (delirium tremens, or DTs) when drinking ceases. This includes agitation, tremors, hallucinations and possibly seizures.

Most likely, a combination of biological, psychological and cultural factors contributes to the development of alcoholism in any individual. Alcoholism often runs in families. Although there is no conclusive indication of how the alcoholism of family members is associated, studies show that fifty to eighty percent of all alcoholics have had a close relative who is an alcoholic. Some researchers, therefore, suggest that some alcoholics have an inherited physical predisposition to alcohol addiction.

Rodents can be selectively bred to become "heavy" drinkers. Human twin studies almost always show that identical twins are both more likely to be alcoholic than are fraternal twins. Perhaps the most persuasive evidence for a genetic factor in alcoholism is the finding in several studies that children of alcoholics have a high rate of alcoholism whether they are raised by their alcoholic biological parents or by adoptive parents who are not excessive drinkers. The presence or absence of certain genes has been reported to be associated with alcoholism, but later studies have failed to confirm this association.

Alcoholism is commonly believed to be related to underlying emotional problems, but this is difficult to prove. Heavy drinking produces anxiety and depression as well as guilt. Prospective studies of individuals who have later become alcoholic have not consistently shown emotional disturbances when the individuals were children. Some studies show an association of alcoholism with bipolar disorder and others do not. More consistently there seems to be an association with anxiety disorders, such as social phobias. Psychologists suggest that alcoholics have conflicts about oral dependency, gender identity and family roles. There is little systematic evidence that these problems precede heavy drinking. No one has identified a single personality type associated with alcoholism.

Social and cultural factors are assumed to play a role in establishing drinking patterns in alcoholism. Given the wide divergence of alcoholism rates from culture to culture, this is certainly plausible. There is a great deal of speculation about the role of culture in drinking, but the theories are as widely variable as variation in alcoholism rates.

Social Effects

The effects of alcoholism range from the direct physiological impact on the individual to a widespread effect on society. In the United States, one family in three is estimated to be affected in some way by a drinking problem.

Children may be affected by their father or mother's alcoholism in several ways. Having a problem-drinking parent increases the risk of becoming a problem drinker oneself. This may happen because of identification with or imitation of the alcoholic parent, but also because the social and family conditions associated with alcoholism are among those believed to contribute to the development of alcoholism. These include family conflict, divorce, job insecurity, social stigma, and the availability of alcohol in the home. Other problems reported in children of alcoholic parents in the United States and in Europe include hyperactivity, school problems, antisocial behavior and drug use. As noted, adoption studies indicate that children of alcoholics have an increased risk of alcoholism even when they have no exposure to drinking parents. Thus, imitation and domestic turmoil cannot explain the development of alcoholism in every case. Alcoholism is an enormous public health problem. Alcoholism and alcohol abuse in the United States cost society an estimated $98 billion and takes 100,000 lives per year, according to the National Institute on Alcohol Abuse and Alcoholism. These high costs are due to lost production, increased health and medical care, motor vehicle accidents, violent crimes and social programs that respond to alcohol problems. One-half of all traffic fatalities and one-third of all traffic injuries are related to the abuse of alcohol. Also, one-third of all suicides and one-third of all mental health disorders are estimated to be associated with serious alcohol abuse. Accidents associated with alcohol problems are especially prominent among teenagers. It has been estimated that there are over 4 million problem drinkers between the ages of 14 and 17 in the United States.

Treatment

Alcoholism is a complex disorder for which a combination of treatments may be necessary for recovery. If the alcoholic is in the acute phase of alcoholism and is suffering from complications such as DTs or serious health problems, hospitalization may be necessary to let the alcoholic detoxify or "dry out." Many types of treatment programs are available, ranging from self-help groups such as Alcoholics Anonymous, outpatient clinics, halfway houses, psychotherapists, social centers, religious organizations, foster homes, hospitals and inpatient centers. Most programs combine counseling and behavior modification. Two 1992

studies found that the drug Naltrexone can reduce the craving for alcohol in recovering alcoholics and, in combination with other programs, may reduce relapses.

Because alcoholism is a chronic condition, hospitalization is only a first step toward recovery. Many alcoholics go through several brief hospitalizations for detoxification before they commit themselves to a program of recovery. Some large corporations sponsor treatment programs for employees. An assessment of the patient's medical, emotional, and social needs is important in making the proper referral. Not every type of facility is available in every community, but every community probably has access to a state- or citywide system that provides for alcoholics and can help make referrals.

No one can make an alcoholic commit himself or herself to recovery. Some therapists suggest that family members may influence the alcoholic by not supporting drinking activities, by seeking therapy for themselves, and by not joining in the alcoholic's denial of the problem. Because alcoholism is sometimes thought of as a family disease, the involvement of family members can aid the progress of the alcoholic's recovery. For the fewer than 5 percent who fit the stereotype of the homeless, jobless, skid-row drunk, alcohol worsens the deterioration of family, economic and social resources.

Perhaps a minute percentage of alcoholics can return to moderate drinking. For the overwhelming majority, abstinence from alcohol is the one real hope of returning to a normal life. Once drinking has ceased, the alcoholic is free to cope with problems that may be associated with alcoholism.

The 12 Steps of Alcoholics Anonymous

Step 1: "We admitted we were powerless over alcohol — that our lives had become unmanageable."

- Powerlessness and helplessness (Numbers 11:14-17; Jeremiah 9:23-24; Luke 13:10-13; John 15:5; Romans 5:1-6; 7:18–8:2; 2 Corinthians 1:9; 3:4-5).
- Man's Extremity of weakness becomes God's opportunity to help (Psalm 116:5-9; Mark 4:35-41; 5:21-29).
- Strength in weakness (2 Corinthians 12:1-10; Hebrews 11:32-34).

Step 2: "We came to believe that a power greater than ourselves could restore us to sanity" (Jesus).

- Examples of weak faith (Matthew 6:28-30; 8:23-26; 14:23-32).
- Examples of strong faith (Matthew 8:1-3; 8:8-10; 9:18-25; 9:27-29).
- Obstacles that test faith of believers (Matthew 15:21-28; Mark 5:35-36; 10:13; Luke 5:17-26; John 9:1-25; 11:1-6).
- Insanity — Hebrew word for "fool" (Psalm 14:1; Proverbs 12:15).

Step 3: "We made a decision to turn our will and our lives over to the care of God as we understood Him."

- The surrendered life (Matthew 11:28-30; John 10:1-10; Galatians 2:20).
- Submission to Divine will (Psalm 32:8-9; 40; 143:10-11; Proverbs 3:5-6; 28:26).
- Pleasing God (Proverbs 16:7).
- Understanding (Psalm 119:104-106; Proverbs 2:6).
- Salvation through Christ (John 3:16; Acts 2:21; 4:12; 15:11).

Step 4: "We made a searching and fearless moral inventory of ourselves."

- Principle of cataloging (Deuteronomy 30:1-3; Psalm 32:3-5; 51:3; Proverbs 28:13; Isaiah 59:9-12; Jeremiah 3:13; 14:20-22; Lamentations 3:20-23; 39-40; 1 John 1:5-10).

- Inventory of ourselves (Matthew 7:1-5; 2 Corinthians 13:5; 2 Peter 1:5-10).
- Willingness to forgive others (Matthew 6:14-15; Ephesians 4:31-32; Colossians 3:12-13).

Step 5: "We admitted to God, to ourselves and to another human being the exact nature of our wrongs."

- Principle of confession (Psalm 32:3-5; Proverbs 28:13; Galatians 6:1-3; James 5:16).
- Examples of confession (1 Samuel 15:24; 2 Samuel 12:13; Matthew 3:1-6; Luke 15:11-32; Acts 19:13-20).
- Need for honesty (Romans 12-17; 2 Corinthians 8:16-21; 1 Peter 2:12).

Step 6: "We were entirely ready to have God remove all these defects of character."

- Humility acknowledges defects (Hebrews 12:1-2).
- Be ready for pruning of self-will (2 Timothy 2:20-22).
- Preparation precedes blessings (2 Kings 3:16-20; 4:1-7; Hosea 10:12; Joel 2:12-13).
- Principle of cleansing (Psalm 103:10-12; Isaiah 1:18; Micah 7:18-20; Romans 6:1-14; 2 Corinthians 5:15-17; 1 John 1:9).

Step 7: "We humbly asked Him to remove our shortcomings."

- Humility (Proverbs 16:18-19; 22:4; 29:23; Isaiah 57:15; Micah 6:8; James 4:7-10).
- Examples of humility (Genesis 32:9-10; 1 Samuel 7:1-18; 9:15-21; 1 Kings 3:3-7).
- Promises to the humble (Isaiah 66:1-2; Matthew 5:1-3; Luke 14:7-11; 2 Corinthians 8:9; 12:7-10).

Step 8: "We made a list of all persons we had harmed and became willing to make amends to them all."

- Preparation precedes blessing (Matthew 5:23-24).
- Willingness (Nehemiah 11:1-2; Isaiah 1:18-19; 2 Corinthians 8:3, 9-12; 1 Peter 5:2).

Step 9: "We made direct amends to such people wherever possible, except when to do so would injure them or others."

- Get rid of the weight (Hebrews 12:1).
- Reconciliation with a brother (Matthew 18:15).
- Reconciled with God through Christ (2 Corinthians 5:18-21; Ephesians 2:14-18; Colossians 1:20; Hebrews 2:17-18).

Step 10: "We continued to take personal inventory, and when we were wrong, promptly admitted it."

- Principles of continuance (Psalm 139:23-24; Romans 6:1-4; Galatians 6:1-5; 2 Timothy 3:14)
- Confession (Matthew 5:43-44, 6:12; Ephesians 4:23-32; James 5:16; 1 John 1:8-10).
- If you question a wrong, ask God to examine you (Psalm 26:1-12; Proverbs 28:13-14; Lamentations 3:39-40).

Step 11: "We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out."

- Prayer (Matthew 6:5-15; Luke 11:1-13, 18:1-8; John 17).
- Holy Spirit aids in prayer (1 Chronicles 16:11 Matthew 7:7-11, 26:39-41; James 5:13).
- Prayer answered (Exodus 15:25; Judges 6:36-40; 1 Kings 18:36-39).

- Promises of answer (Isaiah 65:24; John 15:5-7).
- Causes of failure (Psalm 66:16-20; 2 Corinthians 12:8-10; James 1:5-8).
- Meditation (Psalm 1:2; 19:12-14).

Step 12: "Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs."

- Spiritual awakening essential (Matthew 18:1-3).
- Carrying the message (Isaiah 52:7; Matthew 10:8; John 4:34-38; Romans 10:14-15; 1 Peter 3:15).

Suggested Topics and Related Scripture

Action (walk like we talk): Isaiah 30:21; Romans 6:4; 1 Corinthians 4:20 (LB); 2 Corinthians 5:7; Galatians 5:16; Ephesians 4:1, 5:2, 15.

Anger/Resentment: Leviticus 19:18 (LB); Psalm 37:8-11; Proverbs 14:17 (KJV); 15:1 (LB), 16:32, 19:11, 20:22 (LB), 22:24; Ecclesiastes 7:9 (KJV); Matthew 5:21-26, 39; James 1:19-20; 1 Peter 3:8-18.

Blame (excuses): Genesis 3:9-15; Exodus 32:19-24; 1 Samuel 13:11-14, 15:16-23; Jeremiah 1:6-7; Luke 14:15-24; Romans 1:20.

Courage: Deuteronomy 31:1-6; 2 Chronicles 32:1-8; Psalm 27:14; 28:6-9; 34:1-2 (LB); 46:1-2 (LB); 91 (LB); 118:5-7 (LB); 143:5-10; John 16:33 (LB); Ephesians 6:10-17 (LB); Philippians 1:27-28 (LB).

Dependence Upon God: Deuteronomy 33:27; 2 Chronicles 20:6-12; Psalm 127:1; 139:1-5; Jeremiah 10:23-24; Matthew 28:18; John 3:22-27; 15:5; 2 Corinthians 3:4-5.

Freedom: Genesis 2:16; Matthew 10:8; John 8:32; Romans 6:7 (LB); 6:22; 8:2 (LB); 8:21; Galatians 5:1, 13-14 (LB); 1 Peter 2:16.

Friendship with God: Exodus 33:11; Job 16:20-22; Psalm 38:11; 147:1-11; 149:4-5; Proverbs 17:17; 18:24; Matthew 11:19; 28:20; John 15:13-14; Acts 17:28-29; Hebrews 13:5-6; James 4:4-10 (LB).

God's Will: Psalm 40:6-8, 143:5-10; Matthew 12:46-50; 26:42; John 17:14-17 (LB); Romans 12:1-2 (LB); Ephesians 6:6-7; James 4:13-16 (LB).

Gratitude: Psalm 9:11-12 (LB); 106:1 (LB); 107:1-2; Isaiah 12:1-2; Matthew 15:11-32 (LB); Luke 15:11-32 (LB); 17:11-19 (LB); 2 Corinthians 4:15-18; Colossians 1:12-14; Hebrews 13:11-16; 1 Peter 2:7-10 (LB).

Honesty: Leviticus 19:11, 35-56 (LB); Proverbs 16:8; Romans 12:17; 13:12-14; 2 Corinthians 8:16-21; 13:7; Philippians 4:8; 1 Peter 3:10; 1 John 1:8-9.

Let Go & Let God (powerless, surrender): Psalm 31:24; 33:18-22; 39:1-7; 42:9-11; 71:1-5; Jeremiah 17:7-8; 2 Corinthians 1:9 (LB).

Live & Let Live (acceptance, criticism, judging): Matthew 7:1, 3-5; Luke 10:38-42; Romans 2:1; 14:4; 13; 1 Corinthians 4:5; 1 Thessalonians 4:11.

One Day at a Time (anxiety, fear, worry, faith): Deuteronomy 28:67; Matthew 6:25-34; Luke 12:11-12, 25-26; Philippians 4:6; 1 Peter 5:7.

Open-mindedness: Proverbs 18:15; Isaiah 30:21; 32:18-19; 55:8-9 (LB); Hosea 12:6; Matthew 8:3; 16:23; 21:31; Mark 9:23; 12:10-11; Luke 23:43; John 9:39; 2 Corinthians 10:3; Ephesians 3:16 (LB); 3:20; Hebrews 3:10.

Overcoming: Psalm 40:1-2; Isaiah 40:28-31; Nahum 1:7; John 1:16-17; 8:31-32; 16:33; Romans 12:21; 13:14; Galatians 4:8-9; 5:13-16; 2 Timothy 3:14-17; 1 John 5:4-5.

Serenity (peace): Psalm 5:11; 16:11; 30:5; 51:12; 146:5; Proverbs 17:22; Isaiah 26:3; Jeremiah 15:16 (LB); Matthew 5:6-10; John 15:11; Philippians 4:6-7; 1 Peter 1:8; 3:11 (LB).

Vengeance: Leviticus 19:18; Proverbs 20:22; 24:28-29 (KJV); Matthew 5:38-39 (LB); Romans 12:14-18 (LB); 1 Peter 3:9 (LB).

Willingness: Exodus 35:5 (KJV); Judges 5:1-2 (KJV), 8:23-25 (KJV); Psalm 110:3; Isaiah 1:18-19 (KJV); Nehemiah 11:1-2; 2 Corinthians 8:1-3 (LB); 1 Thessalonians 2:8 (KJV).

Euthanasia

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Euthanasia must be called a false mercy,
and indeed a disturbing 'perversion' of mercy.
True 'compassion' leads to sharing another's pain;
it does not kill the person whose suffering we cannot bear.

— Pope John Paul II, *Evangelium Vitae - Gospel of Life*, 1995

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Or do you not know that your body is the temple of the Holy Spirit who is in you, whom you have from God, and you are not your own? For you were bought at a price; therefore, glorify God in your body and in your spirit, which are God's.

— 1 Corinthians 6:19-20 (NKJV)

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Euthanasia (Greek: "easy or good death") is the act of inducing a gentle, painless death. In recent decades, the term has come to mean deliberately terminating life to prevent unavoidable suffering. *Passive* euthanasia is usually defined as allowing someone to die when s/he could be kept alive by appropriate medical procedures (like discontinuing life-sustaining treatment of the ill or stopping so-called extraordinary treatment). *Active* euthanasia, or "mercy" killing, is usually defined as taking direct action (like intentionally giving a lethal dose of a drug) to end the life of a person who, due to disease or extreme age, can no longer lead a meaningful life. The term can also include an act of voluntary euthanasia, or suicide, for similar reasons.

Passive Euthanasia

Passive euthanasia is the direct failure to prevent an innocent person from dying, such as not giving necessary medication (like insulin). The intent is to end the person's life prematurely.

Many physicians consider it good medical practice not to artificially prolong the life of a suffering person whose disease is inevitably fatal. Instead, they provide comfort and relief while the patient awaits death. Passive euthanasia; however, has only recently gained legal support. In 1976, the New Jersey Supreme Court ruled that doctors may disconnect a mechanical respirator that is keeping a comatose patient alive because it prevents the patient from dying with decency and dignity. In 1977, "right to die" bills were introduced into several state legislatures. Since then, more than 30 states have passed laws that confer the authority to withdraw life support from a patient upon the request of a designated relative, friend, legal or religious advisor, or court. In 1990 the U.S. Supreme Court ruled that people who make their wishes known have a constitutional right to have life-sustaining treatment discontinued. In the cases of permanently unconscious persons who have left no clear instructions; however, the state may deny the request by family members to terminate treatment. This ruling gave legal backing to the living will, which provides evidence

of a person's desire not to be kept alive by artificial means should that person become terminally ill and incompetent.

Passive euthanasia continues to raise many legal problems; however, such as in cases where parents and doctors decide not to pursue drastic life-saving measures for children born with severe birth defects. An enduring ethical question is also raised by the Hippocratic Oath, which requires physicians both to relieve suffering and to prolong life. The problem is intensified because the definition of death has become blurred. Formerly a person was considered dead when breathing and heart action ceased. Since these functions can be maintained artificially now, a definition of death that includes brain death (lack of electrical activity for a period long enough to make return to functioning virtually impossible) is widely accepted.

Active Euthanasia

Active euthanasia is the direct ending of the life of an innocent person. This is often done by administering a lethal injection.

In the United States, active euthanasia is a serious crime, punishable by life imprisonment. Some doctors are helping terminally ill patients commit suicide—a so-called physician-assisted suicide—without being punished. In some countries active euthanasia is a special crime with lighter penalties, and in Uruguay it is not a crime. In the Netherlands, doctors are not prosecuted if they follow specific guidelines on euthanasia. A 1992 survey showed that not all doctors were following the guidelines and thus were committing involuntary euthanasia on some patients.

Physician-Assisted Suicide

Physician-assisted suicide is a form of euthanasia by complicity. It provides the means and information to kill people by directly enabling and encouraging them to kill themselves. Physician-assisted suicide occurs when a physician gives a patient something to use that will directly cause death (like drugs, a plastic bag, etc.). The question is whether to take action that causes death prematurely or to care for patients while they die naturally.

By contrast, "letting go" means the physician's actions allows patients in the terminal phase of dying to die, but the acts do not cause death. Here, death is imminent and nothing can prevent it. Acknowledging that heroic treatment only prolongs dying, such measures are stopped. The person is allowed to die.

Questions Answered on Euthanasia

What is euthanasia? The Greek meaning is: "*eu*": easy, good, happy, painless; "*thanatos*": death. A British House of Lords definition is: "a deliberate intervention undertaken with the express intention of ending a life to relieve intractable suffering."[5] Some draw a distinction between "passive" and "active" euthanasia: the difference between the withdrawal of treatment to allow death and deliberately putting someone to death (usually to secure release from pain, sometimes called "mercy killing"). Other definitions to remember are: "voluntary euthanasia": with the person's consent; "living-will": declaration made in advance where the person directs that they should not be kept alive by artificial means (usually this is associated with a "Durable Power of Attorney for Health Care" where someone is appointed in advance to make medical decisions for the person when they are unable to do so for themselves).

Why is the euthanasia debate becoming so prominent? There is a growing drive to legalize euthanasia and a proliferation of "Right to Die" societies. Back in 1948, the World Medical Association adopted the Declaration of Geneva. It rephrases in modern language the 24 centuries old Hippocratic Oath containing the words: *"I will give no deadly drug to any, though it be asked of me, nor will I counsel such."* However, this has been contradicted in the past few decades. An editorial of the Californian Medical Association of September 1970 ("A New Ethic for Medicine and Society") stated that in the future people will be

[5] House of Lords (Session 1993-94), Report of the Select Committee on Medical Ethics, Volume 1-Report, p. 10, paragraph 20, London, UK.

eliminated whose quality of life does not meet certain medical criteria, and that next to birth control there will be death control. Society will accept euthanasia, either voluntary or compulsory, as "the new ethics of relative rather than absolute and equal value will ultimately prevail."

One needs to consider the whole picture to understand the "new ethics" that justifies the killing of human beings. Humanistic thought, which controls most educational systems and governments, is responsible for this new, anti-Christian way of thinking. For instance, the British Humanist Association states: "Humanists are sympathetic to voluntary euthanasia. By this we mean helping people to die painlessly if their lives have become hopeless, with no prospect of relief before death and if they wish to die. But these conditions must be rigidly adhered to." Humanists consider euthanasia as part of their agenda, together with homosexual rights, abortion on demand, etc. Since humanism believes that man is simply a product of evolution, it has no foundation for upholding the sanctity of life. Killing unwanted babies and the aged are the logical conclusion of humanistic philosophy.

Though seldom admitted, economic pressures are often the reason for advocating euthanasia rights. Some openly argue that a family should be able to decide what happens to their older members so that they can free resources to care for their younger members. Others have gone so far as to suggest that people should "volunteer" to be "put down" at the age of 65 and be given "hero status" for their contribution to society.

Surely, euthanasia is acceptable if it is voluntary? Besides the obvious Biblical response that states that God has given life and only He has the right to take it, there are also several other considerations why "voluntary" euthanasia is unacceptable and dangerous.

- The "voluntary" aspect of euthanasia is often counterfeit and always questionable. In the Netherlands, doctors have tried to coerce patients, wives have coerced husbands, and husbands have coerced their wives to undergo "voluntary" euthanasia. Elderly people begin to believe that this is what society expects of them and that euthanasia is "brave," "wise" and "progressive." The result, as Dutch Attorney General T.M. Schalken stated in 1984, is that "elderly people begin to consider themselves a burden to the society and feel under an obligation to start conversations on euthanasia, or even to request it."
- Voluntary euthanasia is often inseparable from and inherently linked to overtly involuntary forms of euthanasia. There is now ample evidence from Holland, which is the forerunner in liberalizing euthanasia, that "voluntary" euthanasia is accompanied by the practice of "crypthanasia" (active euthanasia on sick people without their knowledge). Besides many other recorded cases, one of the most infamous was the report, in 1985, of mass secret killings (no voluntary request for euthanasia could be proven) in the De Terp senior citizen's home in The Hague. The residents were injected with insulin. A member of the Board of the Dutch Society of Voluntary Euthanasia has pleaded for involuntary active euthanasia for the demented, the elderly, the unconscious victims of road accidents, and Thalidomide-impaired children. The president of this same society has publicly defended the perpetrator of the De Terp killings.
- Society undergoes an ominous change when euthanasia is practiced. The elderly are made to feel that society would not mind getting rid of them. The Dutch Patients' Association stated in 1985: "[I]n recent months the fear of euthanasia among people has considerably increased." In their fears, people do not distinguish "voluntary" from "involuntary" euthanasia. A study conducted among Dutch hospital patients showed that many fear their own families because these are the people who could decide or pressure them to request death. Out of fear of euthanasia some elderly people refuse to be hospitalized, to see doctors or to take medicines.
- The idea of "voluntary" euthanasia is false. Euthanasia is supposed to spare the sick person the agony that precedes death or the sufferings of a prolonged illness. When Wibo van den Linden filmed one Dutch patient's preparations for "voluntary" euthanasia (shown on national TV), the

unfortunate lady displayed extreme anguish and despair as the fixed day of execution approached. The normal way to die, if God permits, is to be surrounded by cherished members of one's family who will not let one go. Euthanasia causes extreme psychological suffering — the exclusion of a person from the community of the living while one is still alive. Because of the cruelty of the procedure, some of the most prominent champions of euthanasia (Foster-Kennedy in America, Lenz in Germany, and van den Benz in Holland) did not even consider "voluntary" euthanasia and advocated only the covert, involuntary variety.

- Voluntary euthanasia must also be rejected because of the fundamental discrepancy between the uncertainty of human and medical judgments, which are fallible, and the deadly certainty of the act of euthanasia. Patients' requests for euthanasia are often unreliable because of pressures from society and the family. Doctors have traditionally rejected euthanasia because they realized that diagnoses are uncertain and prognoses of the time of death are notoriously unreliable.
- Voluntary euthanasia is unnecessary because pain and suffering can be controlled. The Hospice Movement has shown that it is possible to control pain, provide companionship and assist terminal patients and families in preparing for death. Hospice patients hardly ever request euthanasia because they do not feel abandoned nor do they feel that they are a burden.
- Voluntary euthanasia should be feared and rejected because of the irreparable emotional damage it causes to medicine. The certainty that the doctor will do everything in his or her power to help the patient vanishes when euthanasia is allowed. Patients realize that some doctors who are prepared to put someone to death at their own request will also be capable of doing it without a person's knowledge. In an era of euthanasia, a patient's attitude toward doctors is increasingly marked by distrust, suspicion and fear.

What does the Bible have to say? Human beings are not animals, but unique beings made "in the image of God" (Genesis 1:26-28). And according to Exodus 20:13, "You shall not murder."

Life is a gift from God, and the moment of death is God's prerogative. "Man's days are determined; You have decreed the number of his months and have set limits he cannot exceed" (Job 14:5). "My times are in Your hands; deliver me from my enemies and from those who pursue me" (Psalm 31:15). "There is a time for everything, and a season for every activity under heaven: a time to be born and a time to die" (Ecclesiastes 3:1-2).

God can bring blessing out of suffering or in the midst of suffering: "…we also rejoice in our sufferings, because we know that suffering produces perseverance; perseverance, character; and character, hope" (Romans 5:3-4). "Do not be afraid of what you are about to suffer….Be faithful even to the point of death, and I will give you the crown of life" (Revelations 2:10).

What can we do about euthanasia? Start by holding fast to God's revelation about life and death (see Scriptures above). Do not allow humanist thoughts to infiltrate our own way of thinking. Paul's warning must be heeded: "See to it that no one takes you captive through hollow and deceptive philosophy, which depends on human tradition and the basic principles of this world rather than on Christ" (Colossians 2:8). Hold on to the fact that each human being has objective value in an absolute sense, since God declares this to be so. Refuse the relativistic moral code of humanism that results in the killing of the weak, the unborn and the aged. Be ready to show God's love to the sick and dying. Let them feel wanted and loved, especially when death is unpleasant and painful.

Earnestly seek God for revival. Only the supernatural intervention of God that brings people back to a culture of godliness will be effective in reversing humanism and its culture of killing.

Suicide

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There is but one truly serious philosophical problem, and that is suicide.

— Albert Camus[6]

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Suicide Defined

According to Lalande's *Vocabulary,* suicide is "the act of willfully causing one's own death in order to escape a condition of living that one esteems intolerable."[7]

Suicidal people feel all options have been exhausted. For them, life has no meaning, no purpose, and no future, so why continue to endure its extreme unhappiness, anguish, hopelessness and despair? The obsession that nothing will ever change for the better leaves them feeling helpless, hapless, and hopeless, with the conviction that death is the only way out.

Sadly, once every minute someone in the United States attempts suicide. Every day seventy Americans take their own lives. In this nation, twenty-four percent more die by suicide than by homicide. In Los Angeles County, more people kill themselves than die in traffic accidents. Suicide is the number nine cause of adult death in America. For those between fifteen and thirty years old it is the number three cause of death.

Common Myths about Suicide

Myth #1: People who talk about suicide do not commit suicide. Fact: Contrary to popular opinion, people who threaten suicide often mean it. In fact, eight out of ten people who kill themselves have given definite warnings of their suicidal intentions to someone prior to the act. Take any suicide threat seriously. Talk to the person about it, reassuring him or her that you will listen.

Myth #2: Suicide happens without warning. Fact: Studies reveal that the suicidal person gives many clues and warnings regarding his or her suicidal intentions. Four of five who commit suicide have tried it previously.

Myth #3: Suicidal people are fully intent on dying. Fact: Most suicidal people are undecided about living or dying, and they gamble with death, leaving it to others to save them. It is very often a desperate cry for help. Many who attempt suicide are not choosing death as much as they are choosing to end their unbearable pain.

Myth #4: Once a person is suicidal, s/he is suicidal forever. Fact: Happily, individuals who wish to kill themselves are "suicidal" only for a limited period of time.

Myth #5: Suicide is a problem of a specific class of people. Fact: Suicide is neither the curse of the rich nor the disease of the poor. Suicide is represented proportionately among all levels of society.

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[6] Albert Camus, *The Myth of Sisyphus: And Other Essays* (London, UK: Vintage, 1959). Though HCMA does not share the philosophy of Camus, his comment about suicide is worth thinking about as we consider our chaplaincy care role.

[7] Andre Lalande, *Vocabulaire Technique Et Critique De La Philosophie*. Twelfth ed. (New York: French & European Publications, 1972).

Myth #6: Improvement following a suicidal crisis means that the suicidal risk is over. Fact: Almost half of suicides occur within three months following the first suicidal crisis.

Myth #7: Suicide is inherited or "runs" in the family. Fact: Suicidal tendencies are not inherited. It is an individual matter and can be prevented.

Myth #8: All suicidal individuals are mentally ill, and suicide is always the act of a psychotic person. Fact: Although the suicidal person is extremely unhappy, s/he is not mentally ill.

Motives for Suicide

Suicide is the ultimate rejection of oneself. Why would one deliberately take his or her own life, apart from the ethical motive of sacrifice? Dr. Gabriel Deshaies explains the answer in *The Psychology of Suicide* as "the law of the three doors."[8]

Door #1: The Emergency Exit. Death becomes a desired escape from a life of pain, failure, and/or guilt, real or imagined. A suicidal person sees his or her situation as intolerable and unlivable.

Door #2: The Simple Exit. Death is desired as the destruction of life—annihilation. It is a kind of vengeance on oneself or others.

Door #3: An Entrance. Death is desired as non-life, non-being, nothingness. His or her life is empty and no longer makes any sense. S/he feels like an unnecessary part of life and has a heightened consciousness of his or her loneliness. The emptiness of death attracts him or her.

Signs of Suicidal Intention

Alertness to the following distress signals—these cries for help—may help prevent a tragedy. Of course, these are not always "sure signs," but anyone that seems unusually suspicious warrants our time and our offer of help.

- The Suicidal Attempt. This is the most clear and dramatic cry for help.
- The Suicidal Threat. Anyone who mentions anything about ending one's life needs to be taken seriously.
- The Suicidal Hint. They make statements like, "You would be better off without me," or "Life has lost all meaning for me," or "I hate to face each day," or "What does God think of a person who commits suicide?"
- Suicidal Activity. The following could all be clues that a person is considering suicide: making sure all the bills are paid, making out a will, making funeral arrangements, making arrangements as if they are going on a long trip, saving pills, and/or the sudden purchase of a firearm.
- Suicidal Signals. All the following may be signs that a person may be thinking about attempting to take his or her life: a long, serious illness; a sudden change in personality; chemical abuse (drugs and/or alcohol); deep, agitated depression; a marked withdrawal from social life.
- A Recent Crisis. The death of a loved one, failure at work or school, marital or home problems, loss of a job, broken romance, financial reversal, divorce or separation, or a rejection or loss of any kind that involves people about whom the person cares may cause an individual to question the value of living.

Dealing With a Suicidal Person

According to Norman Farberow, "Probably no single event in the course of psychotherapy carries so much emotional impact and requires so much skill, knowledge, sensitivity, ability, and fortitude on the part

[8] Gabriel Deshaies, *La Psychologie du Suicide* (Paris, France: Université of France, 1947).

of the therapist as a suicidal crisis in his patient."[9] Your task in such a crisis is to keep a precious life intact—by judging how serious the person is about killing himself or herself, and by taking some kind of action based on this evaluation. As Paul said it in Romans 15:1, "...we who are strong ought to bear the weakness of those without strength...." Here is how to do this:

1. Engagement. The initial moments of conversation are terribly important. Establish rapport, listen actively, and absorb their story. This will begin to build a bond. Remember that a suicidal person is ambivalent toward life and death. S/he is tired of what is going on in his or her life and wishes to end the suffering by ending his or her life. At the same time, this hurting person wants to be rescued by someone. Our relationship with this person could be the reason s/he decides to stay alive.
2. Inquiry. Once the person appears willing to talk, several items of information will prove helpful. Spacing out the questions amid casual conversation is often the best tactic. Straightforward questions often work best:
   - Identify and clarify the problem(s). "What has led to where you are now?" "What is bothering you right now?" "What have you tried before to cope with the problem(s)?"
   - "Have you ever felt like taking your life?" "When you say you want to 'end it all,' do you mean you're thinking of suicide?"
   - "Have you ever done anything to hurt yourself before?" Previous suicide attempts can be a warning sign.
   - "How do you plan to end your life?" Be aware that the more specific the plan, the greater the risk of suicide. If the person has a gun or bottle of pills, and a specific plan, intervention is imperative.
   - "Is there someone you can turn to for help?" Refer the person to a counselor or mental health professional. Explain that seeing a counselor doesn't mean s/he is crazy. If no resources are available, call the National Hotline: 1-800-SUICIDE (7842433).
3. Appraisal. The information we gather will determine the action to take.
   - How urgent is this suicide threat? Is there a valid, specific, and lethal suicide plan? Is the means to carry out the threat readily available? Is there evidence of agitated depression? Is there a lack of support systems? Is there a history of suicide attempts? Has there been a sudden turn for the better after a period of melancholy?
   - What circumstances have led up to this crisis point? According to Dr. Marv Miller, a consultant in suicidology, "Suicide is usually the result of a gradual wearing away of a person's ability to cope."[10]
   - Identify for him or her several options far less drastic than suicide. Reassure the person that depression and suicidal tendencies can be treated. Don't lecture or point out all the reasons for living—it doesn't help. Inspire hope—it is the light at the end of the dark tunnel.
   - What is this person's understanding of suicide? Does s/he think it is wrong?
   - Is it to "get even" ("I'll show them!") or to get attention? ("Maybe now they'll notice and care about me!").
   - What resources does this person have available to help him or her?
   - Are friends or relatives nearby, and are they willing to be supportive? Are counseling services

[9] Norman L. Farberow, *The Psychology of Suicide* (Santa Rosa, CA: Science House, 1970): 415.

[10] Marv Miller, *1985 Training Workshop Manual* (San Diego, CA: The Information Center, 1985): 1, 3, 5.

available, and is this person willing to see them?

- What are the stresses and symptoms in this person's life?
- If the stress factors and symptoms are high, then the risk is high and positive intervention is needed.

4. Action. What can we do?
   - Talking is an antidote. Having someone listen and care can be healing in itself.
   - Obtain some kind of commitment from the person. For example, a promise to call us before the person would attempt to take his or her life, or a promise to get rid of the means for carrying out the suicide, or a promise to keep an appointment with a clergyperson or counselor.
   - Help the person determine his or her strengths and resources.
   - Assure the person that there is a solution for his or her problems and there is always hope.
5. Aftercare. People who have attempted or threatened suicide are at risk to repeat. They need extended care, usually from a mental health professional.

Understanding Why

Suicide is a devastating tragedy—it shatters the lives of the shocked survivors. In many ways, it is one of the most difficult deaths to grieve. According to Richard McGee, director of a suicide prevention center in Florida, "Suicide is the most difficult bereavement crisis for any family to face and resolve in an effective manner."[11]

Why would anyone willingly cause his/her own death?

Known Reasons. Typically, the person felt helplessly trapped by what s/he perceived as a hopeless situation:

- Financial burdens that could not be met.
- Marriage or family problems that could not be resolved.
- Divorce.
- Scholastic goals that could not be reached.
- Loss of a loved one or special friend.
- A chronic, incurable illness.

Unknown Reasons. There is a need to want to understand. However, sometimes there are no apparent causes. We may never completely understand the suicide victim's reasons for ending his/her life. The whys may never be answered; the puzzle never resolved to anyone's complete satisfaction.

Healing the Questions. We must gradually let go of asking the whys that may haunt us. We must eventually accept what has happened and go on living. To continue to ask "why" for years afterward can become an obsession that would be destructive to those around us and to ourselves.

Understanding Reactions

Shock. This is a common, initial reaction to a suicide. This numbness can be healthy—like a shock absorber protecting you from the overwhelming impact of the painful loss. It may last a few days or persist for several weeks.

Anger. It is normal to find ourselves angry with the deceased ("How could s/he do this to me?"), with others ("Why couldn't they prevent this?"), with yourself ("Why wasn't I able to help?"), or with God ("How could a good God let this happen?"). We need to find constructive ways to express our anger so that

[11] Quoted by Delores Kuening in *Helping People Through Grief* (Minneapolis: Bethany, 1987): 173.

healing can take place. Verbalizing our anger helps externalize it (rather than internalize it) so we can better deal with it. For example, we may talk with someone about our strong feelings, we might release the emotional tension through exercise, or we could write a letter to the deceased in which we say good-bye and forgive him/her. If we are angry with God, we need permission to share our strong feelings. God can handle people yelling at Him. We need to resolve our anger at God for allowing this to happen. In addition, we need to forgive ourselves for what we may have done or not done while the person was alive.

Embarrassment. There is a stigma, or shame, associated with suicide. Many people are very uncomfortable acknowledging a suicide and/or talking about it; however, this is an important part of the recovery process. We need to "pick up the pieces" by reaffirming our commitment to life, and rebuilding confidence in ourselves. One helpful way to accomplish this is by becoming actively involved in a grief support group.

Guilt. Most survivors blame themselves for what they did or did not do or say: "If only…." or "I should have…." We find it difficult to let go of our rescue fantasies. We must accept the fact the no individual can take responsibility for another person's actions. Healing takes place when we realize that we cannot judge our yesterdays with the knowledge of today and admit that there are limits to our power and responsibility.

Relief. If there was significant suffering and burdens involved prior to the suicide—either by the deceased and/or by us in relation to the deceased—then we may be feeling a sense of relief that we do not have to worry anymore or that his/her pain has finally ended. We must accept our relief for what it is and not let it grow into inappropriate guilt.

Understanding Healing

Crying is healthy and therapeutic.

It is better to openly talk about our feelings rather than to hold them inside. We need to talk about our loss and our pain—about the good times as well as the bad memories.

Become involved in a bereavement support group. Through sharing with others who have experienced similar pains, we will ease our loneliness, gain understanding of our own reactions, and learn ways to cope.

We need to be willing to seek professional help and family counseling if necessary.

Neither tranquilizers nor alcohol will end the pain. They will only mask it for a while, thereby complicating the healing process. Therefore, don't rely on them to help us cope!

We need to be patient with the healing process. It often takes years to heal the deep wounds of grief after suicide. We need to choose to survive and our loneliness and sadness will eventually subside. We can trust God to give us strength one day at a time.

Understanding Caregiving

Acknowledge the death the same as we would the death of anyone. Make a phone call, send a card, and come alongside. But don't pry for information about the circumstances.

Acknowledge the pain. Say something like, "I know this must be very painful for you right now."

Show we care. Weep with them. Hold their hand or give them a hug or place a hand on their shoulder to show we care.

Give them our presence. Tell them, "I'm here because I care about you. I want you to know that I'm here for you. Can I sit with you? Are there things I can do for you?" Our sincere presence will give the person permission to grieve.

Give them permission to be angry. Tell them, "It's okay to be angry." Then listen to them express their strong feelings.

Give them permission to talk about their loved one. Use their loved one's name and help them recall pleasant memories.

Listen to them. Don't try to analyze. Don't change the conversation—trying to make it lighter or heaver than it is. Listen.

Suggest a support group or counselor. Express our concern that it might be more than they can handle by themselves. Tell them, "I've watched you and am concerned about you. I think it would be helpful if you spoke with someone who knows how to help someone grieve." Offer options, such as a Pastor, a mental health therapist, or a grief support group.

Watch for warning signs of unhealthy grief. If, after two to three months, we see the following symptoms, there is reason to believe the survivor is experiencing unhealthy grief.

- Withdrawal. The person is less emotionally accessible to friends and family.
- Irritability. The person is very touchy and expresses other depressive symptoms.
- Reduced productivity. The person shows deteriorating work or school performance instead of returning to a fairly normal level of functioning.
- Obsession. The person is preoccupied with details of the death.
- Fantasy. The person talks about the suicide victim as if s/he were still alive.

The role of the caregiver for survivors cannot be underestimated. A caring person can play a key role in the survivor's mental health and healing. In some instances, a sensitive and caring person can prevent further tragedy.

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Chapter Assignments

1. Read a book or several articles on the abortion issue. After spending several minutes in Bible study, reflection and prayer about abortion, write an essay on your position concerning abortion, including alternative choices and help available to pregnant women in your area (identify local agencies for abortion and crisis pregnancy referral). Discuss your insights with the Teaching Chaplain.

2. Read a book or several articles about addictions. After spending time in Bible study, reflection and prayer about the issue of addictions, write an essay on how you would counsel a patient who desperately needs help in overcoming an addiction. Include a description of treatment programs available in your area. Discuss insights with the Teaching Chaplain.

3. Read a book or several articles on HIV/AIDS. After spending several minutes in Bible study, reflection and prayer about the issue, write an essay on how you would minister to someone with HIV/AIDS. Discuss your insights with the Teaching Chaplain.

4. Read a book or several articles on the euthanasia debate. After spending time in Bible study, reflection and prayer about euthanasia, write an essay on what you believe about euthanasia (including physician-assisted suicide) and how you would counsel someone who wanted to end his/her life because of intractable suffering. Discuss your insights with the Teaching Chaplain.

5. Read a book or several articles on suicide. After spending several minutes in Bible study, reflection and prayer about suicide, write an essay on how you would counsel a patient who had attempted suicide as well as ministry to the family. Discuss your insights with the Teaching Chaplain.

6. Make rounds and debrief with the Teaching Chaplain.

7. Write a verbatim report, present it to a peer review group, and discuss your learning issues with the Teaching Chaplain.

8. Interaction with your Teaching Chaplain. Write out your response to each of the following case study scenarios and then discuss each one with your Teaching Chaplain. You may want to role-play some of them.

a. You are paged to maternity. The nurse manager escorts you to a room where a young couple is waiting. Looking at you through tears of pain and desperation, the expectant mother says, "The doctor just told my husband and me that our baby will be born without any arms and may have other complications as well. He strongly advises a late-term abortion, but I am a Christian and cannot agree to this. To make matters worse, my husband goes along with the doctor. Chaplain, I am confused. Will you please help me?" Her husband admits he's not a Christian and says, "My wife thinks having an abortion is the same as committing murder. I don't believe that! How could God hold parents responsible for things like this? Please help my wife to understand that it's the right thing to do." How would you respond?

b. One of the employees from the Neo-Natal Critical Care Unit comes to your office, obviously upset, and blurts out, "Why on earth would God want a baby with severe physical and mental problems to go through life so miserably handicapped? And why would the loving God you preach about burden the family with such pain and suffering? It doesn't make any sense, Chaplain. Wouldn't it be more merciful just to let the baby die?" What do you say?

c. A member of the staff, who works with oncology patients and their families, asks you these questions: "Chaplain, would you let someone in your family who is suffering with intolerable pain and anguish, with absolutely no hope for recovery or a normal life, continue that way indefinitely? Would it not be more compassionate to release him from this state of hopelessness? What is there about your religious beliefs that won't allow you to take this humane and reasonable action?" How do you respond?

d. Someone asks you if God is punishing those who are diagnosed as HIV Positive? What is your answer?

e. You visit a resident who informs you that he is "gay." He has been diagnosed with AIDS and his minister fully supports his lifestyle. He stares at you with a defiant look that seems to say, "What do you think of that?" How would you respond?

f. You enter a room where you find two women, one of whom is the patient who introduces the other as her friend. You soon realize that the "friend" is really her "significant other." The friend asks you to pray for the patient's recovery from AIDS. How would you pray for this patient and her friend? Do you say anything else?

g. You have been requested to officiate at a funeral for a young man who died from AIDS. Because he had been raised in a Christian home and attended church regularly while living there, his parents adamantly refuse to believe their son contracted the disease by homosexual behavior. "He must have gotten it through a blood transfusion or some other way," they insist. During your preparation for the service, you have interviewed some of the son's close friends, who tell you they are "gay" and are planning to attend the service. What is your responsibility to the parents and other family members? To the friends?

h. You are meeting with a social worker on the hospital staff and he raises these questions: "Do you, as a minister of the Christian faith, believe that suicide is a sin? If so, is the person who does so eternally condemned? Is it possible that the person's mental state at the time was such that he could be excused or not held responsible for the act? As in court, is not the plea of 'insanity' a legitimate one?" How do you counsel this person?

i. During a visit with a resident, she unexpectedly confides in you that she often has the desire to commit suicide, even while here in the facility. What steps do you take in handling this situation?

j. During a visit to the mental health unit, you are surprised to see a staff nurse listed as a patient. You are informed, in confidence, that she was caught taking drugs from her medical supply cabinet. She admitted to having a drug problem. As you enter her room, her embarrassment is very obvious, for you know her to be a believer. Reluctantly, and with a deep sense of shame, she reveals several of her concerns: the possibility of losing her job, her license, her family and her freedom by going to jail. However, she still claims to be a "Christian," but feels powerless to overcome her addiction. Sobbing uncontrollably, she pleads, "Chaplain, please help me. I can't hold on anymore." How do you counsel her?

k. One of the ER nurses asks to speak with you privately. Slowly, and with evident emotional pain, she tells you about her history of eating and purging. Finally, she exclaims, "I have tried will-power, prayer, counseling and I don't know what else. Nothing seems to help." How would you advise her?

l. Emily and her husband are retiring, and they want to have kids. But, since Emily is postmenopausal, they cannot conceive naturally. Instead, the couple wants to implant another egg, fertilized with her husband's sperm, into Emily's uterus and allow her to carry it to term. They come to you for counsel about this. What do you say to them?

Chapter Resources

The following annotated bibliography is not intended to be exhaustive in its content, nor does it contain all the latest resources. HCMA does not endorse all the ideas expressed in all the resources listed here. Some of the sources are given simply to expose the Trainee to a variety of viewpoints on the subject. It is expected that even in places of disagreement we will reflect upon and think critically regarding our own views rather than simply dismissing views that run counter to our own.

Abortion

Alcorn, Randy. *Pro-Life Answers to Pro-Choice Arguments*. Portland, OR: Multnomah, 2000.
Offers timely information and inspiration from a "sanctity of life" perspective. Real answers to real questions about abortion appear in logical and concise form.

Baird, Robert M., and Stuart E. Rosenbaum. *The Ethics of Abortion: Pro-Life vs Pro-Choice*. Third ed. Amherst, NY: Prometheus, 2001.
Comprehensive and balanced, this new third edition again makes available the most useful writing on the controversial abortion issue.

Beckwith, Frank. *Politically Correct Death: Answering the Arguments for Abortion Rights*. Grand Rapids, MI: Baker, 1994.
Thorough explanation of sixty-nine ethical and philosophical arguments sometimes given to defend a pro-choice position and persuasive pro-life responses to each.

Chacon, Frank, and Jim Burnham. *Beginning Apologetics 5: How to Answer Tough Moral Questions—Abortion, Contraception, Euthanasia, Test-Tube Babies, Cloning, & Sexual Ethics*. Farmington, NM: San Juan Catholic Seminars, 2000.
Answers questions about abortion, contraception, euthanasia, cloning, and sexual ethics using clear moral principles and the authoritative teachings of the Catholic Church.

Currie, Stephen. *Opposing Viewpoints Digest—Abortion*. Chicago, IL: Greenhaven, 1999.

Abortion is one of the most divisive issues in America today. Is abortion murder? Should it be legal? This engaging volume addresses these broad issues as well as specific controversies such as parental consent laws, waiting periods, and partial-birth abortions.

De Puy, Candace, and Dana Dovitch. *The Healing Choice: Your Guide to Emotional Recovery After an Abortion*. Wichita, KA: Fireside Catholic, 1997.
Two experienced psychotherapists share their approach to dealing with sensitive and long-overlooked issue of post-abortion pain or trauma. *The Healing Choice* breaks the silence surrounding a topic often clouded by debate and focuses exclusively on helping women chart a path toward emotional recovery. Through a step-by-step process, complete with self-tests, exercises, and interviews with women who share their own post-abortion experiences, Dr. Candace De Puy and Dr. Dana Dovitch will help you come to terms with your post-abortion emotions and offer support as you begin the process of healing.

Fowler, Paul B. *Abortion: Toward an Evangelical Consensus*. Portland, OR: Multnomah, 1987.
Gives what may well be the clearest biblical answers ever to these two questions: 1) What should all Christians understand about the abortion issue? and 2) What should we all do about it?

Gorney, Cynthia. *Articles of Faith: A Frontline History of the Abortion Wars*. New York: Simon & Schuster, 2000.
Presents a balanced political and social narrative of the most significant years in the abortion conflict, told from the perspective of the people who fought the battles on both sides.

Klusendorf, Scott. *Pro-Life 101: A User Friendly Guide to Making Your Case on Campus*. San Pedro, CA: Stand to Reason, 1999.

Koukl, Gregory. *Precious Unborn Humans Persons*. San Pedro, CA: Stand to Reason Press, 2014.
His approach is straightforward, uncomplicated, and fair, each step focusing on specific questions that are carefully answered before moving to the next. The result is an easy-to-follow, well-reasoned discussion about what it means to be human, and what makes humans valuable.

Maguire, Daniel C. *Sacred Choices: The Right to Contraception and Abortion in Ten World Religions*. Minneapolis: Fortress, 2001.
Maguire first shows how interrelated overpopulation is with poverty, ethnic injustice, gender injustice, and the maldistribution of economic resources. Often the world's religions (most notoriously perhaps, Roman Catholicism) are thought to contribute only to the problem, rather than solutions, through their hostility to sex, education and equal rights for women, and birth control. In fact, argues Maguire, the ten scholars who consulted for several years about how these traditions treat issues of contraception and abortion find in them a true religious awe at the sacredness of life, a genuine openness to sexuality as a dimension of the sacred, and "alongside the 'no choice' position . . . a 'pro-choice' position that is too little known, even by adherents to the religion. That is the key message of this book."

Moreland, J. P., and Scott Rae. *Body and Soul: Human Nature & the Crisis in Ethics*. Downers Grove, IL: InterVarsity, 2000.
While most people throughout history have believed that we are both physical and spiritual beings, the rise of science has called into question the existence of the soul. Many now argue that neurophysiology demonstrates the radical dependence, indeed, identity, between mind and brain. Advances in genetics and in mapping human DNA, some say, show there is no need for the hypothesis of body-soul dualism. Even many Christian intellectuals have come to view the soul as a false Greek concept that is outdated and unbiblical. Concurrent with the demise of dualism has been the rise of advanced medical technologies that have brought to the fore difficult issues at both edges of life. Central to questions about abortion, fetal research, reproductive technologies, cloning and euthanasia is our understanding of the nature of human personhood, the reality of life after death and the value of ethical or religious knowledge as compared to scientific knowledge. In this careful treatment, J. P. Moreland and Scott B. Rae argue that the rise of these problems alongside the demise of Christian dualism is no coincidence. They therefore employ a theological realism to meet these pressing issues, and to present a reasonable and biblical depiction of human nature as it impinges upon critical ethical concerns. This vigorous philosophical and ethical defense of human nature as body and soul, regardless of whether one agrees or disagrees, will be for all a touchstone for debate and discussion for years to come.

O'Neil, Jennifer. *You're Not Alone: Healing Through God's Grace After Abortion*. Deerfield Beach, FL: Faith Communications, 2005.
This book is designed to help people heal from their abortions on an individual level, and to finally be able to put guilt, shame, fear, doubt and other negative feelings behind them forever.

Swindoll, Charles R. *Sanctity of Life: The Inescapable Issue*. Dallas, TX: Word, 1990.
A book on resolve, courage, and compassion. It is not the last word on abortion, but it is the definitive position on moral living for Christians today.

Wennberg, Robert N. *Life in the Balance: Exploring the Abortion Controversy*. Grand Rapids, MI: Wm. B. Eerdmans, 1985.
In this book Robert N. Wennberg looks at all the major arguments from the whole spectrum of positions on the abortion issue. He does so both earnestly and fairly, taking care to point out that most of the arguments follow soundly from their premises, and that most of the parties to the debate are altruistically motivated. Cutting through the sensationally prejudicial language often used in arguments about abortion, Wennberg clearly lays out what merit the various arguments have individually so readers can compare them sensibly.

Addictions

Arterburn, Stephen. *Growing Up Addicted*. New York: Balatine, 1987.
The subtitle describes the book: Why Our Children Abuse Alcohol and Drugs and What We Can Do about It.

Cummings, Nicholas A., and Janet L. Cummings. *The First Session with Substance Abusers*. Hoboken, NJ: Jossey-Bass, 2000.
It is during the critical first session with substance abusers that clinicians have the first, and all too often the last, opportunity to break through the wall of denial and create an atmosphere of trust that is so crucial to changing behavior. Written by a father-daughter team of clinical psychologists, *The First Session with Substance Abusers* outlines a proven plan for conducting an initial session that can uncover substance abuse problems with clients no matter how resistant or manipulative they may be. Applying the methods outlined in this book, psychologists and health professionals can use the first session to assess and evaluate the depth and duration of the substance abuse problem and motivate the client to begin the most appropriate form of treatment.

Erickson, Carlton K. *The Science of Addiction: From Neurobiology to Treatment*. New York: W. W. Norton, 2007.
Presents a comprehensive overview of the roles that brain function and genetics play in addiction. It explains in an easy-to-understand way changes in the terminology and characterization of addiction that are emerging based upon new neurobiological research. The author goes on to describe the neuroanatomy and function of brain reward sites, and the genetics of alcohol and other drug dependence. Chapters on the basic pharmacology of stimulants and depressants, alcohol, and other drugs illustrate the specific and unique ways in which the brain and the central nervous system interact with, and are affected by, each of these substances.

Hart, Dr. Archibald D. *Healing Life's Hidden Addictions Overcoming the Closet Compulsions that Waste Your Time and Control Your Life*. Ann Arbor, MI: Servant, 1990.
Easy to read, everyday language explains our tendency to fill our lives with the wrong things, robbing ourselves of happiness. Teaches how to get past these negative attachments and get on with living! You don't have to have an "addiction" to appreciate this book.

Hoffman, John, and Susan Froemke. *Addiction: Why Can't They Just Stop?* Emmaus, PA: Rodale, 2007.
Offers a comprehensive and provocative look at the impact of chemical dependency on addicts, their loved ones, society, and the economy. Breaking the stigma that addicts are simply weak and immoral, it delves into new brain research proving that drugs and alcohol change the chemical composition of addicts' brains, making it veritably impossible for them to quit. The nation's top experts persuasively argue that the time has come for the blame to stop and the healing to begin.

May, Gerald G. *Addiction and Grace: Love and Spirituality in the Healing of Addictions*. San Francisco: HarperOne, 2006.
May examines the "processes of attachment" that leads to addiction and describes the relationship between addiction and spiritual awareness. He also details the various addictions from which we can suffer, not only to

substances like alcohol and drugs, but to work, sex, performance, responsibility, and intimacy. May emphasizes that addiction represents an attempt to assert complete control over our lives.

Minirth, Frank, Paul Meier, Siegfried Fink, Walter Byrd, and Don Hawkins. *Taking Control: New Hope for Substance Abusers and Their Families*. Grand Rapids, MI: Baker, 1993.

Miller, Geri. *Learning the Language of Addiction Counseling*. Fourth ed. Indianapolis, IN: Wiley, 2014.
Fully updated, the fourth edition offers a positive, practice-oriented counseling framework and features: A research-based, clinical application approach to addiction counseling that practitioners can turn to for fundamental, practical, clinical guidelines; Revised chapters that reflect important changes in research and practice, including new DSMTM-5 criteria, new assessment instruments, and new and expanded treatments; Case studies, interactive exercises, end-of-chapter questions, and other resources that facilitate the integration of knowledge into practice; "Personal Reflections" sections at the beginning of each chapter provide an invaluable, unique perspective on the author's evolving views of addiction counseling; Updated and expanded online Instructor's Manual that includes brief video clips, PowerPoint(R) slides, test bank questions for each chapter, and sample syllabi.

Nakken, Craig. *The Addictive Personality: Understanding the Addictive Process and Compulsive Behavior*. Second ed. Center City, MN: Hazelden, 1996.
Brings new depth and dimension to our understanding of how an individual becomes an addict. Going beyond the definition that limits dependency to the realm of alcohol and other drugs, Nakken uncovers the common denominator of all addiction and describes how the process is progressive. The author examines how addictions start, how society pushes people toward addiction, and what happens inside those who become addicted.

Ryan, Dale and Juanita. *Rooted in God's Love: Meditations on Biblical Texts for People in Recovery*. Brea, CA: Christian Recovery International, 2005.
A series of meditations on biblical texts that offer grace and hope to the brokenhearted and the crushed in spirit. Understanding that healing is often a long and difficult journey, Dale and Juanita Ryan speak with open hearts and personal insight about our longing for wholeness, about our resistance to recovery and about reasons for hope along the way.

Selby, Saul. *Twelve Step Christianity: The Christian Roots and Application of the Twelve Steps*. New York: Hazelden, 2000.
As a Christian who practices the Steps, Saul Selby knows them to be an invaluable tool for living out the Christian faith. Selby brings his knowledge to bear in *Twelve Step Christianity*, which teaches Christians in recovery to connect their faith with their program—and shows any Christian a clear path to a more intimate relationship with Christ. Laid out in a workbook format, with room for readers to write answers and track their progress, *Twelve Step Christianity* explores the roots of Twelve Step spirituality, Examines the connections and distinctions between Christianity and Twelve Step programs and offers readers a deeper and broader understanding of the myriad powerful reasons for applying the Twelve Steps to their lives.

Stevens, Patricia, and Robert L. Smith. *Substance Abuse Counseling: Theory and Practice*. Fourth ed. Upper Saddle River, NJ: Prentice Hall, 2008.
Thoroughly examines substance abuse in the population, addressing both ways to measure the problem and how to treat individuals and families who seek assistance. It educates prospective clinicians and counselors by guiding them, step-by-step, through the process of working with substance-abuse clients. Chapter content builds in sequence; however, each chapter can be taken as a stand-alone source of valuable information. Individual chapters on special populations add substantial depth to the text's treatment of its subject.

Thombs, Dennis L., and Cynthia J. Osborn. *Introduction to Addictive Behaviors*. Fourth ed. New York: Guilford, 2013.
Assuming no prior knowledge in the field, the book shows how theory and research can offer a roadmap for effective intervention. It presents multiple perspectives on the causes and mechanisms of substance use problems, reviews their strengths and limitations, and examines their implications for helping people change their behavior. Evidence-based treatment and prevention strategies are described.

Van Cleave, Stephen, Walter Byrd, and Kathy Revell. *Counseling for Substance Abuse and Addiction*. Dallas, TX: Word, 1987.

It has a lot of information on addiction and how to work with addicts as well as their family members.

Welch, Edward R. *Addictions: A Banquet in the Grave. Finding Hope in the Power of the Gospel*. Phillipsburg, NJ: Presbyterian & Reformed Publishing, 2001.

White, Robert K., and Deborah George Wright, eds. *Addiction Intervention: Strategies to Motivate Treatment-Seeking Behavior*. New York: Haworth, 1998.
Shows you how to use the tools of intervention--the words, the steps, and the strategies--to be a change agent in the lives of individuals with alcohol and drug addictions. It is full of effective strategies and case studies coming from widely respected specialists across several disciplines. You'll learn how you can get people to seek help for their chemical dependence, resolving the cause of their problems rather than temporarily fixing the symptoms or side effects of their addictions.

Wilson, Jan R., and Judith A. Wilson. *Addictionary: A Primer of Recovery Terms and Concepts from Abstinence to Withdrawal*. New York: Hazelden, 1999.
Organized alphabetically, the *Addictionary* is a comprehensive resource that defines hundreds of recovery terms. The authors provide clear, in-depth definitions that demystify the language of recovery, address a variety of recovery issues, and focus on addictions to drugs, alcohol, gambling, food, sex, and codependency. Special features include definitions grouped by themes and a directory of recovery groups and organizations.

AIDS

Barnett, Tony, and Alan Whiteside. *AIDS in the Twenty-First Century Disease and Globalization*. Second ed. New York: Palgrave Macmillan, 2006.
Fully revised and updated to take account of the latest facts and developments in the field. Carefully written to be accessible, this book is theoretically informed, practical and remains the leading text in its field.

Beckley, Robert E., and Jerome R. Koch. *The Continuing Challenge of AIDS: Clergy Responses to Patients, Friends, and Family*. Westport, CT: Auburn House, 2002.
Using quantitative and qualitative data from the early 1990s and from follow-up interviews conducted later in the decade, the authors show that many clergy became involved in the pastoral care for and counseling of people stigmatized by AIDS, including gay and bisexual men, despite expressions of antipathy from their denominations. Sociological theories concerning clergy roles, social movements, social space, and social capital provide a framework for analyzing the initial findings and the data from subsequent interviews. The study concludes that this small but dedicated group of clergy who ministered to the needs of this suffering population were part of a social movement that addressed a community problem despite both obstacles and opposition. Using data obtained from structured interviews and responses to questionnaires concerning clergy responses to real and hypothetical situations involving people who are HIV-positive or who have AIDS, the authors illustrate how clergy and organized religious groups confronted a new and acute fatal illness that was initially associated with stigmatized behavior. They demonstrate that many clergy saw their roles as advocates for these individuals and as providers of pastoral and spiritual care, in spite of the rhetoric of conservative and fundamentalist clergy who condemned the victims as an example of the wrath of God against gay and bisexual men. The study also shows that even those who were less actively engaged in AIDS pastoral care and counseling demonstrated tolerance for those affected by it. Follow-up interviews indicate, finally, that as AIDS became more of a chronic illness, the social movement to provide religious and spiritual care and counseling began to wane.

Connolly, Sean. *AIDS Pastoral Care: An Introductory Guide*. Grantsburg, WI: Arc Research, 1994.
This book presents the many issues relating to the care of HIV/AIDS inflicted persons, including the transmission factors, psycho-social issues, ethical issues, dynamics of the caregiver/care-receiver relationship, and grief process and terminal illness issues, including the need for closure for the caregiver.

Dortzback, Deborah, and W. Meredith Long. *The AIDS Crisis: What We Can Do*. Downers Grove, IL: InterVarsity, 2006.
The authors offer personal stories, up-to-date statistics and their years of international experience to give us the global portrait of AIDS: the roots of the problem and the role of the church. They teach us to listen. They allow us to observe. They help us become informed so that we can become involved, partnering with brothers and sisters already at work around the world loving, lobbying, caring, praying.

Hunter, Jonathan. *Embracing Life Series*. Longwood, FL: Xulon, 2006.
A healing, discipleship program for adults with life-altering conditions. It encourages a faith-filled embrace of abundant life, resulting in lasting freedom from death's influences.

Sunderland, Ronald H., and Earl E. Shelp. *AIDS, A Manual for Pastoral Care*. Philadelphia: Westminster, 1987.

Wood, Glenn, and John Dietrich. *The AIDS Epidemic: Balancing Compassion and Justice*. Portland, OR: Multnomah, 1990.
From the Critical Concern Series, this resource not only ministers to those who are victims of this tragic disease, but also will help concerned individuals to understand the medical, psychological, and spiritual aspects of this epidemic with great accuracy and balance.

Alcoholism

Dodes, Lance M. *The Heart of Addiction: A New Approach to Understanding and managing Alcoholism and Other Addictive Behaviors*. New York: Quill, 2003.
Dr. Dodes debunks several such widely accepted myths as: Addictions are fundamentally a physical problem; People with addictions are different from other people; You have to hit bottom before you can get well; and You are wasting your time if you ask "why" you have an addiction.

Hester, Reid K., and William R. Miller. *Handbook of Alcoholism Treatment Approaches*. Third ed. Boston, MA: Allyn & Bacon, 2002.
A comprehensive, results-based guide to alcohol treatment methods. This handbook surveys the various models that have been used to define alcoholism, ending with a discussion of what the authors call "an informed eclecticism." Using this approach, clinicians develop a spectrum of treatment approaches that have proved effective in practice, then match specific clients with the treatment methods that offer the greatest opportunities for success in these specific circumstances.

Ketcham, Katherine, and William F, Asbury. *Beyond the Influence: Understanding and Defeating Alcoholism*. New York: Bantam, 2000.
Based on the latest scientific research, **Beyond the Influence** clearly explains the neurological nature of the disease and reveals why some people drink addictively and others do not. It also spells out what needs to be done to treat alcoholism, including: Steps to take for an intervention; How to find the right treatment program; Which psychological approaches work best; Why spirituality is essential to recovery; New insights into relapse prevention; and What you should know about diet, exercise, and nontraditional treatments such as acupuncture.

Milam, James Robert, and Katherine Ketcham. *Under the Influence: A Guide to the Myths and Realities of Alcoholism*, reissue ed. New York: Bantam, 1984.
Examines the physical factors that set alcoholics and non-alcoholics apart, and suggests a bold, stigma-free way of understanding and treating the alcoholic.

Selby, Saul. *Twelve Step Christianity: The Christian Roots and Application of the Twelve Steps*. New York: Hazelden, 2000.
As a Christian who practices the Steps, Saul Selby knows them to be an invaluable tool for living out the Christian faith. Selby brings his knowledge to bear in *Twelve Step Christianity*, which teaches Christians in recovery to connect their faith with their program—and shows any Christian a clear path to a more intimate relationship with Christ. Laid out in a workbook format, with room for readers to write answers and track their progress, *Twelve Step Christianity* explores the roots of Twelve Step spirituality, Examines the connections and distinctions between Christianity and Twelve Step programs and offers readers a deeper and broader understanding of the myriad powerful reasons for applying the Twelve Steps to their lives.

The Twelve Steps for Christians: Based on Biblical Teachings. San Diego, CA: RPI, 1994.
A powerful resource for merging the practical wisdom of the Twelve Steps with the spiritual truths of the Bible.

Eating Disorders

Bode, Janet. *Food Fight: A Guide to Eating Disorders for Preteens and Their Parents*. New York: Alladin, 1998.
A complete resource for preteens and their parents candidly discusses the symptoms and possible causes of anorexia, bulimia, compulsive overeating, and other eating disorders and includes interviews with children who suffer from them.

Costin, Carolyn. *The Eating Disorder Sourcebook: A Comprehensive Guide to the Causes, Treatments, and Prevention of Eating Disorders*. Second ed. Columbus, OH: McGraw Hill, 1999.
Therapist Carolyn Costin, herself recovered from anorexia, brings three decades of experience and the newest research in the field together, providing readers with the latest treatments, from medication and behavioral therapy to alternative remedies.

Cruse, Sheryl. *Thin Enough: My Spiritual Journey Through the Living Death of an Eating Disorder*. Birmingham, AL: New Hope, 2006.
The teen and college years are a crucial time for girls, when positive or negative views about their bodies often become manifest. Written to eating disorder sufferers who are at this critical age, *Thin Enough* provides hope that, through faith and trust in God, they too can rise above the living death of eating disorders and arise as God's daughters, full of life and with a promising future.

Heaton, Jeanne Albronda, and Claudia J. Straus. *Talking to Eating Disorders: Simple Ways to Support Someone with Anorexia, Bulimia, Binge Eating, or BodyImage Issues*. New York: Amazon, 2005.
This compassionate guide offers ways to tackle the tough topics of body image, media messages, physical touch, diets, and exercise-along with a special section on talking about these issues with children. It includes information about when to get professional help, how to handle emergencies, and answers to difficult questions such as "Am I too fat?" or "Is this ok to eat?"

Siegel, Michele, Judith Brisman, and Margot Weinshel. *Surviving an Eating Disorder: Strategies for Family and Friends*. Third ed. New York: Harper, 1997.
This updated and revised edition provides the latest information on how parents, spouses, friends, and professionals can thoughtfully determine the right course of action in their individual situations.

Vath, Raymond E. *Counseling Those With Eating Disorders: A How-To Approach*. Dallas, TX: Word, 1986.
Part of the Resources for Christian Counseling series, a series that combines the best of current psychological theory with a strict adherence to scriptural truth.

Euthanasia and Physician-Assisted Suicide

Basri, Zakyah. *Euthanasia: Which "M" Is It? Mercy or Murder?* Bloomington, IN: AuthorHouse, 2012.
Presents a simplistic way of thinking in a very complicated debate.

Chell, Byron. *Aid in Dying, the Ultimate Argument: The Clear Ethical Case for Physician-Assisted Suicide*. New York: CreateSpace, 2014.
Here is an intelligible ethical defense of physician assisted death as permitted in Oregon, Washington and Vermont. It demonstrates that there are no ethical arguments sufficient to justify the criminalization of aid in dying in our secular, pluralistic society. None. All of the traditional and continuing objections to aid in dying are examined. It addresses the decision of the dying individual, the role of the physician, and the feared consequences of permitting aid in dying.

Chia, Roland. *The Right to Die? A Christian Response to Euthanasia*. Singapore: Armour, 2009.
This book provides an exposition of the position of the National Council of Churches of Singapore (NCCS) on euthanasia. It serves as a primer for pastors, church leaders and Christians who wish to understand the Christian response to this important issue. Part One defines euthanasia, analyses the different types of euthanasia and gives a brief history of euthanasia. Part Two presents the NCCS' case against euthanasia. Finally, in Part Three, the possible impact that legalised euthanasia may have on our society is examined.

Dworkin, Gerald, R. G. Frey, and Sissela Bok. *Euthanasia and Physician-Assisted Suicide: For and Against*. New York: Cambridge UP, 2004.

Two prominent philosophers, Gerald Dworkin and R. G. Frey argue that in certain circumstances it is morally and should be legally permissible for physicians to provide the knowledge and means by which patients can take their lives. One of the best-known ethicists in the US (author of Lying: Moral Choice in Public and Private) Sissela Bok argues that the legalization of euthanasia and physician-assisted suicide would entail grave risks and would in no way deal adequately with the needs of those at the end of their lives, least of all in societies without health insurance available to all. All the moral and factual issues relevant to this controversy are explored.

Dyck, Arthur J. *Life's Worth: The Case against Assisted Suicide*. Grand Rapids, MI: Wm. B. Eerdmans, 2002.

Over the course of four interconnected, tightly reasoned arguments, Dyck takes readers from a basic concern for human suffering—the main focus of those who support assisted suicide—to the deeper truths of life's inherent worth. Dyck begins by examining the arguments of some physicians, moral philosophers, and theologians for making assisted suicide available. He also discusses the alternative practice of comfort-only care, explaining why it differs morally from assisted suicide and euthanasia. Dyck then explores and defends the moral structure underlying the West's long tradition of homicide law as well as current law against assisted suicide and euthanasia—laws designed to protect both freedom and human life. Finally, Dyck shows that the moral structure undergirding our system of law is compatible with the views of Christianity, and he points to certain Christian beliefs that provide comfort and hope to those who are suffering, dying, or experiencing the death of loved ones.

Haerens, Margaret. *Euthanasia: Opposing Viewpoints*. Chicago, IL: Greenhaven, 2015.

The viewpoints are selected from a wide range of highly respected sources and publications.

Keown, John, ed. *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives*. New York: Cambridge UP, 1997.

Whether euthanasia or assisted suicide should be legalized is one of the most pressing and profound questions facing legislators, health care professionals, their patients, and all members of society. Regrettably, the debate is too often characterized by rhetoric rather than reason. This book aims to inform the debate by acquainting anyone interested in this vital question with some of the major ethical, legal, clinical and theological issues involved. The essays it contains are authoritative in that they have been commissioned from some of the world's leading experts, balanced in that they reflect divergent viewpoints (including a vigorous debate between two eminent philosophers), and readable in that they should be readily understood by the general reader.

Larson, Edward J., and Darrell W. Amundsen. *A Different Death: Euthanasia & the Christian Tradition*. Downers Grove, IL: InterVarsity, 1998.

This is an excellent book that is worth every minute of reading it.

Manning, Michael. *Euthanasia and Physician-Assisted Suicide: Killing or Caring?* Mahwah, NJ: Paulist, 1998.

A concise overview of the history and arguments surrounding euthanasia and physician-assisted suicide.

Orfali, Robert. *Death with Dignity: The Case for Legalizing Physician-Assisted Suicide Dying and Euthanasia*. Minneapolis: Mill City, 2011.

Provides an in-depth look at how we die in America today. It examines the shortcomings of our end-of-life system. You'll learn about terminal torture in hospital ICUs and about the alternatives: hospice and palliative care. With laser-sharp focus, Orfali scrutinizes the good, the bad, and the ugly. He provides an insightful critique of the practice of palliative sedation. The book makes a strong case that assisted dying complements hospice.

Paterson, Craig. *The Contribution of Natural Law Theory to Moral and Legal Debate Concerning Suicide, Assisted Suicide and Euthanasia*. New York: CreateSpace, 2010.

In chapter one, Paterson argues for the important contribution that a natural law based framework can make towards an analysis of key controversies surrounding the practices of suicide, assisted suicide, and voluntary euthanasia. In the second chapter, he considers a number of historical contributions to the debate. The third chapter takes up the modern context of ideas that have increasingly come to the fore in shaping the 'push' for reform. Particular areas focused upon include the value of human life, the value of personal autonomy, and the rejection of double effect reasoning. In chapter four, Paterson engages in the task of pointing out structural weakness in utilitarianism and deontology. He argues that major systemic weaknesses in both approaches can be overcome by a teleology of basic human goods. In chapter five, Paterson argues for the defense of the intrinsic good of human life from direct attack. He defends the proposition "it is always a serious moral wrong to intentionally kill a human

person, whether self or another, regardless of a further appeal to consequences or motive." In chapter six, Paterson argues that the natural law conception of the person in society, centered on the common good, provides a solid framework for assessing both the justification for, as well as the limits on, the role of the state to use its power to legally impose certain moral standards. In chapter seven, he addresses the concrete relationship between natural law and legal policy by exploring the issue of assisted suicide in the constitutional context of the United States.

Smith, Wesley J. *Forced Exit: Euthanasia, Assisted Suicide and the New Duty to Die*. New York: Encounter Books, 2006.
Filled with new reporting and research, this expanded edition of a classic book makes a compelling case against legalized euthanasia and takes a closer look at the truly humane and compassionate alternatives.

Snyder, Carrie L., ed. *Euthanasia: Opposing Viewpoints*. Chicago, IL: Greenhaven, 2006.
The viewpoints are selected from a wide range of highly respected sources and publications.

Spring, Beth and Ed Larson. *Euthanasia: Spiritual, Medical & Legal Issues in Terminal Health Care*. Portland, OR: Multnomah, 1988.
Provides an eye-opening overview of the debate over euthanasia. Their helpful assessment of current theological, medical, social, and legal attitudes toward the dying, graphically illustrated by actual case studies, underscores the ethical dilemma we now face.

Tada, Joni Eaeckson. *When Is it Right to Die?* Carson, CA: Rose, 2012.
This pamphlet goes into detail about: What to say to someone who is struggling with suicidal thoughts; God's plan for your life with a disability; What the Bible says about struggling through the tough questions on life and death; and Artificial Life support.

Wennberg, Robert N. *Terminal Choices: Euthanasia, Suicide, and the Right to Die*. Grand Rapids, MI: Wm. B. Eerdmans, 1989.
Beginning with an unargued for and frankly Christian perspective that life is a gift from God, Wennberg argues that suicide and euthanasia are generally immoral. The author may shock nonbelievers when he claims that justified suicide is rarer than justified homicide, but Wennberg does use many secular arguments to recognize exceptions to both prohibitions. Moreover, he deals sensitively with the conceptual issues that are dear to the hearts of analytic philosophers. He contributes valuably to understanding various kinds of euthanasia.

Homosexuality

Dallas, Joe. *A Strong Delusion: Confronting the "Gay Christian" Movement*. Eugene, OR: Harvest House, 1996.
Author and counselor Joe Dallas, in a loving and biblical manner, spells out what pro-gay theology is and how to confront it, then examines the believer's personal response and the need for bold love and commitment. He also gives detailed responses to the main scriptural arguments posed by the pro-gay movement, and evaluates the movement's impact on culture and the church.

Dallas, Joe, and Nancy Heche, eds. *The Complete Christian Guide to Understanding Homosexuality: A Biblical and Compassionate Response to Same-Sex Attraction*. Eugene, OR: Harvest House, 2010.
Readers will find the answers to these and many more important questions: What is homosexuality? Is the tendency for homosexuality genetic? How should the church respond?

Davies, Bob, and Lori Rentzel. *Coming Out of Homosexuality: New Freedom for Men & Women*. Downers Grove, IL: InterVarsity, 1994.
This is not a theoretical book: it is a practical guide for people struggling with same-sex desires. You'll find answers to your questions about what it means to be a man or woman, how your past relates to your present tensions, how biblical principles apply to your daily life, how you can form healthy relationships, and how your healing may eventually prepare you for heterosexual romance and marriage. Along the way you will read stories of other Christians who have dealt with the same issues you are facing and their personal failures and successes. Most of all, you'll find strategies that work because they have been developed and used by real people like you.

DeYoung, Kevin. *What does the Bible Really Teach about Homosexuality?* Wheaton, IL: Crossway, 2015.

After examining key biblical passages in both the Old and New Testaments and the Bible's overarching teaching regarding sexuality, DeYoung responds to popular objections raised by Christians and non-Christians alike, making this an indispensable resource for thinking through one of the most pressing issues of our day.

Gagnon, Robert A. J., and Dan O. Via. *Homosexuality and the Bible: Two Views*. Minneapolis: Fortress, 2003.
In this brief book, two New Testament scholars discuss the relevant biblical texts on the subject of homosexual behavior and orientation. Discussing both Old Testament and New Testament texts, each author also raises important interpretive and moral questions and then offers a response to the other's main assertions. Chief questions examined by each include what the Bible has to say about homosexuality and homosexual behavior, the meaning of those texts in their cultural contexts, and the larger hermeneutical dilemma of what kind of authority the Bible's teaching, if recoverable, has for Christians today.

Haley, Mike. *101 Questions Frequently Asked About Homosexuality*. Irvine, CA: Harvest House, 2004.
Here are the answers to the most often asked questions about homosexuality, fielded by an expert on the subject...and a former homosexual himself.

Jones, Stanton L., and Mark A. Yarhouse. *Homosexuality: The Use of Scientific Research in the Church's Moral Debate*. Downers Grove, IL: InterVarsity, 2000.
How prevalent is homosexuality? What causes it? Is it a psychopathology? Can it be changed? Questions like these often accompany discussions of homosexual behavior. For answers we naturally look to scientific studies. But what does the scientific research actually show? More important, what place should this research have in shaping the church's response? Stanton Jones and Mark Yarhouse help us face these issues squarely and honestly. In four central chapters they examine how scientific research has been used within church debates--in particular within Methodist, Presbyterian and Episcopal contexts. They then survey the most recent and best scientific research and sort out what it actually shows. Next they help us to interpret the research's relevance to the moral debate within the church. In a concluding chapter they make a strong case for a traditional Christian sexual ethic.

Konrad, Jeff. *You Don't Have to Be Gay*. Hilo, HI: Pacific, 1998.
A non-technical, true-to-life book that shatters the myths about homosexuality, its causes and cures. Not based on simple pat answers, *You Don't Have To Be Gay* gives clear instruction, well-documented argumentation, heartening encouragement, honest self-analysis and practical suggestions.

Koukl, Gregory, and Thomas Schmidt. "Straight Down a Crooked Path: A Christian Response to Homosexuality" (Tapes). San Pedro, CA: Stand to Reason Press, unknown date.
Includes the following two tapes: (1) *Setting the Record Straight: The Bible and Homosexuality* - Greg Koukl focuses on one thing only: What is the most reasonable way to understand the biblical texts pertaining to homosexuality? Using only a handful of the clearest verses, Greg judiciously weighs the evidence, leading to an unmistakable conclusion. Includes PDF study notes. (2) *Homosexuality & Christian Morality* - Dr. Thomas Schmidt offers a deeply compassionate, yet incisive analysis of homosexuality. Given at Texas A&M University as part of the Veritas Forum, this lecture is perfect for someone who might be sensitive to a heavy-handed biblical treatment of the homosexuality issue.

Lee, Justin. *Torn: Rescuing the Gospel from the Gays-vs.-Christians Debate*. Nashville: Jericho, 2013.
As a teenager and young man, Justin Lee felt deeply torn. Nicknamed "God Boy" by his peers, he knew that he was called to a life in the evangelical Christian ministry. But Lee harbored a secret: He also knew that he was gay. In this groundbreaking book, Lee recalls the events--his coming out to his parents, his experiences with the "ex-gay" movement, and his in-depth study of the Bible--that led him, eventually, to self-acceptance. But more than just a memoir, TORN provides insightful, practical guidance for all committed Christians who wonder how to relate to gay friends or family members--or who struggle with their own sexuality. Convinced that "in a culture that sees gays and Christians as enemies, gay Christians are in a unique position to bring peace," Lee demonstrates that people of faith on both sides of the debate can respect, learn from, and love one another.

Rogers, Jack. *Jesus, the Bible, and Homosexuality: Explode the Myths, Heal the Church*. Louisville, KY: Westminster John Knox, 2005.
Former seminary professor and church official Jack Rogers argues unequivocally for the ordination of homosexuals and for the extension of full and equal rights in society to all people who are homosexual.

Schmidt, Thomas E. *Straight & Narrow? Compassion & Clarity in the Homosexuality Debate*. Downers Grove, IL: InterVarsity, 1995.
In this book Schmidt brings the discussion back into empathetic contact with the circumstances and the choices of individuals. At the same time he offers thoroughly researched and up-to-date information and assessment from an evangelical Christian perspective on all the main points of the debate. He includes chapters on what the Bible really says (and means) about homosexuality, the health effects of homosexual behavior, whether or not people are born with homosexual orientations, and the cogency of recent progay reconstructions of history such as John Boswell's.

Vines, Matthew. *God and the Gay Christian: The Biblical Case in Support of Same-Sex Relationships*. New York: Convergent, 2015.
Feeling the tension between his understanding of the Bible and the reality of his same-sex orientation, Vines devoted years of intensive research into what the Bible says about homosexuality. With care and precision, Vines asked questions such as: Do biblical teachings on the marriage covenant preclude same-sex marriage or not? How should we apply the teachings of Jesus to the gay debate? Can celibacy be a calling when it is mandated, not chosen? What did Paul have in mind when he warned against same-sex relations?

Welch, Edward T. Homosexuality: Speaking the Truth in Love. Phillipsburg, NJ: P & R, 2000.
How can we answer claims that the Bible does not prohibit committed homosexual relationships? Or that science proves that homosexuality is genetic, not a chosen lifestyle? Welch supplies us with timely biblical and biological insight into homosexuality. Just as importantly, he calls us to examine our attitudes in order to minister to homosexuals truthfully, compassionately, humbly, and persuasively.

Social Issues – General

Anderson, J. Kerby. *Moral Dilemmas: Biblical Perspectives on Contemporary Ethical Issues*. Waco, TX: Word, 1998.
Presents a penetrating volume of solid, practical answers to some of the most perplexing issues facing our society today-issues such as abortion, euthanasia, cloning, capital punishment, genetic engineering, and the environment.

Bouma, Hessel III, Douglas Diekema, Edward Langerah, Theodore Rottman and Allen Verhey. *Christian Faith, Health, & Medical Practice*. Grand Rapids, MI: Wm. B. Eerdmans, 1989.

Field, David F., David J. Atkinson, Oliver O'Donovan, and Arthur Holmes, eds. *New Dictionary of Christian Ethics and Pastoral Theology*. Downers Grove, IL: InterVarsity, 1995.
Besides hundreds of articles on specific issues, the *Dictionary* includes eighteen major keynote articles which provide a basic introduction to the main themes of Christian ethics and pastoral theology.

Finsterbusch, Kurt. *Taking Sides: Clashing Views on Social Issues*. Fifteenth ed. Columbus, OH: McGraw-Hill, 2013.
Presents current controversial issues in a debate-style format designed to stimulate student interest and develop critical thinking skills.

Foreman, Mark W. *Christianity & Bioethics: Confronting Clinical Issues*. Eugene, OR: Wipf, 2011.
Careful, articulate Christian treatment of ethical issues.

Geisler, Norman, and Frank Tureck. *Legislating Morality*. Eugene, OR: Wipf, 2003.
Advocates a moral base for America without sacrificing religious and cultural diversity, debunking the myth that "morality can't be legislated" and amply demonstrating how liberals, moderates, and conservatives alike exploit law to promote good and curtail evil.

Harrison, R. K., ed. *Encyclopedia of Biblical & Christian Ethics*. Nashville: T. Nelson, 1992.
A comprehensive reference work for everyone concerned with the complicated moral issues of this world, this unique volume clearly communicates what Scripture teaches about the ethical dilemmas facing our society. Biological warfare, corporate responsibility, human rights, computer ethics, and much more are discussed by over fifty scholars who explain the moral guidelines in the Bible and historic Christian teachings.

Holmes, Arthur F. *Ethics: Approaching Moral Decisions*. Downers Grove, IL: InterVarsity, 2007.

In this second edition, Arthur Holmes adjusts the argument and information throughout, completely rewriting the original chapter on virtue ethics and adding a new chapter on the moral agent. Holmes addresses the questions: What is good? What is right? How can we know? In doing so he also surveys a variety of approaches to ethics, including cultural relativism, emotivism, ethical egoism and utilitarianism—all with an acknowledgment of the new postmodern environment.

Jones, David W. *An Introduction to Biblical Ethic*. Nashville: B & H, 2013.
Explains the nature, relevancy, coherency, and structure of the moral law as revealed throughout the Bible. In addition to covering the foundational elements of biblical ethics, major issues investigated in this volume include: different types of law in Scripture, the relationship between the law and the gospel, and issues related to the prospect of conflicting moral absolutes.

Kizza, Joseph. *Ethical and Social Issues in the Informational Age*. Fifth ed. New York: Springer, 2013.
This new edition examines the ethical, social, and policy challenges stemming from computing and telecommunication technology, and mobile information-enabling devices. Features: establishes a philosophical framework and analytical tools for discussing moral theories and problems in ethical relativism; offers pertinent discussions on privacy, surveillance, employee monitoring, biometrics, civil liberties, harassment, the digital divide, and discrimination; examines the new ethical, cultural and economic realities of computer social networks; reviews issues of property rights, responsibility and accountability relating to IT and software; discusses how virtualization technology informs ethical behavior; introduces the frontiers of ethics in VR, AI, and the Internet; surveys the social, moral and ethical value systems in mobile telecommunications; explores the evolution of electronic crime, network security, and computer forensics; provides exercises, objectives, and issues for discussion in every chapter.

Lebacqz, Karen, and Joseph D. Driscoll. *Ethics and Spiritual Care: A Guide for Pastors and Spiritual Directors*. Nashville: Abingdon, 2009.
Responds to three phenomena of increasing importance: (1) Although spiritual care is at the heart of ordained ministry, there is no text in professional ethics for clergy that focuses specifically on spiritual care. What ethical guidelines are needed to ensure that spiritual care in ministry is appropriate? (2) Many people in our world do not consider themselves "religious," but use the term "spiritual." The burgeoning interest in "spirituality" is an invitation to people with little training to set themselves up as "spiritual directors." Guidelines are needed not simply for the ethical practice of parish ministry, but for specific practices of spiritual direction. (3) Allegations of "spiritual abuse" have been made both in practice and in the literature; the term is being used with some frequency. The development of this term and its implications requires some scrutiny and response, as sexual abuse is not a good model for understanding spiritual abuse.

Lysaught, M. Theresa, Joseoh J. Kotva, Stephen E. Lammers, and Allen Verhey, eds. *On Moral Medicine: Theological Perspectives in Medical Ethics*. Third ed. Grand Rapids, MI: Wm. B. Eerdmans, 2012.
Remains the definitive anthology for Christian theological reflection on medical ethics. This third edition updates and expands the earlier award winning volumes, providing classrooms and individuals alike with one of the finest available resources for ethics-engaged modern medicine.

McQuilkin, Robertson, and Paul Copan. *An Introduction to Biblical Ethics: Walking in the Way of Wisdom*. Downers Grove, IL: InterVarsity, 2014.
What should we do or not do? What attitudes, behavior and qualities are good? Can we be good without God? What is the highest good, the purpose of human existence? These are the questions the study of ethics seeks to answer. Unlike many approaches to ethics, this book foundationally turns to Scripture, going only as far as Scripture itself goes. The result is an overview of biblical ethics that not only addresses the life of love and wisdom to be lived out by Christians as virtuous individuals, but also as Christians in community, in society and in a world of God's creation. Key preliminary considerations of love, law, sin and virtue are given their due in this thoroughly revised and updated text. The bulk of the work is then organized around the Ten Commandments and ethical themes springing from them—loving God (commandments 1-4) and loving others (commandments 6-10). This new edition includes added material on ethical alternatives such as relativism, social contract, utilitarianism and evolutionary ethics; the seven deadly sins as well as the cardinal virtues vs. theological virtues; end-of-life ethics, stem-cell research, animal rights, sexuality, genetics and technology, and other bioethical issues such as plastic surgery and surrogate motherhood; technology and its depersonalizing effects as well as helping the poor; the church's engagement in society and how Christians can make a difference in the media.

Rubington, Earl, and Martin S. Weinberg. *The Study of Social Problems: Seven Perspectives*. Seventh ed. New York: Oxford UP, 2010.
Uses seven sociological perspectives--social pathology, social disorganization, value conflict, deviant behavior, labeling, the critical perspective, and social constructionism--to examine social problems. Focusing on theory, this critically acclaimed anthology distinguishes itself from other texts, which are organized topically. Each section opens with an overview of the perspective's major contributors, its history, and its main characteristics and closes with a critique of the perspective and questions for discussion. Thirty-six readings drawn from a wide range of primary sources illustrate and expand upon the key elements of each approach.

Rae, Scott. *Moral Choices: And Introduction to Ethics*. Third ed. Grand Rapids, MI: Zondervan, 2009.
This third edition offers extensive updates, revisions, and brand new material, all designed to help students develop a sound and current basis for making ethical decisions in today's complex postmodern culture. Moral Choices outlines the distinctive elements of Christian ethics while avoiding undue dogmatism. The book also introduces other ethical systems and their key historical proponents, including Plato, Aristotle, Augustine, Thomas Aquinas, and Immanuel Kant. After describing a seven-step procedure for tackling ethical dilemmas, author Scott Rae uses case studies to address some of today's most pressing social issues.

Ryrie, Charles C. *Biblical Answers to Contemporary Issues*. Chicago: IL: Moody, 1991.
The subjects covered are good but it doesn't address enough for what is taking place in today's environment.

Wogaman, J. Philip. *Moral Dilemmas: An Introduction to Christian Ethics*. Louisville, KY: Westminster John Knox, 2009.
How can we make decisions that are consistent with our basic values? We must first, J. Philip Wogaman says, identify basic moral presumptions that can guide our thought as we face moral dilemmas. These basic moral presumptions include equality, grace, the value of human life, the unity of humankind, preferential claims for the poor and marginalized, and the goodness of creation. The burden of proof, he argues, must be borne by decisions that are contrary to such presumptions. He pulls into the conversation difficult ethical issues such as divorce, sexuality, abortion, political choices, economic justice, affirmative action, homosexuality, nuclear disarmament, economic globalization, global warming, international security, environmental policies, and military power.

Suicide

Berman, Alan L., David A. Jobes, and Morton M. Silverman. *Adolescent Suicide: Assessment and Intervention*. Second ed. Washington, DC: American Psychological Association, 2005.
This volume reflects on what is current and promising in working with the suicidal adolescent and provides information relevant to theory, research, practice, and intervention. It provides empirically based findings that can be easily integrated and translated for practical use by the clinician. In addition, the book includes discussion of malpractice risk management, over 40 case illustrations, and an extensive list of references—all of which help provide a thorough understanding of the at-risk-for-suicide patient.

Biebel, David B., and Suzanne L. Foster. *Finding Your Way after the Suicide of Someone You Love*. Grand Rapids, MI: Zondervan, 2005.
This gentle and faith-affirming resource helps survivors know what to expect, especially during the first year following a suicide. It includes personal stories of survivors and suggestions on how to move beyond survival to live life again. Designed for use by individuals, couples, and SOS groups, this book offers help for parents, siblings, friends, and extended families, as well as practical guidelines for pastors, Christian counselors, and other church leaders. Topics include: What to do in the immediate aftermath of a suicide; Handling guilt and understanding the role of depression in suicides; Dealing with questions of faith and meaning; Creating a support system; Choosing a Christian therapist; Trusted resources and websites

Biskup, Michael and Tamara L. Roleff, eds. *Suicide: Opposing Viewpoints*. San Diego, CA: Greenhaven, 1997.
Explore the issue of suicide with expert opinions in a pro/con format and encourage critical thinking. Includes discussion questions, bibliography and respected sources.

Demy, Timothy J., and Gary P. Stewart, eds. *Suicide: A Christian Response*. Grand Rapids, MI: Kregel, 1998.

This contemporary resource presents the medical, ethical, legal, pastoral, and personal arguments for choosing life rather than death.

Groothius, Douglas R. *Deceived by the Light*. Eugene, OR: Harvest House, 1995.
Doug Groothuis a well-respected expert on new religious movements, takes us to the teaching of Scripture for some surprising anwers about death, near-death experiences, and what comes after death.

Hsu, Albert. *Grieving a Suicide: A Loved One's Search for Comfort, Answers & Hope*. Downers Grove, IL: InterVarsity, 2002.
After his father's death by suicide, Albert Hsu wrestled with the intense emotional and spiritual questions surrounding suicide. While acknowledging that there are no easy answers, Hsu draws on the resources of the Christian faith to point suicide survivors to the God who offers comfort in our grief and hope for the future.

Lester, David. *Making Sense of Suicide: An In-Depth Look at Why People Kill Themselves*. Philadelphia, PA: Charles Press, 1997.
The author aims to interpret and integrate research on suicidal behavior, particularly motives for suicidal behavior, to provide an encyclopedic reference volume and to summarize facts everyone should know to optimize suicide prevention efforts. Most books about the problem of suicide fail to achieve the smooth integration of studies and facts achieved in this book. There is important place for books that attempt to synthesize knowledge about suicidal behavior. The volume tends toward shallow coverage of clinical matters, such as the recognition of suicide risk, evaluation of suicide potential and the treatment and management of suicidal patients.

Townsend, Loren L. *Suicide: Pastoral Responses*. Nashville: Abingdon, 2006.
Dr. Townsend approaches the potentially suicidal individual and the bereaved person with the heart of a pastor and the experience of a counselor. Integrating basic and effective techniques and spiritual approaches, the author provides a sound framework and presents a wide scope of information to help pastors.

Surrogate Motherhood

Markens, Susan. *Surrogate Motherhood and the Politics of Reproduction*. Berkeley, CA: University of California, 2007.
In an innovative analysis of legislative responses to surrogacy in the bellwether states of New York and California, Markens explores how discourses about gender, family, race, genetics, rights, and choice have shaped policies aimed at this issue. She examines the views of key players, including legislators, women's organizations, religious groups, the media, and others. In a study that finds surprising ideological agreement among those with opposing views of surrogate motherhood, Markens challenges common assumptions about our responses to reproductive technologies and at the same time offers a fascinating picture of how reproductive politics shape social policy.

Rae, Scott B. *Brave New Families: Biblical Ethics and Reproductive Technologies*. Grand Rapids, MI: Baker, 1996.
Scott Rae applies the Bible to the new questions raised by a new generation of reproductive technology, including artificial insemination, surrogate parenting, genetic ests, and embryo transfer.

———. *The Ethics of Commercial Surrogate Motherhood: Brave New Families?* Westport, CT: Praeger, 1994.
This study addresses the two most controversial issues in surrogate motherhood: the commercial aspect of the practice and the issue of parental rights. After setting the legal and moral backdrop of procreative liberty in general, Rae argues that commercial surrogacy is the moral equivalent of baby-selling and should be prohibited. Add to this the potential for exploitation of the surrogate in practices that are already in motion and it is not hard to see the potential for harm to the parties involved. The book concludes with a survey of state and international law to date on surrogacy and a sample legislative proposal that could be adopted by states that are currently deliberating the issues. The commercial aspect of surrogacy makes it a potentially profitable business, not only for the surrogates but also for the brokers who facilitate the arrangements. This book promotes careful forethought, a reconsideration of definitions of parenthood, and a thorough examination of cases past and pending.

Raymond, Janice G. *Women as Wombs: Reproductive Technologies and the Battle Over Women's Freedom*. North Melbourne, Victoria, Australia: Spinifex Press, 1998.

A scathing analysis of high-tech biomedical reproductive techniques, this analysis provides groundbreaking insights into the debate over reproductive technology and its ethical, legal, and political implications. The study asserts that far from being liberatory issues of 'choice,' techniques such as in vitro fertilization, surrogacy, and sex selection are a threat to women's basic human rights.