Christian apologetics and cognitive behavioral therapy: A pastoral model for mental health promotion

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Declaration

I, *Mike E. Jackson*, declare that the thesis entitled "*Christian apologetics and cognitive behavioral therapy: A pastoral model for mental health promotion*" is my own work. All the sources that I have used or quoted in the thesis have been rightfully acknowledged by means of complete references.

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Language usage

The researcher secured agreement that the use of US English would be applied in this thesis.

Abstract

This thesis aims to argue that the Universal Christian Church has a responsibility to assist its congregants who struggle with mental health challenges. This assistance can be facilitated by considering ways in which the clergyman and the psychotherapist can collaborate to address this much-neglected spiritual task. Furthermore, this thesis aims to show that this 'spiritual task' can be accomplished using the practical skills of the Apologists, who in their dialectic process of worldview debate, would be able to redirect their expertise to defend against personal misbeliefs that suppress the spiritual transformation of those who struggle with mental health challenges. By integrating the 'Apologist' skills with those of the cognitive behavioral therapist, the tasks of identifying, challenging, and replacing misbeliefs could be accomplished using the admonition given in 1 Peter 3:15: "always being prepared to give a defense to everyone who asks you to give an account". To correct worldview distortions, Apologists can use their skills within a ministerial church setting to help mental health sufferers alleviate emotional distress by correcting their misbeliefs. Just as the Apologist applies the practical skills (or praxis), in the dialectic process for worldview debate, the professional Christian Counselor applies the same praxis in the modality of Cognitive Behavioral Therapy (CBT). The major interventions used in CBT, such as 'questioning the evidence', 'rational responding', 'examining the options', 'direct disputation', and 'labeling the distortion', are interventions also used in the praxes of Apologists who use them intuitively from their training in the dialectical method. Methodologically, this research will be established on classical realism and the classical Christian approach to Apologetics. Practically, this work will be framed using Osmer's fourfold model of practical theology: the descriptive/empirical task, 'What is going on?'; the interpretive task, 'Why is it going on?'; the normative task, 'What ought to be going on?'; and the pragmatic task, 'How might we respond?'.

Keywords

Christian Apologetics, Cognitive Behavioral Therapy (CBT), pastoral care, pastoral theology, mental health promotion, spiritual formation

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CHAPTER 1: INTRODUCTION; PROBLEM STATEMENT, AND RESEARCH METHOD

1.1 Introduction

1.1.1 Title and keywords

Title: Christian apologetics and cognitive behavioral therapy: A pastoral model for mental health promotion.

Keywords: Christian Apologetics, Cognitive Behavioral Therapy (CBT), pastoral care, pastoral theology, mental health promotion, spiritual formation

1.1.2 Objectives

This thesis argues that the responsibility of assisting with this 'spiritual task' can be accomplished using the practical skills of the Apologists, who in their dialectic process of worldview debate, for example, would be able to defend against personal misbeliefs that suppress the spiritual transformation of those who struggle with mental health challenges.

1.1.3 Concept clarification

- *Classical Christian Apologetics*: An apologetic method built upon a two-step approach that appeals firstly to natural theology, and secondly, to the establishment of worldview of theism.
- *Cognitive:* Cognitive refers to the mental processes of the mind, including dreams, memories, images, thoughts, and attentional focus.
- *Cognitive Behavioral Therapy* (CBT, also known as Cognitive Therapy): Cognitive Therapy is a psychotherapeutic technique that "is less encumbered by imaginative assumption than the now discredited, psychoanalytic therapy as devised by Sigmund Freud. Its basic model derived from the insight that problematic thoughts, emotions, and behaviors, can be treated by modifying dysfunctional (inaccurate or unhelpful) thinking" (Beck, 2011:3).
- *Cognitive model*: The Cognitive model is the essence of CBT. The model affirms that thoughts, feelings, and behaviors interface to influence people's lives.

- *General revelation*: General revelation contends that truths about God and the universe are revealed in nature.
- *Mental health*: A “state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (WHO, 2018).
- *Mental illness*: According to the *American Psychiatric Association* (2018), mental illnesses are health conditions involving significant changes in thinking, emotion, or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities.
- *Mental health promotion*: The goal of mental health promotion, as defined by the World Health Organization (WHO) is to, “promote positive mental health by increasing psychological well-being, competence and resilience, and by creating supporting living conditions and environments” (WHO, 2004a:17).
- *Pastoral care*: Modelled by Christ, “as the Good Shepherd tending his flock” (Purdy, 2013:9); for example, Psalm 23 ‘The Lord is my Shepherd’ (Bible, 2020). “Pastoral care is spiritual care provided by the responsibilities of church leaders to their congregants” (Doehring, 1981:190).
- *Pastoral theology*: Recognized as a branch of Christian theology, it holds that theology is deemed pastoral since “it deals with those consequences as they pertain to the roles, tasks, duties, and work of the pastor” (Oden, 1983:x).
- *Praxis*: An idea referred to in the works of philosophers, Plato and Aristotle, where there is a practice, enactment, or application of a skill or exercise.
- *Prolegomena*: Prolegomena is the first category that lays the foundation for all systematic theology.
- *Psychology*: According to Cardwell (1996:186), it is commonly defined as the “scientific study of mind and behavior”. The definition offered by any psychologist reflects his or her own interpretive bias; thus, some would lay more stress on the “mind” part of this definition, others the “behavior” part.
- *Socratic Method:* The Greek philosopher, Socrates taught by asking questions and drawing out answers from his students by challenging them to think critically for themselves. The Latin term for “leading out” is *ex duco*, which is the basis of the English word ‘education’. *Socratic questioning* is also used today in

psychotherapy to uncover the assumptions lurking in the unconscious and memory, which then manifest in negative thoughts and beliefs – often causing significant distress in individuals.

- *Spiritual formation*: According to Willard (2013:152), "spiritual formation in Christ is the process through which disciples or apprentices of Jesus take on the qualities or characteristics of Christ Himself, in every essential dimension of human personality".
- *Special revelation:*[1] The supernatural communication that Christians today identify as Scripture revealed directly from God, which tells us the way of salvation.
- *Systematic theology*: "The collecting, scientifically arranging, comparing, exhibiting, and defending of all facts from every source concerning God and His works" (Chafer, 1947:6).

1.2 Background and problem statement/rationale

1.2.1 Background

The researcher contends that the praxis used in Apologetics parallels the core interventions used in Cognitive Behavioral Therapy. Since the role of the Christian Apologist is to clarify truth claims, and the purpose of the Cognitive Behavioral Therapist is to correct misbeliefs (Beck, 2011), it follows that this affords the Apologist a ministerial opportunity to synthesize the parallels between the two.

This synthesis is founded on the proposition that what CBT applies as major concepts for counseling interventions, Apologists *intuitively* use in the dialectic method (Corduan, 2020). What CBT applies in practice, acts as present participles functioning as nouns or gerunds; while in Apologetics, these same concepts act as verbs. In other words, what CBT applies in practice acts as the progressive form of the verb to explain the process applied – as in the following example: '*Analyzing* the entrenched misbeliefs

[1] Special revelation is God revealing His truth to humanity and His will for salvation and redemption. According to Akin (2014:138b), examples of this manner of revelation found in the Bible (Bible, 2020), include amongst others, personal encounters with the Lord (as given in Genesis 18 and Exodus 3:1-6); the mighty acts of God (as given in Exodus 14:21-31 and 2 Kings 19:14-35); verbal/propositional revelation (as given in Genesis 12:1-3 and 2 Tim 3:16-17); the incarnation (as given in John 1:14), as well as dreams and visions (as given in Genesis 28:12 and Genesis 15:1).

of a patient is essential in effecting change'; while in Apologetics the same concept of *analyzing* is used as a verb to describe the action required: 'In order to facilitate change in the patient's misbeliefs it is essential that the counselor *analyzes* the origin of those beliefs'.

This study asserts that the following list of what Tan (2011:258-261) deems "major therapeutic techniques" and "interventions" – the researcher contends can be employed interchangeably in the praxis of the disciplines of both Apologetics and CBT:

- Idiosyncratic meaning
- Questioning the evidence
- Reattribution
- Rational responding
- Examining options and alternatives
- Direct disputation
- Labeling the distortion.

Consequently, these Apologetics techniques can not only correct worldview distortions when applied within a ministerial setting, but the Apologist can use their intuitive skills within the Church to help mental health sufferers alleviate emotional distress by correcting the misbeliefs of sufferers to promote mental health.

1.2.2 Cognitive Behavioral Therapy

1.2.2.1 General

Theoretically, CBT is a psychotherapeutic intervention built on the premise that emotional distress can be relieved by changing "dysfunctional (inaccurate and/or unhelpful) thinking and behavior" about oneself, the world and the future (Beck, 2011:3). Dr Aaron Beck, a psychiatrist who initially practiced psychoanalysis, developed Cognitive Behavioral Therapy in the 1960s as a mode of treatment for mental health disorders such as anxiety; depression; substance abuse; eating disorders; and schizophrenia, which includes the use of medication (Beck, 2011). Dr Beck identified an alternative therapeutic approach to psychoanalysis in the treatment of depression when he realized that patients with depression presented with automated negative thoughts, whereas psychoanalysis focused on the unconscious mind.

For the Apologetic community unfamiliar with CBT, further reading of Mckay *et al*. (2011:147) briefly highlights the significance of this practice by emphasizing the fact that one can change one's feelings by changing one's thoughts; these authors endorse the efficacy of this practice by stating that "multiple studies over the last thirty years have proved that this simple insight can be applied to relieve a larger variety of problems more easily and quickly than any other therapeutic technique".

Another benefit of correcting misbeliefs to promote mental health is the potential adaptive change on the brain, despite the distressing nature of adaptive change.

1.2.2.2 Thoughts and physiological brain changes

The research on CBT indicates that by changing our thoughts, we can change the physiology of our brain (Goldapple *et al*., 2004). Also, Pearce (2016), referring to the research of Paquette *et al*. (2003:33), states:

> Neuroscientists have also discovered that our brain is constantly changing – a phenomenon called neuroplasticity – and will do so for as long as we are alive. Mental activity, such as our thoughts, beliefs, and expectations, play an important role in changing the structure and function of our brains on a cellular, neural, and molecular level.

Historically, the implicit principles of CBT can be found within the history of knowledge that can be traced back to early philosophy and within the early Christian Church. Beck *et al*. (1979:8) point out that, "the philosophical origins of cognitive therapy can be traced back to the Stoic philosophers, particularly Zeno of Citium (fourth century BC), Chrysippus, Cicero, Seneca, Epictetus, and Marcus Aurelius". Likewise, within the historical Universal Christian Church (denoted throughout as "Church"), a connection is found between the application of modern-day Behavioral Therapy and the Patristic Fathers. In his investigation of ascetic literature, Trader[2] (2011:xi) states: "cognitive therapists echo patristic findings in a noticeably altered key and in an ontologically thin, but theoretically elegant form". To show the connection between thoughts (ideas) and feelings (emotions) in CBT, the dictum of Epictetus in his work in *The Enchiridion 5* captures the spirit of CBT thus: *"*Men are disturbed not by things but by the views which they take of them" (Epictetus, 1890).

[2] Trader's voluminous work (2011:xi) on CBT and the early church fathers has been hailed by H. Tristram Engelhardt, Jr. of Rice University/Baylor College of Medicine as "Egyptian Gold in cognitive therapy, to use Father Alexis' metaphor, on which Christians can properly draw in the pursuit of mental health in the broadest sense of the term". The researcher concurs.

1.2.2.3 Praxis parallels between Apologetics and CBT

To demonstrate the praxis parallels, Beck (1976:245-246)[3] explains in the following quote how to *do* Cognitive Therapy compared to how an Apologist *does* Apologetics using the dialectical method or debate process:

> The psychotherapist can apply certain techniques to determine whether the patient's conclusions are inaccurate or unjustified. Since the patient has been habitually making distortions, the therapeutic procedure consists essentially of exploring his conclusions and testing them against reality. The therapist works with the patient to apply the rules of evidence to his conclusions. This consists initially of checking his observations and then following the route to the conclusions.

However, to demonstrate how worldview Apologists use the refutation process in their profession as psychotherapists, notice how, when changing the words 'psychotherapist' to 'Apologist'; 'patient' to 'challenger/opponent'; and the phrase 'therapeutic procedure' to 'debate procedure' (italicized), in the same quotation by Beck (1976:245-246), the praxes are shown to be analogous:

> The *Apologist* can apply certain techniques to determine whether the *challenger*'s conclusions are inaccurate or unjustified. Since the *challenger* has been habitually making distortions, the *debate procedure* consists essentially of exploring his conclusions and testing them against reality. The *Apologist* works with the *opponent* to apply the rules of evidence to his conclusions. This consists initially of checking his observations and then following the route to the conclusions.

1.2.2.4 CBT praxis

As shown above, the praxes of the Apologist and the cognitive behavioral therapist are parallel; using the same method as the Apologist, the therapist, working collaboratively with the patient, uses the following three steps in therapy:

- Step 1 – Exploring conclusions of the patient.
- Step 2 – Testing them against reality.
- Step 3 – Correcting the (implied) error.

[3] Italics are the researcher's own.

1.2.2.5 Worldview Apologetics praxis

Christian Apologist Norman L. Geisler (2017), who has approximately 50 formal debates defending Christianity on his resume, was interviewed by the researcher, and asked: “What are the least common steps in the debate process when applying the Apologetic method?” Notice the question is about understanding the method or the step-by-step praxis and how it coincides with the CBT praxis given in 1.2.2.4, above. In line with Geisler’s response, Figure 1-1 illustrates the three-step foundational parallels between CBT and Worldview Apologetics.

Cognitive Therapy Praxis:	Worldview Apologetics Praxis:
1. Explore the conclusions.	1. Listen for the error in the conclusions.
2. Test them against reality.	2. Assess the error against reality (or truth).
3. Correct false conclusions.	3. Correct the error.

Figure 1-1: Three-step foundational praxis parallels between CBT and Worldview Apologetics

As can be seen in Figure 1-1, with specific reference to the Apologetics community, praxis competency in one discipline offers the opportunity for proficiency in both disciplines.

Thus, the justification and potential for the use of this method is established in the sorites (chain of successive syllogisms) given in Figure 1-2.

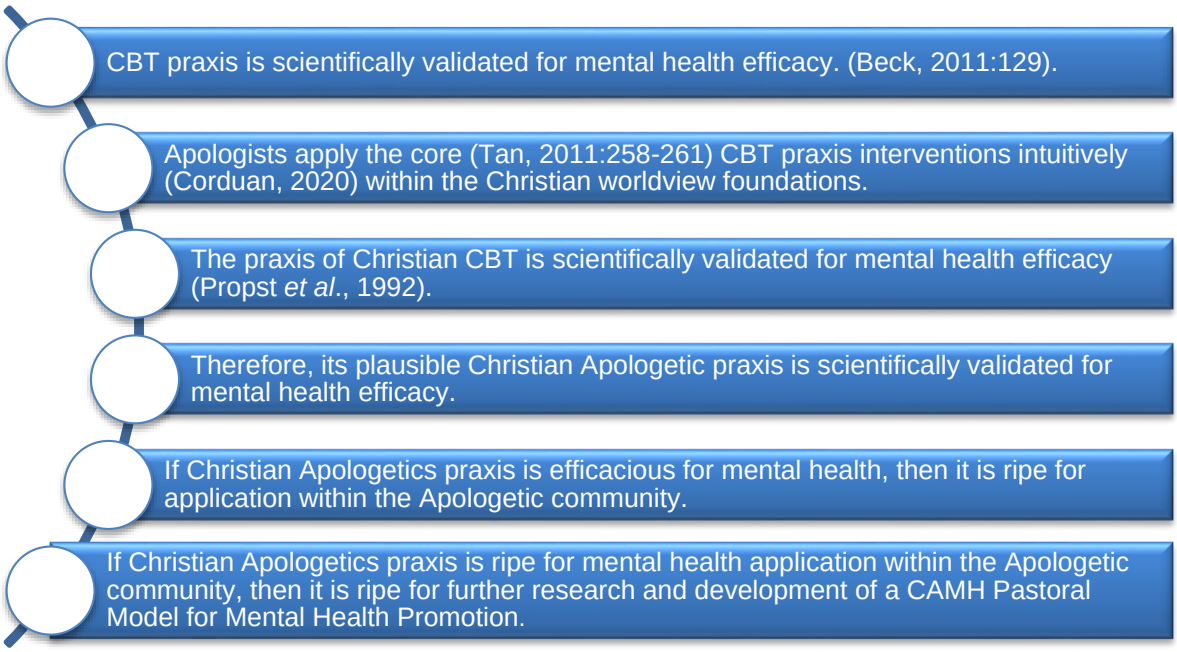

Figure 1-2: Sorites of CBT and Christian Apologetics Syllogisms for mental health promotion

Thus, the potential for the Apologist is found in the effectiveness of the CBT praxis. CBT is widely accepted among the scientific community for its empirically validated research. Butler *et al*. (2006) conducted a review of meta-analyses, which included extensive 16 meta-analytic studies of 332 clinical trials, with 9,995 participants, and which was extensive enough to include 16 mental health disorders.

To adapt Christian Apologetics for Mental Health (CAMH) as an Apologetic classification, the researcher will devise working definitions and concepts that correspond to the language used in both fields. Since Apologetics operates on a limited praxis vocabulary, the researcher will 'borrow' terms for the overlapping ideas from CBT, such as 'direct disputation, rational responding, examining options, and alternatives' (Tan, 2011; Beck, 2011). Nevertheless, the researcher reserves the right to periodically demonstrate the usage derivations within CBT, as found in historical philosophy. For instance, the CBT concept of Labeling the Distortion may overlap as a contemporary term found and accepted in philosophy, such as Aristotelian logical fallacies, based on "epistemological and metaphysical realism" (Kreeft, 2010:20). To establish this unified working definition of concepts and language for the recipient field,

CAMH, the researcher will apply the concept derivation model of Walker and Avant (2021).

1.3 Boundaries and limitations

While CAMH follows the biblical mandate to counsel while applying core CBT interventions, the researcher suggests CAMH presents with boundaries and limitations constrained mostly within the guidelines of professional mental health practice. This means CAMH should not be used as a replacement for professional psychotherapy. As reflected in the title of this proposal, the focus of CAMH is "a Pastoral Model for Mental Health Promotion" and not mental health therapy. Professional therapy entails a broader application, such as patient assessments, diagnosis, and treatment planning (Beck, 2011). Likewise, the researcher agrees with Aten *et al.* (2013:290) that "Pastors are not trained in psychotherapy, and they typically receive little training in counseling (though some may receive a fair amount of training in pastoral care)". Thus, therapy is beyond the scope of ministering or providing professional counseling, as evidenced by the definition offered by the American Psychological Association (2012:474):

> Psychotherapy: Any psychological service provided by a trained professional that primarily uses forms of communication and interaction to assess, diagnose, and treat dysfunctional emotional reactions, ways of thinking, and behavior patterns of an individual, family (see family therapy), or group (see group therapy).

Even though the researcher contends, as framed in the above sorites, CAMH praxis can produce verifiable results, for Apologists, the primary limitation is that of the *role*. While the writer contends that CAMH is appropriate for counseling and ministering, the Apologist should operate within said roles, and not beyond the delineated scope. CAMH, to a greater extent, parallels the category of pastoral counseling (Clebsch & Jaekle, 1967) within a narrower scope. As Townsend contends, after a historical review of the concept of pastoral care, it was understood as "helping acts, done by representative Christian persons, directed toward the healing, sustaining, guiding, and reconciling of troubled persons whose troubles arise in the context of ultimate meanings and concerns" (2009:17).

Consequently, CAMH should assist Apologists and ministers in promoting mental health and not attempting to replace the roles served by licensed professional mental health practitioners. Even within these limitations, the researcher believes CAMH

offers the Apologetic community the opportunity to develop and mature, by molding its own identity in the future; in the same way religious CBT branched off from the work of clinical CBT (Propst *et al.*, 1992; Koenig, 2009).

1.4 Concept derivation

Walker and Avant (2021) provide a method of clarifying or coalescing concepts from one field to another to devise a working definition for the recipient field. Specifically, for this work, the researcher defined the various related meanings in both fields to synchronize the relevant terms and concepts to establish a working vocabulary for the CAMH pastoral model for mental health promotion.

1.5 Language usage and terms

These applications are chosen for their utility and applied between both mental health counseling and Apologetics praxes to consolidate both fields into one working definition.

To establish the concept derivation, this researcher will provide the definitions and descriptions using the following primary reference categories:

- Clinical or scientific definitions.
- Christian Worldview Apologetic examples.

Since the Classical Christian Apologetic method encompasses all historical data, as far back as the ancient philosophers[4], the researcher will add pertinent historical and philosophical definitions when applicable. In cases where there is no, or limited language usage used among the overlapping terms between CBT and Apologetics, the researcher may add peer works or observations and descriptions from lesser resources like dictionaries, thesauruses, and encyclopedia articles.

Even though cognitive theorists agree there may be endless techniques used in CBT to change cognitions (Gurman & Messer, 2003), the researcher will use the core terms

[4] The Classical approach is founded on foundationalism. Howe (2012:63) states: “Aristotle discussed the foundations of knowledge in terms of a basic framework based on the first principles of thought and being: ‘All instruction given or received by way of argument proceeds from pre-existent knowledge’”.

for CAMH, such as found in “major therapeutic techniques and interventions” (Tan, 2011:258-261).

1.6 Research problem and problem statement

1.6.1 Background

Current mental health challenges within the Church parallel observations made close to a century ago by Carl Jung (1875-1961). The researcher purports that today there remains a strong demand to examine those problems and the suggested solutions considering the current mental health issues in the Church.

The needs, as listed in 1.6.2 to 1.6.4, although identified by Jung (1937) years ago, remain current and demand an answer.

1.6.2 The need for a spiritual, mental health response

Jung (cited in Adler *et al*., 2014:344) observed, even then, an urgent need for the church to provide spiritual guidance concerning mental health solutions to alleviate suffering. He concluded that it was the task of secular counselors to answer the spiritual call reserved for the church when he stated: “That is why we psychotherapists must occupy ourselves with problems which, strictly speaking, belong to the theologian”.

1.6.3 The challenge of optimizing general and special revelation

The church could respond by optimizing the use of all truth discovered in general and special revelation (see footnote 1), or theology and science. In the twentieth century, Jung observed an overemphasis on the science apart from faith and voiced his concerns over the dichotomy between “faith and reason” with the universities employing “intellectual rationalism” in the classroom while underestimating the role of faith in the development of the human personality. To those whom he deemed too reliant on reason without faith, he rhetorically challenged by asking: “What would have happened if Paul allowed himself to be talked out of his spiritual journey?” (cited in Adler *et al*., 2014:342).

1.6.4 The substantial imbalance between secular counseling and spiritual counseling

Jung (1937) believed that psychology was at a crossroads in his day, and it was leading to a “mass exodus from the church”, and thus driving sufferers to secular therapists. He cited a Christian minister who observed, “Nowadays people go to the psychotherapist rather than the clergyman” (cited in Adler *et al*., 2014:333). He concluded that this tendency would ultimately leave mental health sufferers with a deficit in the psyche caused by an impotent spiritual response in the counseling process.

Today, almost a century after Jung’s observations, there remains a similar demand and need within the church for a response to mental health issues. This work agrees with the definition of mental illness as given by the National Alliance on Mental Illness (NAMI): “A mental illness is a condition that affects a person's thinking, feeling, or mood. Such conditions may affect someone's ability to relate to others and function each day” (NAMI:n.d.). According to LifeWay Research (2014:6), in sampling churches in North America, “28% of individuals with acute mental illness agree their mental illness hurt/hurts their ability to live like a Christian”. Additionally, research suggests that mental health challenges affect the ability of Christians to practice their faith (Rogers *et al*., 2010:309), and thus could potentially result in individuals avoiding the church.

Moreover, in light of the response of the Church, Stanford (2007:148) reveals in his survey findings that 41.2% of people answered ‘yes’ when asked: “Did anyone at your church ever suggest that you did not really have a mental illness even though a mental health professional had diagnosed you with one?”

Regarding mental illness and balanced theology, Horton (2014) suggests that bad theology, as is sometimes found in discussions on the doctrine of body-soul unity, can be ‘toxic’. It literally ‘kills’ in spiritual reductionistic churches who deal with “mental illness exclusively on the spiritual side of the ledger” when understanding the nature of man (Horton, 2014:22). Additional research suggests that the Church could do more to respond to this need as “65% of family members in a household of someone with

acute mental illness believe local churches should do more in talking about mental illness openly so that the topic is not so taboo" (LifeWay Research, 2014:36).

In conjunction with the research by LifeWay Research (2014), in the United Kingdom (UK), Ryan (2018) with a religion and society research 'think tank' named, *Theos*, found that "mental health is fast becoming a critical area of British public policy" (Ryan, 2018:409). Although, with increased awareness of mental illness in the UK, he observes that it is less "widespread among religious leaders". In the UK, Ryan (2018) notes that the church has the added obstacle of *responsibility*. Currently, he proposes that the question that needs answering in response to the mental health need is: "How do we reconcile that with an increasing body of scientific, medical, and indeed legal analysis that suggests that particular mental issues diminish the responsibility of individuals?" (Ryan, 2018:422).

Perhaps an answer can be found when contrasting the data in both the US and UK studies with the efficacy of incorporating religious interventions into psychotherapy? In contrast to the problem statement, there is slow surfacing data of notable promise found when psychotherapy is used in collaboration with spiritual intervention when treating mental illness. For example, Pearce (2016:xiv), with cross-training in CBT and religion[5], reports persuasive outcome findings for those seeking religious counseling when comparing religious counseling to other modalities. One study Pearce (2016) references involving religious participants and led by Worthington *et al.* (2011:8-9), revealed improved outcomes, both psychologically and spiritually, for those who incorporated religious interventions as opposed to participants who did not receive spiritual therapies.

[5] Pearce lists her training in "CBT at the Duke Cognitive Behavioral Research and Treatment Program, and one in religion and health with the Duke Center for Spirituality, Theology, and Health" (Pearce, 2016:xiv).

1.7 State of the current research

1.7.1 Background

When considering the current gamut of research for mental health within the church, the researcher will draw from various sample studies in the UK and USA.

1.7.2 The United Kingdom

The research of Ryan (2018:410-411) aims to “scope out the field of what British Christians are doing in response to mental health”. He found that ‘anecdotally’, even though “Christians are increasing their involvement and producing more and more services, interventions, resources, and responses to mental health issues”, several observations and questions remain. Questions such as “How Christian is it?” That is, “what is the particular Christian theological or value structure, if any, which underpins that work?” Furthermore, while maintaining that along with more Christian involvement in the mental health community, Christians will see additional challenges, both “practical and political”, driving faith-based organizations to “abandon … or at least [soften] their public faith ethos” (Ryan, 2018:415).

1.7.3 The United States

Research samples reflect similar findings given above. Rogers *et al*. (2010:311) worked with participants ($n = 5899$) in 24 churches representing four Protestant denominations; they examined mental illness within the faith communities and found “mental illness in 27% of families, with those families reporting twice as many stressors on average”.

1.7.4 Research findings

The majority of these families want their church to assist them in dealing with mental illness, but unaffected families and clergy seem oblivious to the problem in their midst. While churches endorse a mission of service to those in need, they appear to be missing this growing issue within their congregations.

When considering mental health in the church, Smietana, in his article on *Tackling* [the] *Stigma of Mental Illness*, discusses a specific case of suicide and the painful aftermath

(2013:14-15); he cites Ed Stetzer, a long-time friend of the suicide victim's family, who emphasizes the following:

- We need to stop hiding mental illness.
- Some evangelical Christians think that if they pray enough or become more spiritual, then their mental illness will go away. But they do not look at other health issues in the same way.

When considering the global need for mental health solutions, the harvest is ripe for this work. The World Health Organization (2016) reported that some of the highest depression, anxiety, and addiction rates were found within the largest global economies with the highest gross domestic product, namely, China, the United States and India. Additionally, over 40% of the global population has less than one psychiatrist per 100,000 people.

1.8 Contribution to the study

As a contribution, this study, CAMH, aims to add to the advancement of knowledge in Apologetics and Pastoral Care, and to provide a systematic approach to Pastoral Counseling to show Apologists and ministers how to integrate the congruent theory and praxis between Christian Apologetics and Cognitive Behavioral Therapy (CBT). Since Christian Apologetics is a systematic field that aims to present a rational basis for a particular worldview belief system by exposing and defending against opposing ideas, the researcher maintains that by factoring in all the known data found in special revelation (as given in the Bible); and general revelation[6] (as provided in nature/creation), the resultant outcomes for treating those with mental illness will be more consistent and coherent for those with a Christian worldview rather than those who practice only CBT. By appealing to general revelation, it is the researcher's position that benefits derived from this work can appeal to populations within the church as well as those outside the church, including in the scientific field; for general revelation is, as Sproul *et al*. (1984:26-27) point out, known to "all mankind … [and has] never been limited to those groups which have been privy to special revelation".

[6] General revelation is defined as "natural theology [referring] to the knowledge of God acquired from God's revelation of Himself in nature. This revelation is sometimes called natural revelation, but is more frequently referred to as general revelation" (Sproul *et al*., 1984:26).

Moreland (2019:28) supports the use of general revelation in Christian practice; as an Apologist, he recognizes that “in valuing extrabiblical knowledge, our brothers and sisters throughout church history were merely following common sense and Scripture itself”. In an interview with Linda Zagzebski (2013), Moreland (Professor of Philosophy at Biola University), encourages Christians to use general and special revelation. He contends, “It’s important for more Christian thinkers to try to understand how to integrate the contemporary findings of science with classic Christian Theology and Doctrine” (Moreland, 2013).

In contrast to studies validated solely on empirical science, like contemporary CBT (Butler *et al*., 2006), the researcher questions whether all theories using science alone should not also be subject to similar scrutiny as regards all known data or a systematic approach. For instance, by incorporating religion and philosophy, thinkers will be obligated to integrate more meaningful life questions, such as: ‘What is the meaning of life?’, ‘Is there a purpose in life?’, ‘What does God require of me’, ‘Where am I going after death?’ and even, ‘Is there a spiritual cause for mental illness, like sin for example?’. However, in the case of CBT, the analysis need not include such philosophical or religious worldview data and does not have to expand the discussion beyond scientism. Even though there has been an increase in ‘religious and spirituality’ research (Worthington *et al*., 2011), the use of religious worldview doctrinal integration, such as sin, objectivity, and the after-life, remain significant ideas that could conceivably factor into one’s psychological well-being. While the researcher recognizes the complexity of quantifying philosophical ideas, the role of such metaphysical considerations remains no less significant.

By way of an example, Robertson (2010:xx), himself an Agnostic, appeals to therapists to consider how their work relates to God. He suggests that therapists must “wrestle” with the more significant, “philosophical” questions of life within the counseling framework – toward a more expansive worldview. The significance of this research, although qualitative and not quantitative, will advance efforts to systematically harmonize the objective truths found in theology, philosophy, and Apologetics with the principles and praxis of CBT. Therefore, this researcher maintains that CAMH advances knowledge since, even though CBT has established efficacy, CAMH (while borrowing from and encapsulating the praxis efficacy of CBT) challenges its systematic

sufficiency. The significance of this study is its contribution to highlighting the ability of CAMH to demonstrate the coherence of the aforementioned clinical and metaphysical concepts of the CAMH Pastoral Model for Mental Health Promotion.

1.9 Research question, aim, and objectives

1.9.1 Research question

The question to be answered by this research is: *How can the praxis of Cognitive Behavioral Therapy be subsumed into the theory and praxis of Christian Apologetics to develop a Christian Apologetics for Mental Health (CAMH) pastoral model for mental health promotion within Christ's Church?*

Based on Osmer's (2008) practical theological research methodology, the following questions arise from the 'research question':

a) To which perspectives does a descriptive-empirical study contribute towards a comprehensive description of the current situation of the unaddressed need for Church ministers to provide mental health solutions to those struggling with mental health challenges within Christ's Church? (Following Osmer's (2008:4) descriptive empirical question: "What is going on?")

b) What elucidation do Christian Apologetics and Cognitive Behavioral Therapy provide in the understanding and explanation of the current situation of common obstacles in the gap between willing Church ministers and those struggling with mental health challenges? (Following Osmer's (2008:4) interpretive question: "Why is this going on?")

c) What are the normative and ethical perspectives that Scripture provides for special and general revelation parallels between Christian Apologetics and CBT to "give an answer" (Bible, 2020) (see 1 Peter 3:15) to those struggling with mental health challenges within Christ's Church? (Following Osmer's (2008:4) normative question: "What ought to be going on?")

d) Which practical-theological perspectives and systematic method can be given to Christ's Church to use the parallels between Christian Apologetics theory and

praxis with CBT praxis to answer mental health challenges and develop a CAMH pastoral model for mental health promotion? (Following Osmer's (2008:4) pragmatic question: "How might we respond?")

1.9.2 Research aim and objectives

1.9.2.1 Aim

The main aim of this study is to demonstrate that the praxis of Cognitive Behavioral Therapy can be subsumed into the theory and praxis of Christian Apologetics to develop a Christian Apologetics for Mental Health (CAMH) pastoral model for mental health promotion within Christ's Church?

1.9.2.2 Objectives

This research will address the questions mentioned above by pursuing the following objectives:

- To gain a clear depiction of the current situation of the unaddressed need for Church ministers to provide mental health solutions to those struggling with mental health challenges within Christ's Church. (Following Osmer's (2008:4) descriptive empirical question: "What is going on?")
- To conduct a literature study of Christian Apologetics and Cognitive Behavioral Therapy to provide an understanding and explanation of the current situation of common obstacles in the gap between willing Church ministers and those struggling with mental health challenges. (Following Osmer's (2008:4) interpretive question: "Why is this going on?")
- To determine the normative and ethical perspectives that Scripture provides for special and general revelation parallels between Christian Apologetics and CBT to, as admonished in 1 Peter 3:15, "give an answer" to those struggling with mental health challenges within Christ's Church. (Following Osmer's (2008:4) normative question: "What ought to be going on?")
- To propose practical-theological perspectives and a systematic method to Christ's Church to use the parallels between Christian Apologetics theory and praxis with CBT praxis to answer mental health challenges and develop a

CAMH pastoral model for mental health promotion. (Following Osmer's (2008:4) pragmatic question: "How might we respond?")

1.10 Central theoretical argument

The central theoretical argument of this study is that the praxis of Cognitive Behavioral Therapy can be subsumed into the theory and praxis of Christian Apologetics to develop a Christian Apologetics for Mental Health (CAMH) pastoral model for mental health promotion within Christ's Church.

1.11 Research methodology (design and method(s))

1.11.1 Methodology

1.11.1.1 Classical realism

The research will operate from a classical realist prolegomena, namely, the Christian philosophical and theological preconditions that underlie classical Christian Apologetics. Additionally, a systematic theology will be provided that coheres with the same prolegomena. Therefore, when considering other Christian Apologetic methods (for example, evidentialist, historical, presuppositional), the researcher will build the CAMH pastoral model for mental health promotion on the classical approach and deem it a more plausible approach bridge to a realist psychology (see Johnson, 2010, for a view on the implications of the realist position as it pertains to psychology). This approach is in the tradition (Geisler, 1998) of the early Apologists: Augustine, Anselm, and Thomas Aquinas and modern classical Apologists: William Paley, John Locke, C. S. Lewis, B. B. Warfield, R. C. Sproul, William Craig, J. P. Moreland, and Norman L. Geisler.

1.11.1.2 Classical Apologetics and CAMH

1.11.1.2.1 Concepts defined

Classical Apologetics is a Christian Apologetic Method that emphasizes proving the existence of God through rational arguments. Geisler (1998:282) states:

> Classical apologetics is so-called because it was the apologetic method practiced by the first thinkers who studied and practiced the application of reason to the defense of Christianity.

Proponents of the classical approach, Sproul, Gerstner, and Lindsey (1984:17-18) purport that the call to give a defense for Christianity to all, is a commandment directly from God and this commandment is not only "reasonable", but also, if there is any question, then based on His commandment, it is even enough or even "reasonable to reason with the unreasonable". In classical Apologetics, the aim is to first establish "valid theistic arguments for the truth of theism apart from (but with appeal to) special revelation in Scripture" (Geisler, 1998:262). Within the process, there is a step-up method that builds one foundation upon another. In providing a case for the classical position, Geisler (1998:283) maintains:

> It makes no sense to speak about the resurrection as an act of God unless as a logical step it is established that there is a God who can act. Likewise, the Bible cannot be the Word of God, unless there is a God who can speak. And Christ cannot be shown to be the Son of God except on the logically prior premise that there is a God who can have a Son.

When considering what is *behind*, or the evidential basis supporting the classical approach, before there can be a discourse about God's existence, classical Apologists maintain that *foundationalism* is the bedrock. In other words, it can be justified in terms of something more basic than itself, for "classical apologetics is based on such first principles, such as the law of noncontradiction, causality" (Geisler, 1998:1320), which are self-evident or reducible to the self-evident. The classical approach is founded on the classical epistemological and metaphysical realist position, as held by Aristotle and Aquinas that there is a "correspondence between thought and thing, between the mind and reality" (Geisler, 1998:1149).

Kreeft (2010:20) states

> Epistemological realism contends that the object of intelligence is reality. Metaphysical realism contends that reality is intelligible; that it includes a real order; that when we say for example that “man is a rational animal” we are not imposing an order on reality that is really random or chaotic or unknowable; that we are expressing our *discovery* of order, not our *creation* of order; that “categories” like “man” or “animal” or “thing” or “attribute” are taken from reality into our language and thought, not imposed on reality from our language or thought.

Therefore, ultimately, CAMH is framed on foundationalism and justified by first principles such as the laws of logic. Subsequently, through general revelation, these principles are found in the very nature or “mind” of God when discovered. Thus, they are the divine reason governing all things in the universe. This concept is what Aquinas explains as the “Eternal law” (Aquinas, 1485, 2010 printing, cited in *Summa Theologica* (2010:556).

For its use in psychology, Johnson (2010:295) defines realism as: “The philosophical position that humans can actually know reality as it really is”. In cognition and even dialogue, truth always affords us an epistemological grounding point, for it corresponds to the real world. To demonstrate the blending of the classical Apologetic approach with psychological practice, Johnson (2010:295) points out that God not only created the human intellect with the ability to know reality, but proposes that “the goal of science is to represent in our understandings God's single, perfect, comprehensive understanding as best we can”.

Consequently, it is the nature of *being* and *knowing* that influences this work and hence the use of the classical Apologetic method for CAMH. Even though the researcher recognizes that other Apologetic methods (see 1.11.1.1.) serve Christian worldview counseling theory ably – in both general and special revelation, this work is legitimized by the praxis in both fields. For this purpose, the researcher offers these considerations as to why the classical approach is the more plausible method of establishing the case for a CAMH pastoral model for mental health promotion.

Foundationalism lends itself more suitably to creating a *synthesis* between the Christian worldview and clinical psychology since it is built upon a bottom-up approach that starts with ultimate reality as a grounding point. This choice is critical for the mental health praxis implications for it progresses from *that which is*, the metaphysical (being),

to the epistemological, or *knowing that which is* (cognition). For instance, if "*realism* is the view that there is a reality external to our minds that we can know" (Geisler, 1998:1149), then explaining *how* it is possible to *know* reality becomes a map for a clinician to establish a foundation from which to operate. Thus, the distinction between imagination and reality is critical in reality testing and clinical counseling (Beck, 1976). In light of psychology and counseling application it is the establishment of a knowable, real external world; one of fact, objective truth, and reality that our minds can *know* that offers mental health sufferers an Archimedean point of reference and grounding to navigate their thought processes – an anchor for intellectual and emotional certainty.

In other words, the cord connecting Apologetics praxis to core CBT intervention is one of metaphysical and epistemological ordering. Ordering is explained more clearly by Aquinas' dictum: "I am; therefore, I think" (Geisler, 1998:459), rather than that of Descartes': "I think; therefore, I am". Subsequently, the connection between foundationalism and counseling is found in how mental health sufferers relate the function of cognition to ultimate reality. It is the goal of counseling to lead people to the truth, facts, and knowable reality; if not, mental health problems and adverse outcomes result from the mind inadequately connecting thoughts and feelings to the external world. Reality testing is the experimental core gauge when assessing psychological disorders, as observed by the founding father of CBT, Dr Aaron Beck (2011). His daughter, Dr Judith Beck, also a clinician, states, "The results of Dr Beck's experiments led him to search for other explanations for depression. He identified distorted, negative cognition (primarily thoughts and beliefs) as a primary feature of depression and developed a short-term treatment, one of whose primary targets was the reality testing of patients' depressed thinking" (Beck, 2011:1). On an extreme level, the inability of one to tether one's cognitions to reality is often found in psychosis (Ryan, 2018). In like fashion, Beck (1976:10) points out the costly experience when one's thoughts distort the perception of reality; he states, "If it were not for man's ability to filter and attach appropriate labels to the blizzard of *external stimuli* so efficiently, his world would be chaotic, and he would be bounced from one crisis to another". Ultimately, the goal of counseling operates with the same objective as that of the classical Apologist; namely, to lead one from one's initial unbelieving worldview (cognitive distortions) to the truths of God (ultimate reality).

1.11.1.2.2 Essential pillars of CAMH

The following list, although not exhaustive, gives the essential pillars of prolegomena for CAMH:

- First Principles: The Self-Evident Precondition.
- Logic: The Rational Precondition.
- Truth: The Epistemological Precondition.
- God: The Metaphysical Precondition.

1.11.1.2.3 Theological preconditions for CAMH

The following are the theological preconditions for CAMH:

- *Revelation*: The revelational precondition
    - General revelation: Truths about God and the universe as revealed in nature.
    - Special revelation: The Bible alone, as revealed in the inspired and infallible written Word of God.

- *Systematic theology*: The methodological precondition.
  Chafer (1947:16) writes that “Systematic Theology may be defined as the collecting, scientifically arranging, comparing, exhibiting, and defending of all facts from any and every source concerning God and His works”. In light of CAMH, the necessary major divisions of systematic theology that form the implied synthesized doctrinal system in this work are as follows:
    - Theology proper: The study of the nature of God
    - Bibliology: The study of the nature of the Bible
    - Christology: The study of the nature and work of Christ
    - Anthropology: The study of the nature of man
    - Hamartiology: The study of the nature of sin
    - Soteriology: The study of the nature of salvation
    - Ecclesiology: The study of the nature of the Church.

1.11.2 Practical theological interpretation for practical theology

1.11.2.1 Interpretation for practical theology

Finally, within the methodology in answering the different research questions, this study will be contextualized using Osmer's (2008:4) fourfold model of Practical Theology: the Descriptive-Empirical Task, "What is going on?"; the Interpretive Task, "Why is it going on?"; the Normative Task, "What ought to be going on?"; and the Pragmatic Task, "How might we respond?". According to Osmer (2008:12) the aim of the four questions is to explore the purpose; to guide interpretation and response to episodes (single events), situations (broader patterns of events or relationships), and contexts (social and natural systems in which situations unfold). Even though all four tasks are applied, the most substantial emphasis will be solutions-based with significant focus on the normative and pragmatic tasks. These tasks are examined in more detail in 1.11.2.2 to 1.11.2.5.

1.11.2.2 The descriptive task ("What is going on/What happened?")

Attention will be given to Osmer's (2008) first task, the descriptive-empirical task, to gain an understanding of "What is going on?" According to Osmer, this function is established through "a spirituality of presence" (Osmer, 2008:33-34); that is, "attending to what is going on in the lives of individuals, families, and congregations". Additionally, the researcher will rely on the existing works found in current practical para-church literature reviews to address the following:

- The breadth and depth of mental illness in the local church.
- The normative ministerial response to assist those with mental illness in the local church.
- Global evangelical potential to address mental health issues beyond the Christian community.

This descriptive literature will employ a close exploration and description of the core themes and patterns that develop considering the critical research question of this study. The objective of the descriptive task will be to gain a clear depiction of the

current situation of unaddressed need for church ministers to provide mental health solutions to those struggling with mental health challenges within Christ's Church.

1.11.2.3 The interpretive task ("Why is it going on?")

The interpretive task asks the question "Why is this going on?" (Osmer, 2008:4). In conformity with Osmer's (2008) model, the interpretive task will establish "why" obstacles are standing in the gap between willing church ministers and those struggling with mental health challenges. The researcher will rely on an empirical and para-church literature review to address these obstacles that impede assistance to those with mental illness in the local church. This objective will be to conduct the literature study of Christian Apologetics and Cognitive Behavioral Therapy to provide an understanding and explanation of the current situation and establish a solutions-based awareness of the mental health needs in the church and illuminate the necessity for pastoral and ministerial interventions addressed by CAMH. The review of literature will be based on secondary sources which include scientific resources, academic books, journal articles and websites. Various search engines will be used that will help in this process: Google Scholar; EBSCO HOST; Psych Info; SAePublication, Psych Articles; SACat, Health Source.

1.11.2.4 The normative task ("What ought to be going on?")

The normative task questions relate to the topic: "What ought to be going on?" (Osmer, 2008:12). It attempts to discern God's will for prevailing realities, and Osmer refers to this task as prophetic discernment (Osmer, 2008:12). This section aims to establish a practical and theological vigilance regarding the role, responsibility, and equipping of the "*saints*" to "*give an answer"* (1 Pet. 3:15) to those in the flock with mental health struggles.

This researcher aspires to address the normative task systematically. Since classical Christian Apologetics is a systematic field that aims to present a rational basis for the Christian worldview, this researcher maintains that the only way to warrant a more consistent and coherent counseling outcome is by factoring in all the known data found in special revelation (Bible) and general revelation (nature/creation) – that is, there will be a primary and authoritative reliance on the Scriptures as the Word of God

(Geisler, 1998:44-52) for special revelation, and the findings in general revelation as found in the literature review in theology, philosophy, and psychology. As the researcher establishes the special and general revelation parallels between Christian Apologetics and CBT, CAMH for Christian mental health sufferers could prove more plausible as a mental health intervention than stand-alone CBT. To establish this systematic case, the researcher will utilize literature review to support this case historically, scientifically, and philosophically. The objective of the normative task will be to determine the normative and ethical perspectives that Scripture provides for special and general revelation parallels between Christian Apologetics and CBT to "give an answer" (1 Pet. 3:15) to those struggling with mental health challenges within Christ's Church.

1.11.2.5 The pragmatic task ("How might we respond?")

The final of the fourfold task, the pragmatic task (Osmer, 2008), will show a systematic response to the research problem that contributes to a biblical, practical, and theological resolution. The outcome of this work is to establish a practical-theological perspective and a systematic method to Christ's Church to use the parallels between Christian Apologetics theory and praxis with CBT praxis to answer mental health challenges and develop a CAMH pastoral model for mental health promotion.

1.12 Ethical implication of the research

1.12.1 Guidelines

Following the ethical guidelines provided by the Research Ethics Committee of North-West University, the researcher will comply and commit to honesty, accountability, professional courtesy, and proper stewardship requirements on behalf of all aspects of this research. This work will also use the Harvard Style of writing and referencing. The research poses a minimal ethical risk since it does not involve human participants, but consists of a literature review of sources with divergent views on the same subject.

1.12.2 Rationale for the specific methodology of the review

The researcher will be examining the literature review with a non-empirical, histo-philosophical methodology. Additionally, the review will include a comprehensive, empirically-validated literature review of the relevant literature in psychology and counseling as is referenced in this proposal. The method applied to accomplish the research goals will be data collection, data analysis, and an examination of the applicability of the collected data toward the study.

1.12.3 Search strategy

The researcher will approach data collection and analysis by using a descriptive literature study. Additionally, the researcher will utilize the electronic online library of Liberty University to access their national and international academic books, journal articles, and authoritative websites. The research portals include, but are not limited to, EBSCO HOST, PsychInfo, PsychArticles, Google Scholar, SACat, SAePublication, and Worldcat.

1.12.4 Criteria for article selection

The researcher will make use of popular articles and researchers within like-minded published works. Clinically, the researcher will attempt to avoid research literature in works older than 20 years, unless they are referencing foundational theoretical works in the field (such as those referring to CBT) when using the theory discoveries from its founder, Dr Aaron Beck (1976). Additionally, since this work factors in the framework of theology and philosophy, the researcher reserves the right to operate outside any timeline constraints unless its foundational basis drives empirical influence, as found in the case of ‘spiritual counseling’ (Worthington *et al*., 2011).

1.12.5 Risk of bias and trustworthiness

The researcher anticipates the research risks in this work are minimal since this work relies on literature review; that is to say, lower risks attributed to the presumption that the researcher is not sampling human data collections. Also, to limit the risk of subject bias, the researcher will venture to include data and observations with contrasting viewpoints on the same subjects.

1.12.6 Benefits for participants/researchers/institutions/the Christian church

The contribution to the advancement of knowledge in literature is for Christian Apologetics, theology, and clinical psychology. The research will benefit Christian Apologists, ministers, Christian institutions, and like-minded researchers by providing more educational and ministerial tools within the relevant subject to develop a CAMH pastoral model for mental health promotion.

1.12.7 Expertise, skills, and legal competencies

This research substantiates the researcher's academic competencies, vocational training, expertise, and experience within the combined fields of Apologetics, theology, and counseling. This established researcher's suitability for this work is a combination of education and experience. In terms of education: Graduate degrees in both Apologetics and Professional Counseling; in terms of experience: a graduate researcher in theology; post-graduate work in clinical counseling with occupational experience teaching in a psychiatric hospital and professional counseling in private practice.

1.12.8 Monitoring of research

The researcher will ensure literature research compliance to the required standards and protocols required by the ethical guidelines of North-West University that involve accountability for consistent examination, communication, and feedback from assigned promoters.

1.13 Classification of headings/chapters

Note: See Table 1-1 for a summation of the research procedures.

The various chapters of this study are based on the four tasks of practical theological interpretation as given in Osmer's model (2008:4), as follows:

Chapter 1: Introduction; Problem statement, and Research method.

Chapter 2: The Descriptive Task: A comprehensive description of the unaddressed need for church ministers to provide mental health solutions to mental health sufferers within Christ's Church.

Chapter 3: The Interpretive Task: The obstacles in the gap between willing church ministers and those struggling with mental health challenges.

Chapter 4: The Normative Task: The special and general revelation parallels between Christian Apologetics praxis and CBT to "give an answer" (1 Pet. 3:15) to those struggling with mental health challenges within Christ's Church.

Chapter 5: The Pragmatic Task: A practical-theological perspective and a systematic method to Christ's Universal Church to use the parallels between Christian Apologetics theory and praxis with CBT praxis to answer mental health challenges and develop a CAMH pastoral model for mental health promotion.

Chapter 6: The development that can be gleaned from the study: Christian Apologetics and Cognitive Behavioral Therapy: A pastoral model for mental health promotion.

Table 1-1: Schematic presentation of research procedures

Research title: *Christian Apologetics and Cognitive Behavioral Therapy: A Pastoral Model for Mental Health Promotion*		
Research Question	**Aim and Objectives**	**Research Method**
Can the praxis of CBT be subsumed into the theory and praxis of Christian Apologetics; thereby, creating a systematic counseling approach called *Christian Apologetics for Mental Health Promotion* that can be applied by both Apologists and ministers to address numerous mental health challenges within Christ's Church?	This study aims to synthesize the intersecting principles and applications found in classical Christian Apologetics[7] and CBT to form the final work: *Christian Apologetics for Mental Health Promotion* to assist Apologists, pastors, and ministers in their endeavor to help mental/emotional health sufferers by "*giving an answer*" (1 Pet. 3:15) to our global mental health challenges in the Christian Church.	This research will use Osmer's (2008) fourfold model for Practical Theology which includes the Descriptive Task ("What's going on?"); the Interpretive Task ("Why is it going on?"); the Normative Task ("What ought to be going on?"); and the Pragmatic Task (How might we respond?"). The greater part of this research will be solution-based and weighted toward the last two tasks.
Further question 1: Is there a current unaddressed need for church ministers to provide mental health solutions to mental health sufferers within Christ's Church?	**Objective 1:** To establish that there is a need to "give an "answer" (1 Pet. 3:15) to those struggling with mental health challenges within Christ's Church.	**Descriptive Empirical Task** A literature review, grounded in a spirituality of presence and priestly listening (Osmer, 2008:33-35) will be conducted to establish the prevalence of an unmet need for mental well-being within Christ's Church.
Further question 2: What common obstacles stand in the gap between willing church ministers and mental health sufferers?	**Objective 2:** Identify the obstacles that interfere with the process of addressing the mental health challenges within Christ's Church.	**Interpretive Task** Following Osmer's model (2008:79), the Interpretive Task will address the problem question by actively seeking God's guidance through an interdisciplinary, literature review study to identify the obstacles interfering with "giving an answer" (1 Pet. 3:15) to those struggling with mental health challenges within the Church.

[7] The researcher establishes the basis for choosing the classical approach for Apologetics in clause 1.11.1: Methodology.

Research title: *Christian Apologetics and Cognitive Behavioral Therapy: A Pastoral Model for Mental Health Promotion*		
Research Question	**Aim and Objectives**	**Research Method**
Further question 3: Are there special and general revelation parallels between Christian Apologetics praxis and CBT? To "give an answer" (1 Pet. 3:15) to those struggling with mental health challenges within Christ's Church?	**Objective 3:** Identify the special and general revelation parallels between Christian Apologetics praxis and CBT to "give an answer" (1 Pet. 3:15) to those struggling with mental health challenges within Christ's Church.	**Normative Task** The method applied will be Osmer (2008:138) Normative Task by actively seeking God's guidance through an interdisciplinary literature review study to identify special and general revelation parallels between the disciplines of theology, Apologetics, and psychology (Cognitive Behavioral Theory) in accordance with the Christian Scriptures.
Further question 4: How can we use the parallels between Christian Apologetics theory and praxis with CBT praxis to provide a systematic approach to answer mental health challenges within Christ's Church?	**Objective 4:** To synthesize Christian Apologetics theory and praxis with CBT praxis into a systematic counseling approach called *Apologetics for Mental Health* that can be used to address mental health challenges within Christ's Church.	**Pragmatic Task** Provide practical case studies to demonstrate the synthesis between Christian Apologetics theory and praxis with CBT praxis to formulate a philosophical response to the mental health challenges within Christ's Church. (Osmer, 2008).

CHAPTER 2: THE DESCRIPTIVE TASK

2.1 Introduction

This chapter forms the foundation for examining the rationale and context of this research. The objective is to assess the present situation by "gathering information that helps us discern patterns and dynamics in particular episodes" (Osmer, 2008:4), and inform the first key descriptive and empirical research task: "What is going on?" In so doing the writer will provide evidence to establish confirmation for the first objective of this research, namely, the need to "give an answer" (1 Pet. 3:15) to those struggling with mental health challenges within Christ's Church. The descriptive task is built on the following considerations:

- The extent of the mental health challenges in the Church.
- The normative response to assist those with mental health illness in the Church.
- The global evangelical potential to address mental health issues beyond the Christian community.

2.2 The extent of mental health challenges within the Church

2.2.1 General

The data given in Chapter 1 suggests that mental health difficulties take a toll on local churches. When considering the research on how mental health challenges impact the Church, there is a concerning need that warrants attention and an appropriate response. Both Pierce (2018) and Rogers *et al*. (2010) concur that the adverse spiritual and practical toll of mental health on the body of Christ permeates not only the personal life of the member but also that of their family and ultimately the congregation.

2.2.2 Statistics on mental health

2.2.2.1 Types of mental illness

According to Stanford (2021:3): "In the United States, one out of every five adults (48 million) will experience mental illness in a given year". In addition, Stanford's research (2021:3) found that "ethnic minorities access mental health care at even lower

rates than Caucasians (African-American, 30 percent; Hispanic, 27 percent; Asian, 18 percent; and Caucasian, 46 percent)".

In light of the above statistics, Stanford (2021:3), points out: "Perhaps a more disturbing statistic is that almost 60 percent of adults diagnosed with a mental illness receive no treatment".

Within the Church, LifeWay Research, namely, *Study of Acute Mental Illness and Christian Faith* (2014) is often cited for its vast[8] mental health research. Consider here their findings along with supporting research that references confirming or contrary data on the relevant topics within this work.

The following statistics show the extent of mental illness amongst individuals and family members (LifeWay Research, 2014:8):

- Moderate depression 63%
- Severe depression 31%
- Bipolar 24%
- Schizophrenia 14%

2.2.2.2 Effects of mental health within congregations

Simpson (2013:52-55) reports surveying readers from journals and publications like the *Leadership Journal* and *Christianity Today*; the 500 responses received showed the following statistics:

- Eighty-four percent of church leaders are aware of some type of anxiety disorder within their congregation.
- Ninety-one percent of church leaders have seen mood disorders such as depression within their churches.
- Thirty-seven percent of church leaders indicated that someone in their congregation had suffered from a psychotic disorder such as schizophrenia.

[8] See Appendix A for the methodology.

2.2.2.3 Effects of mental health on church leaders

Along with data supporting the impact mental health challenges has on the congregation, church leaders are not exempt from the same challenges.

The numbers suggest that “more than 1 in 5 pastors have personally struggled with a mental illness of some kind” (Lifeway Research, 2014:13). In a broader sense, the inquiry by Barna (2017), a Christian polling group, regarding senior church leaders and their personal knowledge of those who left ministry because of mental illness, such as “depression, anxiety or addiction” within the last five years – revealed that: “One in four says they know just one (25%), and 16 percent report knowing two or more pastors who left ministry for mental health reasons. In light of addiction, they report: “Among the one in five pastors who reports struggling with an addiction, the most common is “porn/sexual addiction (61%)”. (Barna, 2017:47-49).

Among church leaders, Simpson (2013:52-55) reports the following:

- Of the Church leaders in the survey, 38.7 percent indicated they had suffered from a mood disorder such as depression or bipolar disorder.
- Twenty-three percent indicated they had suffered from an anxiety disorder, such as generalized anxiety disorder, post-traumatic stress disorder, obsessive-compulsive disorder, panic disorder or social anxiety disorder.
- Nine percent of church leaders indicated they had personally suffered from impulse control and addiction disorders such as pyromania, kleptomania, compulsive gambling, and alcohol and drug addictions.
- Church leaders indicated that within their own families 10.6 percent had suffered from a psychotic disorder such as schizophrenia. (According to the National Institute of Mental Health, 1.1 percent of the American population suffers from schizophrenia in a given year.)
- Church leaders who had suffered from mental illness indicated a much higher incidence of suffering within their families. For example, among those who had suffered from any kind of mental illness, 85 percent had family members suffering from mood disorders, compared with 56 percent of those who had not suffered from mental illness themselves.

On a positive side, mental health is only one ingredient to the overall life satisfaction in the Barna (2017:6) research since it factored in the “spiritual, physical, financial” aspects into the quality of the life.

In addition, while Barna (2017) reports mental health struggles are prevalent within the pastorate, they offer at least these two positive observations regarding pastoral mental health struggles:

- For the most part, pastors present a positive picture. The most common self-descriptions include having a good overall quality of life (91%), ranking spiritual well-being as excellent or good (88%), and being in good emotional and mental health (85%) (Barna, 2017:16-17).
- Mental and emotional disorders—especially depression—are a common experience among today’s pastors. Far from being a ministry-ender, however, it’s entirely possible that dealing well (and maybe even openly) with mental health issues when they arise can form a pastor into a wiser and more compassionate shepherd for the people under his or her care (Barna, 2017:49).

2.2.2.4 Effects of mental health on families

Christian Psychiatrist Grcevich (2018) shares his opinion on how professional counselors often view church mental healthcare; the first chapter, in his book, *Mental Health and the Church: A Ministry Handbook*, he entitled: *Disconnect*, as he feels he operates in ‘two different worlds’; one in his role as a mental health professional, and the other concerned with his role in the Church. Here, the researcher provides the following extended quote from his illuminating first-hand account for the reader to gain insight into the impact mental health conditions have on families within the Church (Grcevich, 2018:16):

> Several families had adopted children from orphanages in Russia and Bulgaria after the fall of the Iron Curtain. Many of the adopted children arrived in America with complex emotional, behavioral, and developmental disabilities. Their families struggled to stay involved with the church. The severity of aggressive behavior, meltdowns, and impulsiveness demonstrated by the children prevented their families from attending Sunday morning worship services and hindered their ability to maintain their volunteer commitments or small group involvement. As I listened to our children’s ministry director discuss the needs of our church’s adoptive families, the challenges she was describing were like those of families seeking help through our practice. I

> began routinely asking parents of the kids I was treating—kids with common conditions, including ADHD, anxiety, autism, depression, and other mood disorders—how their child's condition impacted their ability to attend church. Their answers made my jaw drop. I was struck by the hurt and disappointment described by parents following unsuccessful attempts to attend church together as a family.

The above quote parallels the findings of Cummings, Keller and Davies (2005) showing that mental health disorders can compromise relationships with both the spouse and the children. Likewise, Rogers *et al.* (2010:308) maintain that those struggling with family mental illness, not only reported more stress, but they were also forced to ask for more 'crisis' assistance, relative to other families.

Considering the data on family mental health struggles, Rogers *et al.* (2010:308-309) report that there is a desire for more help by the Church; the family "continues to struggle without having their problem effectively addressed"; likewise, they state the reason for this is that churches "lack awareness of the issues and understanding of the important ways that they can help".

In recent years, however, there are positive indications of an improved response by the Church to mental health issues.

In the UK, Ryan (2018) reports that Christians are increasing their involvement in responding to the need for church mental healthcare. Likewise, Simpson (2013:142-143) found that "although 80 percent of church leaders said they believe mental illness is 'a real, treatable, and manageable illness caused by genetic, biological or environmental factors', only 12.5 percent of them said mental illness is openly discussed in a healthy way in their church". Awareness of the necessity for a mental health response within the Church appears to be growing among high profile and influential church leaders as well. Globally known pastor, Rick Warren and his wife lit a powerful candle in the experience of the darkness, brought on by their son's suicide as a result of a long battle with mental illness, by promoting annual mental health awareness seminars streamed all over the world from their Saddleback Church in California, USA; often with over 30,000 viewers. In like fashion, trustworthiness in the Church remains strong as evidenced in a sampling of opinions taken by Campbell and Littleton (2018:337), who point out that even though Black Americans seek out professional counseling less, based on factors like "disparities in access to mental

health services due to stigma associated with mental illness, [and] cultural mistrust of providers", they "prefer to turn to the church for help".

2.2.2.5 Effects of mental health issues on personal spiritual growth

Research on the impact of mental health struggles on spiritual formation suggests challenges ranging from practicing personal faith (Hathaway, 2003) to even "less involvement" in faith practice (Rogers *et al*., 2010:308). This coincides with reports by Pearce (2016:6-7) who asserts that mental illness sufferers can experience difficulties in their relationship with God and others in the Church community, resulting in "sadness, distress, doubt, fear, and guilt". Additionally, Pearce (2016:6) cites the research findings of Pirutinsky *et al*. (2011), which found that of the "2,754 clients across the United States, 20 percent endorsed clinically significant levels of religious or spiritual distress". Pearce adds that this has even left some "feeling punished or abandoned by God" (2016:6-7). In the same fashion "71% of the religious patient group consented to the statement: 'my psychological problems make it difficult for me to live my faith in the way I would like to'. Personal interviews with patients often revealed that anxiety and social withdrawal reduce their capacity to express their religious need and convictions in socially visible forms, which in turn can increase social isolation" (Pfeifer & Waelty 1999:43).

Along with the effects already noted, one less often discussed obstacle that stands out as an impediment to mental health is the effect of Social Determinants of Health (SDH). Marmot and Bell (2012:S4) define SDH as, "the conditions in which people are born, grow, live, work and age, and the fundamental drivers of these conditions: the distribution of power; money; and resources".

2.2.3 Social determinants of mental health

When considering the global impact of SDH on mental health, Marmot and Bell (2012:S5) report:

> The final report of the World Health Organization Commission on the Social Determinants of Health (CSDH), published in 2008, affirmed that social injustice was killing on a grand scale, with a toxic combination of 'poor social policies and programs, unfair economic arrangements, and bad politics' being responsible for producing and reinforcing health inequalities.

Supporting these observations, are vast narrative reviews[9] on existing publications evidencing the connection between mental health and socio-demographic considerations such as found in the work of Silva *et al*. (2016:285); here they identify the problem as well as suggest a solution:

> The studies reviewed suggest that exposure to a wide range of social stressors continues to play an important role in the aetiology and the course of mental health problems and disorders. Higher rates of mental disorders are associated with social disadvantage, especially with low income, limited education, occupational status and financial strain. Lack of social support, high-demand or low control over work, critical life events, unemployment, adverse neighborhood characteristics, and income inequality were also identified as psychosocial risks that increase the chances of poor mental health. Importantly, this review highlighted some important protective factors: having trust in people, feeling safe in the community, and having social reciprocity is associated with lower risk of mental health distress. Our results suggest that both individuals and neighborhoods need to be targeted in order to enhance mental health.

Saraceno (2004:5) argued that in parallel to the classical biopsychosocial etiological hypothesis, an identical paradigm for mental health intervention is needed: "the social dimension of mental illness should be an intrinsic component of intervention and not just a concession in etiological modelling". The present review suggests that ameliorating the economic situation of individuals, enhancing community connectedness, and combating neighborhood disadvantage and social isolation may improve the population's mental health.

2.2.4 The role of the Church in caring for acute mental illness

For a brief outline of how participants believe the Church is responding to those suffering from mental health challenges, LifeWay Research (2014:8) lists these key findings:

- 56% of pastors, 46% of family members in a household of someone with acute mental illness, and 39% of individuals with acute mental illness strongly agree

[9] "The electronic search identified 1228 titles and 150 documents that were accepted. We categorized studies according to the outcome measure, and divided them into studies examining the association of social factors with mental health or mental disorders (34 studies), common mental disorders (94 studies), and suicide (22 studies). We grouped the studies according to the independent variable (individual demographic and socioeconomic factors or neighborhood characteristics). Thirty-nine studies were conducted in Europe, 67 in North America, 9 in South America, 5 in Africa, 18 in Asia, 8 in Australia, and one in multiple continents. Three of the studies were systematic reviews" (Silva *et al*., 2016:262).

that local churches have a responsibility to provide resources and support to individuals with mental illness and their families.

- 69% of individuals with acute mental illness indicate churches should help families find local resources for support.
- 68% of pastors but only 28% of family members in a household of someone with acute mental illness indicate their church provides care for the mentally ill or their families by maintaining lists of experts to refer people to.
- 70% of individuals with acute mental illness would prefer to have relationships with people in a local church through individuals who get to know them as a friend.
- Likewise, considering the attitudes of the Church community regarding the potential spiritual growth for those with mental health illness, LifeWay Research (2014:8) reports the following on spiritual development:

    - 76% of pastors agree that a Christian with an acute mental illness can thrive spiritually regardless of whether or not the illness has been stabilized.
    - 74% of family members in a household of someone with acute mental illness agree that a Christian with an acute mental illness can thrive spiritually even if the illness has not been stabilized.
    - 95% of family members in a household of someone with acute mental illness agree that a Christian with an acute mental illness can thrive spiritually after the illness has been stabilized.

2.2.5 The need for spiritual counseling

The statistics given in 2.2.4 strongly imply that the need for spiritual counseling has become a necessity. Unfortunately, testimony outside of the Church, noted more than a century ago by Jung, indicated the need for a holistic approach to mental health issues; yet this approach has not yet been fully integrated into the view of the Church regarding mental health. Jung (1937), historically not known for his strong spiritual endorsement, acknowledged that religious counseling necessitates the spiritual components of meaning and purpose in life. He stated (cited in Adler *et al*., 2014:337):

> When conscious life has lost its meaning and promise, it is as though a panic had broken loose: ‘Let us eat and drink, for tomorrow we die! It is this mood, born of the

> meaninglessness of life that causes the disturbance in the unconscious and provokes the painfully curbed instincts to break out anew.

Interestingly, mental philosopher Robertson (2010), as the voice of an agnostic, makes the same connection for the need to incorporate a spiritual worldview within contemporary psychotherapy. He inquires about the role of worldviews within the practice of therapy. Robertson (2010:xx) asks:

> How does a therapist relate to God? How does he relate to the absence of God? What does he make of life itself? What happens when, in a quiet contemplation, he puts himself on the treatment couch, or when he attempts to think of his relationship with the universe itself, in its totality using the intellectual tools of his trade? What is the point of doing psychotherapy? These are the philosophical questions that must surely stir in the minds of many professional psychotherapists, and which philosophy can at least strive to answer.

Today much of the contemporary research for the need for spiritual counseling is not only extensive (Rogers *et al*., 2010), but it points to sufferers desiring to have their religious beliefs added into their counseling (Pearce, 2016). In accordance with the desire for more religious counseling, outcome studies demonstrate the benefits of its use. Koenig (2009:289) found that

> In general, studies of subjects in different settings (such as medical, psychiatric, and the general population), from different ethnic backgrounds (such as Caucasian, African American, Hispanic, and Native American), in different age groups (young, middle-aged, and elderly), and in different locations (such as the United States and Canada, Europe, and countries in the East) find that religious involvement is related to better coping with stress and less depression, suicide, anxiety, and substance abuse.

Pearce (2016:4) points out that religious counseling is meaningful to clients since their spirituality is part of who they are. Moreover, she observes the significance of this "identity" is founded on the idea that people cannot just

> …check their worldview, spirituality, or values at our door any more than we can choose to leave our hands and feet behind when we go to work. A religious identity and worldview are integral aspects of how religious clients think about, experience, respond to, and take action upon their world.

Additionally, Pearce (2016:4) cites a report by the *American Association of Pastoral Counselors and the Samaritan Institute* (2016:4) on a United States poll, which found that of the 1000 respondents, 83% believed their religious beliefs and emotional health to be closely related. In the same poll, 72% "preferred to see a therapist who respected and integrated their religious beliefs into therapy" (Pearce, 2016:4). Baetz *et al*.

(2004:265-71, cited in Pearce, 2016:4) found that most therapists' clients (53% to 77%), "want to have a discussion about religious and spiritual issues with their therapist". It seems that the "more religious a client is, the more likely she or he will want religion to play a role in therapy" (Morrow *et al*., 1993:452-656, cited in Pearce, 2016:4). According to McCullough and Worthington (1995:626-634, cited in Pearce, 2016:4), it seems that clients rate therapists that can integrate religion and spirituality in their therapy to be more competent.

Even though there is a desire for more religious counseling, pastoral training, and church education to meet this need, it varies. LifeWay Research (2014) found that 14% of churches they surveyed had a counselor trained in mental illness on the staff, and that only 49% of pastors reported that they rarely or never speak about acute mental illness. Additionally, they found the following among the surveyed pastors (LifeWay Research, 2014:14):

- 60% have personal experience with friends or family members suffering with mental health issues.
- 41% have taken seminary courses on care for the mentally ill.
- 38% have taken graduate school courses in counseling.
- 10% have obtained graduate degrees in counseling or psychology.

Likewise, in one sample of ministers surveyed across a variety of denominations in the state of Hawaii, Farrell and Goebert (2008:437-440) found that among their respondents, most of whom have served more than 20 years in the ministry and have a seminary degree, "50% to 80% of clergy members have reported that counseling training in seminary and post-seminary continuing education was inadequate". When asked of the participants if they felt their training adequacy was sufficient to identify most of the chronic mental health disorders, namely major depression, bipolar disorder, and schizophrenia, 29% responded: yes, 55% responded: no, and 16% were unsure.

Along with these findings, Grcevich (2018:21) adds:

> Far too many pastors, church leaders, and attendees within our Christian subculture demonstrate an insufficient understanding of the nature of mental illness and struggle to respond to those affected in a manner that demonstrates compassion and concern

> and promotes spiritual growth. Fewer still possess a basic understanding of how the experience of mental illness impacts the ability of affected children, adults, and their families to participate in worship services, small groups, educational programming, and service activities through which spiritual growth takes place.

Lastly, within church leadership, while "38% of pastors strongly agree they feel equipped to identify a person dealing with acute mental illness that may require a referral to a medical professional, the remaining pastors are less confident or even disagree" (LifeWay Research, 2014:17).

In contrast, the data on training outside the Church suggests that even though "Religion/spirituality and its relationship with psychology has evolved through several iterations" (Brawer *et al*., 2002:206), and the American Psychological Association (APA) mandates religious diversity competence within their ethical standards (APA, 2016), Hage (2006, cited in Pearce, 2016:12) reports that most graduate schools and "doctoral programs" provide little to no religious training.

When surveying the religious training considerations from 69 counseling psychology programs in the US, with 40 responses received Schulte *et al*. (2002:118) found the programs contained "relatively little in the way of formal course work in religious or spiritual issues". Today, while evidence suggests that religion remains an essential consideration in the role of counseling settings (Oxhandler *et al.*, 2018), as a foretelling voice from history, over eighty years ago, again Jung (1937, cited in Adler *et al.,* 2014:335), alerts us of a void only religious counseling can meet:

> It seems to me that, side by side with the decline of religious life, the neuroses grow noticeably more frequent. There are as yet no statistics with actual figures to prove this increase … Among my patients from many countries, all of them educated persons, there is a considerable number who came to see me not because they were suffering from a neurosis but because they could find no meaning in their lives or were torturing themselves with questions which neither our philosophy nor our religion could answer.

2.3 The normative response to assist those with mental illness within the Church

2.3.1 Background

When considering the clergy's normative response in helping those with mental illness in the local church, the writer will cite pastoral responses to mental illness struggles in

the categories of *adaptive* or *maladaptive*. In their findings of *"How Well Churches are Caring for those with Acute Mental Illness"*, LifeWay Research (2014:4-8) reports:

- 17% of family members in a household of someone with acute mental illness say their family member's mental illness impacted which church their family chose to attend.
- 53% of individuals with acute mental illness say their church has been supportive.
- Among individuals with acute mental illness who attended church regularly as an adult, 67% say their church has been supportive.
- 75% of family members in a household of someone with acute mental illness say their church has been supportive.
- 39% of individuals with acute mental illness agree that their local church has specifically helped them think through and live out their faith in the context of their mental illness.

2.3.2 Adaptive responses

Stanford and McAlister (2008:145) found that some clergy believed they had "an informed, scientifically based understanding of the causes of mental disorders" (cited in Lafuze, 2020:901). While in the U.K., Ryan (2018) recognizes a growth trend in church mental health services; Bornsheuer *et al.* (2012) note the same in the United States. In the United States, they found in a small sample of conservative Protestant pastors from four churches[10] that participants expressed a greater desire for better collaboration between the Church and mental health professionals. Likewise, Bornsheuer *et al.* (2012:209) report that participants are open to the integration of "religious practices into the counseling process … knowledgeable mental health professionals, and the safety and security that comes from close relationships with church staff and other members in guiding them in the right direction when they seek mental health services".

In addition to the clergy's willingness to address mental health challenges, there is broad-based evidence that churches are very proactive in meeting the demand of mental healthcare; Franklin and Fong (2011:432) report:

[10] Evangelical Baptist, Southern Baptist, Church of Christ, and Lutheran Church Missouri Synod.

> Ministers counsel on a wide range of personal problems, including alcohol and substance abuse, depression, marital and family conflict, teenage pregnancy, unemployment, and legal problems, and often encounter clients with the same types of psychiatric problems as those seen by professional mental health workers. Faith-based programs have also exhibited a variety of positive outcomes for health-related behavior. (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

Likewise, Franklin and Fong (2011:433) report:

> A 2007 survey from the National Council of Churches (NCC) USA found that the 6,037 reporting congregations had a combined total of 78,907 health ministry programs. Most reporting congregations provided health care ministries to both members and nonmembers. Several program types have emerged to meet the specific needs of those with mental health concerns and their families.

In contrast to the improving trends and the increased requests for a spiritual response to mental health needs, there is contrary data that points to a less adaptive response by the Church, affording it the opportunity for mental health improvements.

2.3.3 Maladaptive responses

2.3.3.1 Background

Unfortunately, along with the pressures facing the Church regarding mental health illness, there is selected data that points to a negative or a maladaptive response by congregants that affords the Church an opportunity for ministerial growth and development.

The following concerning statistics underline the responsibility of the Church to respond to the challenges of mental illness (LifeWay Research, 2014:6-8):

- 20% of individuals with acute mental illness describe the current status of their mental illness as unstable.
- 28% of individuals with acute mental illness agree their mental illness hurt/hurts their ability to live like a Christian.
- The response of people in church to individuals' mental illness caused 18% to break ties with a church and 5% to fail to find a church to attend.

Furthermore, Farrell and Goebert (2008:13) found in one study which they described as "dramatic" that "there was a strong tendency to counsel regardless of the level of training … despite reporting a belief that the most common cause of mental illness is

medical". Consequently, the researcher concludes that these findings suggest that some pastors may be counseling beyond their scope of expertise.

Conjointly, while sufferers desire more counseling from their church (Rogers *et al.,* 2010), LifeWay Research (2014:8) found that "65% of family members in a household of someone with acute mental illness believe local churches should do more in talking about mental illness openly so that the topic is not so taboo". In conjunction with these findings, Simpson (2013:142-143) also reports that "only 12.5% of them [mental health sufferers] openly discuss it willingly and in a healthy manner with their congregations". LifeWay Research (2014:8) found that 49% of pastors rarely or never speak to their church in sermons or large group messages about acute mental illness. If there is a need it receives less attention than desired and it then becomes clear how, as Rogers *et al.* (2010:308) suggests, "these data give the impression that mental illness, while prevalent, is also nearly invisible within the congregation".

Along with the above observations, the researcher contends that there are two notable obstacles present standing between the Church and the struggling community: hyper-spiritualizing and stigma.

2.3.3.2 Hyper-spiritualizing

Alongside the maladaptive reports, there is evidence of churches hyper-spiritualizing mental illness in a way that may be fueling negative clergy responses toward mental health. Horton (2014) uses the term "hyper-supernaturalistic" for the tendency to explain away causes in terms of spiritual considerations. He maintains it is dangerous to overweight theories as either from a purely naturalistic perspective, as often seen in the atheistic worldview, or at the opposite end of the spectrum, solely from a supernatural standpoint. When considering the Church paradigm, there are indications that it has a proclivity to overemphasize spiritual causality in light of mental health concerns. For instance, Stanford and McAlister (2008:146) report that among mental health sufferers in the Church a significant percentage of the sample reported that "their mental disorder was viewed as having only a spiritual basis". Horton (2014:4) points out that when there is an overemphasis of the soul and an under-emphasis of the body, it reflects "not only a lack of appreciation for the rapid growth in medical diagnosis and treatment of such disorders but a cluster of theological

misunderstandings". When distinguishing among denominations, Stanford and McAlister (2008:145) reported that among Pentecostals and conservative Protestants, those who regarded religion as the dominant force in their lives but who were ill-informed regarding psychology or the role of counseling "were more likely to attribute the causes and treatments of major depression and schizophrenia to religious factors". Based on the results of the following questions it becomes clear that there is a tendency in the Church to over-spiritualize the causes of mental illness (Stanford & McAlister, 2008:148):

1. Did anyone at your church ever suggest that you did not really have a mental illness even though a mental health professional had diagnosed you with one?

    - 58.8%: No
    - 41.2%: Yes

2. Did anyone at your church ever suggest that you stop taking psychiatric medication for the treatment of your mental illness?

    - 71.8%: No
    - 28.2%: Yes

3. Did anyone at your church ever suggest that your mental illness was a result of sin?

    - 63.5%: No
    - 36.5%: Yes[11]

Equally, attesting to the risk of over spiritualizing mental health issues, in surveying 293 Christians who reached out to their church for mental health assistance, Stanford (2007:447) found that

> 32.4% of these church members were told that their loved one did not really have a mental illness and that the cause of their problem was solely spiritual in nature (e.g., personal sin, demonic involvement). The same study found that after receiving help from the church, even though 34.1% of the participants reported the problem seemed better, 25.9% reported the problem seemed worse. When responding to the question, "How has this interaction with the church affected your faith?" 36.2% reported it

[11] See Appendix B for Stanford and McAlister's (2008) details of the above results.

> "Strengthened it", 36.5% of participants reported "not affected", but unfortunately, 14.7% of the participants reported it "Weakened it" and 12.6% reported, "I am no longer involved in the faith because of this incident".

Lastly, in a sampling of pastors and ministers in the State of California, Payne (2009:363) reports a distinction among denominations and race regarding spiritual versus medical etiology:

> Mainline Protestants in the study were very committed to their view that depression is caused by medical or biological conditions rather than spiritual causes. This is a significantly different belief than that of Pentecostals, who were more likely to believe that depression was caused by spiritual problems or moral problems rather than biological reasons. Mainline Protestants were more likely to view depression in line with mental health professionals; they were more likely to see depression as having a biological component, and more likely to see it as being separate from a religious issue. Pentecostals, in particular, were more likely to view depression as an issue that depends on the situation and felt depression was strongly influenced by spiritual causes.

In light of race, Payne (2009:356) reports "the idea that African American clergy emphasize spiritual causes of mental illness more than a genetic cause has been alluded to in the literature". The researcher will examine mental health etiology in more detail in the next chapter; however, for now, on the topic of bifurcating causality as "either-or", the researcher concurs that the position of Yarhouse *et al.* (2012:40-41) is more plausible:

> A careful reading of the available evidence makes it impossible, we believe, to adopt a single model mindset that would adequately explain all aspects of abnormality. Thus we intend to promote a more holistic approach, avoiding the extremes of psychological or spiritual reductionism—what we will call the sin of "nothing-but-ism." It is exceedingly rare to see a case of mental illness that does not reflect an almost bewildering combination of biological, psychosocial, sociocultural, and spiritual factors.

In like manner concerning over-spiritualizing mental health causes, the researcher contends that the role of stigma may be a hindrance to mental health advancement within the Church.

2.3.3.3 Stigma

Stigma is defined as a "term for prejudice or negative stereotyping" (Corrigan & Penn, 1999:766). In the US, not only is it widely accepted that "mental illness is one of the most stigmatized conditions in our society" (Stout *et al*., 2004:543), but stigma is a considerable obstacle to national mental health (Corrigan *et al*., 1999; Centers for

Disease Control, 2012). Brown and Bradley (2002:81, citing the Center for Mental Health Services, [CMHS], 2000) report that "each year, an estimated 50 million Americans will experience a mental disorder while only one-fourth of them will seek mental health services". Centers for Disease Control or CDC (2012:4) points out that it is often the "embarrassment" effect of stigma that keeps people from accessing and even following through with mental health care.

To summarize how stigma manifests practically in the lives of those inhibited by it, Corrigan (2004:616-618) identifies the following factors:

- Public stigma: Harm to social opportunities; people with mental illness are frequently unable to obtain good jobs or find suitable housing because of the prejudice of key members in their communities, employers, and landlords.
- Self-stigma: Harm to self-esteem. People may also avoid the stigma of mental illness because of the potential effects of stigma on one's sense of self. Research shows that people with mental illness often internalize stigmatizing ideas that are widely endorsed within society and believe that they are less valued.
- Stigma and diversity: Given concerns about diversity in the service system (for example, some psychotherapies are not sensitive to differences in ethnicity).

When pairing over-spiritualizing mental health issues with stigma, it is rational to assume the same formidable impediments will bleed from the culture into the Church. Rogers *et al*. (2010:308) reports the adverse combination of an "atmosphere where mental disorders are viewed as spiritual problems and hence need only spiritual intervention". This, coupled with pastors who "fail to recognize the disorder", sets a stage where "families may be reluctant to talk about their struggles for fear of being judged" leaving them at risk to ultimately "withdraw from the Church". This disconnect is also supported by Bussema and Bussema (2000:117-124), who report that while some mental health sufferers find a sense of purpose from their religious worldview, the stigma often leaves them feeling "estranged from their primary religious communities". Anecdotally, Grcevich (2018:29-30), who claims that many ministries catering to mental health strugglers have not matured, provides these insights as to why:

> Mental illness is stigmatized in many of our churches in ways that other disabilities aren't … The term "mental illness" is used to describe perception, mood, emotions,

> and behavior. The typical pastor or ministry leader may have some knowledge of the signs and symptoms of some conditions, but an in-depth understanding of how the attributes of common mental health disorders impact church participation or spiritual growth is extremely rare in my experience. We haven't had a commonly accepted ministry model for mental health outreach and inclusion.

In the same way, stigma impedes mental health advancement in the United States, Ryan (2018:421) in the UK observes similar reports: "Some mental health issues are poorly understood (like schizophrenia) and can provoke fear. Common experiences include people not wanting to bring up the subject of a mental health issue for fear of causing offense, saying the wrong thing, or making the situation worse". To contend and give an answer to the obstruction of stigma, Ryan (2018:424) implores believers to meet this need by stating:

> This is a challenge to Christians, partly because of the relational nature of human beings, which demands that we help people to build the common good by communicating with one another. Moreover, the healing ministry of Jesus reveals the importance of reintegration of people into the community once they are healed.

2.4 Global evangelical potential to address mental health issues beyond the Christian community

As the Wonderful Counselor (Isaiah 9:6), Christ heals by His blood and wounds. Bringing hope to a fallen and hurting world, there is a great comfort in knowing that along with His good news as given in Psalm 147:3: "He heals the brokenhearted and binds up their wounds" (Bible, 2020). This evangelical effort offers Christians a global evangelism opportunity to those needing the ministerial tools found in effective counseling. MacArthur (2005:225) exhorts:

> While many evangelistic tools are effective and worthy of attention, it is important to notice that the scriptural model always began by addressing the challenges, sins, or trials that a person was facing. Thus the biblical counselor who follows Scripture will not simply dispense the Word but will endeavor to listen and ask questions, and then will present the gospel of Jesus Christ. Over the years, this method of counseling has been a highly effective tool for evangelism in our church.

However, it appears that to implement MacArthur's exhortation for a counseling outreach, in the case of global mental health, will be somewhat challenging as "the harvest is ripe, but the workers are few" (Matt. 9:37). The World Health Organization (WHO) (2016) reported

> One in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill-health and disability worldwide.

Likewise, indicative of "few workers" referred to in Matthew 9:37, the WHO (2001:8) states: "There is only one psychiatrist per 100,000 people in over half the countries in the world, and 40% of countries have less than one hospital bed reserved for mental disorders per 10,000 people". In addition to the worldwide WHO statistics on mental health, the following data:

- Approximately 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses. Such estimates have drawn attention to the importance of mental disorders for public health (Prince, *et al*., 2007:859).
- The prevalence of anxiety disorders across the world varies from 2.5% to 7% by country. Globally an estimated 284 million people experienced an anxiety disorder in 2017; making it the most prevalent mental health or neurodevelopmental disorder (Hannah, *et al*., 2019).
- According to the Global Burden of Disease (GBD) 2017 findings, issued by the Institute for Health Metrics and Evaluation (IHME), depression is a common illness worldwide, with more than 264 million people affected.
- Every year, about 800000 people commit suicide; 86% of whom are in low-income and middle-income countries, and more than half of whom are aged between 15 and 44 years. Even these figures might be underestimated, since official statistics in low-income and middle-income countries are not reliable. (Prince, *et al*., 2007:860).

Unfortunately, research suggests that sufferers are not receiving help due to a lack of access to mental healthcare providers. For instance, Patel (2014:3), a psychiatrist and joint Director of the Centre for Global Mental Health states:

> It has to be admitted that there is a great shortage of every kind of mental healthcare provider in the developing world, from specialists like psychiatrists and psychologists all the way through to community-based workers who can provide frontline mental healthcare.

In addition, the WHO (2001) reported that

> …more than 40% of countries have no mental health policy, and over 30% have no mental health program. Around 25% of countries have no mental health legislation. The magnitude of the mental health burden is not matched by the size and effectiveness of the response it demands. Currently, more than 33% of countries allocate less than 1% of their total health budgets to mental health, with another 33% spending just 1% of their budgets on mental health. A limited range of medicines is sufficient to treat the majority of mental disorders. About 25% of countries, however, do not have the three most commonly prescribed drugs used to treat schizophrenia, depression, and epilepsy at the primary health care level.

Similarly, in a 2007 survey conducted for the WHO by Wang *et al*., reports:

> Health systems have not yet adequately responded to the burden of mental disorders. As a consequence, the gap between the need for treatment and its provision is wide all over the world. In low- and middle-income countries, between 76% and 85% of people with mental disorders receive no treatment for their disorder.

2.5 Evangelism opportunity

For the Christian, who is "*prepared to make a defense to anyone who asks you for a reason for the hope that is in you*" (1 Pet. 3:15), the very nature of the Church affords the opportunity to give an answer to the vast global mental health demand. The Church serves as a trusted, first-line community to minister to mental health needs both locally and globally. Rogers *et al*. (2010:303) states:

> Religious congregations are often a place of comfort and healing for individuals. In fact, the role of the clergy as "gatekeepers" for treatment access has long been established: Clergy tend to be sought out first and at greater rates than mental health professionals.

Therefore, the inference, as indicated in the research is that "clergy play a heavy role in the treatment of mental illness" (Farrell & Goebert, 2008:437). Specifically, to close this gap, those with mental health struggles offer an audience in both breadth and

depth to respond with the good news for hope as well as healing for relief, not only by direct contact but through the outlet of research and online delivery.

First, in accord with the aspiration of this research, there are those academics who not only recognize this need, but they have brought quality, empirically supported answers to meet the demand for mental healthcare solutions through research in missions. For instance, the Rosemead School of Psychology Biola University and the *Journal of Psychology and Theology*, have been at the forefront of such research for decades. Following the research mission focus, Lewis and Schram (1999) in *Psychology and Missions*: *The Role of the Mental Health Professional in member care* state the vision for their work as: “a vehicle for the dissemination of theoretical and research articles on missions”. Citing Hunter (1993), Lewis and Schram (1999:83) note: “this demonstrates the continuing maturation of the field of mental health and missions in the United States, as in the past, research has lagged behind theory and practice”.

Second, technology offers a great opportunity to bridge the global mental healthcare supply gap; this creates a broad ministerial opportunity that the Church has not met since its inception to fulfill its mission and purpose of evangelizing the world (Matthew 28:19). For instance, in light of the focus of this work, CBT, Kumar, *et al*. (2017) studied the efficacy of Internet-based Cognitive Behavioral Therapy (ICBT) in treating mental health disorders. They found that not only has “ICBT played a significant role in the prevention of suicide” (Kumar *et al*., 2017:4); additionally, they report (2017:11):

> Overall, ICBT is an effective means of treating various mental health illnesses and improving patient care while being cost-effective. Findings showed that ICBT is effective in the treatment and management of various psychiatric disorders such as depression, GAD and social anxiety, panic disorders, phobias, addiction and substance use disorders, adjustment disorder, bipolar disorder, and OCD.

Compounding the technological benefit, they also note the economic advantage of ICBT and report: “moreover, it is cost-effective, both for patients regarding consultation fees and also for the health care system regarding controlling the cost burden” (Kumar *et al*., 2017:11).

To meet the global need for counseling, the fusing of cheaper costs along with shorter sessions in CBT, delivery could prove beneficial to reach the substantial demand for global mental health treatment. The adaptability of CBT establishes one example. It has proven it can be applied and shortened while remaining effective, even when

patients are suffering from the most acute symptoms like suicidality (Bernecker *et al*., 2019). Such is the case with *Brief CBT* (BCBT), which is defined as "the compression of CBT material and the reduction of the average 12-20 sessions into four to eight sessions" (Cully & Teten, 2008:6). To give an example of its use as a critical application, Cully and Teten (2008) found that outcomes show it is a cost-effective alternative when applied to the population of suicidal active-duty military personnel. According to Cully and Teten (2008:6), the efficacy and economic evaluation of BCBT showed:

> In the base-case analysis, BCBT was expected to avert approximately 23 to 25 more suicide attempts and 1 to 3 more suicide deaths per 100 patients treated than treatment as usual. Sensitivity analyses assuming a range of treatment effects showed BCBT to be cost-saving in most scenarios. Using the federal discount rate, the DoD was estimated to save from $15,000 to $16,630 per patient with BCBT vs. treatment as usual.

2.6 Chapter summary

In summation, in light of the evidence provided to establish the Descriptive-Empirical Research Task, the researcher contends that there is a need to "*give an answer*" (1 Pet 3:15) to those struggling with mental health challenges within Christ's Church based on the following cumulative points:

- The presence and levels of mental illness reported in the Church (LifeWay Research, 2014; Simpson, 2013).
- The cost of mental illness on families (Rogers *et al*., 2010).
- The cost of mental illness on personal spiritual growth (Pirutinsky *et al*., 2011).
- The need for and efficacy of religious counseling (Koenig, 2009).
- Undertrained Clergy (Farrell & Goebert, 2008).
- Undertrained Professionals (Hage, 2006).
- The maladaptive responses of the Church (LifeWay Research, 2014).
- The influence of over-spiritualizing (Horton, 2014), and the stigma of mental health (Bussema & Bussema, 2000).
- The global need to respond to the massive need to give an answer to mental illness (WHO, 2001).
- The call of the Church (Matt. 28:19-20; MacArthur, 2005).

CHAPTER 3: THE INTERPRETIVE TASK

3.1 Introduction

In conformity with Osmer's (2008:4) fourfold model of practical theology, the objective in the interpretive task is to conduct a literature study of Christian Apologetics and Cognitive Behavioral Therapy to provide an understanding and explanation of the current situation of common obstacles in the gap between willing Church ministers and those struggling with mental health challenges. To establish the interpretive task or "why" there are obstacles standing in the gap of "*giving an answer*" (1 Pet. 3:15) to the mental health challenges within the Church, the researcher contends that the most compelling reasons are:

- "Blind-spots", defined by Vazire and Wilson (2012:86), as "deficits in self-knowledge".
- "Enemies" to the integration of psychology and theology as a model toward mental health promotion (Entwistle, 2004).
- The "Fragmented" soul (Yarhouse, *et al*., 2012).

3.2 Blind-spots

3.2.1 General

Although inconclusive, the researcher postulates as to whether or not the church has found itself victim to an elusive impediment toward an adaptive response to mental health challenges in the church, namely, the obstacle of 'blind-spots'.

For this reason, the researcher contends that the question of blind-spots relative to the church, needs to be examined. This claim, as stated in 3.1, is substantiated and rests mostly on the following researched evidence:

- A limited awareness of mental health needs within the church since, as the research of Rogers *et al.* (2010:308) suggests, "data gives the impression that mental illness, while prevalent, is also nearly invisible within the congregation".
- A slow response to adapt to the mental health needs within the Church, as evidenced in the Lifeway Research (2016:8), which suggests that the Church

needs to have more transparent conversations regarding mental health in the Church (Simpson, 2013), along with anecdotal observations made close to a century ago, calling for the "church to provide spiritual guidance with regard to mental health solutions" (Jung cited in Adler *et al.*, 2014:344*).*

- The underutilization of science as an integrated component of healthcare solutions, as evidenced by the limited use of the plethora of efficacious religious counseling research (Koenig, 2009), as well as the "Christian Combatant" position on the integration between psychology and theology (Bobgan & Bobgan, 1987).
- Theological misunderstandings, as in the case of the over-spiritualization of mental health symptoms in the Church (Horton, 2014), and the claims supporting a spiritual reductionistic-only approach to mental health (Stanford, 2007).
- Deficient pastoral resourcing, as in the case of under-trained clergy (Farrell & Goebert, 2008), and under-trained professional counselors (Hage, 2006).

Vazire and Wilson (2012:86) characterize blind-spots as "deficits in self-knowledge" or "pockets of ignorance" in "mental contents and personal predispositions". Likewise, they maintain that blind-spots "exist without our realizing it" (Vazire & Wilson, 2012:86). While this researcher concedes the formal definition of "blind-spots" is elusive, Byers (2011) suggests the psychological theory is metaphoric to the physiological blind-spot concept called a *scotoma*, which is the organic phenomenon that exists within the visual field of eyesight and is explained by Larner (2016:2), as "the lack of light-detecting photoreceptor cells on the optic disc of the retina where the optic nerve passes through it"; thus leaving the viewer with a narrower visual scope.

Rationally, if individuals are susceptible to blind-spots, then a group or more than one member of such group, can understandably fall prey to blind-spots, leaving the group exposed to the negative side of *groupthink*.

3.2.2 Groupthink

The term 'groupthink' is defined by the *Merriam-Webster* online dictionary as "a pattern of thought characterized by self-deception, forced manufacture of consent, and

conformity to group values and ethics" (*Merriam-Webster*, 2021). While Christians recognize that "without counsel plans are frustrated, but with many counselors they succeed" (Prov. 15:22), the understandable concern with groupthink is that it can operate in a closed system and this includes "religious organizations" (Sunstein & Hasite, 2015:7). Operating in a closed system rationally forces the decision making to be made with incomplete data. Subsequently, decision making on limited data, can leave groups exposed to potential decisions that may be "disastrous" (Sunstein & Hastie, 2015:6).

In light of the Christian worldview, some suggest the primary source of blind-spots originates as spiritual blind-spots in *sin*. For instance, in the article, *Blind to our Blindness*, Tripp (2013:par. 11-12), maintains that we are "fundamentally deceptive". He notes here on how sin influences spiritual blind-spots:

> Spiritual blindness is not like physical blindness. When you are physically blind, you know you are blind, so you compensate for this significant physical deficit. But spiritually blind people are not only blind, but they are also blind to their own blindness. They think they see well. So, the spiritually blind person walks around with the delusion that no one has a more accurate view of himself than he does.

Subsequently, it is understandable why (Linhart, 2017:9) warns us about blind-spots suggesting that they "pose potential danger" because if we are unaware of our blind-spots they can leave us vulnerable to psycho-social pitfalls.

When witnessing this daily, the researcher, without hesitation, is indubitably convinced that it is human nature to think we know ourselves better than we really do; this conviction comes after leading numerous educational groups in psychiatric settings. In like fashion, we are also inclined to assume others have thinking biases beyond our own; this form of blind-spot is called a 'bias blind spot' (West *et al*., 2012).

It is therefore understandable that if a lesser than accurate level of self-awareness is ordinary in each of us, then there is a much higher need for personal objectivity when the stakes are higher, as is the case with the "beyond reproach" roles in the Church (1 Tim. 3:2). Ministry leaders, pastors, and "heads of households" (1 Cor. 11:3) are important positions within the Church that should logically be open to more light.

Perhaps one of the most recognized examples given in the Bible of falling prey to one's own blind-spots is that found in the experience of King David. When King David was

in denial over his behavior with Bathsheba, it took the wisdom, love, and therapeutic intervention of Nathan to pierce the haze of David's denial with unadulterated truth. Nathan taught David using a story about a rich man who owned many sheep and a poor man with one lamb. He told David that the rich man took the poor man's lamb. David, like most of us, was instantly able to see the error in another's actions but not his own. David had fallen victim to a blind-spot. He became furious and condemned the rich man's behavior as guilty. It was not until Nathan responded with, "*You are that man*!" that David was able to objectively "see" the truth. In 2 Samuel 12:7, Ellicott's Commentary (n.d.) suggests that Nathan's rebuke "aroused his slumbering conscience [for] his conscience had been stupefied by the delirium of prosperity and power" (Loc. 44651). Upon hearing and becoming convicted of the truth, David immediately said, "*I have sinned before the Lord*". Notice, King David worked through his blind-spot and appealed for repentance in order to grow in his relationship with God.[12] David's ultimate appeal to God became: "Search me, God, and know my heart; test me and know my anxious thoughts. See if there is any offensive way in me, and lead me in the way everlasting" (Psalm 139:23-24).

The argument here is, if a spiritual individual, like King David, can have blind-spots, then logically, a group, such as a church, which is collectively made up of individuals, is susceptible to blind-spots, hence the downside of groupthink.

Therefore, the researcher appeals to ministerial leaders to remain open to professional outside data; to address mental health challenges in the Church by use of Evidence-Based Practices in Psychology (EBPP) to enhance treatment support, and thus, give an answer to overcome suspected obstacles, like blind-spots.

[12] And throughout all generations, believers have turned to Psalm 51 for assistance in expressing their repentance to the Lord. As the superscription to Psalm 51 tells us, this Psalm was prompted by David's response "when Nathan the prophet went to him, after he had gone in to Bathsheba". When the words of God came to David through the prophet Nathan, 2 Sam. 12:1-15a informs us that David turned from his sin.

3.2.3 "Enemies" to the integration of psychology and theology model toward mental health promotion

3.2.3.1 Background

Lewis' (2009:57) statement that "good philosophy must exist, if for no other reason, because bad philosophy needs to be answered" is widely voiced in the circles of Christian philosophic academia as an apologetic for Apologists. The researcher concurs with the statement by Lewis, and in terms of its application to psychology, offers the following rewording: 'good *psychology* must exist, if for no other reason, because bad *psychology* needs to be answered'.

3.2.3.2 Limited integration between psychology and theology

3.2.3.2.1 General

The pithy dictum given by Lewis in 3.2.3.1 introduces the next obstacle that hampers adopting a more adaptive response to mental health, namely, the limited use of integration between psychology and theology.

Today, the integration between psychology and theology remains an in-house debate. While the next section (see 3.2.3.2.2) draws attention to those opposed to integration, Chapter 4 will build a case for integration.

The deliberation pertains to the interrelation between psychology and counseling theory within the Church. In the book, *Psychology and Christianity: Five Views*, Johnson (2010:9) points out, "Christian interest in psychology has exploded over the last fifty years"; for this reason his estimations on integration are essential to this study. He states that

> In the midst of this explosion has been an intellectual crisis that the church has been wrestling with for even longer: over the previous 140 years, a complex and rich body of knowledge and practice has proliferated, which has understood and treated human beings in some ways that vary considerably from Christian perspectives on human life. Since this modern psychology is largely secular, there is considerable disagreement about how much the theories and findings of this type of psychology should influence, be absorbed into and even transform the way Christians think about human beings. Some Christians have embraced modern psychology's findings and theories with uncritical enthusiasm, naively trusting that its texts are a perfect reflection of human reality. Others have argued that any appropriation of modern

> psychology is “psychoheresy”, since it necessarily poisons the Christians who imbibe it (Bobgan & Bobgan, 1987:9-10).

Literature examination on the integration of psychology and theology runs the gamut with proponents on a continuum. At one end, there are those who present, almost emphatically, in opposition to integration (Adams, 1970; Bobgan & Bobgan, 1987; MacArthur, 2014); on the opposite end, there are those who support it (McMinn, 1996; Johnson, 2010; Moreland, 2019). To exhibit one sample of the classifications on the spectrum of the integration of psychology and theology, the researcher will use Entwistle’s (2004:136-193) five models for integration, given in 3.2.3.2.2, which he has termed: Enemies, Spies, Neutral Parties, Colonialists, and Allies.

3.2.3.2.2 Entwistle’s five models of integration

The five models are as follows:

1. Enemies’ model: This model is based on the belief that psychology and theology/Christianity are mutually exclusive and incompatible with each other. Entwistle (2004:169-173) identifies the following two subtypes in this model:

    - Secular combatants: antagonistic toward religious belief, and are identified by the following characteristics:

        - Religious worldview cannot achieve its end; it is an enemy to scientific development.
        - Religion seriously sabotages mental health.
        - Religion is neurosis (Ellis, 1980a).

    - Christian combatants: perceive psychology as the enemy, and are identified by the following characteristics:

        - Counseling is the Church’s responsibility and not Psychiatrists/Psychologists; i.e.: Jay Adams and John MacArthur.
        - All information relevant to psychological health is found in the Bible.
        - Psychology is idolatrous.
        - Christianity and Psychology have been enemies from the beginning.

Within the Christian Combatant's subtype, Entwistle (2004:167-169) lists the following epistemological assumptions:

- The care of the soul belongs solely to the Church and that psychology is a mere trespasser in its territory.
- Psychology and Christianity have been enemies from the beginning.
- Soul care belongs solely to the Church.
- True soul study cannot be done by unbelievers. After all only Christians have the resources for comprehending the nature of the human soul and understanding how it can be transformed.
- God's Word should be our counseling authority.
- Secular psychology has nothing to offer for understanding or providing solution to the non-physical problems of people.
- Scripture itself claims to be a sufficient resource for meeting emotional and spiritual needs.

2. Spies model: Entwistle (2004:182 & 187-188) identifies the following two types of spies:

   - Foreigners: psychologists who seek to identify religious elements that have psychological benefits.
   - Domestic: Those who practice a watered-down religion and are interested in proclaiming its psychological benefits.

3. Neutral parties' model: This model views psychology and theology as distinct and not interacting; and which can thus be carried out through psychological neutrality and Christian neutrality. Entwistle (2004:191-193) explains as follows:

   - There can be no actual conflict between faith and psychology because they occupy distinct and non–interacting spheres.
   - Completely different perspectives that cannot be combined because each has views that require different vantage points.

4. Colonialists: This model accepts but filters "isolated psychological findings" (Entwistle, 2004:224) under a worldview; however, their ultimate allegiance is to

theology" (Entwistle, 2004:225). He notes the following characteristics of this model:

- View[s] psychology as legitimate so far as it does not transgress the theological proclamations.
- They align psychological findings to a Christian worldview. God's Word over God's Works.
- Primary allegiance to theological systems; [God's Word]; "psychology can be useful only to the degree that it can be forced to conform to the theological system" (2004:144).

5. Allies: This model of integration espouses the view that both "psychological and theological methods are utilized to gain a more holistic and unified understanding of truth" (Entwistle, 2004:147).

In light of the above categories, it is the researcher's opinion that Entwistle's (2004) *Colonialists* position is the most plausible position for this study, in that it views psychology as legitimate as long as it does not transgress the theological precepts. This work is not a defense of any specific position, although, the researcher builds a case for integration in general where Christian thinkers are open to integration by evidencing those insights that support integration while not transgressing orthodox Christian doctrine.

3.2.3.2.3 Secular combatants

Entwistle (2004) maintains that within the secular combatant's model, psychology is antagonistic toward religious belief. Koenig (2009:283) provides further insight regarding this view, which the researcher deems a historical contribution to the position of the secular combatant model: "Religious and spiritual factors are increasingly being examined in psychiatric research. Religious beliefs and practices have long been linked to hysteria, neurosis, and psychotic delusions". Koenig (2009:284) adds that "in the late 19th century, the famous neurologist Jean Charcot and his star pupil, Sigmund Freud, began to associate religion with hysteria and neurosis. This created a deep divide that would separate religion from mental health care for the next century".

The following are examples of popular Secular combatants with their supporting insights:

- Sigmund Freud (1957:240) called religion the “obsessional neurosis of humanity”.
- Carl Rogers (1961:8) stated: “I could not work in a field where I would be required to believe in some specified religious doctrine”.
- Albert Ellis (1960:188-192) wrote: “There Is No Place for the Concept of Sin in Psychotherapy”.

McMinn (1996:2464-2465) explains Ellis’ point in this way:

> When Ellis refers to the concept of sin as the problem, he means that all we need to do to be healthy is to dismiss our silly ideas about right and wrong and live a life of responsible pleasure seeking. Adams leaves out the word concept, suggesting that sin itself is the problem.

3.2.3.2.4 Christian combatants

Within the Christian combatant’s model, Entwistle (2004) maintains that Christian theology is antagonistic toward psychology. For instance, consider this anecdotal sample of a personal incident Moreland (2019:28) experienced as a speaker in a church where the leadership operates on the Christian combatant’s model. He states:

> While making a point in my message, I rather offhandedly mentioned that I was on an antidepressant, and I urged people who were struggling with anxiety/depression to check out this avenue of help. Well, my point was like teeing off a golf ball in the shower. It quickly ricocheted right back at me! As soon as the service ended, two elders rushed me into a back room and told me in no uncertain terms that their church did not believe in such medications. I was never invited back. The disciplines of psychiatry and psychology are widely rejected by evangelicals.

Moreland (2019:28) gives another example of the Christian combatant’s model by sharing his experience with a church leader who rejects the integrationist position; he states:

> As one Christian leader put it, “True psychology (‘the study of the soul’) can be done only by Christians, since only Christians have the resources for the understanding and the transformation of the soul. Since the secular discipline of psychology is based on godless assumptions and evolutionary foundations, it is capable of dealing with people only superficially and only on the temporal level … Scripture is the manual for all ‘soul work’”.

3.2.3.2.5 Popular Christian combatants

The following popular Christian combatants are examined:

a) Bobgan:

Bobgan and Bobgan argue that psychology is not only “psychoheresy”, but a “slam at the sufficiency of the Word of God” (English, letter to the editor, 17 June 1998). Koenig (2007) points out that Martin and Deidre Bobgan argue that Christians should abstain from mental healthcare, especially when such mental healthcare involves psychotherapy.

b) Jay Adams:

According to McMinn (1996), Jay Adams, former Professor of Practical Theology at Westminster Theological Seminary, is widely accepted as being a Christian combatant. McMinn states that Adams “argued that sin is the cause of virtually all psychopathology”. Likewise, Stanton (2003), a contributor to *Psychology and Christianity: Five Views (*Johnson, 2010:31) states that “Jay Adams … instigated the crisis with the publication of his widely read *Competent to Counsel* (1970), in which he severely criticized modern psychiatry and psychotherapy, arguing that they were “pervasively secular” and that they are “deterministic” humanistic methods as derived from Freud”. To illuminate Adams’ strong stance, Stanton (cited in Johnson, 2010:103-104) records his brief meeting with Adams:

> I met Adams in 1977 at a seminar on biblical counseling. I asked him what I could do to glorify God in my training as a clinical psychologist who was dedicated to remaining faithful to the clear teaching of Scripture. “Drop out of your training”, he replied, “because (1) psychology has nothing to offer the faithful Christian, and (2) everything needed for formulating an utterly comprehensive understanding of the human person and our problems can be found in or deduced from the Bible”. I walked away deeply confused, because I was indeed intent on being faithful to Scripture but (2) I could not see how the Bible could possibly provide all counsel on every issue, and (1) I found myself learning much of value about the human condition in my studies in psychology.

Ultimately Adams (1986a:9) remained firm in his belief that the field of counseling stood apart from the use of the Bible when he said:

> Biblically, there is no warrant for acknowledging the existence of a separate and distinct discipline called psychiatry. There are, in the Scriptures, only three specified

> sources of personal problems in living: demonic activity (principally possession), personal sin, and organic illness.

c) John MacArthur

Dr MacArthur, an influential theologian in Western academia, prolific writer and Seminary President of the Master's College, is widely known for his position on the Enemies: Christian combatant model. Entwistle (2004:203) reiterates this view when he states that MacArthur is by far the "most influential popularizer of the Christian combatant's movement". The researcher provides here this extended quote by MacArthur (John MacArthur on education – Psychology, 2014) to illuminate MacArthur's position on why he does not offer courses in psychology at his college:

> The answer is, by definition, psychology, the study of the soul; a secular, godless, unbiblical approach to understand humanity; designing solutions to their problems. But the truth is, man, in his fallen condition, cannot really make a completely clear and accurate assessment of the human condition; certainly, he cannot give true solutions to what goes on in life, unless you understand people the way the Bible lays them out as fallen, dead in sin, blind, cut off from the life of God, deceived and desperately wicked. You can't get to the solution. But human psychology doesn't see man that way. Human psychology because it's simply a reflection of the pride of man's fallen heart, overestimates man's capability, man's value, man's goodness; consequently never really gets to man's problem. Oh, by the way, as far as psychiatry goes, for many years, since Freud kind of invented that, all kinds of therapy techniques were tried, they kept falling by the wayside, falling by the wayside, until finally, a psychiatrist today basically gives people pills; they medicate them, which doesn't solve anything, but dulls the feelings of anxiety; that's not a solution to anything.

3.2.3.2.6 Overview of integration

While the researcher aspires to build a case for integration in the next chapter, for now, a brief overview of integration and its benefit should be established here.

Carter and Narramore (1979:13) define the concept of integration as the "interface" of any given discipline with theology. Likewise, regarding the nature of integration between the disciplines of psychology and theology, the researcher agrees with Entwistle's (2004:15) two determinants needed for the successful formulation of integration. Entwistle states:

> First, integration is predicated on identifying key Christian commitments that shape how we understand human beings, their relationship to God and to others, and their potentials and their problems. These commitments form a framework from which we study psychology, engage in research, and apply psychotherapeutic interventions.

> Second, integration requires that we have a firm grasp of the theories, methods, and findings of psychology.

Subsequently, the researcher maintains, that by adopting an integrationist view, it provides the Church the ability to enhance ministerial support in the church by adding cross training, thus producing equipped and well-trained counselors; that is, those trained in psychology and theology, to lighten the burden of church leadership. This is in agreement with McMinn's (1996:26) observation that "foundational competence for integration is insufficiently emphasized in most Christian counseling programs". It is this researcher's opinion that for Christian counselors and ministers, euphemistically one must be able to "chew on the hay and spit out the sticks"; that is, embrace good psychology and dispose of bad psychology. In agreement with this notion, Terruwe *et al*. (2016:188,198) purport as follows, on the role of integration in light of "psychic health"[13]:

> Medicine and theology will communicate with one another, when both sciences will base themselves on common philosophical presuppositions. A true science of man, and so also psychology and psychiatry needs to proceed beginning with an understanding of the healthy person – sinful or virtuous, but healthy, and with a common sense vision of human nature. Without such a base, which by nature is philosophical, psychology and psychiatry are incapable of even giving a definition of "psychic health". The transposition on healthy people of conclusions worked out through the observation of the sick or even worse of animals always ends in the mutilation of man. (Terruwe *et al*., 2016:loc. 188, para. 2-3; loc. 198, para. 1).

Interestingly, Ellis (1993, cited in McMinn, 1996:336), an atheist, observes the benefits of his contrasting position, namely, the integration of religion into psychology when he states, "I think that I can safely say that the Judeo-Christian Bible is a self-help book that has probably enabled more people to make more extensive and intensive personality and behavioral changes than all professional therapists combined". For those serving in a ministerial role within the Church, McMinn (1996:14) believes that Christian counselors who are best prepared to help people are those who are not only highly trained in counseling theory and techniques and in theology but also personally trained to reflect Christian character inside and outside of the counseling office.

[13] Terruwe, *et al*. (2016:229) note comments here concerning the definition of "psychic health": "Editors' note: Dr Terruwe and Dr Baars used the term psychic wholeness as referring to the emotional, intellectual, and spiritual aspects of the human person as well as the life of the will. It is unfortunate that this term has sometimes been confused with occult terminology. Therefore, throughout this revised edition of Psychic Wholeness and Healing the terms "psychic" and "psychological" will be used interchangeably and should be understood in the context of psychological wholeness and not as referring to anything mystical, magical or telepathic".

Likewise, he uses the term ‘multi-tasking counselor’ to describe a counselor who is able to consider simultaneous proficiency in psychology, theology, and spirituality. (McMinn, 1996:269). For Christian counselors who aspire to reach this level of proficiency, he summarizes the cross-training challenges they face as follows (McMinn, 1996:9-26):

- Moving from two areas of competence to three
- Expanding definitions of training
- Confronting the dominant views of mental health
- Establishing a scientific base.

Ultimately, after contemplating the ‘Biblical counseling only’ position, the researcher maintains that the argument against integration is a genetic fallacy, or fallacy of the source, or origin. That is, attacking the origin to discredit the position, or as Dancy *et al*. (2010:393) describe the fallacy: “Arguments based on origins are not always fallacious, but this kind of argument can be used as a sophistical tactic to try to transfer negative connotations in lieu of going into the real merits of an argument or practice”.

Even though this work supports an integrative counseling position, the researcher recognizes it is not without its limits. In summarizing this case for integration, the insight of Johnson (2017:355-356) distinguishes what this researcher would agree are the limits of general revelation’s influence on integration:

> The development of science is humanity’s God-given calling, part of the creation mandate, and God did not choose to reveal all his knowledge about humanity in the Bible. Rather, through Scripture God gives us a way of seeing the world (Powlison, 2003), including biopsychosocial damage, that accords with his omniscient understanding and that guides us toward his complete understanding and evaluation.

Another obstacle hindering a more effective response to mental health within the Church is an ill-informed understanding of the nature of the body and soul, namely, the ‘fragmented soul’, as discussed in 3.3.

3.3 The fragmented soul

3.3.1 What is the soul?

The normative Christian theological position of the nature of humans is dualistic, in that we are comprised of a unity of material bodies and immaterial soul that has its own "properties" (Habermas & Moreland, 1998:23). However, the researcher contends it is the unbalanced emphasis between the two – what Yarhouse *et al*. (2012) deem *the fragmented soul* – that impedes mental health counseling.

3.3.2 The soul and spiritual growth

The significance in understanding the proper nature of the soul within the Christian counseling worldview is that it lends itself to a more accurate diagnosis, which is preliminary to proper treatment, since, without the proper identification of causes, counseling results in a hit-or-miss scenario, at best. Or worse, this researcher contends, entering a Christian counseling assessment with faulty presuppositions about the nature of the soul, could lead to ministerial oversights and consequently impede mental health progress. For instance, Moreland (2014:17-18) explains that a proper understanding of the soul is needed in the process of spiritual growth; here he cites Willard (1998:82):

> In *The Divine Conspiracy*, Dallas Willard says that understanding the immaterial nature of the human spirit is crucial to grasping the essence of spiritual growth: "To understand spirit as 'substance' is of the utmost importance in our current world, which is so largely devoted to the ultimacy of matter".[14] Willard argues that without a careful grasp of the soul's nature, it becomes virtually impossible to develop a detailed model of spiritual formation. Thus, knowledge of "the existence and nature of the soul is crucial for our self-understanding and for developing a view about how to mature in the Way of Jesus".

Likewise, Gray (2010:638) points out the importance of the soul with regard to spiritual growth: "We all have a soul, but some have a more developed and refined soul than others, spiritual disciplines help us to allow God to develop our souls, and hence become better people, making better choices and stronger at resisting temptation".

[14] Willard, D. 1998. *The Divine Conspiracy*.

3.3.3 The obstacle of psychological accommodation

While there are those who overemphasize the soul's influence in driving mental health struggles – discussed in Chapter 2 as "hyper-supernaturalistic" considerations (Horton, 2014) – in contrast, there are those who overemphasize the biopsychosocial causes with little regard for the soul. The researcher contends this poses another obstacle impeding the proper view of the soul, within the Church, namely, an over-weighted reliance on psychology devoid of soul considerations in the counseling setting.

Yarhouse *et al*. (2012) observe that there has been a clergy care psychotherapeutic movement toward what Oden (1988:22-23) would deem "psychological accommodation". Likewise, Yarhouse *et al*., refer to Benner's (1998) explanation that this movement led to an increase in the distancing between the spiritual and psychological understanding of personhood. Yarhouse *et al*. (2012:13-14) add that according to Benner, psychological accommodation impacted church counseling settings as a by-product of the psychological and spiritual partitioning within man's essence by

- the Church "being judged to be relevant only to the spiritual part of persons"
- the Church "largely [abandoning] efforts to chart or offer guidance regarding matters of the inner life in its totality"
- an ultimate "displacement of clergy by psychotherapists as curates of the soul".

In addition, this over reliance by the psychotherapeutic movement underestimates any mental health causes and cures driven by spiritual determinants, such as the mind and soul. In like manner, both the Christian combatants and the Secular combatant community are missing the mark on the benefits of psychology – when using *psychological counseling* in isolation only, and considering a core component for proper mental health etiology and treatment, namely, *the mind*.

Counseling, apart from factoring in the soul and its influences on the mind, leaves Christian mental health caretakers to provide an answer apart from a systematic approach as described by Yarhouse *et al*. (2012:34), in the concept of the "fragmented soul":

> Diseases and remedies for each have become the purview of almost totally separate disciplines with separate ideologies, separate pathways of training and separate professional identities. Specialists in the “psychological” nature of persons can be trained without regard for the “spiritual” nature of persons, and experts in the “spiritual” nature of persons can be trained with little or no regard for the “psychological” nature of persons. We have accepted the idea of a fragmented soul, and so our attempts to understand the psychological nature of human pain and struggle (psychopathology) are often undertaken without regard for spiritual realities, historic Christian perspectives or an understanding of the spiritual implications of these views.

When considering the benefits of a systematic approach to human nature and whether or not the mind warrants such philosophical academic attention, Kenny and Kenny (1994:15) contend:

> Some people think of the mind as being a kind of inner environment, the polar opposite of the external environment of the physical universe. This, I shall argue, is not the correct way to think of the mind: the boundary between the mental and the material is not the same as the boundary between inner and outer. If we are to explore the geography of the mind, we must delineate the different mental faculties such as the intellect and the will; we must investigate the relations between the senses and the intellect; the contrast between outer senses and inner senses; the two kinds of imagination, fantastic and creative. The intellect is most helpfully thought of as the capacity for operation with signs, and the will as the capacity for the pursuit of rational goals. If we are to clarify what is meant by 'mind', we must also investigate the relation between the mind, the brain and the body.

When there is an overweighting of psychological accommodation, unfortunately, the role of sin may easily be overlooked in the counseling assessment process with great peril as well.

3.3.4 Personal sin and the soul in mental health

Johnson (2017:355-356), comments on the role personal sin plays on the impact of biopsychosocial mental health struggles as found in the Bible. He states:

> There are very few direct references to what we would call biopsychosocial deficits in the Bible (Wilkinson, 1998). “Madness” and “bewilderment of heart” were threatened as punishment for disobedience (Deut. 28:28). Saul had repeated bouts with paranoia (1 Sam. 18:12; 24:9) and homicidal intentions (1 Sam. 18:10-11) due to his disobedience and an evil spirit (1 Sam. 16:14-16), which were treated with music (1 Sam. 16:16, 23). David, we are told, once feigned madness (1 Sam. 21:10-15); and Nebuchadnezzar lost his reason as judgment for his arrogance (Dan. 4:29-37). In most of these instances, the cause of the psychological abnormality was designated as personal sin. This inspired perspective is in keeping with the emphasis of biblical revelation, especially in the Old Testament, on the revelation of sin and its destructive consequences, which God gave to form a strong ethical awareness in his people, ultimately to lead them to Christ (Gal. 3:24).

Interestingly, with reference to Saul's mental health struggles in 1 Samuel 18, Grcevich (2018:24), a psychiatrist, suggests not only a sin cause and effect when he observes: "The Spirit of the Lord departed from Saul after his disobedience led God to reject him as Israel's king"; in addition, he intimates that Saul's symptoms are indicative of obsessive-compulsive disorder (OCD).[15]

The interconnection between thoughts and the soul is uniformly noteworthy. Given that Yarhouse *et al*. (2012), as well as Kenny and Kenny (1994) argue that if thoughts trigger feelings and emotions, then memories, stored thoughts and associations, can add another layer to the understanding of how our emotional state can be derived from our soul, since memories influence the cognitive triad, ideas, emotions, and behaviors. Moreland (2019:129-130) supports this distinction:

> Memories and consciousness generally are not in the brain (when your soul leaves your body at death, your memories go with you because they reside in the soul and can exist without the brain). Rather, while we are in the body, events-especially traumatic ones – create grooves in the brain that, when triggered bring about a memory in the soul (as long as the brain is not damaged and you are "scanning" your past, trying to access the memory.

He continues with the example from Psalm 19:2-24, which "urges us to invite God to search us and know us, especially anxious thoughts we may have, the invitation applies to all our aspects–the body, and all its members, along with the soul and all its faculties (e.g., mental, volitional, emotional faculties)".

This informs us that counselors and ministers need to assess the role of sin and its theological implication for mental health. To do this, this researcher aims to treat the following example with caution, to avoid reading into Scripture any views that are not accurate; however, conceivably there is evidence found in the Bible where sinful behavior affects mental health.

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[15] Grcevich (2018:196) adds a footnote: "A common treatment strategy for patients suffering from obsessive-compulsive disorder is to provide distraction from recurrent, intrusive thoughts. Scripture suggests Saul was tormented by the realization he had been rejected by God as king and by the evidence that God's favor was upon David. David's music initially brought Saul relief by serving as a distraction from his obsessive thoughts. As Saul's obsessions became increasingly severe (see 1 Samuel 18:10-11), he twice attempted to kill David by hurling his spear at him. Extreme irritability and violent behavior are not uncommon in my experience of treating patients unable to obtain relief from their obsessive thinking".

One case, where the aftermath of sin may have been felt as bodily symptoms is that of King David in 2 Samuel 11:24. The outcome of David's sins, his behavior as well as the lack of confession, seemingly resulted in depressive psychological and bodily symptoms. Notice what King David says in Psalm 32:3: "When I kept silent about my sin, my body wasted away through my groaning all day long". Likewise, characteristic of sinful behavior affecting our mental state is referenced by Ryan (2018:419) who cites the following case as found in a prayer by the sons of Korah:

> Psalm 88 is sometimes taken as a passage that speaks very closely to the experience of depression. The psalmist expresses feelings of being cut off and forgotten by God and then laments: "You have put me in the lowest pit, in the darkest depths. Your wrath lies heavily on me; you have overwhelmed me with all your waves. You have taken from me my closest friends and have made me repulsive to them. I am confined and cannot escape; my eyes are dim with grief" (Psalm 88:6-9 NASV); "From my youth I have suffered and been close to death; I have borne your terrors and am in despair. Your wrath has swept over me; your terrors have destroyed me. All day long they surround me like a flood; they have completely engulfed me. You have taken from me friend and neighbor – darkness is my closest friend" (Psalm 88:15-18 NASV).

3.3.5 Obstacle of hyper-spiritualism

3.3.5.1 General

Subsequently, while there are those who overemphasize the biopsychosocial causes in a secular sense, with little regard for the soul, there are those who overemphasize the soul with little regard for the biopsychosocial. Consider these two observations, which the researcher agrees applies to the current state of integration in the Church.

Grcevich (2018:21-22) answers the question, "Why does the church struggle to minister to persons affected by mental illness?" by suggesting that "one possible explanation is that many Christians find it hard to integrate mental illness into our understanding of the relationship between our bodies, minds, and souls". In agreement, Apologist and theologian (Horton, 2014:20-22) in *Faith and Mental Illness* provides his theological understanding as to why the Church and seminarians may be creating a *toxic* position regarding mental healthcare. He states:

> We are not souls incarcerated in bodies, but body-soul creatures … Because we are psychosomatic (body-soul) unities, physical and spiritual issues intersect in ways that cannot be easily pulled apart. A person suffering from a spinal cord injury will be especially susceptible to bouts of spiritual depression, doubts, and even anger. The

> same is true of mental illness … When combined with a mind-body dualism that places mental illness exclusively on the spiritual side of the ledger, this linking of suffering to particular sins (and therefore its remedy of simply more faith and obedience) is toxic—both spiritually and physically. If psychology (more than psychiatry) as discipline reflects an obvious bias toward reductive physicalism, many conservative churches tilt toward a reductive spiritualism or moralism.

3.3.5.2 The body/organic causes of mental health challenges

Most Christians, even those holding to the Biblical Counseling 'only' model, recognize the premise that organic challenges can lead to mental health difficulties (MacArthur, 2005). Since there is broad acceptance of organic or bodily causes that lead to mental health struggles, indicating a reduced need to establish its case, the researcher will only add these brief observations to explain the significance of the body, in light of mental illness.

Johnson (2017:351) explains this significance as follows:

> Unfortunately, the current human condition entails the potential for many kinds of stigmas, including biological and psychosocial damage. People can have genetic defects; their bodies and brains can malfunction; they can experience catastrophic or chronic trauma, which can alter brain function; their thinking and emotions can be consistently distorted.

Additionally, in agreement with the evidence of a body/soul dualistic connection, when asked about how to address the most common of all psychiatric disorders, namely, anxiety, in an interview entitled, *Anxiety: Sin, Disorder, or Both*?, theologian, Piper (2014) responded:

> It is true that there are psychophysical conditions that make extreme anxiety and panic attacks, for example – uncontrollable phobias – a real life problem. So, there is a continuum for all of us but I do want to acknowledge for some in these unusual cases the believer needs very wise counsel from those who know him best and knows those physical and psychological conditions best. Here is the bigger picture, the physical brain and the spiritual soul are interdependent in ways we cannot physically see. This means that there are and always will be physical strategies as well as spiritual strategies for dealing with the conditions of our soul. That's a huge statement (par. 6).

Subsequently, the researcher will now consider the need to respond spiritually within the counseling setting towards mental health when the cause is personal sin.

3.3.6 A balanced integration view of the soul

While there are those who overemphasize the biopsychosocial causes of mental health struggles, with little regard for the soul, and there are those who overemphasize the soul with little regard for the biopsychosocial, it is the researcher's contention, as purported in these brief observations toward a balanced approach that must be considered when counseling within the CAMH model.

Firstly, as stated by Gray (2010:637): "It is important for mental health professionals to be clear about their own and the service users' underlying assumptions about human nature to optimise communication and prevent misdiagnosis".

Secondly, even though this work makes a case for the Integrative Counseling position, it is this researcher's contention, from anecdotal observance that it is not uncommon for Christian counselors to under-assess the biblical and spiritual causality of mental health issues.

Finally, this exhortation by Yarhouse *et al*, (2012:17-18) is critical given the current professional Christian counseling direction that under-emphasizes Biblical treatment:

> Many people, when faced with emotional problems, will turn to mental health professionals to sort out the complexities of their concerns. Symptoms are almost without exception organized and conceptualized with reference to contemporary diagnostic nosology (e.g., the Diagnostic and Statistical Manual of Mental Disorders, APA, 1994), and this may inform case conceptualization and treatment planning, though it may also foreclose prematurely on other resources, including those found within the historic pastoral care literature. As Oden observes, "It is time to listen intently to the scriptural text and early Christian writers. It is time to ask how classical Christianity itself might teach us to understand the providence of God in the midst of our broken and confused modern situation" (1991, p. 36). It is toward this end of "listening intently" to the Scriptures and the voices of Christians who have gone before us and paved the way for our understanding of human experience that we consider the "roots" of Christian caregiving in the historic ministry of pastoral care and some of the more contemporary "shoots" in theology and psychotherapy. Unfortunately, these contemporary trends, coupled with numerous other forces such as the advancement of the empirical study of human behavior, have led to the segregation of psychological and spiritual aspects of care and understandings of mental and emotional suffering.

3.4 Section summary

In light of the evidence presented to establish *The Interpretive Task* or the "Why is it going on?" – it is this researcher's claim that the obstacles interfering with "*giving an*

answer" (1 Pet. 3:15) to those struggling with mental health challenges within Christ's Church are:

- Acknowledgement of blind spots (Vazire & Wilson, 2012).
- The limited use of integrative counseling that optimizes Scripture and good psychology (English, 1990).
- Fragmented understanding of the nature of the body and soul (Horton, 2014); (Moreland, 2019).
- Multi-tasking counselors in need of more training and proficiency in psychology, theology, and spirituality (McMinn, 1996).

CHAPTER 4: THE NORMATIVE TASK

4.1 Introduction

In this chapter, the focus is on Osmer's (2008:4) third task, namely, the normative task, which focuses on the question “What should be going on?” According to Osmer (2008:4), the purpose of this task is accomplished by “using theological concepts to interpret particular episodes, situations, or contexts, constructing ethical norms to guide our responses, and learning from good practice”. Consequently, the researcher will review relevant literature to answer the third research question: “Are there special and general revelation parallels between Christian Apologetics and CBT to “give an answer” (1 Pet. 3:15) to those struggling with mental health challenges within Christ’s Church?” Osmer (2008:171) defined this cross-disciplinary dialogue as follows: “Cross-disciplinary dialogue, thus explores points of intersection and divergence at various levels (positive analogy). This sort of rational communication is possible because the members of different fields share common resources of rationality, in spite of their differences.”

Christian Apologetics is a systematic field that aims to present a rational basis for faith and the researcher will address the normative task systematically, using special revelation (Bible) and general revelation (creation). In synthesizing CAMH and CBT, this work will rely on the primacy of Christian Scriptures as the authoritative Word of God (special revelation) while utilizing the truths discovered in science (general revelation). This comprehensive approach will warrant a more consistent counseling outcome for the Christian Church by subsuming the scientifically verified outcomes of CBT into the Christian worldview framework. To accomplish this synthesis, clauses 4.2 and 4.3, respectively, will present a literature review by building a CAMH case for special revelation; a CAMH case for general revelation; and examine the significant contribution of CAMH by paralleling Christian Apologetics and CBT.

4.2 A CAMH case for special revelation

4.2.1 Background

Since the writer subscribes to the integrative counseling position, this section builds a case for integration by way of *Special Revelation* while extracting the data from

empirically supported science, or general revelation that only coheres with, or can even be subsumed into the Christian worldview. Notice the researcher is not suggesting the subtraction of the Christian worldview foundation with respect to securing solutions for the intellectual, emotional, and behavioral needs in the church, but it is the addition of efficacious science (general revelation). The researcher will build this case by way of special revelation to shepherd the flock's intellectual, emotional, and behavioral needs within the Church, as observed in the roles and responsibilities by way of scripture.

4.2.2 The role of the Church to minister and counsel

The Bible is clear that Christ responded to the great need to minister to the "hurting … those like sheep without a shepherd" (Matt. 9:35, 36) [by] traveling through the crowds and "healing the brokenhearted and binding up their wounds" (Ps.147:3). He modeled for us a pastoral care ministry established through the Church since Pentecost to "shepherd the flock" (1 Pet. 5:2). Similarly, the Bible teaches His followers to "bear one another's burdens" (Gal. 6:2), while offering their God-given talents for "the equipping of the saints for the work of service to the building up of the body of Christ" (Eph. 4:12, 13). Churches today are still responding to this call. Lifeway Research (2014:8) reports that only "28% of family members in a household of someone with acute mental illness indicate that their church provides care for the mentally ill".

Likewise, the following statistics (Lifeway Research, 2014:8) show that the expectation of suffering churchgoers to have their needs addressed, still remains:

- 56% of pastors, 46% of family members in a household of someone with acute mental illness, and 39% of individuals with acute mental illness strongly agree that local churches have a responsibility to provide resources and support to individuals with mental illness and their families.
- 69% of individuals with acute mental illness indicate churches should help families find local resources for support.
- 70% of individuals with acute mental illness would prefer to be counseled by someone in a local church who they could come to consider a friend.

When considering the role of counseling in the Church, MacArthur (2005:222) is emphatic that biblical counseling is for "all church members, not just the pastors and elders"; he further declares that "biblical counseling is not an option, a point on which

Scripture never equivocates". Likewise, he praises the Apostle Paul when referencing Acts 20:31, calling him "a true shepherd actively involved in ministry whenever he was needed ... when he saw fellow believers in trouble, he did not hide; he counseled them day and night". When addressing the nature of counseling within the Church, (MacArthur, 2005:222) clarifies what he deems has been "a widespread misunderstanding"; he states:

> For too long biblical counseling has been seen as an optional ministry in the church… Our Lord commanded believers to love one another, and to consider counseling an optional ministry is to withhold biblical love at the time it is needed most in the believer's life: when he or she is in trouble. As the apostle Paul commanded the Galatian believers, we must be about the business of restoring rather than ignoring such Christians. The greatest threat to the process of discipleship is the believer who is overtaken by sin. The man or woman with a continual pattern of sin needs help to change and to reestablish a pattern of growth. Thus Paul addressed all church members, not just the pastors and elders, when he said, "We urge you brethren, admonish the unruly, encourage the fainthearted, help the weak, be patient with all men" (1 Thess. 5:14). On another occasion, Paul reminded the believers in Rome of their responsibility to counsel and encourage each other, assuring them that they were "able also to admonish one another" (Rom. 15:14).

Subsequently, here are the fundamental points MacArthur (2005:222-225) uses to substantiate the role of counseling in the Church and why:

- The Church: Essential to Counseling: While counseling is a necessary part of the local church, we must remember that it is only one part. An hour of counseling once a week for the hurting people in the Church is not God's complete plan for their spiritual growth; it is only part of the plan. In God's blueprint for ministry, counseling synchronizes a part of the whole. Indeed, the most effective use of counseling is when it is part of the local church.
- Counseling: An Integral Part of the Church: Counseling must never be thought of as a weekly hour of magic, or an independent ministry conducted aside from the Church. Preaching, teaching, evangelism, discipleship, and counseling are all integral parts that make up effective, biblical ministry. The local church is the instrument Christ ordained to help believers grow into His likeness. It is the only organization—or better, organism—He promised to build, sustain, and use. Counseling is an essential part of the local church's ministry as it disciples and helps believers mature in Christ's image.

- The Pastor's Involvement and Leadership in Counseling: Counseling is the responsibility of each believer, and its only rightful arena is the church. These truths carry a strong implication: the pastor's involvement and leadership is crucial ... Paul reminded the Ephesian elders of his ministry to them, of his selfless sacrifice, and his bold, nouthetic confrontation (counsel) night and day as he ministered with tears. Paul dared not abandon his God-ordained duty.
- The Church is Incomplete without Counseling: When a pastor neglects the ministry of counseling others, crucial areas of his ministry suffer. For example, his preaching is dramatically affected. Paul said the weapons of our warfare are not carnal but spiritual, empowered by God to tear down the mental strongholds and arguments that have been raised against God.
- Counseling and the Pastor's Effectiveness: One of the most tragic reasons pastors do not counsel people and help them understand progressive sanctification is because the pastors themselves do not understand the doctrine ... That is why the pastor who desires to counsel biblically must become saturated with the truths of progressive sanctification and must come to terms with the sufficiency of Scripture. He must realize that when used correctly, God's Word can identify sinful thought processes and habits and replace them with biblical ones. If he is not counseling from the Word of God alone, he will often fail to differentiate between special revelation and human opinion, theory, or general advice.
- Counseling and Evangelism: Biblical counseling can also benefit the local church in evangelism. While many evangelistic tools are effective and worthy of attention, it is important to notice that the scriptural model always began by addressing the challenges, sins, or trials that a person was facing. Thus the biblical counselor who follows Scripture will not simply dispense the Word but will endeavor to listen and ask questions and then will present the gospel of Jesus Christ. Over the years, this method of counseling has been a highly effective tool for evangelism in our church.

4.2.3 The role of the Christian Apologist

The practice or praxis of the Apologist parallels that of the counselor, namely, correcting error. “Apologetics comes from the Greek word *apologia*” (Craig, 2010:13). Apologetics (“speaking in defense”) is a systematic field that aims to present a rational basis for a particular belief system by defending against objections and opposing ideas. In political terms, one would give a defense for policies and actions of those who maintain opposing positions over policies like legislating and spending. In Worldview Apologetics, such as atheism and theism, or Religious Apologetics, like Christianity, Islam, and Judaism, the Apologist defends each view accordingly. The Christian Apologist’s task is first, to be able to answer those questions with gentleness and respect; and second, to clarify truth claims. In describing the role of the Apologist, the succinct prescription for doing cognitive therapy in this twofold application is respect and clarification of truth claims. Additionally, to progress to being a capable Apologist, substantial training and education are necessary. Stott and Groothuis (2011:27) state:

> While apologetics in one sense may be considered a branch of theology, it also walks arm in arm with philosophy. A Christian-qua-apologist, then, must be a good philosopher (even if not a professional philosopher). This is non-negotiable and indispensable. As a logical and persuasive discipline, the connection of apologetics to philosophy is vital.

In light of the question that Craig (2010) asks: “Does Christian Apologetics add value to the faith of believers by using Apologetics?” He answers in the affirmative, with this supporting breakdown on the benefits of effective Apologetics (2010:14-21):

1. Shaping culture. This struggle is not just political. It has a religious or spiritual dimension as well. Secularists are bent on eliminating religion from the public square.

2. Strengthening believers.

    - First of all, knowing why you believe as well as what you believe will make you more confident in sharing your faith with others.
    - Second, apologetics can also help you to keep the faith in times of doubt and struggle. Emotions will carry you only so far, and then you’re going to need something more substantial.
    - Finally, the study of apologetics is going to make you a deeper and more interesting person. Studying apologetics is going to take you beyond all that to life’s deepest questions, questions about the existence and nature of God, the origin of the universe, the source of moral values, the problem of suffering and evil, and so on. As you wrestle with these deep questions, you yourself will be changed. You will become more thoughtful and well-rounded.

3. Winning unbelievers. By the very nature of the case, we should expect that most unbelievers will remain unconvinced by our apologetic arguments, just as most remain unmoved by the preaching of the cross. And remember, no one knows for sure about the cumulative effect of such arguments, as the seed is planted and then watered again and again in ways we can't even imagine … But we patiently plant and water in hopes that over time the seed will grow and bear fruit.

4.2.4 Apologetic mandate

The Christian Scriptures have a great deal to say about defending the Christian faith against untruths; below are the Biblical proof texts that support the case for Christian Apologetics.

- 1 Peter 3:15: "Always being prepared to [give] a reason for the hope that is in you."
- Philippians 1:7: "I am put here for the defense of the Gospel."
- Philippians 1:15-16: "Some, to be sure, are preaching Christ even from envy and strife, but some also from good will; the latter do it out of love, knowing that I am appointed for the defense of the gospel."
- Colossians 4:6: "Let your speech be always gracious, seasoned with salt, so that you may know how you ought to answer each person."
- Jude 1:3: "I found it necessary to write appealing to you to contend for the faith that was once for all delivered to the saints."

In Matthew 22:37, Jesus commands us to "love the Lord your God with all your heart and with all your soul and with all your mind". This verse implies that if God commands it, then defending the faith is the role of every Christian; it is not optional.

Even though in Ephesians 4:11-12 God calls some Christians to specific roles (such as, to be apostles, prophets, evangelists, pastors and teachers who assist in equipping His people for works of service), some roles are the responsibility for every Christian. For instance, we are not all called to be evangelists, yet, we are all called to evangelize, as evidenced in Acts 8:4: "Those who had been scattered preached the word wherever they went". Likewise, Jesus commanded us to "therefore go and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, and teaching them to obey everything I have commanded you. And surely, I am with you always, to the very end of the age" (Matt. 28:19-20). However, in the case of

Apologetics, even though there is not an official office (as assigned by Christ in Eph. 4:11-12), as an Apologist, the responsibility to evangelize rests with every believer (1 Pet. 3:15; Col. 4:6; Jude 3). This responsibility is magnified when it applies to those in positions of church leadership (including pastors, overseers, and elders); Apologetics; as well as teaching. The Bible qualifies these requirements as the entry conditions for church leadership:

- Now the overseer is to be above reproach, faithful to his wife, temperate, self-controlled, respectable, hospitable, able to teach ... (1 Tim. 3:2-3).
- An elder must ... hold firmly to the trustworthy message as it has been taught, so that he can encourage others by sound doctrine and refute those who oppose it (Titus 1:6-9).

4.2.5 Apologetic history

4.2.5.1 The early Church

For Christians throughout the history of the Church, God has identified valuable thinkers, including Apologists, to defend the Christian faith, not by might or by the sword, but by words and through writings. These Christian faith defenders like the Apostle Paul, Justin Martyr, and Polycarp defended the faith against opposing critics as far back as the first century. Sproul (2009) suggests that during a time when Judaism was accepted, Christianity did not have the privilege of legal protection and hence was forced to respond to persecution and intellectual offenses charging the new "sect" with accusations. According to Sproul (2009:15), the allegations included

> …destabilizing the governmental empire for not capitulating to its practices, holding "secret meetings" in places like the catacombs … the practice of "love feasts" (where early Christians partook in a common meal—including Holy Communion—attesting to their unity with Christ and each other) … rumors of incest and sexual perversion, and even cannibalism, the eating and drinking of human flesh and blood mistaken for "the practice of the Eucharist.

The Apologists rose to *give an answer* to defend Christianity against false claims. One of the early writings is the First Apology by Justin Martyr; a writing motivated to inform the emperor and challenge the false claims against Christianity.

Sproul (2009:14-14) explains:

> Justin Martyr argued that Christians were exemplary models of civic virtue, paid their taxes, and submitted to the civil laws, but were unable to confess Caesar as lord because Jesus was the one and only Lord worthy of worship. Justin, therefore, challenged the authorities to not convict Christians on the basis of invalidated rumors.

Those within the Church who refused to bow and worship the gods of Rome, like Polycarp, were executed for the accusation of atheism by the emperor Marcus Aurelius. Ultimately, Justin Martyr, in his affirmation in a theist God, was murdered for defending the faith in his *Apology* against atheism and polytheism. Throughout history, and even today, the torch is still carried by defenders of the faith. Some notables with prolific writings include, Augustine, Anselm, and Thomas Aquinas. More contemporary writers include G.K. Chesterton and C.S. Lewis. Modern-day Classical Apologists include, Dr. Edward Feser, Dr. William Lane Craig, and Dr. Winfried Corduan, Dr. Norman Geisler, and Dr. R.C. Sproul.

4.2.5.2 Old Testament examples

To establish the use of Apologetics in the Old Testament, Moreland (2015:2236-2246) writes:

> Regularly, the prophets appealed to evidence to justify belief in the biblical God or in the divine authority of their inspired message: fulfilled prophecy, the historical fact of miracles, the inadequacy of finite pagan deities to be a cause of such a large, well-ordered universe compared to the God of the Bible, and so forth. They did not say, "God said it that settles it, you should believe it!" They provided a rational defense for their claims.

In another account, God encouraged the Israelites with a reminder of His faithfulness; when challenged with doubt, He helps them overcome their trials and calm their fears with evidence through *signs and wonders*. As shown in Deuteronomy 7:18-19, there was enough evidence to ground their faith in Him: "you shall not be afraid of them; you shall well remember what the Lord your God did to Pharaoh and to all Egypt: the great trials which your eyes saw and the signs and the wonders and the mighty hand and the outstretched arm by which the Lord your God brought you out".

4.2.5.3 New Testament examples

To establish the use of Apologetics in the New Testament, Acts 17 provides us with a primary example of the use of Apologetics by Paul, when he courageously challenged two well-established schools of philosophy, the Epicureans and Stoics. The following verses show us how Paul:

- Persuaded “some of the Jews” to join him and Silas (Acts 17:4).
- Reasoned in the “synagogue with the Jews and with the Gentile worshipers, and in the marketplace daily with those who happened to be there” (Acts 17:17).
- Reasoned “every Sabbath … in the synagogue, trying to persuade Jews and Greeks” (Acts 18:4).
- Tried “persuading the people to worship God” (Acts 18:13).
- Came to Ephesus where “he himself entered the synagogue and reasoned with the Jews” (Acts 18:19).
- Entered the “synagogue and spoke boldly there for three months, arguing persuasively about the kingdom of God” (Acts 19:8).

Likewise, in Acts 5:40, the honored teacher of the law, Gamaliel’s “speech persuaded them”, and in Acts 18:28, “he [Apollos] vigorously refuted the Jews publicly, showing from the Scriptures that Jesus is the Christ”.

4.2.5.4 Jesus and Apologetics

Additionally, the use of Apologetics is evident too in the evangelism of Jesus, who, as He preached and shared the good news, often used evidence to establish who He is. The following texts attest to the evidence used by Jesus:

- In Luke 24:25-27, He fulfilled prophecy to confirm He is the Christ.
- In Matthew 12:38-42, He evidenced His resurrection as a sign to confirm His claim.
- In John 2:18-21, the Jews asked Him: “What sign do You show us as your authority for doing these things?” Jesus answered them, “Destroy this temple, and in three days I will raise it up”.
- In Mark 2:10-11, He says to the paralytic: “but that you may know that the Son of Man has power on earth to forgive sins”, and then bids the paralytic to “arise, take up your bed, and go to your house”.

- In John 10:37-38, Jesus says: “if I do not do the works of My Father, do not believe Me; but if I do, though you do not believe Me, believe the works, that you may know and believe that the Father is in Me, and I in Him”.
- In John 15:24, He refers to evidence of His miracles when He says: “if I had not done among them the works which no one else did, they would have no sin; but now they have seen and also hated both Me and My Father”.
- In John 20:29, Jesus says to Thomas, “because you have seen Me, you have believed. Blessed are those who have not seen and yet have believed”.

4.2.6 Apologetic efficacy

4.2.6.1 Introduction

However, it is Paul debating on Mars Hill (Acts 17:2-4) that remains one of the most agreed upon proof-texts demonstrating the use and effectiveness of Apologetics. Beckwith *et al*. (2004:42-43) points out that “indeed, in the passage from Acts 17:2-4 … Paul’s explaining, proving and persuading is directly associated with ‘large numbers’ of converts and undoubtedly played a role”. Among the *large numbers* saved, one included was a philosopher named Dionysius. Note this proof-text in Acts 17:34: “A few men became followers of Paul and believed. Among them was Dionysius, a member of the Areopagus, also a woman named Damaris, and a number of others”.

For the skeptic challenging the use and efficacy of Apologetics, Geisler (2012:28) responds:

> The charge is made that no one ever comes to Christ through apologetics. If this implies that the Holy Spirit never uses apologetic evidence to bring people to Christ, this is clearly false. C. S. Lewis noted that “nearly everyone I know who has embraced Christianity in adult life has been influenced by what seemed to him to be at least a probable argument for Theism” (Lewis, 173). Lewis is an example of an atheist who came to Christ under the influence of apologetics. The skeptic Frank Morrison was converted while attempting to write a book refuting the evidence for the resurrection of Christ [see Morrison, 2015]. Augustine tells in his Confessions how he was led toward Christianity by hearing a Christian debate an unbeliever. Harvard Law School professor Simon Greenleaf was led to accept the authenticity of the Gospels by applying the rules of legal evidence to the New Testament. God has used evidence and reason in some way to reach virtually all adults who come to Christ.

4.2.6.2 A deficient Apologetic

Today, in light of the contemporary culture, it is evident that the need for Apologetics may be more significant than ever. Moreland (2005, loc. 142-493), in his book, *Love Your God with All Your Mind: The Role of Reason in the Life of the Soul*, lists in his observations the aftermath of not remaining obedient to the Apologetics call that led to the "loss of the Christian Mind in American Christianity". He states that ignoring the call brings about:

- The emergence of anti-intellectualism
- Evangelical withdrawal began
- Anti-Intellectualism's impact on the Church
- A misunderstanding of faith's relationship to reason
- The separation of the secular and the sacred
- Weakened world missions
- Anti-intellectualism has spawned an irrelevant gospel
- A loss of boldness in confronting the idea structures in our culture with effective Christian witness
- Culture is secular
- Secularism is primary a view of knowledge
- Secular view of knowledge is responsible for unfortunate social trends
- In our scientifically oriented culture, traditional understanding of morality and related notation are considered passé
- Secular ideas have replaced the traditional view
- Scientific naturalism
- Postmodernism.

4.3 A CAMH case for general revelation

> "Where the truth is, in so far as it is truth, there God is". (Cervantes in Don Quixote, 1603:23.)

4.3.1 Background

It is this researcher's assertion that a significant obstacle constraining a more adaptive response to mental health within the Church is the often non-utilized use of general revelation, or extra-biblical truths when counseling or ministering to mental health sufferers.

Now, to *scientifically* corroborate the objective for the normative task, the researcher will appeal to extra-biblical knowledge by using scientific, empirically supported data with the vital goal of taking full advantage of the established truths discovered in God's general revelation to support the case for integration. While the researcher contends the case for integration should recognize that if all truth is God's truth and if Christianity is true, then scientific truth, assuming it is tested as valid, should never contradict Biblical claims such as found in the work of Pearce (2016). Likewise, even though science cannot account for, or test all there is in ultimate reality or even human experience, for instance, the laws of logic, ethics, value judgments (right and wrong), mathematics, beauty, and advancements in science it can aid the task of the Worldview Apologist such as seen in the modern discipline of the intelligent design movement. In like fashion, the primary motivation for this section is not only to establish scientific efficacy for psychology and theological interventions, but to align the goals of any science by seeing psychological science, as Worthington (2010:149) says: "as a derivative of philosophy … [which] attempts to conceptualize the nature of reality by observing, measuring, and quantifying life experiences". This researcher concurs with this goal as well as with that of Johnson (2010:293), who succinctly describes the goal of any science from the Christian perspective as "the increasingly comprehensive conformity of our understanding to God's absolutely comprehensive understanding or, as some have said, "to think God's thoughts after him"".

Moreland (2019:28) also attests to the application of general revelation as evidenced in special revelation, when he suggests:

> In valuing extrabiblical knowledge, our brothers and sisters throughout church history were merely following common sense and Scripture itself. Repeatedly, Scripture acknowledges the wisdom of cultures outside—for example, Egypt (Isaiah 19:11-13), the Edomites (Jeremiah 49:7), the Phoenicians (Zechariah 9:2), and many, many others. The remarkable achievements produced by human wisdom are acknowledged in Job 28:1-11. The wisdom of Solomon is compared to that of "all the people of the east" and "all the wisdom of Egypt" to show that it surpassed that of people with a longstanding, well-deserved reputation for wisdom (1 Kings 4:29-34). Paul approvingly quotes pagan philosophers (Acts 17:28), and Jude cites the noncanonical book Assumption of Moses in Jude 9.

To build on the premise that integration can enhance counseling applications, Moreland (2019:29) offers this insight on how to apply general revelation to mental health promotion as found within special revelation:

> The book of Proverbs is filled with examples in which knowledge, even moral and spiritual knowledge, can be gained from studying things (for example, ants) in the natural world. Once Jesus taught that we should know we are to love our enemies, not on the basis of an Old Testament text, but from careful reflection on how the sun and rain behave (Matthew 5:44-45). We can and must cultivate a Christian approach to anxiety and depression, but in that tilling we may also include the study of extrabiblical knowledge that supplements and does not contradict Scripture. I believe naysayers make two mistakes: (1) They have seen abuses of "all truth is God's truth" and have thrown the baby out with the bathwater, and (2) they fail to see the implications of a biblical view of the human person for developing and sustaining mental health.

Ultimately, the critical aspect in relation to this work is the connection between general revelation and special revelation within psychology. English (1990:229) succinctly explains the considerations those on the spectrum of integration must consider when counseling from a Christian perspective:

> Conversely, the truths of general revelation are not delineated for us by God. Instead, they are 'discovered" by fallible humans. At this point, it does not matter whether the 'explorer' is a Christian or an atheist. Truths discovered in general revelation must be studied and examined for their trustworthiness, regardless of the religious beliefs of the giver. There are good, solid methods of discovering truth in the experimental process, and many truths derived from appropriate processes can be adaptable and useful for the integrationist even if they are discovered by an atheist. Once the validity of a theory is proven, the theory becomes useful for the integrationist if it is compatible with Scripture. While the explorer may not be a Christian, the truth he or she discovers is still valid for the integrationist. For biblical counselors to ask integrationist[s] to delineate psychological truths that are as trustworthy as Scriptural truths is an absurd question that cannot be answered by integrationists or any scientist who studies any segment of general revelation.

In like fashion, Worthington (2010:149) states that another benefit when applying general revelation to the discipline of psychological science is that "psychological

science has developed specialized tools, and it continues to add new ones. These new tools and methods can help not only psychology progress but also advance our knowledge about God".

In light of the integration between Christianity and psychology, the researcher aligns with Integrationists like Entwistle (2004:260) who maintains that the "integration of psychology and Christianity is a multifaceted attempt to discern the underlying truths about the nature and functioning of human beings from the unique vantage points of psychology (in its various sub-disciplines, utilizing diverse methodologies) and Christianity (in theology, faith, and practice)". When factoring in the role of psychology, he states: "Psychological awareness of multiple determinants of behavior (genetics, social environment, reinforcement history) might help us understand why one individual struggles with certain sins while the same sins are not tempting for other individuals" (Entwistle, 2004:256). Regarding the benefits at the opposite end of the integrative pole, namely, the benefits of using the Biblical approach to the counseling process, he states: "Likewise, Christian theology could help us understand the pervasiveness of human sin that causes each of us to struggle with sin of some form or another" (Entwistle, 2004:256). In the same spirit of Entwistle (2004), Johnson (2010), sets up a case for integration based on the cultural shift thus evidencing an imbalance in integration where science now dominates the Christian contribution to psychology. Johnson (2010:25) posits the following:

> Which of the two communities exercise the most influence in our culture at large (in its universities, scholarly media, and mental health and therapy institutions), and which has the greater influence on the other? To state the obvious, it has been largely one-directional: the Christian community has had very little explicit, constructive influence on the contemporary psychological scene, and what influence it has had was accomplished by playing according to the rules of late modernism and not by being explicitly Christian. By contrast, the modern psychological community has had an enormous influence on the Christian community, within the latter's counseling centers and colleges and universities, some of its books, and even within its churches.

When responding to the "crisis" shift that is weighted in favor of secular influence, Johnson (2010:25) states:

> …psychology has amassed a stunning set of empirical findings regarding human beings and developed many psychological theories of great complexity, using novel empirical methods to discover aspects of human nature never before known, and so never discussed in the Christian tradition. Furthermore, this "new tradition" developed a dazzling array of systems and techniques for improving human psychological well-

> being, far outstripping in scientific complexity the work of the Christian tradition. Today we live in a science-oriented culture, and modern psychology has been more scientific than any of its predecessors and worldview alternatives. In addition, modern psychology has simply made what the majority of (mostly modernist) intellectuals today consider to be a compelling case: that its version of human beings is simply better than those that went before it–more accurate, more comprehensive and less distorted.

Just as good science in the intelligent design movement adjuncts and lends support to the certitude of Worldview Apologetics, the researcher contends there is room for the integration of theology with 'good' (true) psychological science. Perhaps this is what Moreland (2013:para. 5) has in mind when he implores the Apologetics community: "It's important for more Christian thinkers to try to understand how to integrate the contemporary findings of science with classic Christian Theology and Doctrine".

Interestingly, Moreland (2013) makes his case here for the Apologist to add science to defend against potential theological counterclaims. In other words, his work on the relationship between the brain and the soul offers a Christian defense for Worldview Apologetics as well as Mental Philosophical Apologetics; and thus, it has significant implications for mental health. For instance, his work on *Neuroscience and the Soul* (2013) at Biola's Research Center for Christian Thought, offers a defense to counter scientific arguments that there is no such thing as the soul. Notice, imbedded within this proposition, is that consciousness; Christian philosophical; theological, and ethical concerns, reside in the brain as opposed to the soul. The point here is, if we are only a body and brain (no soul), then psychotropic drugs (i.e., anti-depressants) will be the ultimate tool to help change human behavior. If drugs can induce change and positive behavior, and if consciousness resides in the brain, then what need would we have for a soul? Logically, the end in this slope is if we do not *need* a soul, then it must not exist; if the soul does not exist, then why do we need to posit a soul Creator (God)? For a balanced example from a theologian who recognizes the use of science in the field of mental health without compromising the nature of the soul – Piper (2014:para.8) reflects on the benefits gleaned from science within the practice of psychiatry:

> There will always be physical things you do and spiritual things you pursue and do in dealing with the condition of the soul. Which simply means there may be extreme cases that require special physical efforts like medication that provide a kind of equilibrium where the more natural strategies can have their best effects. In other

> words, medication may bring a person to the point where they could avail themselves more effectively of the God-given natural strategies.

Anecdotally, as a trained practicing therapist in the Gottman Method[16], who weekly, witnesses the work of couple's researcher's Gottman and Gottman (2018), it is the researcher's contention that the core empirically supported interventions used in the Gottman Method not only enhance principles found in Scripture, but the researcher is not aware of any of their interventions that are contraindicative to Scripture. Here, Worthington (2010:17) also recognizes the significance of Gottman's work:

> In the early 1990s, John Gottman, a clinical psychologist now retired from the University of Washington, upset most of the researchers who study marriage. He claimed that if he had ten minutes of videotaped interaction of a couple who were discussing a marital issue, he could with 94 percent certainty—not 93 percent, not 95 percent, but 94 percent certainty—predict who would remain together and be happy four years in the future. What really got the goat of other researchers who studied couples was how he proposed to make the prediction. If the couple had at least five times as many positive as negative interactions with each other, Gottman said they will be together and happy four years from today. Ninety-four percent certainty. But with less than a five to one ratio, they had better pack their bags and save four years of bitter decline (or hope to be one of the lucky 6 percent who defies the odds).

Notice, when there have been over four decades of secular research and data predicting extraordinary outcomes, one could easily understand the draw to adjunct biblical counseling with 'secular research' as long as it does not contradict or compromise the beliefs found in Scripture. As a practicing counselor, this researcher has noted Gottman's findings when counseling couples; and specifically those of Buehlman *et al*. (1992) that predict divorce with over 93 percent accuracy if the four horsemen of the apocalypse (criticism, contempt, defensiveness, and stonewalling) persist within the couple's conflict dynamic. In the book by Gottman *et al*., *The Science of Couples and Family Therapy: Behind the Scenes at the Love Lab,* Buehlman *et al.*

[16] "The Gottman Method is an approach to couples therapy that includes a thorough assessment of the couple relationship and integrates research-based interventions based on the Sound Relationship House Theory. They draw upon four decades of breakthrough research with more than 3,000 couples. The Sound Relationship House Theory is the foundation of the Gottman Method, which uses a practical approach to help couples break through barriers to achieve greater understanding, connection, and intimacy in their relationships" (cited from the Gottman Institute at Gottman.com).

(1992) explains this, thus providing additional support for how science and psychology have evolved:

> In that study the Buehlman coding of our Oral History Interview could predict divorce or stability in the next four years with 94% accuracy. A low carrying capacity for negative affect is strongly related to a negative story of us. With a low carrying capacity, a person is much more likely to see the partner as an enemy and not a friend. Whatever the partner says tends to be seen as adversarial. We discovered that people with a low carrying capacity for a partner's negative affect are more likely to: (1) escalate their own negative affect during conflict; (2) become more physiologically aroused during the conflict; (3) criticize their partner or withdraw, that is, stonewall during conflict; (4) report being unhappily married; (5) seriously consider separation and divorce; and (6) rate the interaction as negative in our video recall rating procedure. We also need to introduce another concept that is aligned with carrying capacity: whether or not the couple is connecting emotionally (loc. 2169).

Notice, within these findings, there is nothing in the data that is contrary to scripture even though it is arguably extra-biblical research.

4.3.2 Personal anecdotal feedback

4.3.2.1 General

As a licensed practicing professional counselor, this researcher often receives feedback from clients that the clinical methods of the Gottman approach seem to offer significant treatment results for the more challenging relationship conflicts between emotionally disconnected couples as opposed to the approach(s) often practiced today "by their pastor from the Church". For instance, the most new clients in session state that their reason for entering couples therapy is: "We tried talking to our pastor, but we feel we are being counseled with information that we already know; but we do not know why we are stuck and not seeing progress". What is the reason for this paradigm, especially if believers are taught that the Bible is "sufficient for teaching"? (2 Tim. 3:16). The answer may be found in what the researcher can personally attest to, namely that within those seeking help outside the Church, there seems to be increased requests for empirically supported interventions. Note, these requests are to adjunct, not replace, their pastor's counsel. Along with the couple's treatment taught by Gottman and Gottman (2018) and Johnson (2016), there are other scientifically supported interventions commonly requested by Christians that do not contradict Scripture, such as Cognitive Behavioral Therapy (CBT) (Beck, 2011); for individual treatment, eye movement desensitizing and reprocessing (EMDR) (Shapiro, 2013); for trauma

treatment, and exposure and response prevention (ERP), for extreme anxiety and obsessive-compulsive disorder (OCD) (Foa *et al*., 1986).

As the dialogue continues on the role of integration, it is obvious that reliable outcomes such as those just mentioned, mark the growing influence the impact of science is having on modern psychology; therefore, it is understandable that researchers like Worthington (2010:11) observe, “I’ll suggest that the relationship between psychological science and Christianity is more like an emerging marriage than either a war or a mere dialogue. Although there may be marital spats, there is potentially an intimate relationship”. In addition, Johnson (2010:26), replies likewise to the question: “Is Christianity a living or dead tradition of psychology and therapy?” by saying, “there is evidence … that it is very much alive!”

Subsequently, considering the fact that the field of research psychology is growing, there is an indication that demand is emerging for more research within the scope of religion and spirituality. To further illuminate the need for the integration of psychology and theology, consider the frequent mental illness case study examples given in 4.3.2.2.

4.3.2.2 Case considerations

This researcher would encourage all pastoral and ministerial readers to take an honest self-appraisal as to what course of action, or treatment plan would be followed if counseling any one of these regenerated, *[whose] soul prospers* (3 John 1:2) Christians, who requested an urgent intervention as they reported being in a crisis and felt like they were “having a nervous break-down”. In other words, what would be the next action step as a minister, during the confidential meeting, if the sufferer were shaking, crying, even reporting suicidal thoughts over their high level of distress, while revealing the information given in the following case studies:

> **Case 1**: “I need help for flashbacks, nightmares, panic attacks and heightening anxiety ever since I found out my husband has been cheating on me. Even though I want to repair my marriage, I forgave him, I do not want a divorce, I mean, we have three young kids to raise; however, honestly, I cannot get out of bed and what is worse, I cannot get these thoughts out of my head. Moreover, intimately, I do not even want him to touch me!”

> **Case 2**: “I have a strong *urge* to harm my wife! I have had scary thoughts about it for months; they are so intense. It feels like an impulse that I have to resist every day to not act on.”

> **Case 3**: “I am about ready to lose my job over lateness. I am late every day because it takes me an hour to shower each morning and 30 minutes checking the door before I leave my house.”

These above case illustrations are a sampling of what many professional counselors, including this researcher, have been accustomed to in various counseling settings; it is also what professional counselors and psychologists hear about and treat daily. In fact, adding in another layer of gravity – factor into the counseling case, church/state ethical regulations such as mandated reporting and congregational protection. Note that with ‘deeper’ cases, by abstaining from decision making, the decision not to act has been made – which could have dire consequences. In the example given in case 4, what plan of action would be required should an adult congregant in the Church report the following:

> **Case 4**: “I am having sexual obsessive thoughts and urges with my own children and the younger kids in Sunday school class.”

Considering these above cases, it is understandable that Adams (1986b:310) reports pastors have often been told, “This person’s problem is much too deep [the key word that is used all the time is ‘deep’] for a pastor to handle. He will need professional help. I will have to send him to a psychiatrist”. Although, for the anti-integrationist, the more relevant questions may be: Should I solicit more help in the above cases? Whose help will you appeal to after you eliminate from your referral network everyone who studied counselling or psychology, “since it is not needed?” (MacArthur, 2014), or, should you refer out, and to whom? These situations are the reality of a church community that have been operating without the advancements in psychology over the past few decades. Would the Christians from the above cases survive without seeking help from the very psychologists that could help, despite them not being ‘Christian’ counselors? Furthermore, if so, what quality of life would they have, or more importantly, what kind of life would they be forced to tolerate because of the lack of integrated treatment? For the most part, they may survive, just like people survived for centuries with migraine headaches, without eye glasses, and even antibiotics – without the benefits of empirically supported treatments. Of course, this ‘begs-the-question’, if these

innovations bring much-needed relief, why not also obtain treatment for mental anguish?

Teachers/ministers like Adams (1970) and MacArthur (2005) who affirm biological and spiritual etiology for mental health, would rightly treat these above cases by praying for, and offering biblical counsel to the sufferer; they may even refer the sufferer to their family doctor for an assessment. However, a seasoned, trained therapist would not only be familiar with these above cases, they would also be able to diagnose the cause of the mental anguish reasonably quickly; they would also be able assess the required integrated treatment using evidence-based practice in psychology (EBPP),[17] which has demonstrated high treatment success rates after decades of testing. What is critical, is that a trained clinician would know how to regulate and apply treatment for these cases; while also managing crisis risks to ensure safety and successful treatment. The point is that without the scientific research regarding human experience and decades of scientific testing, we would not know or have at our disposal proven mental health protocols that could treat the above cases. For instance, a trained therapist would apply effective treatments to cases 2, 3, and 4 such as Exposure and Response Prevention (Abramowitz, *et al*., 2003), and CBT (Beck, 2011), for they are textbook cases of mostly impotent, although, extremely terrifying: obsessive-compulsive disorder (OCD) that is a disorder "ranked by the World Health Organization (WHO) as among the 10 most debilitating disorders" (Lars-Göran *et al*., 2016:58). Moreover, for case 1, the wife suffering in the vortex of an affair, research has not only made it easy to discern her post-traumatic stress disorder diagnosis, but there are best practices shown to treat it (Glass, 2007; Gottman & Gottman, 2018; Shapiro, 2013).

In addition to the above common case examples, the researcher contends that the need for integration dates as far back as the 20th century; thus indicating that while the Church is making improvements in mental health promotion (Ryan, 2018) this offers confirmation of a lagging church response (Lifeway Research, 2014). Along with

[17] "Building consensus on the definition of evidence and ensuring that evidence-based practice in psychology (EBPP) recognizes not only the research but also the clinician's expertise and the patient's preferences, values, and culture is important to the future of the profession and quality patient care. Some psychologists believe that psychological interventions should be based solely on randomized clinical trials, while others believe that other forms of evidence have their value" (Levant & Hasan, 2008:658-662).

utilizing special revelation, around 80 years ago Jung (1937) (cited in Adler, *et al.*, 2014:342-343) noted the need to optimize sciences, the academy, and reason along with faith. He observed:

> We are now reaping the fruit of nineteenth-century education. Throughout that period the Church preached to young people the merit of blind faith, while the universities inculcated an intellectual rationalism, with the result that today we plead in vain whether for faith or reason. Tired of this warfare of opinions, the modern man wishes to find out for himself how things are. Furthermore, though this desire opens the door to the most dangerous possibilities, we cannot help seeing it as a courageous enterprise and giving it some measure of sympathy. It is no reckless adventure, but an effort inspired by deep spiritual distress to bring meaning once more into life on the basis of fresh and unprejudiced experience. Caution has its place, no doubt, but we cannot refuse our support to a serious venture which challenges the whole of the personality. If we oppose it, we are trying to suppress what is best in man—his daring and his aspirations. And should we succeed, we should only have stood in the way of that invaluable experience which might have given a meaning to life.

While the researcher used Entwistle's (2004) five categories for integration as given in Chapter 3, to demonstrate one sampling of integration, for simplification, the remaining sections of this work will be adapted into the following three categories as described by English (1990:22):

- Biblical Counseling: will refer to counseling which employs only the Bible for theories of personality and treatment and shuns any use of psychology.
- Integrative Counseling: will refer to counseling which utilizes both Scripture and psychology, but only when psychology does not conflict with Scripture.
- Psychological Counseling: will refer to the type of counseling which operates on psychology theories and does not use any biblical principles.

As proposed in the previous chapter regarding the case for integration, if there is benefit in both biblical and clinical counseling, logically, it opens the door to establish the need for additional spiritual research to enhance the counseling process.

4.4 The need for spiritual/religious research

4.4.1 Background

As stated above by Jung (1937), the demand for religious integration within psychotherapy was urgent – at least a century ago; therefore, one can conclude that the necessity for integration is even more pressing now, considering the fact that

congregants are still suffering unaddressed mental health challenges within the Church. Mowrer (1961:60), an atheist, even purported a “Moral Model” – thus alluding to the need for a spiritual remedy for man’s problems by saying:

> ...the patient’s problems are moral, not medical. He suffers from real guilt, not guilt feelings (false guilt). The basic irregularity is not emotional, but behavioral. He is not a victim of his conscience, but a violator of it. He must stop blaming others and accept responsibility for his own poor behavior. Problems may be solved, not by ventilation of feelings, but rather by confession of sin.[18]

This need within the Christian community has not gone without notice; the momentum to bring research to Christian claims has seen more focused labor in recent times.

4.4.2 Examples of Christian researchers

We see a growing contribution to the psychological research within the Christian academic commitment to science to enhance the mission and purpose of Christ’s Church. Yarhouse *et al.* (2012:17-18) frames the need to embrace Christian pastoral counseling this way:

> Many people, when faced with emotional problems, will turn to mental health professionals to sort out the complexities of their concerns. Symptoms are almost without exception organized and conceptualized with reference to contemporary diagnostic nosology (e.g., the Diagnostic and Statistical Manual of Mental Disorders, APA, 1994), and this may inform case conceptualization and treatment planning, though it may also foreclose prematurely on other resources, including those found within the historic pastoral care literature. As Oden observes, “It is time to listen intently to the scriptural text and early Christian writers. It is time to ask how classical Christianity itself might teach us to understand the providence of God in the midst of our broken and confused modern situation” (1991:36). It is toward this end of “listening intently” to the Scriptures and the voices of Christians who have gone before us and paved the way for our understanding of human experience that we consider the “roots” of Christian caregiving in the historic ministry of pastoral care and some of the more contemporary “shoots” in theology and psychotherapy.

Likewise, there is an indication that Christian research in psychology is advancing. As cited above, the Rosemead School of Psychology Biola University, *Journal of Psychology and Theology* cites such work, and they have been at the forefront of the

[18] As cited in Adams (1970), he states: “Religious terminology in Mowrer’s books must be translated. He redefines words like “sin” and “confession” in humanistic ways. He once told me that the Bible would be fine if the vertical dimension could be removed from it. Dr. Carroll R. Stegall, Jr.’s recent endorsement of Mowrer: “Dr. Mowrer at least knows where help comes from – God” (The Reformed Presbyterian Reporter, February 1967), is a typical instance of such a failure to “translate” and is a clear example of the kind of accommodation which Christians must avoid" (p. 268).

Christian academic community providing empirical research since 1973. The journal provides original, empirically supported, peer-reviewed, clinical and experimental information, both domestically and interculturally, built on the integration of psychology and Christian theology.

Below are other identified researchers:

- Dr. Fernando Garzon: A professor in the Center for Counseling and Family Studies at Liberty University is a licensed psychologist, and the Chair of the Institutional Review Board of Liberty University. Dr. Garzon's research interests and publications focus on spiritual interventions in psychotherapy. For an example of how his research corroborates biblical claims, his article, *Interventions that Apply to Scripture in Psychotherapy* (2005), empirically established that to be emotionally healthy, you have to be a person who is willing to let go and forgive past events.
- Dr. Harold G. Koenig: Director of the Center for Spirituality, Theology, and Health at Duke University. He has published extensively in the fields of mental health and religion, with nearly 400 scientific peer-reviewed articles and book chapters and 40 books in print. He is the former editor-in-chief of the *International Journal of Psychiatry in Medicine*.
- Prof. James P. Mooreland is a distinguished Professor of Philosophy at Talbot School of Philosophy at Biola University. He is philosopher, theologian and Christian Apologist, and is one of the few Christian Apologists actively challenging the materialistic view on neuroscience.

In the next section, the researcher will begin to establish the CAMH model by examining the significance between Christian Apologetics and CBT to harmonize precepts found in special revelation with the psychological science found in general revelation, starting first with the background of CBT.

4.5 The CAMH significance between Christian Apologetics and CBT

> "I say that we must talk to ourselves instead of allowing ourselves to talk to us". (Lloyd-Jones, 1965)

4.5.1 CBT: Introduction

4.5.1.1 Background

Figure 4-1 shows the rapid growth in publications in the field of CBT. Dobson *et al*. (2016:1-2) states:

> Cognitive-behavioral therapy has broad evidence as a powerful intervention for mental health problems in adults, and interest in this approach to psychotherapy has grown dramatically. A 2015 search of publications in the database PsycINFO using the keywords "Cognitive Behavioral Therapy" demonstrated an almost exponential growth of the field in the period from 1980 to 2014.

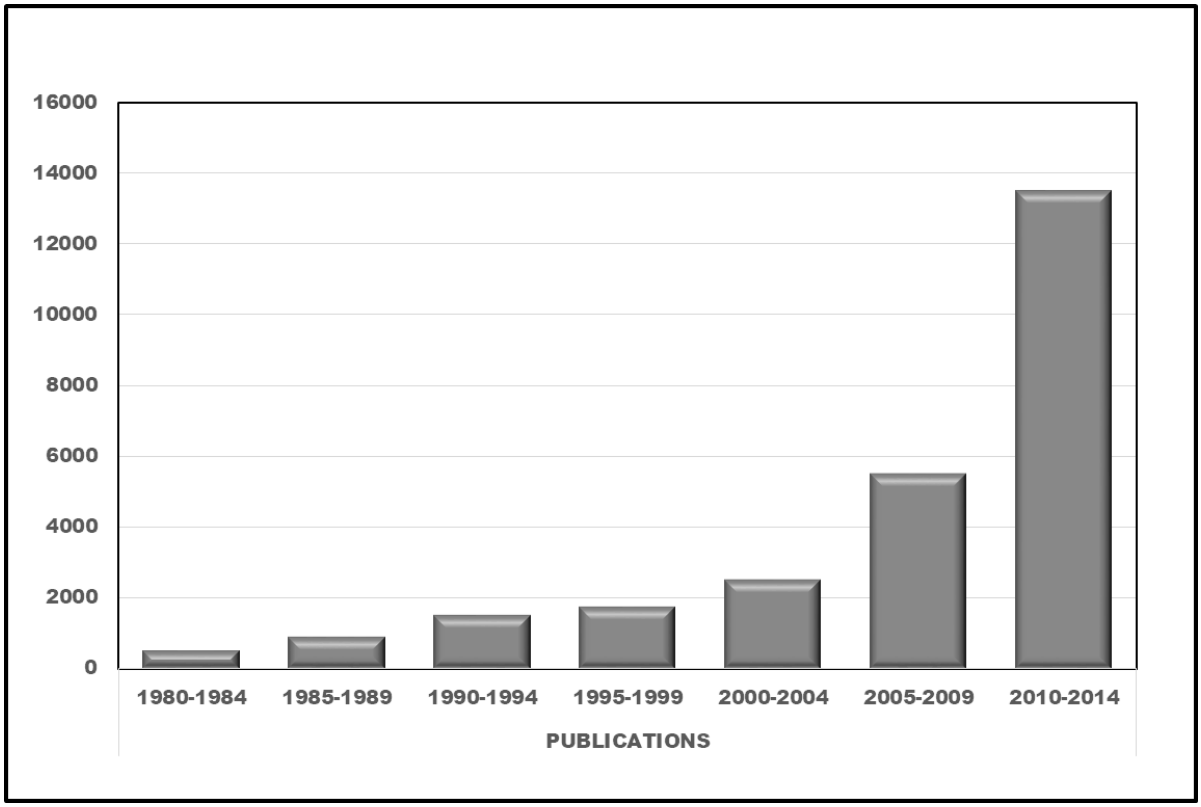

Figure 4-1: Increases in cognitive-behavioral therapy publications

Contemporary Apologist Dr. Gary Habermas, as a New Testament and resurrection scholar and philosopher of religion, is well recognized for his research defending the

Christian worldview. To highlight the impact of CBT for the Apologetics community, interestingly, even though counseling is not his professional vocation, Habermas (*Dealing with emotional doubt*, 2013) offers a strong endorsement for the practice and efficacy of CBT as an intervention. In a lecture on how Christians can deal with emotional doubt he stated:

> The only time I've gone back to school after doing my Ph.D. was to study a specific kind of psychology. Today it is the most revolutionary psychology taught by Christian and non-Christian counselors alike. Many people think it's thoroughly biblical. Now the most popular form of it is called cognitive or Cognitive Behavioral Therapy. Cognitive therapy is what we basically read in Philippians 4:8. Cognitive therapy says to use your thoughts to change the direction of your emotions. Here is what often happens. Have you ever wondered why you do things you do not want to do or you think things that you do not want to think? It is because we usually get the ball rolling and we start the bad thought and we start the bad action and this is often how it works. Think bad thoughts and you will feel pain. God made us this way. Think bad thoughts and you'll start feeling pain. If you think thoughts that have poor emotions for a long time you will change your behavior. Now I can go for the good like I'm going to start reading scripture every day, I'm going to start praying or it could go the other way where you can go deeper and deeper into your anxiety or your depression. I'm not a health care person but I've studied some of these principles and this is the most revolutionary one. It's the A.B.C. method. And this might be, I would think for all us, this would be one of the five most revolutionary things we could learn in our lives. It is absolutely life-transforming.

4.5.1.2 CBT defined

The American Psychological Association defines CBT as

> …a form of psychotherapy that integrates theories of cognition and learning with treatment techniques derived from cognitive therapy and behavior therapy. CBT assumes that cognitive, emotional, and behavioral variables are functionally interrelated. Treatment aims to identify and modify the client's maladaptive thought processes and problematic behaviors through cognitive restructuring and behavioral techniques to achieve change (cited in VandenBos, G.R. ed. 2015:202).

4.5.1.3 The history of CBT

Historically, the catalyst that initiated CBT decades ago was the discontentment of Dr. Aaron Beck with the long-term effects of psychoanalytic approaches that draw behavioral motivations from the unconscious. Dr. Judith S. Beck (2011:325), daughter of Aaron Beck and now president of the Beck Institute, describes the genesis of her father's work this way:

> A revolution in the field of mental health was initiated in the early 1960s by Aaron T. Beck, MD, then an assistant professor of psychiatry at the University of

> Pennsylvania. Dr. Beck was a fully trained and practicing psychoanalyst. A scientist at heart, he believed that in order for psychoanalysis to be accepted by the medical community, its theories needed to be demonstrated as empirically valid. In the late 1950s and early 1960s, he embarked on a series of experiments that he fully expected would produce such validation. Instead, the opposite occurred. The results of Dr. Beck's experiments led him to search for other explanations for depression. He identified distorted, negative cognition (primarily thoughts and beliefs) as a primary feature of depression and developed a short-term treatment, one of whose primary targets was the reality testing of patients' depressed thinking.

Hershfield *et al*. (2013:25) add that after noticing the strong reactions patients were having within testing to critical thoughts, "this led to an examination of how thoughts lead to emotions, and how emotions influence behavior". By understanding the experience between thoughts, emotions, and behaviors, CBT gained attention for its model of correcting the maladaptive thoughts, emotions, and behaviors as an agency to treatment.

4.5.1.4 Philosophical origins of CBT

Cognitive theory owes its genesis to the great philosophers but for now consider the influence that philosophy had on one of the progenitors of CBT, Dr. Albert Ellis:

> On November 8, 1991, in a memorial lecture for Alfred Korzybski, Albert Ellis stated: I never would have originated rational-emotive therapy (RET) had I not been strongly influenced by philosophers rather than psychotherapists. For when I founded RET in 1955, the field of therapy was almost completely run by clinicians, ranging from psychoanalysis to behaviorists, who firmly, and rather dogmatically, believed that people's early experiences, especially with their sacred parents, made them or conditioned them to become emotionally disturbed. [19]

In one of his earliest writings on Rational Therapy, Reason and Emotion in Psychotherapy (1962), Ellis explains that the philosophical underpinning of his theory is that individuals are more affected by their internal framing of events rather than the outside event itself; or, as he states, "he is affected by his perceptions, attitudes, or internalized sentences about outside things and events" (Ellis, 1962:54). Historically, Ellis explains the roots of this theory as follows:

> This principle, which I have inducted from many psychotherapeutic sessions with scores of patients during the last several years, was originally discovered and stated

[19] Ellis, A. 1991. General Semantics and Rational Emotive Therapy (RET). 8 November 1991. Albert Korzybski Memorial Lecture. *ETC: A Review of General Semantics,* 64(4):301-319. Accessed on 23 August 2007. Available from: http://learn-gs.org/library/ellis.htm

> by the ancient Stoic philosophers, especially Zeno of Cilium (the founder of the school), Chrysippus (his most influential disciple), Panaetius of Rhodes (who introduced Stoicism into Rome), Cicero, Seneca, Epictetus, and Marcus Aurelius. The truths of Stoicism were perhaps best set forth by Epictetus, who, in the first century A.D., wrote in the Enchiridion: "Men are disturbed not by the things, but by the views which they take of them." Shakespeare, many centuries later, rephrased this thought in Thimilet: "There is nothing good or bad, but thinking makes it so."

In agreement with the philosophical roots, along with understanding the significance of CBT, Dr. Beck's original treatment manual for depression also gives recognition to the early philosophers for his theoretical discoveries; notice:

> Moreover, following Ellis, at the beginning of *Cognitive Therapy of Depression* (1979), Aaron Beck and his colleagues explicitly claimed that the philosophical origins of their approach lay in the ancient Stoic tradition … Like Stoicism, Eastern philosophies such as Taoism and Buddhism have emphasized that human emotions are based on ideas. Control of most intense feelings may be achieved by changing one's ideas.[20]

Likewise, Robertson (2010:6) points out the early philosophers recognized its promise; he states: "History gives us several outstanding instances of people who change themselves and helped changed others by hard-headed thinking: Zeno of Citium, for example, who flourished in the third century B.C., and founded the Greek Stoic school of philosophy…"

4.5.1.5 Efficacy of CBT

To answer the question, "Does Cognitive Behavioral Therapy work?" the evidence affirms that, indeed, it is "successful" (Beck, 2011). In light of counseling theory, cognitive therapy is often listed at the top of the popularity hierarchy for treating the broadest and the most challenging gamut of psychological disorders (Beck, 2011). David *et al.* (2018:para. 3), argue in the affirmative that "CBT is the *gold-standard* psychological treatment as the best standard we have in the field currently available—for the following reasons: [see also Hofmann *et al*. (2012)[21] [22]].

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[20] Cited in Beck *et al*. (1979:8).

[21] Hofmann, *et al*. (2012).
The researcher notes the parsing of what David *et al*. (2018:para. 2) define as *gold-standard*: "We think that many issues factor into the *gold-standard* designation. If *gold standard* is defined as best standard we can have in the field, then, indeed, CBT is not the *gold standard*, and CBT, as a progressive research program, would not even argue for such a status at this moment. However, if *gold standard* is defined as best standard we have in the field at the moment, then we argue that CBT is, indeed, the *gold standard*."

(1) CBT is the most researched form of psychotherapy.

(2) No other form of psychotherapy has been shown to be systematically superior to CBT; if there are systematic differences between psychotherapies, they typically favor CBT.

(3) Moreover, the CBT theoretical models/mechanisms of change have been the most researched and are in line with the current mainstream paradigms of the human mind and behavior (e.g., information processing).[23]

The popularity and efficacy of CBT have been researched more extensively than any other therapeutic approach worldwide, with more physicians and psychiatrists referring their patients for cognitive therapy to treat the widest of all disorders. Beck (2011:4-5) states:

> Cognitive behavior therapy has been extensively tested since the first outcome study was published in 1977 (Rush, Beck, Kovacs, & Hollon, 1977). At this point, more than 500 outcome studies have demonstrated the efficacy of cognitive behavior therapy for a wide range of psychiatric disorders, psychological problems, and medical problems with psychological components (see, e.g., Butler, Chapman, Forman, & Beck, 2005; Chambless & Ollendick, 2001) ... Studies have been conducted that demonstrate the effectiveness of cognitive behavior therapy in community settings (see, e.g., Shadish, Matt, Navarro & Philips, 2000; Simons *et al*., 2010; Stirman, Buchhofer, McLaulin, Evans, & Beck, 2009) ... And several researchers have demonstrated that there are neurobiological changes associated with cognitive behavior therapy treatment for various disorders (see, e.g., Goldapple *et al*., 2004). Hundreds of research studies have also validated the cognitive model of depression and of anxiety. A comprehensive review of these studies can be found in Clark and colleagues (1999) and in Clark and Beck (2010:4-5).

Table 4-1 gives a partial list of the disorders that have been successfully treated by CBT (source: Beck, 2011:4).

[23] David *et al.* (2018:para. 2) add: "At the same time, there is clearly room for further improvement, both in terms of CBT's efficacy/effectiveness and its underlying theories/mechanisms of change. We further argue for an integrated scientific psychotherapy, with CBT serving as the foundational platform for integration".

Table 4-1: List of disorders successfully treated with CBT

Psychiatric disorders	Psychological problems	Medical problems with psychological components
Major depressive disorder	Couple problems	Chronic back pain
Geriatric depression	Family problems	Sickle cell disease pain
Generalized anxiety disorder	Pathological gambling	Migraine headaches
Geriatric anxiety	Complicated grief	Tinnitus
Panic disorder	Caregiver distress	Cancer pain
Agoraphobia	Anger and hostility	Somatoform disorders
Social phobia		Irritable bowel syndrome
Obsessive-compulsive disorder		Chronic fatigue syndrome
Conduct disorder		Rheumatic disease pain
Substance abuse		Erectile dysfunction
Attention-deficit/hyperactivity		Insomnia
Health anxiety		Obesity
Body dysmorphic disorder		Vulvodynia
Eating disorders		Hypertension
Personality disorders		Gulf War syndrome
Sex offenders		
Habit disorders		
Bipolar disorder (with medication)		
Schizophrenia (with medication)		

In light of the broad-based use of CBT, Robertson (2010:loc.:75-82) states:

> In The United Kingdom (UK) the National Institute for Health and Clinical Excellence (NICE) … has taken the next logical step and funded cognitive-behavioural therapy training as part of the Improving Access to Psychological Therapies (IATP) programme. Stressed, depressed, and anxious citizens cost countries billions of pounds, according to the research data.

Likewise, Knapp (2016), reports the following regarding randomized controlled trials (RCTs) on CBT:

> …there has been a steady dissemination and adoption of the cognitive-behavioral therapies in practitioner's clinical work in a wide array of psychiatric and medical conditions. The high number of randomized clinical trials conducted in a single year, with worldwide study samples, reporting an increasingly widespread use for different clinical conditions, demonstrates a definite consolidation of cognitive behavioral therapies in the contemporary therapeutic scene.[24]

In a broad sense, when considering whether CBT is worth the time and even worth the economic treatment efforts, Chisholm *et al*. (2016:3) suggest, "CBT's return on

[24] See: *CBT: Review of Randomized Trials*. Available from: https://www.beckinstitute.org/cbt-review-randomized-trials/

investment is substantial; an economic analysis estimated that the costs of treating anxiety and depression using evidence-based procedures, such as CBT, in 36 countries between 2016 and 2030 are $147 billion USD".

4.5.1.6 Theoretical assumptions of CBT

Underlying the theoretical assumptions within the nature of CBT are these core postulates: The Cognitive Model, Automatic, Intermediate and Core Thoughts/Beliefs, Meaning Assignment, Focus, and Validity of Cognition.

4.5.1.7 The cognitive model

According to Beck (2011:31), the cognitive model is the "theoretical basis" underlying CBT, which posits that "people's emotions, behaviors, and physiology are influenced by their perception of events". Figure 4-2 (adapted from Beck, 2011:30), illustrates that "it is not a situation in and of itself that determines what people feel, but rather how they construe a situation" (Beck, 1964; Ellis, 1962).

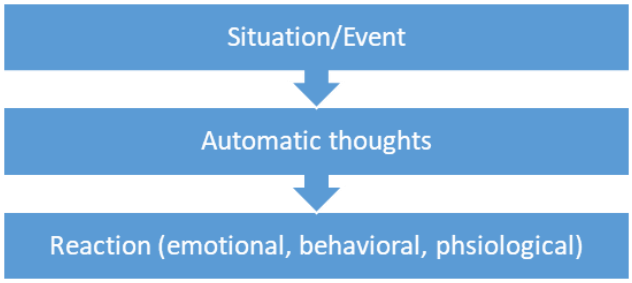

Figure 4-2: Thought progression in a given situation

In other words, if one finds oneself in a situation/event, often called a "trigger" in counseling, the outcome, or reaction, will follow; this means, it is less about the situation/event (trigger) and more about the automatic thought about the situation/event (trigger) that leads to the reaction. For instance, one person may awake in the morning, look out the window to find it snowing outside (situation/event/trigger), and have the emotion (reaction) of joy, created by the automatic thought, "Yay, we get to go skiing today!" In contrast, for another person, the same (situation/event/trigger), snowing outside, elicits an emotion (reaction), driven by the automatic thought, "Oh no, I have to shovel snow all day today!"

4.5.1.8 The generic cognitive model

The Generic Cognitive Model, as defined by Hofmann and Asmundson and Beck (2013:199-212), states that “perceptions of situations, rather than the situation itself, directly influence emotion, physiology, and behavior. Situation-specific thoughts or automatic thoughts typically arise spontaneously are often brief and fleeting, take the form of a thought or image, and are regarded as true without reflection or evaluation”. Likewise, “Professor Keith Dobson, one of the leading authorities in the field of CBT, asserts that “Cognitive activity affects behavior”; and when cognitive activity is monitored and altered then the “desired behavior change may be affected through cognitive change”. (Dobson & Dozois, 2001:4, cited by Robertson, 2010:3). Clinically, the process of thoughts driving or prompting feelings and behaviors has been named the *mediation hypothesis*, and is explained by Dobson and Dobson (2016:5-6) as follows:

> The mediation hypothesis states that our thoughts mediate our emotional and behavioral responses to the various situations in which we find ourselves. The cognitive-behavioral model does not endorse the idea that people simply have an emotional response to an event or situation, or simply act without any cognitive processes, but rather, the model holds that the way that we construe or think about the event is pivotal to the way we feel.

The counseling and clinical significance here, as Beck (2011:3) explains is, “in a nutshell, the cognitive model proposes that dysfunctional thinking (which influences the patient’s mood and behavior) is common to all psychological disturbances”. Likewise, the basic model here not only runs across all disorders, such as the “partial list of the disorders” given in Table 4-1, but can even be explicitly tailored “for any given disorder” Beck (n.d., online training: Module 3).

As seen in Figure 4-2, thoughts lead to reactions; and the cognitive model suggests that each point on the cognitive triad of thoughts, emotions, and behaviors can be the originating source that affects the other points. Figure 4-3 shows the interplay between each point on the triangle.

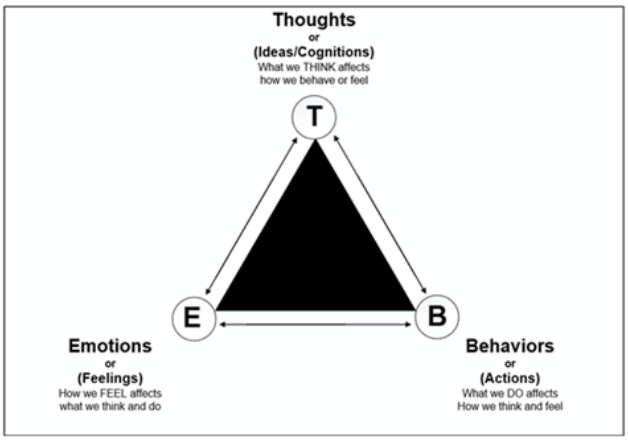

Figure 4-3: Cognitive interplay

Beck (2011; 2013:199-212) explains this 'interplay':

> The core model of CT holds that cognitions causally influence emotions and behaviors and, in the case of dysfunctional thoughts and cognitive distortions, contribute to the maintenance of psychopathology. It should be noted that the relationship between emotions and cognitions is bidirectional because changes in emotions can also lead to changes in cognitions. The CT model simply builds on the fact that emotions are strongly, and causally, influenced by the perception of events or situations.

One of the underlying hypotheses of the cognitive model that ultimately drives CBT, is that our thoughts give rise to the interplay between our emotions and ultimately our behavior. Additionally, Dobson and Dobson (2016:5-6) explain this concept and the implications thereof, as follows:

> The mediation hypothesis states that our thoughts mediate our emotional and behavioral responses to the various situations in which we find ourselves. The cognitive-behavioral model does not endorse the idea that people simply have an emotional response to an event or situation, or simply act without any cognitive processes, but rather, the model holds that the way that we construe or think about the event is pivotal to the way we feel. Similarly, it is our cognitions or thoughts that strongly influence our behavioral patterns in various life situations. For example, we feel anxious only when we view a situation as threatening. When we have a "threat cognition", we are also likely to attempt to escape the situation or to avoid it in the future, if possible. These thoughts, as well as the corresponding emotional responses and behavioral reactions, may all become routine and "automatic" over time. Even in cases where emotional and behavioral responses seem to be reflexive, though, cognitive behavioral theorists argue that there is cognitive mediation between the event and the person's typical responses in that situation.

It is clear, our thoughts, and as stated above, often our 'automatic thoughts' play a pivotal role in the interplay with the other two points, namely, our emotions and behaviors. Clause 4.5.2 will examine the nature of automatic thoughts.

4.5.2 Apologetics and CBT on offense

4.5.2.1 Background

To set up the following sections, namely, core beliefs; intermediate beliefs; automatic thoughts; meaning assignment, and focus, the researcher here will offer a glimpse into the rest of this work while reserving the remaining content for the next chapter – for the Apologist and minister to begin understanding 'what to listen for' so as to effectively respond in a counseling setting; as: "*Every battle is won before it's ever fought*". (Sun Tzu: The Art of War)[25]

For the Apologists, who from their training, already have a sensitive radar to identify an error, notice that while examining the nature of beliefs and thoughts as defined by CBT theorists – that 'doing' cognitive therapy is 'doing' Apologetics!

This researcher asserts that it is clear that Apologetics praxis is aligned with the role of the counselor in terms of identifying errors. Notice in the quote below the language and concept similarities between CBT and Apologetics praxis; such as validity; truth value; perception; inferences; faulty thinking, and reality. Beck (1976:244-245), states:

> It generally does not occur to a person to question the validity of his thoughts. He tends to regard ideas as though they were a microcosm of the outside world. He attaches the same truth value to his thought as he does to his perception of the external world. Even after a patient is able to make a clear distinction between his internal mental processes and the outside world that stimulates them, it is still necessary to educate him regarding the procedures for acquiring accurate knowledge. People continually set up hypotheses and draw inferences. They tend to equate an inference with reality and to accept a hypothesis as though it were a fact. Under ordinary circumstances, they might be able to function adequately because their ideation may be sufficiently in phase with the real world so as not to substantially interfere with their adjustment.

To 'do' cognitive therapy, counselors perform cognitive restructuring. In its straightforward form, therapists collaboratively work with mental health strugglers by helping them identify their beliefs and evaluate them. If the belief is inaccurate, the therapist then helps them to challenge and correct the misbelief (Beck, 1976). Note, a

[25] The quote cited above is popularly paraphrased. This original translation is: "Now the general who wins a battle makes many calculations in his temple ere the battle is fought. The general who loses a battle makes but few calculations beforehand. Thus, do many calculations lead to victory, and few calculations to defeat: how much more no calculation at all! It is by attention to this point that I can foresee who is likely to win or lose" (Tzu, S., *The Art of War*. 5th Century:1.26).

critical component within the praxis for the Apologist and the counselor is the ability to assess, and from personal experience as a practitioner in both fields, *very* quickly determine one's conclusion to check if it is inaccurate. This point is critical in the practice of both counseling and Apologetics: that is, the ability to trace the thinking, as rightly pointed out by Beck by "following the route to the conclusions" (1976:245-246).

4.5.2.2 Core beliefs

A *worldview* is a lens through which we view and interpret all aspects of life as well as deduce meaning. Zondervan and Nash (1992:10) define a worldview as "a conceptual scheme by which we consciously or unconsciously place or fit everything we believe and by which we interpret and judge reality". Most of us adopt our worldview in an uncritical and reactionary way without evaluation. Lawhead (2006:xxv), explains how we acquire our worldview:

> We catch our beliefs and values the way we catch a cold … however, you usually do not know that you caught the cold … What happened is that the cold virus was floating around in your environment, and you simply breathed it in, and now it is part of your internal system.

Our worldview is inescapable, so the issue is not 'if' we have a worldview, the issue is "Is our worldview consistent and coherent?" In other words, does it factor in all the data? The significance of a consistent and coherent worldview is that we operate from it; so it is only rational that our worldview drives every aspect of the way we live out our lives.

In contrast to the philosophical and apologetic idea of *worldviews*, it is the parallel concept within mental health and CBT, namely, our cognitive worldview, as derived from our *core beliefs.*

Neenan and Dryden (2011:5) explain *core beliefs* as follows:

> These are the fundamental beliefs about ourselves (e.g., 'I'm weak'), others (e.g. 'People will walk all over me') and the world (e.g. 'It's harsh and uncaring') that help us to make sense of our life experiences. We usually have both positive (e.g., 'I'm great') and negative (e.g., 'I'm useless') core beliefs. … Core beliefs can also be recently acquired, such as by experiencing a traumatic incident, e.g., a person who has always seen herself as strong and resolute fails to 'bounce back' from a serious car accident and concludes that she is weak and pathetic.

Beck (2011:35) concurs, and citing the observations of Rosen (1988), suggests that our core beliefs begin in childhood, and form as a result of children "trying to make

sense of their environment" to "organize their experience in a coherent way in order to function adaptively". Beck (2005:21) explains how our experience delineates and forms our adaptive versus maladaptive core beliefs:

> As children struggle to make sense of themselves, other people, and their worlds, they develop organizing concepts in their minds. They actively seek meaning and continually fit new data into existing schemas or templates. When childhood experience is perceived negatively, children often begin to attribute negative qualities to themselves. If they have enough meaningful positive experiences, they may see themselves in a negative light from time to time, but they basically believe that they are okay: reasonably effective, reasonably likable, reasonably worthwhile. If they do not, they may begin to develop negative views of themselves, their world, and/or other people. If these negative concepts become organizing structures in their minds, children may begin to process information in a distorted and dysfunctional way, perceiving and focusing too strongly on the negative and discounting or failing to process positive information.

As to how these, often, "latent" (Otani *et al*., 2017:2585) beliefs influence our daily emotions and behaviors, Gurman and Messer (2003:229) maintain that "Individuals develop idiosyncratic belief systems that guide behavior. Beliefs and assumptions influence an individual's perceptions and memories and lead the memories to be activated by specific stimuli or events". Moreover, rationally, as an inaccurate worldview leads to negative consequences, we can likewise suffer psychologically when our core beliefs are negative and maladaptive. When leading psycho-educational groups, this researcher witnessed innumerable times a pattern that seemed to resurface within the majority of mental health sufferers. Over time, this pattern became easier to identify and assess. It was if *all roads led to Rome* for it was the culprit driving the majority of patients into the vortex of psychological anguish. The observation was: a patient's emotions, guided by personal negative assumptions (or lies defined by the Christian worldview), slotted into these three engrained negative core beliefs: "I'm insignificant," "I'm inadequate," and, or therefore, "I'm unworthy of love".

Paralleling this observation, Beck (2011:228) identifies three categories for negative core beliefs:

1. Helplessness
2. Lovability
3. Worthlessness

Listed here are examples of how these beliefs present as ideas, or in dialogue, within these three categories; in other words, practically, these are cues counselors listen for when working with struggling counselee's (Beck, 2011:233):

Helpless core beliefs:

I am incompetent	I am out of control
I am ineffective	I am a failure
I can't do anything right	I am defective [i.e., I do not measure up to others]
I am helpless	I am not good enough [in terms of achievement]
I am powerless	I am a loser
I am weak	I am vulnerable
I am vulnerable	

Unlovable core beliefs:

I am unlovable	I am defective [so others will not love me]
I am unlikeable	I am not good enough [to be loved by others]
I am undesirable	I am bound to be rejected
I am unattractive	I am bound to be abandoned
I am unwanted	I am bound to be alone
I am uncared for	I am different
I am different	
I am bad [so others will not love me]	

Worthless core beliefs:

I am worthless
I am unacceptable
I am bad
I am immoral
I am evil
I don't deserve to live

In similar fashion regarding core beliefs about the self, we can also have negative core beliefs about other people and our worlds. For instance, Beck (2011:229) identifies these global beliefs as:

- Helpless
- Other people are untrustworthy
- Other people will hurt me
- The world is a rotten place
- The world is dangerous.

Paralleling the above categories, trauma therapy pioneer Shapiro (2013:76) identifies those distortions usually fall into the following three categories:

1. Responsibility: i.e., inadequate or defective, I'm not good enough.
2. Lack of safety: i.e., a child may be afraid to fly after seeing a plane crash in a cartoon.
3. Lack of power/control: i.e., "Where does my dog go when he dies?"

These core beliefs are not only potent, but theorists also suggest that mental health sufferers deem them as "so fundamental and deep that they often do not articulate them, even to themselves", and they are regarded as absolute truths or just the way things "are" (Beck, 1987, cited in Beck, 2011:32).

Contrary to negative core beliefs, Beck (2011:228) suggests that people do have "relatively positive and realistic core beliefs (for example, "I am substantially in control"; "I am a functional human being"; "I am likable"; "I am worthwhile".

The significance here is that our core belief systems drive how individuals react in their thoughts, feelings, and behaviors to their life experiences. A core belief could be triggered in a variety of ways, such as receiving a bad employment review or low score on an exam. If a person has negative core beliefs of incompetence (that was adapted from his/her worldview), then an automatic (activated – mostly unknowingly) thought could set off that core belief. Once this negative core belief of incompetence is activated, then more often than not, an equal negative feeling follows, which, if not corrected, could lead to negative behaviors (acting out). Since our disempowering beliefs highly influence our behaviors/actions, in agreement with Gurman and Messer (2003:245), we can see that "the limits of our words are the limits of our world".

Lastly, within the nature of core beliefs, they not only activate negative thoughts, but it is also suggested that events can even reinforce existing maladaptive ideas. Wenzel (2012:18), states that "as with core beliefs, they exacerbate information processing biases that reinforce unhelpful core beliefs, and conversely, information processing biases strengthen the rigidity of these rules and assumptions. Figure 4-4 illustrates Beck's (2011:32) suggestion as to how non-adaptive information is processed and that it even perpetuates the core beliefs. Notice, any negative activated

idea, “occurs automatically”, whether from a depressed state or not, the rectangles, fit, and are readily accepted into the core belief “I’m incompetent”. In contrast, the positive ideas, the triangles, do not fit, or are not accepted into the core belief. Hence, this ultimately makes the belief more robust.

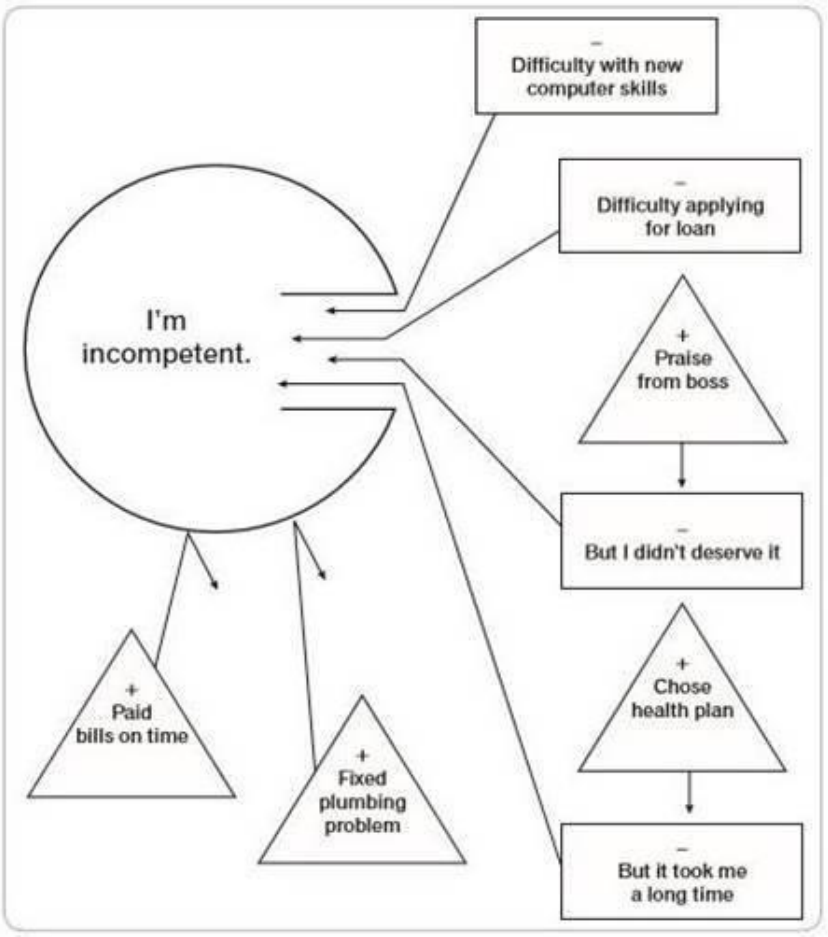

Figure 4-4: Processing of non-adaptive information

Later, the researcher will demonstrate a case example on how to change maladaptive beliefs. Beck (2011:35) provides the following explanation for the treatment target to challenge negative core beliefs:

> Of particular significance to the cognitive behavior therapist is that dysfunctional beliefs can be unlearned, and more reality-based and functional new beliefs can be developed and strengthened through treatment. The quickest way to help patients feel better and behave more adaptively is to facilitate the direct modification of their core beliefs as soon as possible, because once they do so, patients will tend to interpret future situations or problems in a more constructive way.

Our core beliefs seem to be the most foundational level of belief. They present as universal and rigid as well as often over-generalized; however, within CBT, it is our

intermediate beliefs that underlie our operating principles and expectations that often manifest as conditional statements.

4.5.2.3 Intermediate beliefs

The beliefs working in conjunction with core beliefs are *intermediate beliefs.* These beliefs are the level of ideas between core beliefs and automatic thoughts that are defined as one's personal "rules, attitudes, and assumptions" (Beck, 2011:198). In contrast to core beliefs, intermediate beliefs are comprised of rules, attitudes, and assumptions, whereas core beliefs are "rigid, global ideas about oneself, others, or the world (Beck, 2011:198). Notice, here, Beck (2011:35) offers these examples within the categories of intermediate beliefs:

- Attitude: "It's terrible to fail".
- Rule: "Give up if a challenge seems too great".
- Assumptions: "If I try to do something difficult, I'll fail. If I avoid doing it, I'll be okay".

For a counselee, just like core beliefs, Beck (2011:36) states that "these beliefs influence his view of a situation, which in turn influences how he thinks, feels, and behaves". In contrast to core beliefs, Wenzel (2012:18) found that intermediate beliefs play a large role in the way in which people live their lives and respond to life's challenges and stressors for she states:

> In many instances, they are worded as "if-then" conditional statements that prescribe specific rules that must be met in order for the person to protect him or herself from a painful core belief. For example, a person with an "I'm a failure" core belief might live by the rule, "If I get all A's, then I'm successful," which is viewed as a positive intermediate belief because it specifies a path toward a positive outcome. However, that same person might also live by a negative intermediate belief, "If I get anything less than all A's, then I am a failure". Intermediate beliefs that do not use conditional language are often expressed as heavily valenced attitudes (e.g., "It would be terrible to get anything less than an A.") or assumptions about the way the world works (e.g., "Successful people should get all A's in their classes.").

The researcher adds here more common examples of dysfunctional intermediate beliefs heard daily in counseling settings:

- "If I look a certain way, then I will be accepted by others since only attractive people are accepted."

- “Unless I am perfect at my job, my employment is at risk, because only competent employees do not get fired.”
- “If I share my true feelings with others, I will get hurt, for showing vulnerability is a weakness and chance to be rejected by others.”
- “The last few times I went to the doctor’s office; I was given a poor health report; therefore, I should avoid getting a physical exam.”
- “Life has no purpose and meaning, so there is no reason to set life goals.”

To understand the interconnection between the levels of core and intermediate beliefs, Vernon and Doyle (2017:81) give this example of how core beliefs drive the intermediate belief level:

> As individuals develop a negative dysfunctional schema about themselves or the world around them, they will struggle against the predictions from the core belief. Such efforts are reflected as a set of assumptions, rules, and attitudes that can help them cope with the schema (J.S. Beck, 2011; Dozois & Beck, 2008). Individuals with an unlovable core belief might think that it is awful to be rejected by others (an assumption) and develop the rule that if they do not please others they will be rejected. This is translated into a rule stating that they must always please others. The content of these intermediate beliefs is often translated into behavioral strategies to cope with the schema. However, in the long run, these behaviors prevent these individuals from confronting the schema with discrepant information (Dozois & Beck, 2008).

The relationship between the intermediate beliefs, core beliefs, and automatic thoughts is shown in Figure 4-5 (source: Beck, 2011:36).

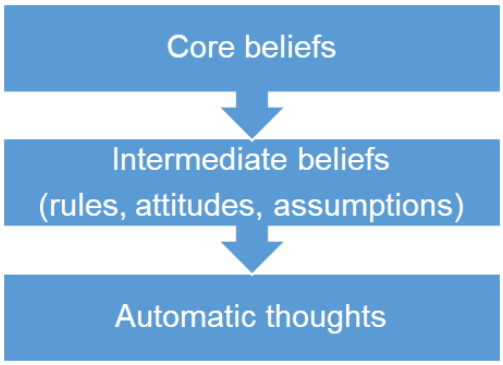

Figure 4-5: Interconnection of belief systems

When we add automatic thoughts to the interconnection between core and intermediate beliefs, automatic thoughts are seen as a function of beliefs persuaded by both core and intermediate beliefs (Clark *et al*., 1999). This means when there are faulty beliefs at the core level; “their impact on automatic thoughts is mediated by an

intermediate level of cognitions" (Vernon & Doyle, 2017:81). Once the cognitions are awakened, the thought process is mobilized through the lens of both adaptive and maladaptive belief systems. Bieling and Segal (2000:102) describe this point:

> Activation is the phenomenon which connects external stimuli with negative moods by triggering relevant belief systems for the individual. Together the structure of cognition and the activation process account for negative automatic thoughts. Just as important, constructive modes can be brought to bear (or created) that result in more reflective modes of beliefs, leading to more positive emotion.

Therapeutically, the treatment or ministerial goal is to help a mental health sufferer "identify intermediate beliefs by recognizing when a belief has been expressed as an automatic thought, by providing part of an assumption, by directly eliciting a rule or an attitude" (Beck, 2011:227).

Furthermore, while, challenging intermediate beliefs, they are "more malleable than core beliefs" but "less modifiable than automatic thoughts" (Beck, 2011:198); hence, the goal within CBT becomes the identification of intermediate beliefs, then ultimately, helping the counselee change them. Beck (2011:205) offers here ways to identify intermediate beliefs:

- Recognizing when a belief is expressed as an automatic thought.
- Directly eliciting a rule or attitude.
- Using the vertical/downward arrow technique.[26]
- Asking the patient directly.

Pairing the premises that "automatic thoughts are viewed as a derivative of beliefs influenced by core and intermediary beliefs" (Clark *et al*., 1999), with the idea, as Beck (2011:10) states that we have "hundreds of automatic thoughts a day that affect mood, behavior, and physiology", it is easy to identify and resonate with Milton's (2014:Book 1:8) insight here: "*The mind is its own place and in itself, can make a Heaven of Hell, a Hell of Heaven*".

[26] The researcher will define and demonstrate the vertical/down arrow technique in Chapter 5.

4.5.2.4 Automatic thoughts

The concept of automatic thoughts has been an essential topic within CBT since its founding (Beck, 1963b). Automatic thoughts are ideas and often images; a thought in picture form that passes through our mind; as Trader (2011:58) describes it, they are, "brief bursts" of "internal communication". Automatic thoughts have been described as the most superficial level of the thinking process (Beck, 2011). Most are unaware of the nature and prevalence of these thoughts; they seemingly, "arise as if by reflex, without any apparent antecedent reflection or reasoning. They seemed plausible to the patient even though implausible to other people" (Beck, 1976:90). The 'automatic thoughts' postulate is what gave rise to CBT; Beck (2019:17, cited in Beck, 1963b) explains this formation as follows:

> The elucidation of these automatic thoughts then laid the groundwork for a theory of human psychopathology. In parallel to noticing my clients experiencing automatic thoughts, I also noticed that when I focused on my own reactions to a particular stimulus, I became aware of these thoughts. They appeared to emerge automatically (hence the label of "automatic thoughts"). When I experienced either anxiety or anger, I would have an intervening automatic thought, the content of which explained the particular emotion. Thus, themes of threat or anxiety led to anger, loss led to sadness, and gain led to exhilaration. When I was able to put all of this together, I had an "a-ha" experience. I felt as though I had discovered something new. I also observed that the automatic thoughts actually were exaggerations or even misconstructions or misinterpretations of a situation. Thus, for example, I might misinterpret somebody's brief response to a question as a slight and become angry. I found that when I looked for the evidence for the thought, it was either very weak or nonexistent. I then found that my patients' automatic thoughts were similar to my own, and this formed a bridge to their affective experience. In the case of my patients, these automatic thoughts were generally distortions that fit their diagnosis. My first concerted venture was to examine these thoughts in patients with depression, who constituted the majority of my caseload.

For a brief explanation of the nature of automatic thoughts, Beck (2011:28) describes the process this way:

> For example, while you are reading this text, you may notice two levels in your thinking. Part of your mind is focusing on the information in the text; that is, you are trying to understand and integrate the information. At another level, however, you may be having some quick, evaluative thoughts. These thoughts are called automatic thoughts and are not the result of deliberation or reasoning. Rather, these thoughts seem to spring up spontaneously; they are often quite rapid and brief. You may barely be aware of these thoughts; you are far more likely to be aware of the emotion or behavior that follows. Even if you are aware of your thoughts, you most likely accept them uncritically, believing that they are true. You don't even think of questioning them. You can learn, however, to identify your automatic thoughts by attending to your shifts in affect, your behavior, and/or your physiology.

Automatic thoughts, in general, are not problematic; however, it is the reaction to dysfunctional thoughts, or which Bloch (2004:861) calls “hot cognitions”, or the instant “irrational messages” (Phillipson, n.d.) that ultimately determine their emotional significance. Nevertheless, there is evidence that we have limited, to no control over these thoughts. Spiritually, Trader (2011) posits, “While it is not in a person’s power to decide whether a demonic or angelic thought will pass through one’s mind, people can choose to act on it or to ignore it” (Trader, 2011:60).[27] Clinically, Phillipson (n.d.) explains the cause-effect progression of automatic thoughts as follows:

> How is it that highly intelligent people with well-developed reasoning skills can react so strongly to, and be so effectively controlled by, ideas that are so irrational? The answer, I believe, is that our brains are capable of sending signals that we experience as thoughts, feelings, and/or physiological responses independent of our conscious, volitional control. For example, if a person stubs his toe, he may find himself thinking, “You’re a clumsy idiot!” What’s important here is not the content of thoughts like these, but the fact that no one can prevent his or her brain from sending messages like this in the first place. The automatic, involuntary manner in which such thoughts emerge suggests that they are products of what I call independent systems in the brain. Unfortunately, patients often find it difficult to distinguish such reflexive thoughts from those that reflect their core beliefs, and may mistake them for sincere insights about themselves. And since these automatic thoughts can be harshly self-critical, patients may agonize over what this internal dialogue suggests about their potential for good or ill.

To illustrate the interconnection of automatic thoughts, intermediate and core beliefs, the researcher presents the following example of this synergy:

> John, a member of your church, reveals to you during Sunday school that he is struggling with depression which he feels comes from his social isolation. When you meet him later that evening for a cup of tea, John shares that since his childhood he has always felt socially inept. He says he was often overly criticized by his parents and never believed he relationally fit in with his schoolmates. Now as an adult, John has the core belief of vulnerability in the category of helplessness. John has developed the intermediate belief (assumptions and rules) that “If I avoid other people then I'll be okay for I won’t be ignored or criticized during social events. And if I don't avoid them, and I attend social functions, then eventually I will get hurt”.

[27] Trader’s citation here is “See Methodius Discourse on the Resurrection 3.2 (PG 18.300c)”. Trader cites PG as Patrologia cursus completes: Series graeca. ed. J. P. Migne. Vol. 1-161. Paris: J. P. Migne, 1857-66.

Notice, John's automatic thoughts may be triggered by an invitation to church fellowship gatherings. This trigger may lead to an automatic image (thought in picture form) of standing in the corner alone watching everyone socializing, laughing, and having a great time. Which in turn could lead to John's automatic thought: "I cannot go because what if no one talks to me?" Unfortunately, if John does not identify and modify these negative thoughts, they could escalate into painful "bursts" of additional thoughts and emotions that play out in the way the researcher describes as follows:

> Since no one talks to John, it may re-activate an automatic thought for him that "I am alone". This thought may instantly drive the emotion of sadness and despair. The combination of this thought with these feelings could understandably drive John's behavior, which in this case, could lead to John leaving the event to avoid pain. This schema could reinforce the intermediate belief that going out leads to pain. And this pain may activate or reinforce his core belief of vulnerability or unlovability. Thus, John could often find himself staying home alone to avoid the perceived pain of rejection.

Notice, in this example, the counselor and Apologist can explore, listen for, and identify, John's thoughts, then work to correct them using the truth or facts.

4.5.2.5 Meaning assignment

"Humans do not simply respond to stimuli; they interpret them." (Albert Bandura)[28]

One primary concept underlying CBT that both the clinician and the Apologist are trained to work with is meaning assignment. Understanding the role and the proper application of meaning assignment can be a powerful tool for emotional regulation. It is the meaning we deduce, appraise, or the label we assign to the various events in our lives; in other words, it is what we conclude or believe about a situation, activating event, or trigger. As it relates to our mental health, the thoughts that regulate our emotions are established, "depending on their content and meaning" (Beck, 2011:139). Notice in these typical examples, how the same event/situation leads to diverse emotional experiences by different people:

[28] Trader, A. (2011:51, citing: Bandura, *Social Learning Theory*, 59).

- Event/situation: Your boss requests to see you in the office:
    - Person 1: … begins to feel annoyed.
    - Person 2: … feels afraid.
    - Person 3: … feels excited.
    - Person 4: … feels ambivalent.
- Event/situation: When a spouse is an hour late for dinner:
    - Person 1: … feels worried.
    - Person 2: … feels jealous.
    - Person 3: … feels angry.
    - Person 4: … feels nothing.

As seen here, it is rational, and there is no doubt that these events can lead to different feelings; however, when it comes to our emotional reactions, the critical, subtle distinction is the role and placement of the meaning assignment in the progression. It is precisely the meaning, instantly following the event that each person assigns to the event that precedes and activates the emotion. Notice here, Trader (2011:49-50), identifies the point or place, which he calls the "marker", where meaning assignment lines up in the sequence of events, thoughts, and emotions within the cognitive model; he purports this marker is understood as "the common-sense notion that thoughts come in between events and feelings" . Likewise, Trader (2011:58) points out that not only can the process of *meaning assignment* be elusive, it is immediate and evaluative:

> Meaning assignment is not a premeditated process, but a rapid evaluation of a situation. We know meaning assignment has taken place by what Beck calls automatic thoughts that we have about our present state of affairs. In addition to explicit thoughts and ideas that we may develop or express, we also have other brief bursts of thought that are used for internal communication consisting of "self-appraisal, self-evaluation, self-warning, and self-instructional".

When considering the role *meaning assignment* plays within the treatment of various clinical mental health disorders, Beck (2016, n.p.) explains:

> Many times, when I've given a workshop people would say well, do I have to learn something new for each of the disorders, or is there some easy way of going about it? My answer to that is that there is this generic cognitive model which runs across all of the disorders, but there is one difference for each of the disorders which can account for the disorder and that is the *meanings* that the patients attribute to their

> experiences. And the meaning has to do with the belief that people have. So, the disorders are similar in many ways but they are differentiated by the specific beliefs that the people have.

In like manner, the concept of *meaning assignment* is found within the historic church. Trader (2011:57) suggests that "both the fathers and cognitive psychologists recognize that meaning assignment or the interpretation of the events inevitably affect mood, behavior, and character". He adds, "Elder Paisios draws on this same teaching when he explains why the same incident is viewed by one person as a blessing, but by someone else, a tragedy". He characteristically remarks, "Everyone interprets events in a way that is consistent with his own thoughts. Everything can be viewed from its good or bad side" (Trader, 2011:52). Although, paralleling the efforts in this work, Trader (2011:53) makes a critical distinction between general CBT practice and the early church, namely, that the early church was motivated more by the spiritual *meaning assignment* within life events. He states, "Whereas cognitive therapists strive to make their patients' interpretations vertical and objective, the fathers believe that it is more important to spontaneously fulfill Christ's commandment to "love one's neighbor"[29] and "to judge not"[30] than to perceive a situation accurately. Ultimately, Trader (2011:53) concludes, that meaning assignment, like all else, should be "subjected unto Christ".[31]

Biblically, we see a case where a distortive meaning assignment led to a tragic outcome in the Book of Genesis as Trader (2011:56) identifies: "For example, if Cain interprets Abel's frustrating behavior as intentional, Cain sees himself as a wronged victim and feels distressed. To compensate for uncomfortable feelings of weakness, Cain will also empower himself with feelings of anger that may swell into violent behavior".

In contrast, consider here this biblical case where an empowering meaning assignment leads to spiritual victory, in the case of what we learn from the Apostle Paul. While, with all self-honesty, imagine what meaning most would assign to the following events and experiences of the Apostle Paul's trials:

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[29] Trader's citation here is Jn. 13:34.

[30] Trader's citation here is Mt. 7:1.

[31] Trader's citation here is 1 Cor. 15:28.

> Five times I received from the Jews the forty lashes minus one. Three times I was beaten with rods, once I was pelted with stones, three times I was shipwrecked, I spent a night and a day in the open sea, I have been constantly on the move. I have been in danger from rivers, in danger from bandits, in danger from my fellow Jews, in danger from Gentiles; in danger in the city, in danger in the country, in danger at sea; and in danger from false believers. I have labored and toiled and have often gone without sleep; I have known hunger and thirst and have often gone without food; I have been cold and naked. Besides everything else, I face daily the pressure of my concern for all the churches. Who is weak, and I do not feel weak? Who is led into sin, and I do not inwardly burn? (2 Cor. 11:24-29).

After reading about Paul's hardships above, it would be naturally conceivable to instantly assign the meaning, "What am I doing wrong to deserve this?" or, "Why is God punishing me?" Such as initially thought by Job's friends who thought he was the reason for his calamity as cited in Job 4:7-8. However, note Paul's empowering meaning assignment when he concluded that his troubles are: "For momentary, light affliction is producing for us an eternal weight of glory far beyond all comparison" (2 Cor. 4:17). Likewise, what we also learn from Paul regarding meaning assignment, is how he processed perhaps one of life's greatest fears, the "sting of death" (1 Cor. 15:55-57). Again, evaluating with self-honesty, after the flurry of automatic thoughts about death that surface during instances when we are reminded of our finite nature, such as attending a funeral or visiting a hospital, what meaning do we give consent? Is it the same meaning Paul chose here?

> For to me to live is Christ, and to die is gain. If I am to live in the flesh, that means fruitful labor for me. Yet which I shall choose I cannot tell. I am hard-pressed between the two. My desire is to depart and be with Christ, for that is far better. But to remain in the flesh is more necessary on your account. Convinced of this, I know that I will remain and continue with you all, for your progress and joy in the faith, so that in me you may have ample cause to glory in Christ Jesus, because of my coming to you again (Phil. 1:21-24).

Consequently, what is empowering for us when considering mental health, is that we have latitude over the meaning we assign the events in our lives. However, for a needed distinction, even though we have free will in choosing the meaning we assign to our experiences in events, this is not a relativistic, subjective, "looking for the positive" or "finding the silver lining". The goal is an accurate meaning assignment, as we have learned from the Apostle Paul, for more adaptive thoughts, and not inaccurate, wishful thinking. Regarding this point, Beck (2015) clarifies this point for CBT:

> A myth about cognitive therapy is the myth that it's the power of positive thinking. That's really quite inaccurate. Cognitive therapy is really the power of realistic thinking.

> It's not just helping a patient develop a rosy picture about his experience of what's going on in the world. If we did that it would be providing a disservice to patients because their experiences not necessarily rosy and the world is not necessarily rosy; however, when patients come to see us they're usually in distress and frequently their thinking is unrealistic and negative. We never know when we hear a patient express a thought that he's been having whether that is 100% true or 0% true or someplace in the middle. And so, one of the very important things we do is help patients evaluate their thinking. We ask questions like “What is the evidence that this thought is true?” “Do you have any other evidence?” “Is there any evidence on the other side that maybe it is not true?” “Is there another explanation for what is going on here?” So we asked them a series of questions to help them figure out to what degree their negative thinking is realistic or unrealistic. Furthermore, if unrealistic, we help them develop a more realistic view, which for most patients is in a positive direction. But it's not the power of positive thinking it's the power of realistic thinking. And in fact when we work with patients who are bipolar and are in a manic episode their thoughts are hyper positive and when we do some reality checks with them, we are helping them actually change their thinking in a more negative direction so that it's more realistic and we sometimes find the same hyper positive thinking with other patients as well.[32]

Subsequently, as we will see shortly, the role of meaning assignment has a clinical use in tracing down distressing automatic thoughts. Moreover, these thoughts that often manifest in “shorthand” form, “can be easily spelled out when you ask for the meaning of the thought” (Beck, 2011:139). Once this thought is traced, “Then you ask the patient for the meaning of this cognition, assuming the automatic thought is true” (Beck, 2011:207).

In the same way of choosing an accurate meaning, this researcher believes that another relevant and core principle found within CBT is that of *focus*. Just like the process of meaning assignment, since we have free-will, we have the option in our thought world, to choose what we get to focus on or pay attention to, to regulate our emotional state at any given time.

[32] Beck, J. 2015. *The Power of Realistic Thinking in CBT*. [Video clip].

4.5.2.6 Focus

4.5.2.6.1 Background

According to Lewis (2009:25) “we are half-hearted creatures, fooling about with drink and sex and ambition when infinite joy is offered us, like an ignorant child who wants to go on making mud pies in a slum because he cannot imagine what is meant by the offer of a holiday at the sea. We are far too easily pleased”.

Lewis’ quote here implies the concept of focus. Specifically, in this quote, he is referring to a universal (“broad”), spiritual life focus; however, the point is, focus, even a local (“smaller”) focus, directs the target on which we tether our efforts. In other words, whatever we focus our attention or cognition on, we will move towards, behaviorally or emotionally. Emotionally, since our thoughts lead to feelings, then, whatever we focus on, we feel in our emotions.

While working in co-morbid rehabilitation agencies and an acute psychiatric hospital, one observation this researcher noticed while teaching countless psycho-educational groups is that most of the patients resonated well with the usage of aphorisms. One thought-provoking saying that never failed to unanimously inspire patients to pick up the pen to take notes more than any other insight was: “Where Focus goes energy flows!”[33] This saying should be interpreted as, whatever we are giving our thoughts to or what we are focusing on, we give our metaphoric “energy” to, such as behaviors, time, effort, goals, and even more thoughts. The topic of focus is one significant area where CBT has gained more attention recently (Beck & Beck, 2013). For instance, when someone who struggles with “chronic pain focuses too much on the back pain and then the back pain gets worse”; and one with “an anxiety disorder focuses too much on the experience of the anxiety, then the anxiety gets worse” (Beck, J.S., 2013). Beck, A (2013) concurs and states that focusing is a “major part of the theory”. He continues by explaining how focusing fits into the cognitive model triad as well as mental health disorder case formulation:

[33] This is metaphorical and implying metaphysical energy or mysticism. Also, this researcher was not able to track down if this in an original quote; however, it is widely accepted to be stated by the Life Coaching community.

> I can usually come up with a formulation for the case within five minutes … First of all, I have to try to discern, "What is the belief that's behind this particular problem, what is the behavior that's behind this problem, and what is the kind of focusing that the person is doing? Once you have this triad, the belief, the behavior, and the focusing, it can give you a thumbnail sketch, or you can address it to any particular problem. So – what is really idiosyncratic is very specific and unique to every condition, every problem is the belief; there's some overlap in terms of the behavior, and every one of them has the focus. So, if you take depression, for example, and let's say there's a loss, though, the person may be focusing on the girlfriend who rejected the guy. So, there's a focus on that and his mind is going over and over again. There may be a focus on a person who feels sad; so, the patient focuses on the sadness and that magnifies the sadness. Then the person feels kind of fatigued then the person withdraws and focuses his attention on that. Then the person withdraws from other people. This may stimulate the belief, "I just don't have the energy, I feel weak and helpless, I can't do anything". They focus on the rejection and have a belief "My whole life is ruined; I might as well kill myself". So, then you get this triad, and you get this kind of thumbnail sketch for every single problem or disorder (Beck & Beck, 2013).

Likewise, Beck (2011:26), by using the example of depression, suggests the direction of our focus is often established devoid of consideration; she states, "Most patients, especially those with depression, tend to focus unduly on the negative. When they are in a depressive mode, they automatically (i.e., without conscious awareness) and selectively attend to and put great emphasis on a negative experience. They either discount or fail to recognize a more positive experience". Subsequently, most of us are unconscious of our focus until our feelings begin to affect us.

4.5.2.6.2 Focus and feelings

The significance of the *focus* concept is found in the interconnection within the cognitive model, that is, "If thoughts lead to emotions," then what we focus on in our mind, we feel, or we feel in our emotions. In other words, we feel our focus or feel what we pay attention to, or since our feelings and emotions are such a strong component of our experience, stated another way, "What we pay attention to, we experience". This tells us that our focus plays a significant role in our mental health. For the reader who wants to behavioral test this concept, take a minute to focus on what is wrong in your life, and you will feel your emotions or mood become negative. Conversely, take a minute to focus on what is right in your life, and your emotions and mood become positive. This is the concept underlying the science of practicing *gratitude*, which has shown that the practice of, leads to less depression, anxiety, as well as increased positive affect (Emmons & McCullough, 2003).

The concept of *focus* was also found within the early church. Trader (2011:54) points out, “Saint Theodore the Studite characteristically notes, “We feel radiant when we think about something good, and then become dark and gloomy when we entertain somber thoughts … The change is volitional and within our own power”.[34] The idea of *choosing our focus* is found clinically as well. Beck (2011:26) states, if our focus is often automatic or “without conscious awareness” then this suggests that not only can we choose our focus, but the preliminary step before managing our focus thus allowing us to learn first to recognize it. This researcher will provide a technique in the next section under *Catch it, Check it, Change it*, to demonstrate how to identify and redirect our focus, consider the Apostle Paul, and a few of his life experiences. Likewise, the researcher will add how the Apologist can apply the *Catch it, Check it, Change it* concept as a simplified three-step tool to use when applying Apologetics praxis.

4.5.2.6.3 Apostle Paul and focus

Perhaps, one of the most powerful lessons we find on the concept of *focus,* even *spiritual focus,* is taught by the Apostle Paul, found in Philippians 3:13: “Brethren, I do not regard myself as having laid hold of it yet; but one thing I do: forgetting what lies behind and reaching forward to what lies ahead” (Phil. 3:13). This verse that instructs us on where and what should capture our focus is a lesson that teaches us we can separate our life problems from our overall joy. Or, at a minimum, we can experience joy in the midst of life challenges. In fact, Paul seemed to model the principle that we should focus on what we want or where we desire to be, instead of where we are or what we have to go through. Paul received the emotional freedom that allowed him to partition his external world from his internal emotions by choosing the right focus. This afforded him the privilege of “distancing” his circumstances from his contentment and joy. This demonstrates to us that “Our life events do not have to determine our happiness”, like is commonly believed.

Paul’s wisdom teaches another mental health lesson in his *choice* of focus in light of his (*meaning assigned*) focus on “momentary light afflictions” (2 Cor. 4:17). Most of us

[34] Trader’s citation here is “Theodore the Studite Catechetical Discourses 100 (*HPE* 18a. 368-370*). Cf. Latin translation in PG* 99.638d”. Trader cites HPE as Hellenes pateres tes ekklesias. Vol. 1-Thessaoniki, Greece: Gregorios ho Palamas, 1979- and PG as Patrologia cursus completes: Series graeca. ed. J. P. Migne. Vol. 1-161. Paris: J. P. Migne, 1857-66.

have never lived through the adversities Paul lived through. If anyone had the "right" to dwell and focus daily on his current and past struggles to afford himself to feel abandoned by God, discouraged, bitter, or even traumatized, Paul did. Notice here how, approximately two thousand years ago, Paul virtually intuits what it takes to be a seasoned CBT practitioner; a point, likewise Habermas (2013) alludes to in this verse when Paul implores the Church: "Finally, brethren, whatsoever things are true, whatsoever things are honest, whatsoever things are just, whatsoever things are pure, whatsoever things are lovely, whatsoever things are of good report; if there be any virtue, and if there be any praise, think on these things" (Phil. 4:8).

Perhaps, by cognitively mastering proficiency with the skills of *meaning assignment* and *focus,* Paul was able to say, "Not that I am speaking of being in need, for I have learned in whatever situation I am to be content" (Phil. 4:11). The good news is, just like choosing an accurate meaning, we have free-will in choosing on what to focus.

4.5.2.6.4 Validity of cognition

According to Matthew 14:22-31, when Jesus asked Peter to walk on water (v. 29), "he was afraid" and cried out, "Lord save me" (v. 30). As Jesus saved Peter, He declared Peter had "little faith" and he "doubted" (v. 31). Envision, in Peter's moment of fear, if one of the disciples asked him in that moment, "How certain are you that you will successfully walk on water without drowning?"; on a scale of 1 to 10 with 1 as no certainty (all doubt) and 10 measuring absolute certainty (all faith), could Peter's conviction, certitude level, be scored any higher than perhaps a 5 at best?" Perhaps not.

In contrast, to Peter's lack of certainty (belief level) when asked to walk on water, is the certainty level displayed by the Apostle Paul. When facing his personal trial he seems to report a high conviction level that they would produce, "an eternal weight of glory" (2 Cor. 4:17); when he was "whipped five times, beaten, stoned, shipwrecked, in danger from robbers, danger at sea; had gone without sleep; had gone hungry" (2 Cor. 11:24-27). Paul's certitude level seems to have been grounded in his future focus. Namely, again, not his current pains or adversities, but he was focused on the anticipated pleasure he would receive when he reached his destination. Notice Paul's

choice and application of focus when contemplating his future destination (death) in (Phil. 1:21-24). Here, he declared, seemingly without reservation (high certainty):

> For to me, to live is Christ and to die is gain. But if I am to live on in the flesh, this will mean fruitful labor for me; and I do not know which to choose. But I am hard-pressed from both directions, having the desire to depart and be with Christ, for that is very much better; yet to remain on in the flesh is more necessary for your sake.

The examples given above of the experiences of two of Christ's followers, illustrate how each action was driven by their strength of belief, or level of *faith*. As we have seen in the cognitive model shown in Figure 4.2 that thoughts, or beliefs, lead to behaviors or actions; and it is clear that Paul was operating at a higher certainty level of belief, or faith.

It has been said, "What would you do differently in your life if you knew you would never fail?" This question connotes that one's strength of belief drives not only motivation, but behaviors, and even emotional relief from distress. This *strength of the belief* concept is found in clinical counseling and is often called the *Validity of Cognition* or VOC rating (Shapiro, 2017). Validity testing is also found within CBT. Beck (2011:214) gives the example when working with client's, she says, "You continue to ask patients how much they currently believe a given belief (0–100%), at both an "intellectual" and at a "gut" or "emotional" level, to gauge whether further work is needed".

In contrast to checking thoughts for their accuracy, or "testing for their validity" (Beck, 2011:297), a "VOC rating" tests a belief, not "how true it is objectively," it tests the strength of one's belief or "how believable" the "cognition feels to the person (Shapiro, 2017:56). For its use within CBT, the goal is to "decrease the strength" of old, maladaptive beliefs, as well as to "increase the strength" of new, more empowering beliefs. (Beck, 2011:231). Perhaps this could also be said to be an implied goal of the Apologetics worldview debate.

To "strengthen" new beliefs, Beck (2011:240) suggests that

> … you deliberately elicit positive data from patients through questioning, and you also point out positive data to them—especially when the data contradict the old, negative core belief but support a new, more reality-based belief. Two, when specifically working on strengthening their new core beliefs, you ask patients to examine their experiences in a new way that facilitates their ability to recognize positive data themselves.

Correctly, within a counseling session, the counselor will assess a counselee's beliefs, "both in the past and present" (Beck, 2011:9); although, to facilitate or increase the strength of a belief (Beck, 2011:246) suggests asking the counselee, "When you believed least strongly that you were incompetent or most strongly that you were competent, what was going on? ... Discussing these (more positive) situations provides an opportunity to gather or reinforce evidence".

Lastly, when considering the rating scale, Shapiro, (2017:10) appraises the VOC by asking clients to "rate how true they felt this positive belief was using a 7-point semantic differential scale ... in which 1 represents "completely false" and 7 means "completely true". Therefore, the VOC measures the strength of a belief, and the scale is the measuring instrument used to gauge the levels, increase or decrease, of validity.

4.5.2.6.5 Meaning and focus combination

Subsequently, for a biblical example which illustrates the combination for the proper use of both spiritual *meaning assignment* and *focus,* consider Joseph's life in Genesis 37:50. His trial was anything but problem- and pain-free. Imagine if your own family plotted to kill you, and you were sold into slavery on false charges? Yet, what seemed to keep Joseph from drifting from pain into suffering was his faith that God was orchestrating something for him and God's glory behind the scenes. Joseph's faith evidenced that he knew the right *meaning* behind his pain and his *focus* (on God's promises), which helped him, after the fact, operate without bitterness and resentment, which would have caused him more emotional pain. Notice from this proof-text, that it was his level of faith that assisted him in adapting the accurate meaning and focus while he endured his adversity: "But Joseph said to them, Do not fear, for am I in the place of God? You meant evil against me, but God meant it for good in order to bring about this present result" (Gen. 50:19-20).

4.5.2.6.6 Scaling

Along with the *Validity of Cognition or* VOC, we can complement the assessment process with *scaling,* to gauge the level of conviction (certainty) or even the intensity of the emotions and behaviors. For instance, when working with counselees (Beck 2011:214), the concept of, "how much they currently believe a given belief (0–100%)";

the 0–100% is not the strength or validity of the cognition, it is the *scale* or the meter used to measure the strength of a belief. This is called *scaling*.

For example, clinicians can use scaling to measure emotions to assist the counselor in identifying the belief degree on the *scale* by asking, “How sad did you feel, 0 to 100%? Or, when gauging between counseling sessions, one could, “rate their emotions on a 0 to 100 or 0 to 10 scale” (Beck, 2011:128). Likewise, “A patient who is chronically irritated or angry might utilize an anger scale. Using such a scale is particularly useful for patients who either do not seem to notice small to moderate shifts in affect or patients who chronically over- or underestimate degrees of emotion” (Beck, 2011:263). Scaling is not only a cognitive or emotion measurement, but it can also be applied to challenge common thought distortions such as *either/or* distortive thinking (see Appendix C for Pearce’s *Ten Common Distorted Thinking Styles* for the most common distorted thinking patterns (Pearce, 2016:66-70)).

For instance, Gurman and Messer (2003:247) explain:

> For those patients who see things as all or nothing, the technique of scaling along a continuum can be quite useful. Scaling of emotions, for example, can lead patients to gain a sense of distance and perspective. A depressed patient who believes that he is “incompetent,” for example, might first be asked to rate the strength of his belief in this statement on a 100-point scale. He can then be asked to establish anchor points for his belief — identifying the “most incompetent person in the world” (0) and the “most highly skilled and competent person in the world” (100). When asked to rate himself on the “competence scale” he has developed, he typically would recognize that he is neither entirely incompetent nor the most competent individual but that, like others, he has strengths and weaknesses and has at least a modicum of competence.

In like fashion, as a trained life coach, this researcher, when working with clients, often gauges for a baseline to track how satisfied one is with their life by asking, “On a scale of 1 to 10, with 10 as completely fulfilled, what is your current *life satisfaction index*?” The benefit of this question is, this measurement can instantly appraise one’s life fulfillment, or how satisfied one is with their life. By this, we can measure and track progress towards one’s goals as to where they are in the gap between their current location (baseline) and their desired destination (goal). This researcher contends that Apologists, ministers, therapists, and even life coaches, should strive to become *belief change experts*.[35] Beliefs are often tethered to *levels of certainty*. The more convinced one is, or, the stronger the belief one has, the higher level of certainty. The certainty

[35] As a Christian, the researcher recognizes that ultimate change is to be found in the Holy Spirit.

level drives feelings and behaviors. The researcher will elaborate more on this process in the next chapter, for now, one Socratic question that the researcher often uses to evoke empowering cognitions to promote certainty, or the strength of a belief is: “What would you have to believe to be more certain about X?” Notice, this question reveals, as well as offers, the opportunity to add evidence to enhance belief.

Within clinical counseling, there are a variety of assessments to gauge hundreds of a counselee’s cognitions and emotions; listed here are a few of the most popular ones (Beck, 2011:366-367):

- Beck Depression Inventory–II
- Beck Depression Inventory—Fast Screen for Medical Patients
- Beck Anxiety Inventory
- Beck Hopelessness Scale
- Beck Scale for Suicidal Ideation
- Clark–Beck Obsessive-Compulsive Inventory.

4.6 Section summary

In this chapter, the focus was on Osmer's (2008:4) third task, namely, the normative task, which focuses on the question “What should be going on?”. The researcher reviewed relevant literature in a cross-disciplinary dialogue (Osmer, 2008:171) to explore points of intersection and divergence at various levels between Christian Apologetics and CBT.

Since the Church is called to minister to the sick (Mt 9:35-6; Ps. 147:3; Gal. 6:2), teach and defend the truth (Eph. 4:12–13; 1 Pet. 3:15; Phil. 1:7; Phil. 1:15-16; Jude 3), has a long history of “correcting error” (Sproul, 2009:14), and has an Apologetic method that has proven successful (Acts 17:2-4, Acts 17:34), then the use of the integrative approach that factors in special revelation (MacArthur, 2005) and general revelation (Moreland, 2019:29), could empower the Church by utilizing scientific psychology (Worthington, 2010), with efficacious interventions such as CBT (Beck, 2011:4-5) that Christians agree does not compromise the use of Scripture (Johnson, 2010; Habermas, 2013; Pearce, 2016) to assist those with mental health challenges within Christ’s Church.

CHAPTER 5: THE PRAGMATIC TASK

5.1 Introduction

In this chapter, the focus is on Osmer's (2008:4) fourth task, namely, the pragmatic task, which focuses on the question “How should we respond?” According to Osmer (2008:176), the purpose of this task focuses on strategies and actions that are undertaken to shape events toward desired goals. A hermeneutical integration is established between the research results of the descriptive, interpretive and normative tasks to propose practical-theological perspectives and systematic method in order to answer mental health challenges and develop a CAMH Pastoral Model for Mental Health Promotion. The aim of this chapter was to answer the fourth research question:

- Which practical-theological perspectives and systematic method can be given to Christ’s Church to use the parallels between Christian Apologetics theory and praxis with CBT praxis to answer mental health challenges and develop a CAMH Pastoral Model for Mental Health Promotion?

How should we respond? The researcher asserts that the response is to be found by integrating Classical Christian Apologetics theory and praxis with Cognitive-behavioral therapy praxis to forge a Christian Apologetics for Mental Health.

5.2 A case for integrated Apologetics and CBT praxis

Summary statement by the researcher for Christian Apologetics and Cognitive-behavioral therapy: A Pastoral Model for Mental Health Promotion:

> Christian Apologetics for Mental Health is established in Christian Theism and employs the scientifically tested principles of Cognitive-Behavioral Therapy to assist Apologists to minister to mental health sufferers by correcting misbeliefs towards spiritual formation. Likewise, CAMH affirms the techniques and interventions (praxis) of CBT, while rejecting its relativistic and reductionistic foundations. This rejection is qualified, for it is possible for a cognitive-behavioral counselor to unknowingly or knowingly ground their counsel in absolute truth. However, unlike CAMH, even a seasoned CBT practitioner will agree that neither is necessary unless requested by the client.[36] In other words, a CBT practitioner may get there but not know or care why

[36] Pearce (2016:13-14) reports, “One study even showed that Christian clients who received religious therapy from nonreligious therapists did better than when they received such therapy from religious therapists [Pearce cites here: Propst *et al*., *Comparative Efficacy of Religious and Nonreligious*

they got there. On this basis, the researcher contends that CAMH can be equal in its techniques and interventions but operates on a more coherent metaphysical approach in its application and foundation, thus ultimately proving to be an option that supports mental health promotion for Christians, rather than stand-alone CBT.

5.3 Theory-praxis distinction

An important question to be considered is whether there is a significant distinction between *Christian Apologetics for Mental Health* and *Cognitive Behavioral Therapy?* To answer this, the researcher maintains, this is a "nothing-buttery" fallacy for the significant distinction between CAMH and CBT as one of a theory-praxis distinction. CAMH adapts the praxis, interventions, and techniques defined in CBT while maintaining the systematic nature and Biblical principles of the Christian Worldview. This agreement is within method and means, namely its application in techniques and interventions, but not in its philosophical framework or undergirding. The goal, when synthesizing any Christian counseling theory with CBT is to approach it using the Christian Scriptures as the primary source for spiritual formation. Here, Tan (1987:103-112) draws out the nature of this distinction:

> Use only those techniques which are consistent with biblical truth and will not simplistically use whatever techniques work. It will reaffirm Scriptural perspectives on suffering, including the possibility of the "blessings of mental anguish" (Evans, 1986), with the ultimate goal of counseling being holiness or Christ-likeness (Romans 8:29), not necessarily temporal happiness (Grounds, 1976). However, such a goal will include being more open to receiving God's love and grace, and growing thereby to be more Christlike and overcoming mental anguish due to unbiblical, erroneous beliefs (i.e., misbeliefs).

To further explore the theory-praxis distinction, the researcher will now contrast the foremost similarities and differences between CAMH and CBT.

Cognitive-Behavior Therapy]. The reason is not clear, but the finding is interesting, nonetheless. One group of researchers at Iowa State University wanted to know how important it is for clients and therapists to share a religious belief system. The research team investigated what factors led to the greatest degree of clinical change and closeness between Christian clients and their therapists. Two hundred and twenty clients and fifty-one therapists at Christian and secular counseling centers were surveyed. [Pearce cites here: Wade *et al*., *Effectiveness of Religiously Tailored Interventions*]. Interestingly, it wasn't the similarity of religious commitment between clients and their therapists that mattered. Rather, when therapists used religious interventions that matched their clients' level of religious commitment, Christian clients rated their change in symptoms and closeness to their therapists most highly. In other words, being of the same religious persuasion wasn't necessary or important, rather it was administering a religious therapy for highly religious clients that enhanced the therapeutic relationship and led to better treatment outcomes."

5.4 CAMH and CBT: Similarities and differences

5.4.1 Historical concept origin of CBT

This research would not have been possible without the groundbreaking work of Dr. Albert Ellis and Dr. Aaron Beck as pioneers in the development of CBT.

Dr. Albert Ellis

Albert Ellis (1913-2007) held a PhD degree in Clinical Psychology from Columbia University. He was the founder of Rational Emotive Behavior Therapy (REBT), and is widely accepted by the pioneers of CBT, like Aaron Beck, for developing its fundamental concepts. Ellis is credited with publishing over 700 articles and more than 50 books on the gamut of individual, marital, and family therapy. He was the progenitor of the modern thought movement that led to him founding and creating the prestigious Albert Ellis Institute in New York. As mentioned above, it was Aaron Beck's acknowledgment of Ellis' ABC model that provided "a major impetus in the historical development of cognitive-behavioral therapies" (Beck *et al*., 1979:8).

Dr. Aaron Beck

Leahy (2010:ix-xx), the President of the International Association for Cognitive Psychotherapy, effectively sums up the undisputed contribution of Aaron Beck to Cognitive Theory as follows:

> It was his struggle as a lone voice of psychiatry against the dominant, if not doctrinaire, psychoanalysts. Beck got the patient off the couch and into the real world to test out their "Cognitions" with behavioral experiments. He was a revolutionary of the mind—literally turning psychology on its head […] for [his] pursuit of truth and the courage to carve out a road less traveled has led to one of the most significant contributions in the history of psychiatry and psychology.

5.4.2 Philosophical roots of CAMH

One reason the researcher devised the model for CAMH is that it borrows, again, just the applications, not the relativistic grounding, from the historical discipline of mental philosophy, which pre-dates CBT. Robertson (2010:xvi-xvii) explains:

> Joseph Wolpe and Arnold Lazarus, two of the founders of behavior therapy recognized that concepts within CBT even go back millennia. While the modern

> behavior therapist deliberately applies principles of learning to this therapeutic operation, empirical behavior therapy is probably as old as civilization … Ancient writings contain innumerable behavioral prescriptions that accord with this broad conception of behavior therapy.[37]

Agreeing that CBT has deep historical roots, Ellis (1962:54) states:

> This principle, which I have inducted from many psychotherapeutic sessions with scores of patients during the last several years, was initially discovered and stated by the ancient Stoic philosophers, especially Zeno of Citium (the founder of the school), Chrysippus (his most influential disciple), Panaetius of Rhodes (who introduced Stoicism into Rome), Cicero, Seneca, Epictetus, and Marcus Aurelius. The truths of Stoicism were perhaps best set forth by Epictetus, who, in the first century AD wrote in the Enchiridion: "Men are disturbed not by things, but by the views which they take of them." Shakespeare, many centuries later, rephrased this thought in Hamlet: "There's nothing good or bad but thinking makes it so.[38]

It is clear from the above acknowledgments that the widely accepted progenitors of modern CBT, Ellis and Beck, support the premise that ancient philosophy formed the theoretical essence of cognitive therapy.

5.4.3 Contemporary traces of CBT

While CBT dates back to the founding of philosophy, in recent times there is evidence that Rational Emotional Behavior Therapy (REBT), a type of cognitive therapy, was, as Overholser (2003:197) suggests: "derived from several modern constructivist philosophers, such as Immanuel Kant, Bertrand Russell, John Dewey, and Ludwig Wittgenstein". Here are specific examples of historical traces that demonstrate the continuity of how the popular contemporaries maintain the idea that *meaning assignment* (a core tenant in CBT as shown in Chapter 4) drives emotions. Although the researcher does not necessarily agree with their conclusions, these examples are listed to show how meaning assignment influences human emotions and what Thurman (1999:283) uses as secular instances for the "importance of right thinking for emotional and spiritual health":

- William Shakespeare: "There is nothing either good or bad, but thinking makes it so."

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[37] Ellis and MacLaren (2005:16) as cited in Robertson, *The Philosophy of Cognitive Behavioural Therapy* (2010).

[38] As cited in Robertson, *The Philosophy of Cognitive Behavioural Therapy* (2010:5).

- Benedict (Baruch) Spinoza: “I saw that all the things I feared, and which feared me, had nothing good or bad in them insofar as the mind was affected by them.”

- Marcus Aurelius: “If you are pained by an external thing, it is not the thing that disturbs you, but your own judgment about it. And it is in your power to wipe out this judgment now.”

- Immanuel Kant: “The only feature common to all mental disorders is the loss of common sense and the compensatory development of a unique private sense of reasoning.”

- W. E. B. DuBois: “If we wish to change the sentiments it is necessary before all to modify the idea which produced them and to recognize either that it is not correct itself, or that it does not touch our interests.”

- Alfred Adler: “It is very obvious that we are influenced not by ‘facts’ but by our interpretation of facts.”

- E. Farber: “The one thing psychologists can count on is that their subjects will talk if only to themselves, and not infrequently, whether relevant or irrelevant, the things people say to themselves determine the rest of the things they do.”

5.4.4 Similarities between CAMH and the core pillars of CBT

5.4.4.1 Background

As explained in the previous chapter, below are the core postulates that CAMH and CBT share:

- The cognitive model
- Automatic thoughts
- Intermediate beliefs
- Core beliefs
- Meaning assignment
- Attentional focus
- Validity of cognition
- Scaling

Furthermore, the researcher suggests that CAMH would also cohere with the following assumptions of CBT:

- Cognitive distortions via Aristotelian material logical fallacies
- Socratic questioning

5.4.4.2 Cognitive distortions via Aristotelian material logical fallacies

5.4.4.2.1 Background

Centuries before Christ, Aristotle (384-322 B.C.E.) penned "the world's first logic textbook" (Kreeft, 2010:15). Millennia later, understandably, he remains a formidable name within Christian Apologetics. Considering cognitive therapy, theorists use Aristotelian terms to label fallacy disputation; these are called thinking or *thought distortions.*[39] Thought distortions are defined as thinking or thought processing errors; Gregory (2013:vii) explains their significance as follows:

> When people are upset, these feelings are often preceded by a series of automatic thoughts or self-statements. People develop mental habits like filtering information, where the brain tends to focus only on the negative. Helping people identify and label distortions can help people learn how to develop more balanced and positive thinking habits.

5.4.4.2.2 Significance of cognitive distortions for CAMH

While the researcher will explain the concept "distortions" which are adaptable to CAMH in more detail in clause 5.5.1: *Concept derivation of CAMH*, for now, their significance to CAMH because various cognitive distortions come from Aristotelian material logical fallacies, thus giving the contemporary Apologist a familiar tool to challenge misbeliefs. For example, Burns (2012:41) highlights the concept of "black-and-white thinking" as

> …the CBT label or cognitive distortion of *All-or-Nothing-Thinking*; i.e., "If your performance falls short of perfect, you see yourself as a total failure".

Pearce (2016:66-70) offers this example of black-and-white thinking: "if performance falls short of perfect, this is interpreted as a total failure. This way of evaluating things is unrealistic because life is rarely completely one way or the other". In other words, the distortion presents in absolute terms such as "always, every, and never". In this example, everything short of 100% success is seen as a failure; i.e., "I only got a 94% on the exam; I must not be smart!" In Aristotelian terms, black-and-white thinking is a material logical fallacy; Kreeft (2010:89) states:

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[39] For a list of *Ten Common Distorted Thinking Styles*, see Appendix C.

> This is similar to *dicto simpliciter* but the fallacy here consists in not allowing for gradations or mean between extremes; *dicto simpliciter* consisted in not allowing for exceptions to a simple rule. There are blacks and whites, but there are also grays. Not everything is an "either-or". The fallacy here consists in arguing, "it is not this one extreme; therefore, it must be the opposite extreme. Examples: "Do you hate me?" "No." "How wonderful! You love me!"

Likewise, another Aristotelian distorted thinking style is "overgeneralization". Burns (2012:42) defines this as "You see a single negative event as a never-ending pattern of defeat"; and he gives this example (Burns, 2012:33-34):

> When you overgeneralize, this is performing the mental equivalent of Svengali. You arbitrarily conclude that one thing that happened to you once will occur over and over again, will multiply like the Jack of Spades. Since what happened is invariably unpleasant, you feel upset …The pain of rejection is generated almost entirely from overgeneralization. In its absence, a personal affront is temporarily disappointing but cannot be seriously disturbing. A shy young man mustered up his courage to ask a girl for a date. When she politely declined because of a previous engagement, he said to himself, "I'm never going to get a date. No girl would ever want a date with me. I'll be lonely and miserable all my life". In his distorted cognitions, he concluded that because she turned him down once, she would always do so and that since all women have 100 percent identical tastes, he would be endlessly and repeatedly rejected by any eligible woman on the face of the earth. Svengali!

In Aristotelian terms, Kreeft (2010:100) calls this the logical fallacy of hasty generalization stating:

> This is the commonest and simplest fallacy of induction, and it occurs in the commonest and simplest form of inductions, the inference from some specific examples to a general principle. Mere examples never conclusively prove a general principle, of course; they only render it more probable as the examples are more numerous, more diverse, and more representative. So, whether or not an inductive generalization is "hasty", and thus fallacious, is a matter of degree and a common-sense "judgment call".

Kreeft (2010:100) provides this example as a hasty generalization: "We went to three ball games this year, and the home team lost each one. They're losers".

One core tool Apologists use in their arsenal is *Socratic questioning*. Apologists utilize Socratic questioning to drill down into ideas to expose faulty worldview assumptions; this skill and technique almost becomes second nature for a seasoned Apologist. The book, *Motivational Interviewing: Helping People Change* (Miller & Rollnick, 2012) is a commonly suggested training resource for new counselors in mental health treatment, as it assists them in learning to ask the right therapeutic questions to elicit behavioral change. As a practicing counselor, this researcher has observed an increasing trend

in seminars offered to teach current therapists to use Socratic questioning as a tool in their therapeutic toolbox. Beck *et al*. (2005:167) recognizes the use of "the Socratic Method" as a primary tool used by counselors. Clark and Egan (2015:863) state:

> The Socratic Method is considered to be an important component of Cognitive Behavioural Therapy (CBT) interventions (e.g., Ehlers *et al*., 2005). The approach has been described as a "cornerstone" (Padesky, 1993) of CBT and as an essential core competency of CBT therapists (Roth & Pilling, 2007). Yet despite the purported significance of the Socratic Method, it has been subject to relatively little description or empirical investigation (Overholser, 2011). The Socratic Method has been defined as "a method of guided discovery in which the therapist asks a series of carefully sequenced questions to help define problems, assist in the identification of thoughts and beliefs, examine the meaning of events, or assess the ramifications of particular thoughts or behaviors" (Beck and Dozois 2011:401).

To illuminate the power behind questioning, notice how often Jesus asked questions to draw out and communicate spiritual truths for His listeners. In fact, Christ asked over 150 questions in the gospels alone. When reading the story about Jesus healing the paralytic at the well at Bethesda (John 5:5-9), it seems curious to ask a paralytic of thirty-eight years this question first: "Do you wish to get well?" Rationally, one could ask, "Why wouldn't anyone who has been sick for that long not want to get well?" However, after teaching psycho-educational groups for a number of years, the researcher has concluded from interactions with patients that Christ's question to the person with paralysis is a lesson in personal growth in that it is essential to first make the choice of exercising one's will. In contrast to Jesus, Satan, was insidious enough to challenge the entire course of history with just one potent question: "Has God said?"

As the Apologist knows, Socratic questioning is a powerful tool to help draw out one's worldview assumptions. In like manner, Socratic questioning also assists mental health counselors to elicit the assumptions of mental health sufferers that drive maladaptive beliefs. Beck (2011:747-756) lists some of the Socratic questions practitioners use to help mental health sufferers realize their faulty thinking – thinking which may be provoking their negative emotions:

- What's the evidence that your thought is true, that people will be critical of you? Is there any evidence on the other side, that people might not be critical?
- Is there another way of looking at this situation?
- What's the most realistic outcome?

- What could be the effect of changing your thinking?
- What would you tell your friend [think of a specific person] if he or she were in this same situation and had this thought? How might that apply to you?
- What should you do now?

As stated in 5.3, while CAMH borrows from the praxis, interventions, and techniques defined in CBT, CAMH refutes the philosophical framework or undergirding of CBT since it is not bound to the systematic nature and Biblical principles of the Christian worldview. To continue with this distinction, the researcher will address here the differences between CAMH and CBT Proper.

5.4.5 Differences between CAMH and the core pillars of CBT

5.4.5.1 Philosophical differences between CAMH and CBT

The researcher contends, CAMH can encapsulate the efficacy of CBT, but it challenges its sufficiency since it is not grounded systematically. Specifically, from a Christian worldview, CBT does not factor in all the theological and philosophical data, such as the use of general revelation (creation), special revelation (Bible), or primarily relying on the Scriptures as the Word of God. Understandably, modern psychology does not endeavor to coalesce with the Christian worldview, for it is mostly framed on a secular model. Therefore, when viewed through a Christian lens, the presuppositions are inherently lacking in CBT, for they do not provide a solution or explore these considerations in-depth.

5.4.5.2 CAMH is philosophically validated and eternally grounded

Ironically, from an agnostic's view, Robertson (2010:xix-xx) explains the need here for a systematic approach when counseling that includes the "bigger picture", namely, a Supreme Being. He suggests [italics added by researcher]:

> To return to the questions with which we began: why, then, should philosophers and psychotherapists be concerned with one another? First of all, the difference between what the ancients did and what modern therapy does lie largely, but not exclusively, in its scope. *Philosophy answers a craving for something more expansive; it embraces the totality of things through their essence. It has the capacity to raise the head of modern psychotherapy and tilt its gaze upwards towards the vastness around us, perhaps even the whole of time and space, as Socrates and the Stoics, literally, recommend*.

In the same manner that Robertson (2010) suggests psychology must consider the bigger, philosophical picture, something more ultimate than life itself; just so, American existentialist psychiatrist, Professor Emeritus from Stanford University, Yalom (2013:loc.:1761-1767), here points out the need – the deeper philosophical, worldview desire that surfaces when patients seek out therapy:

> More individuals seek therapy because of concerns about the meaning in life than therapists often realize, Jung reported that one-third of his patients consulted him for that reason, the complaints take many different forms: for example, “My life has no coherence,” “I have no passion for anything.”, “Why am I living?” To what end?” “Surely, life must have some deeper significance.” “I feel so empty-watching TV every night, it makes me feel so pointless, so useless”. Even now at the age of fifty I still don’t know what I want to do when I grow up”.

5.4.5.3 Philosophical construct of CAMH is grounded in the eternal nature of God

CAMH is philosophically grounded in that it is established by a classical epistemology and metaphysical realism. Conversely, CBT is established by a relativistic framing (Tan, 1987:103-112).

CAMH is grounded in foundationalism and established in first principles, principles not created by man, but discovered in general revelation. These principles are the divine reasoning that not only govern the universe, but what is most remarkable is the fact that these principles are eternal and found in the nature of God. Aquinas (cited in Summa Theologica, 2010:556) explains these foundational principles as:

> …a dictate of practical reason emanating from the ruler who governs a perfect community. Now it is evident, granted that the world is ruled by Divine Providence, as was stated in the First Part (Q. 22, AA. 1, 2), that the whole community of the universe is governed by Divine Reason. Wherefore the very idea of the government of things in God, the Ruler of the universe, has the nature of a law. And since the Divine Reason's conception of things is not subject to time but is eternal, according to Prov. 8:23, therefore it is that this kind of law must be called eternal.

In other words, as explained by Geisler (1998:779-781):

> Insofar as logic manifests reason it flows from the very nature of God … Further, God did not create laws of logic. They manifest His uncreated nature. God is rational, and there are certain basic principles of rationality that cannot change any more than God can change his own essential nature.

Since these laws and principles are a reflection of God's nature, they must be eternal, since God and His essence are eternal. Therefore, if God is foundational, (eternal), and God's very nature established logic, then logic is foundational, eternal, objective, absolute, and unchangeable. The following Biblical proof-texts attest to the eternal nature of God:

- Genesis 1:1: "In the beginning, God created the heavens and the earth."
- Hebrews 1:2: God speaks of a Son whom "He appointed heir of all things, and through whom He also made the universe".
- Isaiah 57:15: "For thus says the One who is high and lifted up, who inhabits eternity…"
- 1 Corinthians 2:7: "No, we speak of God's secret wisdom, a wisdom that has been hidden and that God destined for our glory before time began."
- John 17:5: "Father, glorify me in your presence with the glory I had with you before the world began."
- Jude 25: Here Jude speaks of "Jesus Christ, our Lord, before all ages, now and forevermore".

To summarize the points supporting the philosophical validation for CAMH, consider this sorites:

- That which is eternal is timeless and outside time.
- Time indicates a change of 'before(s)' and 'after(s)'.
- If God created both time and space, then He must be outside time and space, or He could never have created them.
- If God is outside time and space, then He must be eternal.
- If God and His attributes are eternal, then He and His standards (like truth) cannot change.
- Consequently, this tells us that God's eternal perspective is the only accurate measurement by which we should ever appraise everything like truth because it is the ultimate, only, unchangeable, fixed point.

5.4.5.4 Special revelation (Biblical) precedent of CAMH

The theoretical framework of CAMH would technically pre-date CBT since Biblical precepts can subsume it. While CAMH accepts the cognitive model, unlike CBT, the goal of CAMH is to integrate only empirical data from general revelation that harmonizes with the Bible. English (1990:149) explains this approach this way: “Once the validity of a theory is proven, the theory becomes useful for the integrationist if it is compatible with Scripture”. Attesting to this compatibility, note Thurman’s (1999) Biblical proof-texts signifying the mediation hypothesis concept, since it evidences the “importance of right thinking for emotional and spiritual health”.

- Proverbs 14:15: “A simple man believes anything (…but a prudent man gives thought to his steps.).”
- Proverbs 23:7: “For as [a man] thinketh in his heart, so is he.”
- Isaiah 26:3: “You will keep him in perfect peace whose mind is steadfast because he trusts you.”
- John 8:32 “… you will know the truth, and the truth will set you free.”
- Romans 1:28: “Furthermore, since they did not think it worth-while to retain the knowledge of God, he gave them over to a depraved mind, to do what ought not to be done.”
- Romans 12:2: “Do not conform any longer to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God's will is—his good, pleasing, and perfect will.”
- 1 Corinthians 10:5 “We are destroying speculations, and every lofty thing raised up against the knowledge of God, and we are taking every thought captive to the obedience of Christ.”
- 2 Corinthians 10:5: “We demolish arguments and every pretension that sets itself up against the knowledge of God, and we take captive every thought and make it obedient to Christ.”
- Ephesians 4:22: “You were taught, with regard to your former way of life, to put off the old self, which is being corrupted by its deceitful desires; to be made new in the attitude of your minds, and to put on the new self, created to be like God in true righteousness and holiness.”

- Philippians 4:8: “Finally, brothers, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy, think about such things.”
- Colossians 3:2: “Set your minds on things above, not on earthly things.”

Subsequently, since data supports successful outcomes when practicing CBT within a Christian framework, Pearce (2016), in agreement with Tan (1981), states that CBT can be applied from “a more broad-based, biblical perspective” (Tan, 1981, cited in Tan, 1987:103-12). Therefore, CAMH is distinguished from CBT since the Christian Scriptures bind it.

5.4.5.5 Justifiable, absolute, universal standard of appraisal for CAMH

There is a significant, perhaps even eternal, difference between CAMH and CBT; namely, since CAMH operates from a philosophically grounded, eternal standard of measurement, this offers one an ultimate fixed point of appraisal to assess all life matters, such as meaning, purpose, human suffering, and moral principles for right and wrong.

By contrast, in the context of mental health, CBT with its origin in secular psychiatry, operates with the theoretical risk of relativism and is traditionally conducted by licensed mental health practitioners.

5.4.5.6 Distinctive moral standard

To illustrate why an ultimate moral standard is needed to appraise value judgments, consider the distinction in this example: During a debate at Kings College on the topic of *hell*, Hitchens and Wilson (2008), Hitchens (an atheist), stated, “One of Christianity’s specifically horrible contributions to human mythology and delusion is the terrifying idea that you could be tortured forever”. Wilson (a theist) replied, “Horrible by what standard?” Hitchens paused for a moment, then responded, “Horrible by ... well, good question.” As the reader can see, to avoid relativism, the question, “Horrible by what standard?” reveals there is no systematic, philosophical validation to anchor an absolute moral standard by which to measure and justify Hitchens’ value judgment. The significance to counseling is that there are difficult determinations demanding

solutions that must be adjudicated by one standard that transcends all others to ultimately determine what is right and wrong, such as abortion conversations, spousal abuse, relationship boundaries, gender identity cases, what constitutes “cheating”, and divorce. Consequently, without this ultimate moral standard, counseling is left with relativistic solutions.

Whereas CAMH is philosophically validated, CBT furnishes a modest, to no recognizable philosophical foundation onto which to anchor its moral theory. Thus, making it deficient in light of the Christian worldview, for if there is no ultimate standard of appraisal, this leads to subjectivity and relativism. As Tan (1987:103-112) points out − for the Christian, there is the risk of applying CBT apart from a justifiable absolute philosophical grounding:

> CBT may result in therapists imposing their own relativistic, empirically oriented values onto the client**.** For example, Ellis (1980) is clear about what values he advocates, and in addition to breaking down irrational beliefs, he may also end up destroying conservative, theistic, Christian beliefs. Absolute truth as revealed in Scriptures and perceived and interpreted as accurately as possible with the best hermeneutical and exegetical tools available should still be the Christian therapist’s ultimate guide (cf. 2 Tim. 3:16-17).

Subsequently, since CAMH operates from a philosophically grounded, eternal standard of measurement that supports a justifiable, absolute, universal standard of appraisal that incorporates biblical truths, it can offer a systematic and coherent anthropology.

5.4.5.7 Systematic and coherent anthropology of CAMH

Most theorists recognize that illness manifests in a variety of ways, such as “guilt, anxiety, resentment, uncontrolled appetites, lack of self-acceptance, feelings of personal unworthiness, insecurity, wrong priorities, and selfishness” (Crabb, 1977:34). However, what is more complicated for theorists is to understand the primary cause identified as the nucleus of these illnesses. Christians recognize ultimately that what drives the etiology or mental health challenges is sin within the fallen nature of man. The Greek word for sin is *hamartia*, which means to miss the mark; however, again, what is critical is that we understand the nature of sin, which, as implied by the Greek word, could result in us ‘missing the mark’ by not correctly identifying the problem, and thus ultimately result in wrongdoing and its resultant consequences. Put another way,

improper assessment of the problem could result in the counselor chasing the effects, not the cause. Consequently, this leaves the human condition as self-determining with full responsibility to growth. CBT operates on an incomplete anthropology in that it not only minimizes God's role in personal formation toward spiritual growth, but this assumption also contravenes the Christian Scriptures, thus leaving the theoretical foundation of CBT wanting, for, as Tan (1987:103-112) purports:

> As a secular approach, CBT ignores God, Jesus' redemptive work, and the Holy Spirit's ministry in bringing about inner healing, as well as cognitive, behavioral, and emotional change. There is a danger in secular cognitive-behavior therapy to bring about changes only in psychological self-talk, or external behavior change, without a deeper transformation of the inner person or the soul/spirit of the person (Sandford & Sandford, 1982), which only the Holy Spirit can produce, and which requires prayer and affirmation of God's Word. Self-efficacy theory if misapplied can lead to sinful self-sufficiency apart from the Lord and his work of grace. There is a paradoxical, biblical truth of strength being made perfect in weakness (2 Cor. 12:9-10), which leads to a "self-efficacy," which is really "Christ-efficacy"—"I can do all things through Christ who strengthens me" (Phil 4:13). However, this does not mean that a Christian cannot have a sense of self-efficacy or be appropriately assertive (Sanders & Malony, 1985)—only that such self-efficacy and appropriate assertiveness of the Christian are to be centered in the Lord Jesus Christ and the power and wisdom of the Holy Spirit, and not in proud self-sufficiency apart from God and his love and grace.

5.4.5.8 CAMH and CBT: Comparable methods — Different outcomes

5.4.5.8.1 Background

To determine outcome CAMH begins with God's belief system, not man's − namely, spiritual growth; as evidenced in James 1:2-4, "Consider it pure joy, my brothers and sisters, whenever you face trials of many kinds because you know that the testing of your faith produces perseverance. Let perseverance finish its work so that you may be mature and complete, not lacking anything". CAMH recognizes that God is more concerned about our character than our comfort; knowing that the former will always produce joy and contentment later but rarely does the later produce the former. CAMH begins with ultimate reality and tries to conform the client's thoughts to reality, which leads to better utility; CBT begins with a client's belief system and seeks first to change those beliefs for better utility. Tan (1987:103-112) suggests that CBT is at risk of leading to pragmatism; he states, "the pragmatic, empirical orientation of cognitive-behavior therapists tends to lead them to use whatever techniques work". In CBT, when defining "what works", the goal often found in the literature seems to end with

symptom elimination only and not spiritual growth. Notice the implied goal here; the researcher refers to Beck (2011:134) here but italicizes the common treatment outcome for secular CBT practitioners:

> Much of the time, merely describing a problem or identifying dysfunctional thoughts or beliefs related to the problem will not result in *the patient's feeling better*. You should be conscious of your goal to help patients (during the session itself) respond to their dysfunctional cognitions, solve or partially solve a problem, and set up homework assignments designed to ameliorate the problem or *help them feel less distressed*. Throughout the session, you should ask yourself: "*How can I help the patient feel better by the end of the session*?" "*How can I help the patient have a better week*?"

Of course, feeling better is not wrong in itself, although, the intention of the counselor practicing CAMH is symptom elimination in accord with spiritual growth. Subsequently, without a justifiable, absolute, universal standard of morality − symptom alleviation, or "that which works" to make the counselee feel better, is understandably the therapeutic goal. This would deem and leave existential problems like evil, abortion, euthanasia, adultery, death anxiety, with inconclusive outcomes in the normative CBT counseling setting. Of course, this begs the question when correcting distortive beliefs, "Who or what defines a belief as faulty? Is it the client? Is it the therapist? Is it the *Diagnostic* and *Statistical Manual of Mental Disorders* (DSM), or perhaps society itself?" For instance:

- If the therapist and patient determine whether or not a child, four weeks from conception is not useful to the parents' economic status, by what authority does the patient have the right over the unborn child to determine its usefulness?
- If you do not feel like being married anymore, who determines whether or not to condone a divorce or whether or not there is biblical justification to remarry?
- What gives us value? What if you do not feel useful anymore?
- What or who validates the "self-esteem" I am taught to embrace?
- In CBT, who determines who I am, where am I going, and why am I here?
- Additionally, how do you answer existential, spiritual, and worldview issues that manifest psychologically, like "How do I deal with death anxiety?"

While philosophers and theologians commonly discuss the above questions, research suggests psychologists likewise are finding clinical value in these topics (Furer & Walker, 2008).

To contrast CAMH and CBT, the researcher will parse out an example here within psychology to illustrate that CAMH is not only sufficient to CBT in its application, but it also answers the root concerns that manifest in counseling settings. Consider a sample on *death anxiety* for which psychology must *give an answer* since it surfaces as a trigger for "many forms of anxiety and phobia" (Furer & Walker, 2008:167-182). Death anxiety is the fear over death, the process of dying, and the afterlife. For death anxiety treatment planning, Furer and Walker (2008:167-182) suggest using:

- Cognitive-behavioral intervention: Avoidance is one of the most common ways of dealing with the fear of death, so we place particular emphasis on exposure (both in vivo and imaginal) to feared themes related to death. The most powerful way to deal with the fear of death is to face fear rather than avoiding it.
- Exposure: Exposure may be implemented through in vivo exposure to avoided situations, imaginal exposure focused on thoughts and memories related to death, and interoceptive exposure in the case of bodily symptoms that are cues for death anxiety.
- Cognitive reappraisal: Helping the client move toward more balanced views of these issues may help them cope more calmly with the prospect of death. Exposure exercises involving education about death experiences and the adjustments that family members make can help the client move from catastrophic thoughts about death to a more realistic appraisal of death.
- Enhancing enjoyment of life: As much as possible, the clinician allocates time during each session to a focus on enhancing the enjoyment of life and moving toward personal goals.
- Healthy lifestyle: Common problems include difficult or disappointing relationships, limited social support, a stressful work situation, and unhealthy aspects of lifestyle. When possible, we integrate the work on a healthy lifestyle into regular treatment sessions.

While the researcher sees the merit in the above interventions, especially since, there are reports that even the religious can struggle with death anxiety[40] – when contrasting

[40] Furer and Walker (2008:167-182), reference, "Higher levels of religious belief and participation in religious practice are not associated with lower levels of death anxiety" (cited in Kastenbaum (2000).

this with CAMH, which could theoretically subsume the above, the ultimate answer to death anxiety is found in the death and resurrection of Jesus Christ. Therefore, the above interventions may be helpful, but not sufficient when there is a Biblical answer for the following:

- Our own death: John 3:16: “For God so loved the world that he gave his one and only Son, that whoever believes in him shall not perish but have eternal life.”
- Fears that our loved ones are not believers: Genesis 18:25: “Shall not the judge of all the earth do what is just?”
- Loved ones who are believers who have died: 1 Thessalonians. 4:13-15: “Brothers and sisters, we do not want you to be uninformed about those who sleep in death, so that you do not grieve like the rest of mankind, who have no hope. For we believe that Jesus died and rose again and so we believe that God will bring with Jesus those who have fallen asleep in him.”

The researcher concurs with Tan (1987:103-112) when he says: “Eliminating symptoms is, therefore, not always the most viable or valid goal in Christian counseling; in other words, holiness, and not temporal happiness, is the ultimate goal of Christian therapy”. Furthermore, the researcher is in agreement with Crabb (1977), Jones (1984), and Tan (1987), who conclude that in order to address the pragmatic approach of CBT, there is, in addition, a need to develop and use an ethical, “righteous” perspective so that Christian therapists will not just use “what works”, but also that which is consistent with Scriptures (Tan, 1987:103-112).

For CAMH, while recognizing that CBT praxis can be utilized as Tan (1987:103-112) suggests, as long as it is “consistent with the view that it is God’s will to set the Christian free from any mental anguish caused by erroneous or unbiblical cognitions and beliefs”, the researcher likewise acknowledges that Christian ministers should remain cognizant of over self-reliance and avoid encouraging self-sufficiency inadvertently (cf. Phil. 4:13) (Tan, 1987:103-112).

Consequently, without tethering the praxis of CBT to Biblical principles, one may be left with a comparable method but a different outcome.

Consequently, the goal then for CAMH is primarily spiritual growth and to be conformed to Christ (Romans 8:29), not merely symptom alleviation.

5.4.5.8.2 Human suffering

Therefore, if the goal in CBT, is pragmatism, and symptom alleviation *only*, then for the Christian, CAMH is a more plausible counseling modality, since spiritual formation is its ultimate goal. For, CAMH finds meaning and purpose within the symptoms of mental pain and human suffering rather than avoiding it. Tan (1987:103-112) makes a case for this same assertion when he says:

> There is also a need to reaffirm Scriptural perspectives on suffering, including the possibility of the "blessings of mental anguish" (Evans, 1986; Grounds, 1976), in order to overcome the tendency of therapists, including cognitive-behavior therapists, to seek only "cure," and hence to use what works in our "therapeutic society". Evans has recently pointed out that "the primary goal of a Christian counselor is not to help people become merely 'normal,' but to help them love God with all their heart, minds, and souls" (p. 29; and this may involve God using and working through our human weaknesses.

In summary, as formulated by the above propositions, the researcher contends that Apologists can bring needed support to the mental health needs in the Church by only applying what they do intuitively within Worldview Apologetics (Corduan, 2020). Below is a summary of the benefits of CAMH over CBT:

- Philosophically validated
- Philosophically coherent
- Eternally anchored
- Grounded in the eternal nature of God
- Justifiable: Absolute, universal standard of appraisal
- Systematic and coherent anthropology.

5.5 Applied Christian Apologetics for Mental Health

> "The mind is its own place and in itself, can make a Heaven of Hell, a Hell of Heaven." (John Milton, 1667: *Paradise Lost*)

5.5.1 Concept derivation of CAMH

5.5.1.1 Introduction

As stated above, to adapt CAMH for Apologists and ministers, the researcher must provide working definitions and concepts to employ, and which align with the language usage of both fields (Walker & Avant, 2021). Clauses 5.5.1.2 to 5.5.1.9.7 review the relevant terms the researcher suggests can be synthesized between both fields.

5.5.1.2 Socratic Method

5.5.1.2.1 Background

Historically and philosophically, Socrates was one of the most exceptional educators in history; he taught by asking questions and thus drawing out answers from his pupils ("ex duco"), which means to "lead out," which is the root of "education".

Dillion (2016:19), states the following, when Socratic questioning is used in CBT:

> Properly employed, the Socratic Method should leave the student filled with knowledge rather than feeling like he has been taken apart. If done well, the student will feel that he or she has derived the knowledge themselves rather than through the hand of the teacher.

Below are examples of the questioning that are commonly employed in Socratic questioning and that do have worldview and counseling application:

- Getting students to clarify their thinking: e.g., "Why do you say that?", "Where do you think your idea about yourself came from?"
- Evidence supported ideas: e.g., "What is the evidence for that belief?"
- Implications and consequences: e.g., "But if ... happened, what else would result?"

5.5.1.2.2 Clinical definition and example

In counseling, *motivational interviewing* (Miller & Rollnick, 2012) is a process that applies the Socratic Method to create self-awareness towards behavioral change within the client. Miller and Rollnick (2020:12) define it this way:

> Motivational interviewing is a collaborative conversation style for strengthening a person's own motivation and commitment to change. MI is, first and foremost, a conversation about change. If we had called it anything else, it probably would have been "motivational conversation".

Subsequently, in both counseling and Apologetics, Socratic questioning is a method that affords the thinker the wherewithal to arrive at their own beliefs without being informed. The approach is a strategy of "Ask, do not tell". Below are a few examples of questions by Beck (2016) that can be used from the generic model to examine the validity of one's thoughts. Only one, or a few variations of the questions here may be needed:

- What's the evidence that the thought is true?
- What is the evidence on the other side of the belief?
- Is their evidence that the thought is false?
- What is another way of looking at this situation?
- What could be the effect of changing your thinking about this?

Once the dialogue is primed with these general questions, depending on the issues, the counselor can drill down with more specific, sometimes leading questions, such as:

- Where do you suppose mankind should find meaning and purpose in life?
- Ultimately, besides God, who or what does gives us personal value and significance?
- Are there any other spiritual options that can be considered for coping with anxiety, apart from correcting thought distortions?
- Could God have a purpose in your current suffering?

5.5.1.2.3 Worldview Apologetic example

In Worldview Apologetics, this is called the *dialectic,* a method of reasoning through dialogue and disagreement to uncover truth. Regarding both, note that the process is not just questioning. It is systematic, directed, more in-depth dialogue to get the student or counselee to uncover assumptions to discern false beliefs from ultimate reality (truth). For the Apologist, to identify and correct fallacies, they often operate within the terms and concepts of Aristotelian logic. The researcher will elaborate more on this application later, although for now, know that most cognitive therapists use Socratic questioning to identify cognitive distortions during therapy. Since clinical counseling and the Apologetics worldview community both use and agree on the recognized term Socratic Method and its practice of asking open-ended questioning, for the finalized adapted working definition CAMH, the researcher will use the same term: Socratic Method.

5.5.1.3 Idiosyncratic meaning

5.5.1.3.1 Background

Words are powerful. If, for no other reason, they influence our thoughts, feelings, and behaviors. Words can positively or negatively impact us since words lead us to instantly conjure up our deductions of the meaning assignment, personal images, or associations to other ideas and images. The meanings are, as defined in the *Merriam-Webster Dictionary* (2021), idiosyncratic − comprising “an individualizing characteristic or quality”.

5.5.1.3.2 Clinical definition and example

Gurman and Messer (2003:229) maintain that “Individuals develop idiosyncratic belief systems that guide behavior. Beliefs and assumptions influence an individual’s perceptions and memories and lead the memories to be activated by specific stimuli or events”.

5.5.1.3.3 Worldview Apologetic example

Consider here an example of an *idiosyncratic* worldview *meaning* in this question: "Would we live differently if our philosophy of life is "*All is vanity*" (Eccles.1:2), "*life is meaningless*" (Eccles. 2:11), and the purpose of life is hedonistic (2 Tim. 3:4)? Or by contrast, how would our lives be different if we lived life with the meaning assignment that affects a flourishing afterlife as Ecclesiastes 12:13 decrees: "*Fear God and keep his commandments, for this is the whole duty of man*" (Eccles. 12:13)? Of course, there would be differences in life outcomes in these two examples since our universal beliefs rationally affect our local beliefs. Just as our religious worldview has implications on our eternal destiny, our cognitive worldview has implications on our mental health. We often suffer more with psychological conditions when our core beliefs are negative and maladaptive. Tan (2011:258) explains here the role counselor's play in understanding the specific meanings counselees assign to their life events:

> Cognitive therapists ask clients to explore and clarify the personal or idiosyncratic meaning of specific words they use to describe their thoughts and feelings. Active listening skills and wise Socratic questioning and dialogue are used by the therapist to sensitively understand the idiosyncratic meaning of the client's words and thoughts.

Since clinical counseling uses the recognized term, *Idiosyncratic Meaning* and the Apologetics worldview has no universally recognized term for the same concept, for the finalized adapted working definition CAMH the researcher will use the clinical term: *Idiosyncratic Meaning.*

5.5.1.4 Questioning the evidence

5.5.1.4.1 Background

Questioning the evidence is virtually defined in the very name. It is the questioning or examination of the evidence for an idea or a truth claim.

5.5.1.4.2 Clinical definition and example

Gurman and Messer (2003:245) suggest: "This involves systematically examining evidence in support of a belief, as well as evidence that is inconsistent with it". This technique is one of the most common applications of both the counselor and the Apologist. Both listen to, and quickly assess a claim with a question such as, "Is what

I just heard true?" Both the counselor and Apologist alike are taught to examine not only the evidence the supports a premise but also evidence against the premise. Tan (2011:258) suggests that in a counseling setting: "The cognitive therapist asks key questions such as: On what basis do you say this?" and "Where is the evidence for your view or conclusions?" Clients are encouraged to question and modify their belief in the face of contradictory evidence".

5.5.1.4.3 Worldview Apologetic example

As an example of questioning the evidence in an Apologetic setting, it is common in a debate with an atheist for an Apologist to ask, "Can you prove to me that no God exists?" Or, "What is the evidence that the universe does not need a cause?"

Since the clinical counseling and both the apologetics worldview community both use and agree on the recognized concept and term, for the finalized adapted working definition CAMH the researcher will likewise use the same term: questioning the evidence.

5.5.1.5 Reattribution

5.5.1.5.1 Background

Reattribution is simply attributing an inaccurate cause to an event. In counseling, this presents when the explanation of a cause, feeling, and behavior is applied to the wrong source – often called an *attribution error*. In Apologetics, this happens when the explanation of an idea is applied to the wrong source. This likewise can be called an attribution error.

5.5.1.5.2 Clinical definition and example

The use of the *reattribution* technique in counseling is simply to reapply the responsibility from the wrong source to the right one. For instance, Gurman and Messer (2003:246) assert: "Patients often take responsibility for events and situations that is only minimally attributable to them". Likewise, this often erroneously surfaces as *personalization*, which is taking on or personalizing a situation that should not entirely be applied to the person; or, it happens when one is avoiding taking responsibility for

a situation for which they should take responsibility. Avoiding taking personal responsibility for accurate situations is done to protect ourselves psychologically, often called and used as a *defense mechanism* (see Appendix D for a list of defense mechanisms). These defense mechanisms and attribution errors are common in *denial.*

When working with reattribution, the goal is to assist one to assess and help apply responsibility to the accurate situation, event, or person. Neenan and Dryden (2004:12) explain this application:

> Reattribution helps clients to step back from and look at the many contributions to an adverse outcome. Thus, a client who blames herself for causing a bad outcome is helped to see that she cannot be responsible for all the factors that led to this outcome.

In light of counseling praxis Tan (2011:258) maintains: “In this technique, clients are encouraged to test their automatic thoughts and assumptions by exploring other possible ways of looking at things or alternative causes of events. The cognitive therapist simply asks: “Is there another way of looking at this?” Attributing symptoms to the right cause is critical within clinical healthcare; likewise, it is imperative to use when helping sufferers within the Church. In counseling, the first session is often used to assess the causes driving the presenting mental health problem. While in the broad context all shortcomings and deficits could be slotted into the category of sin, a minister may be susceptible to an attribution error if there is no other consideration driving the symptoms since it is not uncommon for well-meaning ministers to over-spiritualize causes as the sole source of mental health complaints (Horton, 2014). Therefore, a ministerial counselor could ask, “Is there another way of looking at this?” Or, “Could there be another option driving these feelings (i.e., negative mood)?” Without considering different attributions, mental health issues may be under-assessed. For instance, if a minister added into the assessment, a physical examination from a recent family physician, biological considerations (i.e., sleep disorders such as sleep apnea, thyroid conditions), and physiological considerations (i.e., vitamin deficiencies, caffeine, prescribed and un-prescribed medications), then the minister will avoid chasing symptoms and perilous treatment pursuits and the need to later reattribute the mental health symptoms to another cause. Consequently, this will lead to more effective, even quicker treatment.

5.5.1.5.3 Worldview Apologetic example

Within Christian Apologetics, the Apologist hears many attribution errors. Perhaps one of the most common and potent is, “If God created all things, and evil is a thing, then God created evil”. The implication here is, if God created evil, then how can mankind be responsible for its influence over humanity. Of course, when checking the claim, a more plausible claim within Christian theology is to reattribute the cause to human freedom, for *God allowed for the fact of evil, but man’s freewill is the cause for the act of evil.*

Since the clinical counseling community uses the established term *reattribution* and the Apologetics worldview has no known, universally recognized term for this concept, for the finalized adapted working definition, CAMH will use the counseling term: *reattribution.*

5.5.1.6 Rational responding

5.5.1.6.1 Background

The practice of rational responding is also logically found within the very name. That is, the goal is to reply or give an answer to a distortive thought, misbelief, and ideas rationally or logically to ensure each premise supports the conclusion.

5.5.1.6.2 Clinical definition and example

Gurman and Messer (2003:246) assert that *rational responding* is “one of the most powerful techniques in cognitive therapy” to help neutralize maladaptive thoughts. The application of *rational responding* starts with helping sufferers identify (or *catch*) the thought(s) causing them distress. To *catch* these thoughts, *rational responding* involves the following four steps:

1) a systematic examination of the evidence supporting and refuting the belief;
2) the development of an alternative, more adaptive explanation or belief;
3) de-catastrophizing the belief; and
4) identifying specific behavioral steps that can be taken to cope with the problem; the severity of a situation or the likelihood of a negative outcome.

5.5.1.6.3 Worldview Apologetic example

Like the clinical application, *rational responding* also starts with systematically identifying (or *catching)* the distortion or faulty premise and changing the incorrect assumption to an accurate meaning. For instance, consider this common atheistic argument that: "*If God were all-powerful he could destroy evil; if God were all-loving He would destroy evil. Evil still exists; therefore, God is not all-loving and all-powerful.*" Just as the clinician systematically listens, to *catch,* faulty premises underlying the counselee's assumptions, the Apologist also listens systematically to each or the underlying beliefs or ideas formulating an argument. Notice, in the argument posited above, the Apologist will hone in on the premises supporting the faulty conclusions namely, "*Since God has not destroyed evil yet, He cannot. Alternatively, since God has not destroyed evil, then He has no good purpose for allowing evil. As well as, He continues to allow evil, then He has no loving purpose for its continuation*". To rationally use an Apologetic response in answer to this anti-theistic argument, Geisler (2012:142.) replies:

> The theistic answer to apparently purposeless evil is fourfold:
> First, God has a good purpose for everything.
> Second, we do know a good purpose for much evil.
> Third, some evil is a byproduct of good.
> Fourth, God is able to bring good out of evil.

Hence Geisler (1999:28-29) argues:

> The antitheist overlooks an important distinction: God knows a good purpose for all evil, even if we do not. Simply because finite minds cannot conceive of a good purpose for some evil does not mean that there is none. Since God is omniscient, he knows everything. Moreover, since he is omnibenevolent, he has a good purpose for everything. Hence, God does know a good purpose for all evil, even if we do not know it.

While the clinical counseling field operates on the recognized term *rational responding* and the Apologetics worldview has a similar implied conceptual term, for the finalized adapted working definition CAMH will also use the term: *rational responding.*

5.5.1.7 Examining options and alternatives

5.5.1.7.1 Background

The *Examining Options and Alternatives* technique is designed to help one explore different options to broaden their considerations "beyond his or her initial limited range of possible solutions" (Tan, 2011:259).

5.5.1.7.2 Clinical definition and example

While working with a counselee, after the counselor has identified any faulty conclusions driving negative moods or behaviors, the counselor will assist the counselee in cultivating other options and even more plausible alternatives driving their conclusions. For instance, Gurman and Messer (2003:246) explain this is not uncommon for suicidal patients who "often see their alternatives as so limited that death becomes a viable solution. Patients can be assisted to develop, and then to evaluate alternative solutions".

5.5.1.7.3 Worldview Apologetic example

For example, within worldview Apologetics, a believer may encourage a non-theist to consider other options when weighing their conclusions when a non-theist purports: "There is no evidence for God's existence". The Apologist often provides an option or alternative counter-example as a thought-provoking consideration to substantiate evidence that God could exist, such as the design of the universe (teleological argument), causality (cosmological argument), and even universal morality (the moral law argument). Subsequently, *examining options and alternatives* is a universal application both within clinical counseling and Apologetics.

Since clinical counseling has the recognized term *Examining Options and Alternatives* and the Apologetics community utilizes no known universally recognized term for the finalized working definition, CAMH, will adapt CBT counseling's same term.

5.5.1.8 Direct disputation

5.5.1.8.1 Background

Just as the definition and technique of *Rational Responding* (see 5.5.1.6) is found in the very name, likewise, so is that of *Direct Disputation.* Here, the goal is to directly dispute any false claim within both the counseling and Apologetic setting.

5.5.1.8.2 Clinical definition and example

In *Direct Disputation,* one can correct a false claim without Socratic questioning. Tan (2011:261) suggests *Direct Disputation* can challenge *"*dysfunctional thinking by engaging in vigorous debate". In a counseling setting, Gurman and Messer (2003:248) explain its benefit here:

> There are times at which direct disputation is helpful. When there is an imminent risk to the patient, as in the case of suicide, direct disputation might be considered. As these approaches are, in some regard, noncollaborative, the therapist risks becoming embroiled in a power struggle or argument with the patient. Disputation of core beliefs may, in fact, engender avoidance or a passive-aggressive response. Disputation, argument, or debate must be used carefully, judiciously, and with skill.

5.5.1.8.3 Worldview Apologetic example

In the Apologetic setting, such as the dialectic or debate, when one is asserting a contrasting worldview claim, the Apologist could directly challenge the distortion with the following argument:

- "That's wrong."
- "That idea is incorrect."
- "You're reasoning is inaccurate."

Additionally, comparable word usage that satisfies the *Direct Disputation* of faulty beliefs is: "False, inaccurate, flawed, mistaken, unsound, and untrue".

Likewise, since clinical counseling uses the recognized term *Direct Disputation* and the Apologetics community has no known universally recognized term, CAMH will adapt the same counseling term for the finalized working definition.

5.5.1.9 Labeling the distortions and Aristotelian logical fallacies

5.5.1.9.1 Background

The technique of "labeling the distortion" parallels the historic philosophy concept of "Aristotelian logical fallacies". Aristotle refined some of the work of Socrates to help us work with thought distortions. Interestingly, after close to 2500 years later, Aristotle's discoveries are still used in textbooks today. Many cognitive distortions, or what is commonly called in counseling *thinking* or *thought distortions*, are Aristotelian material logical fallacies. For example, black-and-white thinking is a material logical fallacy called *dicto simpliciter;* likewise, overgeneralization is the fallacy of hasty generalization (Kreeft, 2010). These belief fallacies are like the first principles (Aristotle) of thought distortions leading to emotional dysregulation. Burns (2012) popularized a list of primary thought distortions.[41]

For both counselors and counselees alike, a core objective within CBT is to design and label the most common thinking errors or cognitive distortions when they surface (Tan, 2011:261). By this, the counselee will be able to *catch* them, with the aid of quickly labeling them, to make it easier to *check* and *change* them with corrective beliefs.

Clinically, labeling of distortions can help with mood struggles such as anxiety. Gurman and Messer (2003:248) explain:

> Fear of the unknown and "fear of fear" (Foa, Steketee, & Young, 1984) can be essential concerns for anxious patients. The more one can identify the nature and content of the dysfunctional thoughts and help label the types of distortions that patients use, the less frightening the entire process becomes. Patients can learn to identify and label specific distortions during the therapy session, and afterward, they can practice this exercise at home.

Since clinical counseling operates on the recognized term "labeling of distortions" and worldview Apologetics uses the language Aristotelian logical fallacies, CAMH will use both interchangeably and point out when each can be applied within case examples.

[41] See Appendix C for a list of these distortions in *Ten common distorted thinking styles* as offered by Pearce (2016:66-70, cited by Burns 2012).

5.5.1.9.2 All-or-nothing thinking

‘All-or-nothing thinking has multiple, known terms like dichotomous, false dilemma, false dichotomy, or black-and-white *(dicto simpliciter*, or all-or-nothing*)* thinking. It is the Aristotelian material logical fallacy called *dicto simpliciter* (Kreeft, 2010), and the cognitive distortion of seeing things as ‘either-or’.

Pearce (2016:65-66) offers this example of black-and-white *(dicto simpliciter*, *or* all-or-nothing*)* thinking: “if your performance falls short of perfect, you see yourself as a total failure. This way of evaluating things is unrealistic because life is rarely completely one way or the other”. Most of us have experienced this type of distortion; however, on a more polarized level, symptomatically, Gurman and Messer (2003:233) suggest, black-and-white or “all-or-nothing thinking is encountered in borderline and obsessive-compulsive disorders”.

An argument heard within the Apologetics community for all-or-nothing thinking or *dicto simpliciter,* is this common claim often voiced by atheists and agnostics, “With all the suffering in the world, a loving God is not possible”. For a brief reply to this particular distortion, see 5.5.1.6, for the response under *Rational Responding.*

Since clinical counseling has the recognized term ‘all-or-nothing thinking’ and the Apologetics community likewise use the same term, the researcher maintains the use of all-or-nothing thinking, dichotomous, false dilemma, false dichotomy, or black-and-white, or *dicto simpliciter a*re adaptable for a finalized working definition in CAMH.

5.5.1.9.3 Overgeneralization

The cognitive distortion of an ‘overgeneralization’ is the logical fallacy of hasty generalization (Kreeft, 2010).

In the counseling community, the cognitive distortion of overgeneralization happens when one jumps to, or deduces a conclusion with limited information, or, “You make a sweeping negative conclusion that goes far beyond the current situation. For example: “[Because I felt uncomfortable at the meeting] I do not have what it takes to make friends” (Beck, 2011:loc. 3551).

For example, within the Apologetics community, one could overgeneralize by concluding:

- “Some religious people are hypocrites; therefore, all religious people are hypocrites.”
- Members of a world religion are terrorists; this means, all members of the religion are terrorists.”
- “I have never seen a miracle; therefore, miracles do not exist.”
- “I have stumbled onto adversity in my life; this means, God must be punishing me” (Job 4:7-8).

Since clinical counseling has the recognized term overgeneralization and the Apologetics community use the same term along with the term hasty generalization; the researcher maintains the use of both can be adaptable as a finalized working definition for CAMH.

5.5.1.9.4 Emotional reasoning

Emotional Reasoning is the cognitive distortion of experiencing reality through the lens of our feelings and emotions.

Pearce (2016:66) explains: You assume that your negative emotions necessarily reflect the way things are: “I feel it. Therefore, it must be true”. Our emotions reflect our thoughts, beliefs, and physiology; they are not necessarily a reflection of the true state of affairs. Gurman and Messer (2003:233) add: “This distortion is common among individuals suffering from anxiety disorders”. A common misbelief is “I am feeling upset, so there must be something wrong”.

Similarly, within Apologetics, many *Emotional Reasoning* examples can slot into the distortions above, such as, “God does not exist, and He is not loving since life is so difficult”. Alternatively, “I do not feel loved by God; therefore, He must not love me”. By contrast, “I have strong romantic feelings for a girl in the singles group; therefore, this MUST BE of God!” Likewise, theologically, Pearce (2016:66) offers this insight about dealing with *Emotional Reasoning*:

> Individuals in the Bible are described as having times of dryness and darkness, times when they yearned for God, but did not feel his presence. However, not feeling God's presence did not mean he was absent because God says he will never leave or abandon us. Their feelings of being alone were not a true reflection of the situation. We are asked to put our faith in God's promises, not in our feelings.

5.5.1.9.5 Selective abstraction

"Selective abstraction—the process of exclusively focusing on one negative aspect or detail of a situation, magnifying the importance of that detail, *thereby casting the whole situation in a negative context*" [emphasis added] (Yurica & DiTomasso, 2005:119, cited in Maric *et al*., 2011:14).

Used in CBT, *selective abstraction* is a thinking distortion defined by A.T. Beck (1963:324-333) as: "The process of focusing on a detail taken out of context, ignoring other more salient features of the situation, and conceptualizing the whole experience based on this element". Researchers Gurman and Messer (2003) agree with Blake; and as Blake, *et al*. (2016:215) suggest, this distortion is seen often in clients with depression; understandably – for the negative construct is, "I have got to focus on the negative details, the positive things that have happened do not count".

One common example of *selective abstraction* we hear within Apologetics comes from critics of the Bible who deem God as a "moral monster" in the Old Testament for ordering the death of an entire population, including women and babies. However, individuals can fail to recognize that the Canaanites were destroyed for multiple reasons, mainly for their extreme wickedness (Deut. 9:4; 19:9-12; Lev. 18:24-25; Lev. 18:27-28.[42]

Since clinical counseling uses the recognized term *selective abstraction* and the Apologetics worldview has no universally recognized term for the same concept – for the finalized adapted working definition in CAMH the researcher will use the clinical term: *Selective abstraction.*

[42] For an Apologetics overview and response to the "moral monster" claim, see: *Is God a Moral Monster*?: *Making Sense of the Old Testament God*, (Copan, 2011).

5.5.1.9.6 Guided association/discovery

Guided association/discovery, commonly known as the 'vertical/downward arrow' or 'drill-down technique, is a powerful, common technique used in clinical counseling and Apologetics. Like peeling off the outer layers of an onion, one-by-one – to get to the core, a counselor uses this technique to "drill down" from each automatic thought to get to the intermediate and core beliefs.

According to Gurman and Messer (2003:246-247), clinically, it looks like this:

> …the therapist working with the patient to identify relationships between ideas, thoughts, and images by means of Socratic questioning … the therapist provides conjunctions to patients' verbalizations and thus encourages them to identify a series of automatic thoughts. The use of statements such as "And then what?" or "And that means, what?" allows the therapist to guide patients toward an understanding of themes within their stream of automatic thoughts and to identify possible underlying schemata.

Likewise, Leahy (2017:31) offers this example of, after drilling down, finding that the underlying belief is true:

> Sometimes negative thoughts turn out to be true. Let's say a male patient predicts he will be ignored or rebuffed at a party. This is fortune-telling, but it may prove accurate. Exploring the beliefs underlying the fear of that outcome helps to reduce the impact of the thought. With this technique, the therapist continues to ask about that thought or event: "What would then happen if that were true?" or "What would that mean to you if that happened?" We refer to this process as vertical descent because we are attempting to burrow down to the bottom-most belief. Accordingly, the therapist writes the patient's thought on the top of a page and then draws a downward arrow to the series of thoughts or events that is implied by the thought.[43]

Apologists often apply the drill-down technique in debate. Consider this example of a skeptic's common inquiry about moral law. Notice the argument here: "God cannot exist with all the evil in the world!" (drill down), "If evil exists, does that not presuppose that a concept of "good" exists (otherwise one would not be able to label something evil without contrasting it to the good)? "Yes!" (drill down); "And if there is good and evil, does that not presuppose a moral standard to be able to distinguish between the two?" "Yes." (drill down); "And if there is a good (better) and evil (worse) standard, does that not presuppose a best or perfect standard that must exist to measure better or

[43] See Appendix E for a drill-down or vertical/down arrow worksheet.

worse (evil)?" "Yes." (drill down) "Then, if there is a perfect moral standard or law, then where does it come from apart from a Supreme nature (God)?[44]

Since clinical counseling uses the recognized term 'drill-down technique or vertical/downward arrow technique, and the Apologetics worldview has no universally recognized term for the same concept; for the finalized adapted working definition in CAMH the researcher will use the clinical terms and drill-down technique and vertical/vertical arrow technique.

5.5.1.9.7 Advantages and disadvantages

The technique of *advantages and disadvantages* is utilized to weigh the "pros and cons" (Tan, 2011:259) of a problem. Since it is a distinct universal problem-solving technique, it can be applied both within the specific categories of counseling and apologetics.

Considered as a method for "basic problem-solving" (Gurman & Messer 2003), this technique assists counselee's to "examine both the advantages and the disadvantages of both sides of an issue" (Gurman & Messer 2003:246) for a more expanded view. Also, Tan (2011:259) suggests here another benefit to this technique:

> Turning Adversity to Advantage. Clients are helped in this technique to see how a negative experience can be turned into a positive outcome. For example, a client who has been laid off due to cutbacks at work can be encouraged to see how this initially negative experience is opening up opportunities to pursue another job or career.

Commonly overheard in the field of Apologetics, perhaps as a less weighty argument, the "advantages and disadvantages technique" is identified within the example of *Pascal's Wager* to prompt non-believers to consider the benefits of believing in God. Blaise Pascal (1623-1662) posited his case in *Pensées* – that it is a rational and prudent *wager* for one to give their life to God. Here is an example of the weighed advantages and disadvantages technique in this summary of Pascal's *Wager*:

> God is, or He is not. But to which side shall we incline? Reason can decide nothing here. There is an infinite chaos which separated us. A game is being played at the extremity of this infinite distance where heads or tails will turn up … Which will you

[44] The researcher maintains, the moral law argument alone does not prove the existence of the God of the Christian Bible, for this can only be achieved when combined with other arguments pertaining to His existence.

> choose then? Let us see. Since you must choose, let us see which interests you least. You have two things to lose, the true and the good, and two things to stake, your reason and your will, your knowledge and your happiness; and your nature has two things to shun, error, and misery. Your reason is no more shocked in choosing one rather than the other since you must of necessity choose … But your happiness? Let us weigh the gain and the loss in wagering that God is … If you gain, you gain all; if you lose, you lose nothing. Wager, then, without hesitation that He is. (Hájek, 2018).

Since clinical counseling uses the recognized term Advantages and Disadvantages and the Apologetics worldview has no universally recognized term for the same concept, for the finalized adapted working definition in CAMH the researcher will use the clinical terms Advantages and Disadvantages.

While the above terms form the important unified working language for CAMH praxis, the researcher deems this next section to be the most significant for both Apologists and ministers to apply the core of their craft within both fields, namely: *Catch it, Check it, Change it.*

5.5.2 Introduction to the 3 Cs: Catch it, Check it, Change it

> Every day you have to stand guard at the door of your mind. You cannot take the mild approach to the weeds in your mental garden. You have got to hate weeds enough to kill them. Weeds are not something you handle; weeds are something you devastate. (Jim Rohn)

5.5.2.1 Background

Throughout this work, multiple references have been made regarding the synthesis of CAMH and the praxis of CBT, or agreement in means, namely, the techniques and interventions. This next section illustrates how the praxis of Apologetics and CBT accommodate each other; in addition, it demonstrates how their common denominator, can easily be taught, even transferred to learners, by this pithy *3Cs* idiom: *Catch It, Check It, and Change It*. Here, one simply learns to *catch* a claim, *check it* to see if the claim is true or false, and *change it*, if it is false. This is a powerful application that can be applied to both counseling and Apologetics. Granholm *et al*. (2016:110-111), explain here the concept of *Catch It, Check it* and *Change it.*

> The primary skill we will be using to help change our unhelpful thinking is the 3C's: Catch It, Check It, Change It. What is 'it'? 'It' is a thought. The thought might be accurate, or it might be a mistake. Changing mistakes in thinking is a skill that takes practice, like learning to ride a bike.

1. *Catch It*. Learning to catch thoughts (if needed, write them down).
2. *Check It*. Decide whether the thought is accurate or inaccurate, helpful, or unhelpful.
3. *Change It.* If a thought is inaccurate or unhelpful, changing it can help you feel better and do things to achieve your goals.

For the Apologist, when working with thoughts or ideas, this simplified three-step-method: *catch it*, *check it*, *change it* can be utilized as a technique to defend against contrary worldview claims. Therefore, an Apologist and CBT counselor can develop, and even enhance their ability to *catch* the thought, *check* the thought, and *change* the thought. The Apologist can *catch* any opposing worldview assertions, *check* them against the truth, and if the assertion does not correspond to reality (meaning it is a false claim), *change* it to the truth. In like manner counselors *catch* the distorted beliefs, *check* them against reality; if they do not meet the requirement of reality or truth, counselors assist clients to *change* the belief to the truth. For the Apologist, the 3C concept is easy to remember specially to regain one's bearings in the middle of a firestorm debate. Note that to be a skillful Apologist and mental health counselor, one must have a reliable, often expeditious misbelief detector.

As stated in 4.5.1.7, *Cognitive model*, by correcting one point of the cognitive triangle (shown in Figure 5.1 (researcher's own depiction)), one can adaptively improve outcomes underlying the other points. Although, technically, when counseling, one can assess all three points (thoughts, emotions, and behaviors) to progress each. Consequently:

In CAMH, we can catch, check, and change each point of the cognitive triangle towards a lifestyle more reflective of the truths grounded in the Lordship of Jesus Christ.

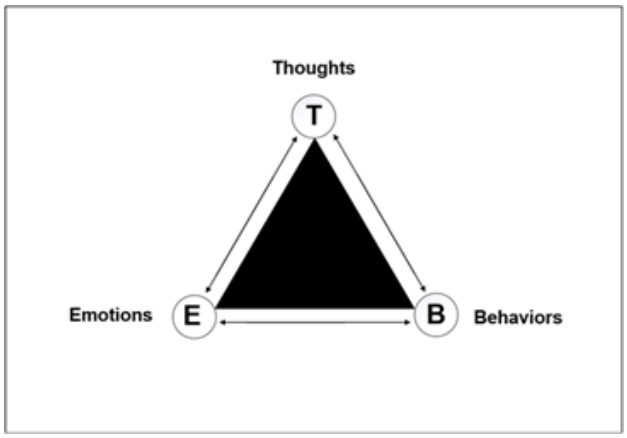

Figure 5-1: Cognitive triangle

To begin, rationally, the first step in helping a counselee in the counseling process is to teach them to be aware of their thoughts (or ideas), emotions (or feelings), and behaviors (or actions). This means, becoming intentional about our thought awareness when our emotions and/or behaviors are askew.

In the CBT counseling setting, the nature of thoughts implies *automatic thoughts*, as well as intermediate and core beliefs. Beck (2011:138-139) suggests automatic thoughts are "quite brief", [they], "seem to pop up spontaneously" and "most of the time we are barely aware of these thoughts, although with just a little training we can easily bring these thoughts into consciousness".

5.5.2.2 Catch It: Catching thoughts

The concept of *Catching It,* or identifying thoughts pre-dates the modern clinical era. (Trader, 2011). The early church found that the very act of *catching* thoughts provides the benefit of adaptive processing. Trader (2011:58) points out, "According to Saint John Cassian, as long as wrong thoughts remain hidden, they hold sway over a person, but once they are discovered, they immediately are weakened even before one begins the task of discerning whether they are good or bad".[45] Clinically, Phillipson (n.d.), maintains that "one of psychology's greatest clinicians, Albert Ellis, advanced the concept of "automatic thoughts". He posited the idea that our mind independently sends spontaneous, irrational messages to our conscious awareness." When

[45] Trader's citation here is "John Cassian Conferences 1.10 (PL. 49.538)". Trader cites PL as Patrologia cursus completes: Series latina. Ed. J. P. Migne. Vol. 1-221. Paris: J. P. Migne, 1884-64.

considering the nature of automatic thoughts, most of the time, we are barely aware of these thoughts, and they often present in “shorthand, verbal, and visual form … [and] with a little training we can easily bring these thoughts into consciousness”. (Beck, 2011:138). Subsequently, this affords us the skill of becoming aware of our thinking (Dobson & Dobson, 2016:5) with the goal of correcting maladaptive or inaccurate thoughts to *check* them against reality or truth. Beck *et al*. (1985:192) suggest a counseling focal and benefit of thought awareness here:

> Merely telling patients to become more aware of their thinking can be sufficient. This is similar to the suggestion that one consciously chooses to remember one's dreams. The patient may be unaware of his thinking because he has considered it unimportant. The therapist needs to stress the effect thinking has on one's life. Automatic thoughts can be presented as being similar to subliminal advertisements: by learning to detect them, the patience can free himself from their effects.

Additionally, since one’s emotions are “logically connected to the content of automatic thoughts” (Beck, 2011:139), then the significance of catching thoughts gains more usefulness considering the evidence that the mind often gravitates towards negative thinking. Hanson (2009:41) suggests that our brains seem naturally wired to focus on the negative; he states: “When an event is flagged, the hippocampus makes sure it is stored carefully for future reference. Once burned, twice shy. Your brain is like Velcro for negative experiences, and Teflon for positive ones- even though most of your experiences are neutral or positive”.

As stated in 5.5.1.2, “Socratic Method”, the power of the question is critical when eliciting thoughts. The more thought-provoking the question, the more it reveals the counselee’s internal cognitive dialogue. Beck (2011:142) notes: “The skill of learning to identify automatic thoughts is analogous to learning any other skill. Some patients (and therapists) catch on quite easily and quickly. Others need much more guidance and practice to identify automatic thoughts and images”. To prime the conversation with a counselee, a counselor can initiate thought exploration with broad questions. Granholm *et al*. (2016:107) offer these questions as examples:

- What were you feeling this week?
- Which pleasant feelings did you have in the past week?
- Where were you?
- Do you remember what you were doing?

- What were you thinking?
- What unpleasant feelings did you have in the past week?
- Where were you?
- What were you doing?
- What were you thinking?

Likewise, daily within counseling sessions, the researcher explores the client's thoughts with questions such as:

- What just crossed your mind?
- Did something capture your mind?
- What is going on?
- What is resonating with you most right now?
- If your feelings had a voice, what would they say?

As discussed in 4.5.1.8, the concept of the *mediation hypothesis*, as explained by Dobson and Dobson (2016:5-6), posits that our "thoughts mediate our emotional and behavioral responses" – thus by first identifying feelings, a counselor can help a mental health sufferer trace back – even play detective in order to identify the preceding thought – often called the automatic thought that flashed through the mind the moment before the feeling occurred. Consequently, when working with automatic thoughts, Beck (2011:139) offers these summary points:

- The emotions patients feel are logically connected to the content of their automatic thoughts.
- Patients are often more aware of the emotion they feel as a result of their thoughts than of the thoughts themselves.
- Evaluating the validity and utility of automatic thoughts and adaptively responding to them generally produces a positive shift in affect.

5.5.2.3 Catching emotions

5.5.2.3.1 Background

To understand working with feelings and emotions, the "it" in the "catch it", is for identifying emotions by beginning with *feelings awareness*. Now, by using the cognitive triangle, a counselor can assess the next point, emotions (or feelings). Since thoughts lead to emotions as found in the mediation hypothesis (Dobson & Dobson, 2016), as we catch our emotions, utilizing questioning to identify the preceding thoughts that influenced the emotions/feeling (intending to correct them), is a critical, useful step in cognitive therapy and praxis. Below is a sample of questions to draw out a counselee's emotions/feelings:

- How have you been feeling lately?
- How is your mood today?
- Did you have any pleasant feelings this week?
- Can you name a few emotions you are currently feeling?
- Of all your emotions, can you pinpoint one emotion that seems to be the strongest?

When dealing with negative effects (emotions), after hearing the client's self-report of how he/she feels, this researcher believes that one of the most compelling questions that elicit considerable therapeutic data for the counselor to work with, is the question: "What does one have to believe to feel _____?" For example, when the counselor asks, "What does one have to believe to feel _____?", if they fill in the blank with emotions such as "depressed", "anxious", or "hopeless", then the counselor can instantly listen for distortive thinking driving the negative emotions/feelings (effect). In so doing, once the emotions/feelings are uncovered, and the counselee reveals their thoughts by answering the question: "What do you have to believe to feel this way?", then the focus for the counselor is to assist the counselee in changing the thoughts which will result in a change in the emotions. Likewise, while often, the counselee's thoughts are present at the surface and take little exploration, sometimes, identifying current thoughts needs some reflection for as Granholm *et al*. (2016:106) point out, "Distinguishing thoughts and feelings can be challenging for some consumers. Many of us were never taught how to differentiate between thoughts and feelings, or that

there is a wide array of emotions". However, one can learn to *play detective* if needed and after a little investigative work, ultimately, trace back the automatic thoughts, so the sufferer can apply a rational response to the thought with the hopes of alleviating the negative emotional affect. This approach parallels the insights from the early church as well. Trader (2011:52) notes of Saint John Cassian[46]: "an etiology of maladaptive thought and behavior primarily requires introspection rather than an investigation of situational factors".

5.5.2.3.2 Playing detective

Subsequently, once we are aware of our negative moods: agitation, melancholy, anxiety, fear, we can *play detective* and ask ourselves questions like, "What was just going through my mind before this feeling?"; "What was I doing before feeling this way?"; or, "What was I thinking about or ruminating on in the last few minutes, or even in the last hour?" For a subtle distinction regarding identifying emotions/feelings, Granholm *et al.* (2016:106) point out that people often describe "a situation or feeling rather than a thought." To adjust this, Granholm, *et al.* (2016:112) suggest:

> Helping consumers label emotions will help them differentiate between thoughts and feelings and, subsequently, challenge their thoughts. There may be some confusion stemming from common English language usage of "I think" and "I feel" synonymously. For example, people often say, "I feel like he does not like me," when they mean, "I think he does not like me".

Another characteristic regarding emotions to consider is, even though they can be a core guide to directing us back to our thinking or cognitions, emotions/feelings are not seen as an accepted gauge to that which is, or the state of reality. Phillipson (n.d.), makes this point:

> The question then arises, what do our *feelings* say about our fundamental beliefs? I believe that the answer to this question is, "Not necessarily very much." Our feelings are *not* a reliable measure of our self-perception. Why? Because automatic thoughts can create feelings that are just as convincing as thoughts that reflect our deeply held beliefs. So, we must not reflexively take the thoughts and feelings that our brains send to *us* at face value.

[46] Trader's citation here is "John Cassian Institutes, 9.7 (PL. 49.356)". Trader cites PL as Patrologia cursus completes: Series latina. Ed. J. P. Migne. Vol. 1-221. Paris: J. P. Migne, 1884-64.

Another feature of the mediation hypothesis is the idea that thoughts not only mediate our emotions; they also mediate our behavioral responses (Dobson & Dobson, 2016:5-6). In addition, when working with *behaviors,* the "it" in "catch it" is identifying our behaviors/actions. Put simply, when we are not doing what we should be, the "it" in *catch it, check it, change it*, implies catching our behavioral/action deficits or disparities within the framework of our desired values and Christian standards.

Again, following the cognitive model and the mediated hypothesis, our thoughts drive our behaviors/actions. Dobson and Dobson (2016:5-6) explain:

> Similarly, it is our cognitions or thoughts that strongly influence our behavioral patterns in various life situations. For example, we feel anxious only when we view a situation as threatening. When we have a "threat cognition", we are also likely to attempt to escape the situation or to avoid it in the future, if possible. These thoughts, as well as the corresponding emotional responses and behavioral reactions, may all become routine and "automatic" over time. Even in cases where emotional and behavioral responses seem to be reflexive, though, cognitive-behavioral theorists argue that there is cognitive mediation between the event and the person's typical responses in that situation.

Even though it is impossible to police every thought, the good news is we do not have to. Primarily, we usually do not consider our thoughts unless an emotional alarm rings, prompting us to play detective to check our previous thoughts that led to a flurry of negative emotions. Therefore, our feelings and behavioral awareness should be added to personal hygiene since emotional hygiene is a category of personal hygiene and proper self-care. To enhance the *catch it*, check it, and *change it* process, we can use the following three tools as a more formal process to check our automatic thoughts, intermediate, and core beliefs:

- List of Socratic questions (see Appendix F);
- Testing your Thinking Worksheet (see Appendix G);
- Thought Record (see Appendix H).

5.5.2.4 Check it: Checking thoughts

The second concept of *checking it,* necessitates that we check thoughts or behaviors for accuracy or truth. Once we *catch* the thoughts and behaviors, when then *check them* – that is, we check the thoughts and behaviors to test whether or not the

thoughts(s) are accurate and correspond to reality. We check our behaviors to ensure that they accurately reflect Christian values and precepts.

When checking thoughts, Moreland (2019:78) suggests:

> It involves identifying the negative message, analyzing it (asking questions like … what kind of cognitive distortion is this? What is it about this message that I find upsetting? Does this remind me of something in my past that bothered me?), and raising counterevidence against the message (asking questions like, what is the evidence for this? Is this always true? Has this really been true in the past?).

As stated, we can *check* thoughts, and behaviors/actions to check if our caught behaviors/actions are maladaptive and not in-line with our values. If not aligned, as we will see next, we can change them. Therefore, CAMH can be useful when we are not living a lifestyle reflective of Christ, such as, “Not loving our wife as Christ loves the Church” (Eph. 5:25). In this example, we *catch* the behavior, *check* the behavior against reality/truth of the Bible, and then change the behavior in accordance with Christ’s Word.

5.5.2.5 Change it: Changing thoughts and behaviors

When changing thoughts, Dobson and Dobson (2016:6) suggest that as we “mediate our responses to different situations, we can intentionally modify the way we respond to events around us. We can become more functional and more adaptive as we come to understand our emotional and behavioral reactions and learn to deploy cognitive strategies systematically in service of our life goals”. In short, the goal for CBT by changing it is to change maladaptive thoughts that often manifest in the form of negative automatic thoughts (NATs). Neenan and Dryden (2011:5) state, “The usual treatment strategy in CT is to focus on tackling NATs to effect symptom-relief before moving on to modify underlying assumptions and core beliefs to achieve longer-term change and thereby reduce the chances of relapse (a return to the original problem)”.

Lastly, in *catch it*, *check it, change it,* the concept of *changing it,* is to take our thoughts and behaviors captive so as to establish a life more reflective of the life of Christ.

To change it, the counselor can use the praxis of: questioning the evidence; using reattribution; rational responding; examining options and alternatives; as well as unpacking the advantages and disadvantages of direct disputation to challenge the

false beliefs so as to increase the strength of the belief or conviction level as measured by the *Validity of Cognition* (VOC) and *scaling*.

Once we *catch* the thoughts and behaviors, then *check* them, if they are not in concert with our Christian standards, then each of us has the capacity either to endorse or reject them, to help us feel better and achieve our goals. (Granholm, *et al*., 2016:110-111).

Subsequently, *catch it*, *check it, change it,* Beck *et al.* (1979:4, as cited in Robertson, 2010:4-5) offer this break-down for counselors when working with counselees:

1. to monitor his negative automatic thoughts or cognitions;
2. to evaluate the relationship between his thoughts, feelings, and actions;
3. to carefully evaluate the evidence for and against his distorted or maladaptive cognitions;
4. to generate alternative cognitions and to substitute them for the negative ones; and
5. to identify and modify underlying dysfunctional assumptions and beliefs which predispose him to negative automatic thoughts.

To summarize the characteristics of CAMH in contrast to CBT, CAMH is a Christian worldview systematic counseling model, framed on a philosophically coherent, universal, justifiable standard of appraisal. Since CAMH relies on special revelation for primary authority the contrast between CAMH and CBT widens in both focus and consequence − both morally and anthropologically.

Practically, CAMH applies the 3 Cs: Catch it, Check it, Change it concept to appraise the counselee's thoughts, behaviors, and emotions, to evaluate if each is in accord with the characteristics and a life more reflective of the life of Christ.

During the Catch It step, the CAMH model assesses for logical fallacies as well as misbeliefs or common thought distortions that manifest in erroneous, idiosyncratic meanings, all-or-nothing thinking, overgeneralization, emotional reasoning, and selective abstraction.

Once these thought distortions are caught, the counselor helps the counselee check and change the beliefs using counseling interventions such as:

- Questioning the evidence
- Rational responding
- Examining options and alternatives
- Direct disputation reattribution.

Ultimately, this process can assist the counselee to change personal behaviors to be more reflective of the life of Christ.

Next, we will see how the CAMH is applied in a model case.

5.6 A model case of CAMH

5.6.1 Christian Apologetics and Cognitive Behavioral Therapy: A pastoral model for mental health promotion – usage disclosure comments

The following assumptions direct the model case:

- Christian Apologetics for Mental Health Promotion is not meant to replace formal or/professional counseling or psychotherapy provided by those with graduate, advanced degrees, and licensure in the field.
- The counselor should always consider bio-medical reasons such as existing conditions, sleep, and medication related symptoms, both prescribed and non-prescribed by a health professional.
- Initially the counselor needs to consider the following question:

  Does the session data warrant a peer consultation, a referral to a more qualified minister, professional counselor, or even a medical professional?

- The researcher is not releasing any confidential or disclosing any personal client information in this model case. While this model case is not an actual case from the researcher's files, this case amalgamates very common counselee experiences and symptoms often heard within a counseling setting while aiming to present all the characteristics of a typical case.

5.6.2 Model case: Considerations

The researcher will present this model case in a detailed, annotated format to establish the working praxis of CAMH. While examining the following model case, the reader will follow the counselor/counselee dialogue to "listen" for any distortions within the counselee's thoughts (ideas), emotions (feelings), and behaviors (actions) that are not in line with Christ-like living. The goal is to *catch* the distortion, to then *check* it, and to eventually work towards helping the counselee *change* it. The researcher will identify and heavily narrate this model case; the annotations will contain relevant "learning markers", which will be included in parentheses, and will facilitate understanding. Despite the fact that professional counseling can last multiple sessions, months, perhaps even years – this model case is shortened to illustrate the critical concepts of CAMH.

The cognitive triangle, as shown in Figure 5.1, shows the interplay between thoughts, emotions and the resultant behaviors, which are considered during each counselling session.

5.6.3 Model case: In Search of meaning and purpose

Background: The counselee, a Christian college student, contacted the counselor stating: "I have been a little depressed for months. I feel unmotivated. I stay up all night and sleep all day. I isolate myself; I'm not working and I'm struggling to finish school".

***Transcript from counseling session*:**

Counselor: The session can begin with many variants of open-ended, Socratic questions such as: "What brings you into my office today?", or, "What motivated you to reach out to talk to a counselor?", or even, "What can I help you with?"

Counselee: "Well, I'm not living up to my potential, it is difficult for me to say, since I have always been a very ambitious person, but lately, I have not felt like myself."

> ***Counselor's comment***: The counselor should already be *catching* and pegging on the cognitive triangle shown in Figure 5-1: "*I am not living up to my potential* (behavioral deficit) and "*I have not felt like myself lately*" (emotional deficit). In addition, the counselor should be mindful of the behavior point on

the triangle here to *check* if the counselee's behaviors are living up to the desired standards of Christ and the *counselee*.

Counselor: "I am sorry to hear you are struggling and I am glad you are reaching out for help." *Socratic questioning*: "Tell me more about what your life has been like recently, what do you do in a typical day, how long have you felt this way?"

Counselee: "For months. My grades are slipping in college. I feel worthless! Like my parents, who never went to college, maybe I am not cut out for it either. However, if I quit school, I'll quit everything and be a failure in life. I guess I'm just worthless!" It causes me to lay up all night thinking I've failed."

> ***Counselor's comment***: Again, 'slipping grades' is a behavioral deficit. However, "I feel worthless" is not a feeling but an *automatic thought* and *meaning assignment* that "I am a failure"; this is a common mismatch. Likewise, this is a core belief that can be classified (labeling or mis-labeling the distortions) as 'all-or-none thinking*'*, which can lead to catastrophizing (*either*, I do well in college, *or*, I'm a failure), an overgeneralization (or hasty generalization), possibly, emotional reasoning and personalization (dropping out of college does not happen to anyone but me), as well as catastrophizing.
>
> Also, notice or *catch* the 'I am not cut out for college' – this is an *intermediate belief* based on, 'none of my family went to college'; therefore, 'I am not cut out for college'. Moreover, "if I quit school, I will quit everything and be a failure in life"; this is an *intermediate belief* that people who quit school are failures in life (*idiosyncratic meaning*). Likewise, "I guess I'm just worthless!" is a *core belief*, that is, one's identity is tied to what one does, and not their essence. Likewise, notice the client's statement revealing his focus (*attentional focus*), "It causes me to lay up all night thinking that I've failed"; again, since focus leads to feelings, imagine how this client "feels" each night (*emotional deficit*)?

Counselor: "Let me ask, when you think about college, what crosses your mind?" *(Socratic questioning to elicit automatic thoughts while looking for meaning assignment).*

Counselee: "Well, I am constantly thinking, I do not belong here; I am not smart enough. People like me do not belong in college."

> ***Counselor's comment***: Notice, the counselor should be catching the automatic thought here: "I am constantly thinking" is an example of *focusing*. Moreover, "I do not belong here; I am not smart enough; people like me do not belong in college" are examples of the appraisal or meaning assignment. Again, each can be classified as a distortion, "I do not belong here" (in labeling the distortion; each could slot into: all-or-nothing thinking*,* overgeneralization

or hasty generalization; possibly emotional reasoning; possibly personalization, or even selective abstraction). Personalization may be present if the client's identity is enmeshed with the outcome for failing out of college. In other words, one's identity is a function of how one performs and not who one is in Christ. Selective abstraction could be identified here since the counselee may not be recognizing any personal accomplishments, while only abstracting his negative personal performance (personalization if the client's identity is enmeshed with the outcome).

Counselor: "People like you?" (Socratic questioning to elicit and *catch* the *automatic thoughts* and the drill-down technique to get to the *intermediate belief*.)

Counselee: "Yeah, uneducated, poor, laborer types." (*Catching* the same *intermediate belief* and *idiosyncratic meaning,* while continuing labeling the distortion: overgeneralization or hasty generalization, emotional reasoning, selective abstraction; and again, possibly personalization.)

***Counselor*:** Let me ask, on a scale of 1 to 10, with 10 as, "I am absolutely sure!", how true does it feel to you in your heart (metaphorically) that you do not belong in college?"

***Counselor's comment*:** Here the counselor is using the *Validity of Cognition* (VOC) to determine the strength of the belief and s*caling*, to measure it. If there is a belief deficit, eventually in the counseling process, the goal will be to decrease the doubt driven by the distorted beliefs, and increase the certainty driven by an accurate belief(s).

Counselee: "About a 3."

Counselor: "So if you dropped out of college, what would that say about you as a person?" (Socratic questioning to elicit *automatic thoughts* and use of the drill-down technique to, this time, pass the intermediate beliefs and get to the core belief(s) about personal identity through *meaning assignment*).

Counselee: "My life is over and I am a failure."

Counselor's comment: *Catching* the *meaning assignment*: "My life is over" is an *intermediate belief*, and "I am a failure" is a *core belief*. When labeling the distortion, these distortions can be classified as all-or-nothing thinking, overgeneralization or hasty generalization, and possibly, emotional reasoning, personalization, selective abstraction, and now catastrophizing since client is fortune-telling a catastrophic outcome.

Counselor: “When you have the thought that your life is over, what does that look like?”

> ***Counselor’s comment***: (Socratic questioning to elicit *automatic thoughts* and drill-down technique to get to the belief and *meaning, or idiosyncratic meaning assignment*). Note, the question “What does that look like?” should conjure up an image (thought in picture form) for the counselee thus revealing a visualization meaning assignment of what his/her anticipated life may look like (i.e., lying in bed all day, or being homeless).

Counselee: “Oh well, life is meaningless anyway, why try?” (*Catching* the *meaning assignment* as an *intermediate belief*).

> ***Counselor’s comment***: When labeling the distortion, these distortions can be classified as all-or-nothing thinking and *o*vergeneralization or hasty generalization and possibly: emotional reasoning, personalization, catastrophizing, and selective abstraction. In addition, the counselor could explore the certainty level, or VOC of this belief to work, or even offer an apologetic, to change this belief.

Counselor: “Sure, I can see why you would not want to get out of bed when thinking “life is meaningless.” Do you mind if I ask you about your worldview? What do you have to believe to conclude that life is meaningless?” (Socratic questioning, *catching* the automatic thoughts and intermediate beliefs).

Counselee: “Well, I believe I am a Christian, but I have my doubts whether or not the Bible is from God. In fact, because of the way I feel, I wonder if God exists, or if He does, if He even cares about me?” (*Catching* the worldview *meaning assignment* and *checking* to see if the thoughts align with a Christian worldview).

Counselor: “Do you think your spiritual beliefs affect the way you live and even how you feel in your life? (Socratic question, drill down, to *catch* the belief and emotions).

Counselee: “Yes, why should I even do anything, like work and set goals if God does not exist and everything is meaningless and purposeless?” (*Catching* the worldview *meaning assignment* and *checking* to see if the thoughts align with the Christian worldview). When labeling the distortion, these distortions can be classified as all-or-nothing thinking, overgeneralization or hasty generalization, and possibly: emotional reasoning, personalization, catastrophizing, and selective abstraction). “And yes,

believing life is meaningless really takes away my energy and drive to want to do anything each day." (*Behavioral deficit*).

Counselor: "What doesn't feel right"; even "Is there anything else we need to talk about or what doesn't feel right?" (Socratic questioning to elicit any other issues in the assessment process).

Counselee: "No, those are the major things I'm struggling with now."

Next, now that we have applied the *catch it* to the counselee's beliefs, we can *check* and *change* them to help the counselee change any misbeliefs so that they are more reflective of reality, the counselee's values, and/or the truths of the Lordship of Jesus Christ.

5.6.4 Discussion from the model case of the misbeliefs the counselor caught

The counselee's belief that he/she belongs in college is low (3). Low beliefs (certainty), lead to decreased behaviors (motivation); decreased behaviors and motivation, lead to decreased results (outcomes). Subsequently, the counselor should work to challenge the false beliefs to increase the strength of the belief or conviction level as measured by the *Validity of Cognition* (VOC.) and *scaling*. And theoretically, the behaviors (motivation) should increase, leading to better results, grades. Therefore, the counseling goal becomes, to correct the idiosyncratic meaning within the core beliefs ("I am worthless, I'm a failure, I'm not smart)", and the intermediate beliefs ("People like me do not belong in college ... uneducated, poor, laborer types"), and in turn, automatic thoughts and maladaptive behaviors will begin to follow.

Likewise, it is this researcher's contention that since worldview beliefs are universal beliefs they operate as core beliefs (see also: Zondervan & Nash, 1992), for they influence local beliefs like how we live our everyday lives, such as mental health (Pearce, 2016), relationships, employment, and finances. (Cummings *et al*, 2005; Rogers *et al*, 2010). This means, that by employing CAMH, a critical focus from the worldview beliefs caught, should correct the distortive beliefs or "doubts whether or not the Bible is from God", along with the beliefs underlying "I wonder if God exists, or if He does, if He even cares about me?" By correcting core worldview beliefs, the

intermediate belief of “life is meaningless anyway, why try?” should improve. In addition, it could even be argued from a Christian point of view and CAMH that by correcting the spiritual core beliefs, it would correct, the personal core beliefs such as “I’m worthless, I’m a failure, and I’m not smart”.

Theoretically, once the core beliefs are corrected, the certainty level for this counselee’s primary presenting concern should improve.

The following information can be gleaned from the session: When the counselor asked, “On a scale of 1 to 10, with 10 as, “I am absolutely sure!”, how true does it feel to you in your heart that you do not belong in college?” using the *Validity of Cognition* (VOC) to determine the strength of the belief and s*caling*, to measure it, the *counselee replied, “*About a 3!” In other words, if we secure a stronger conviction level (VOC), an increase, or an improvement on the scale of 3 and above, should result in behavioral improvements as well.

The key point to remember in this model case and in a CAMH counseling session are the 3 Cs: *catch it*, *check it*, and *change it*, the cognitive model (if needed, check each point on the triangle), and truth or ultimate reality. Just as the Apologist catches the distortion in an argument, when using CAMH, the counselor catches the beliefs, emotions, and behavior to check it, to test it for truth. If one or all three (beliefs, emotions, and behavior) is misaligned, the counselor will assist the counselee to *change it* to reflect the client’s desired values and/or, God’s Biblical precepts.

5.6.5 Summary of Catch it, Check it, Change it

Since we *caught* the distortive belief, now we work with the client, to *check* that belief and *change* it as follows:

1. Catch it: “I’m worthless”: Socratic questioning to explore potential Idiosyncratic Meanings.
2. Check it: To check the idea “I am worthless, the counselor Socratically could question the evidence and/or Examining Options and Alternatives by asking:
    - “Is it true that anyone is worthless? And if so, by what standard?”

- “If we asked your loved ones, your spouse, family, friends, etc., do you think the counselee is worthless, what would they say?”
- “Is there anything about you that is valuable?”
- What do you think God says about your value?” Is there any evidence about how He views and thinks about you?

3. Change it: “To change the misbelief, “I am worthless”: the counselor could use one or all these interventions: Reattribution, Rational Responding, and Direct Disputation.

For instance, the counselor could directly dispute the client’s belief by pointing out: “Your loved ones, your spouse, family, friends, etc., think you are priceless, and they all agree that their lives would not be complete without you in their life. For a biblical case for how God loves and views you, consider:

- *“Just as He chose us in Him before the foundation of the world…*” (Ephesians 1:4).
- *Your eyes saw my unformed body. All the days ordained for me were written in your book before one of them came to be”* (Psalm 139:16).
- [God] *“Determined the times set for them and the exact places where they should live”* (Acts 17:26).
- The Bible confirms the very hairs of your head are all numbered (Matthew 10:30).
- *“*The more you know God, the more you will know yourself, for you are created in His image and likeness. Genesis 1:27, and chapter 6 confirms this truth, *God created man in His own image, in the image of God He created him; male and female He created them. For in the image of God He made man.”* (Jackson, 2014, slide 26).
- “*For God so loved the world that He gave His one and only Son, that whoever believes in Him shall not perish but have eternal life* (John 3:16).
- *God enjoys you taking pleasure in Him and His creation* (Genesis 1:30; Psalm 16:11)

- God, your thoughts about me are priceless. "*No one can possibly add them all up. If I could count them, they would be more than the grains of sand*" (Psalm 139:17-18).

Likewise, the counselor could *rationally respond*, by asking, "Is it rational to believe that when God proclaims He loves the world (John 3:16), He loves the world minus you?"

Catch it: "I'm a failure":

Check it: Similar to the above Socratic questioning, the counselor could apply rational responding, examine options and alternatives, even reattribution, by asking:

- "Is college the only standard to measure your personal success?
- "If we asked your loved ones, your spouse, family, friends, etc., do you think the counselee is a failure, what would they say?"
- "Is there anything you've done in your life that was successful?
- What role do you think God plays in the life of your success?

Change it: What role do you think God plays in the life of your success?

Backus and Chapian (1980:94) explain here the role God plays in our lives to empower us that can be used to counsel this counselee to correct the above misbelief:

> Where are we strong? In the inner man, the inner person, in our souls where our thoughts toss and tumble waiting to create our feelings and our actions. When Paul says, "I can do all things through Christ which strengthened me," he gives us a dynamic lie-shredding principle to stake our very lives on. This verse is true of the entire domain of self-control behavior. Paul was writing of his own experiences as he voluntarily went without, suffered and was deprived for the sake of Christ. "I can do all things!" he triumphantly declared for the ages to hear."

Catch it: "Whether or not the Bible is from God."

Check it*:* This distortion can be tested by the Apologetic evidence that The Bible is the Word of God.

Change it: Set up an action plan that includes whether or not the Bible is from God and if God exists.

Once the counselor has identified the principal issue concerning the counselee, it is essential that the action plan includes the study of, “If the Bible is the Word of God”. For instance, one response may be, according to Geisler (2012:55-56):

> The Bible is the only book that both claims and proves to be the Word of God. It claims to be written by prophets of God who recorded in their own style and language exactly the message God wanted them to give to humankind. The writings of the prophets and apostles claim to be the unbreakable, imperishable, and inerrant words of God. The evidence that their writings are what they claimed to be is found not only in their own moral character but in the supernatural confirmation of their message, its prophetic accuracy, its amazing unity, its transforming power, and the testimony of Jesus who was confirmed to be the Son of God.

Catch it: “If God exists?”

Check it*:* This distortion can be tested by the Apologetic evidence that God exists.

Change it*:* Set up an action plan with counselee that includes the study of, “Does God Exist?” (See: Kreeft, 2000; Craig, 2008).

For a brief Apologetic overview for the evidence for God’s existence, consider this summation by Geisler (1998:510):

> The best-known arguments for God’s existence are the cosmological argument, the teleological argument, the moral argument, and the ontological argument. Respectively, these are the arguments from creation (Gk., cosmos, “universe, world”), design (Gk., telos, “end, purpose”), and the idea of a perfect being (Gk., ontos, “reality, being”). In addition to these the axiological argument, the anthropological argument, and the argument from religious experience are often used. The axiological argument (Gk. axios, “value worth”) is the argument from making value judgments. It is closely associated with the moral argument, the argument from a moral law to a Moral Law Giver.

Catch it: “If He (God) even cares about me.”

Check it and Change it*:* Please refer back to the above *Check it* and *Change it* example, “I’m worthless”, for the same response can be applied here.

Lastly, similar to *Pascal's Wager* in worldview Apologetics, to gauge, embed, or even evoke the client’s sense of motivation to address the issues in the session, the counselor could apply the ‘advantages and disadvantages technique’. This is accomplished by exploring the advantages and disadvantages of taking action to address the issues in counseling.

Essentially, this technique should help counselees draw out the life-style benefits and cost of addressing the issues detected in session. This is a common way to elicit behavioral change; a concept found in the clinical application of motivational interviewing (Arkowitz, 2015). As suggested here by Arkowitz (2015:11-12), this list of Socratic, open-ended questions can be persuasive in assisting the counselee to take action to *change it*:

- “What are some good reasons for you to make this change?” [Change talk]
- “Why haven’t you done it?” [Sustain talk]
- “Knowing what you do about yourself, how might you be able to do it?” [Change talk]
- “What do you like about how things are now?” [Sustain talk]
- “What could be the advantages of making the change and what might happen if they continue on their present course?”
- “How would you like for your life to be different a year from now?” “What is the worst that might happen if you keep on as you have been?”
- “What do you care about most?
- “How would you like to be remembered?”
- “A simple scaling question is to ask “On a scale from 0 to 10, where 0 is not at all important and 10 is the most important thing in your life right now, how important would you say it is for you to?”

5.6.6 Section summary

This chapter gives an answer to the mental health needs in the Church. The researcher provided CAMH as an answer to the Pragmatic Task by coalescing Christian Apologetics theory and praxis with CBT praxis. While distinguishing between the agreements and differences between the Christian worldview and CBT, the CAMH model applies the techniques and interventions apologist use intuitively in their craft to minister to mental health sufferer such as Socratic questioning, questioning the evidence, rational responding, etc. Consequently, CAMH can be applied to train ministers and apologists to *Catch, Check, and Change* false ideas often categorized as, cognitive distortions or fallacies, such as all-or-nothing thinking, overgeneralization, labeling and mislabeling, toward more accurate thinking to improve mental health, as demonstrated in the case example presented in this chapter.

CHAPTER 6: THE DEVELOPMENT THAT CAN BE GLEANED FROM THE STUDY: CHRISTIAN APOLOGETICS AND COGNITIVE BEHAVIORAL THERAPY: A PASTORAL MODEL FOR MENTAL HEALTH PROMOTION

6.1 Introduction

The target of this study is both pastoral and apologetic by nature. The goal was to establish a ministerial model using Christian Apologetics and CBT for Mental Health Promotion (CAMH). The aim of this study is to demonstrate that the praxis of Cognitive Behavioral Therapy can be subsumed into the theory and praxis of Christian Apologetics to develop a Christian Apologetics for Mental Health (CAMH) pastoral model.

Chapter six here, will conclude with a summary of each final chapter on which this work was based, namely, Osmer's (2008) methodology within these four-fold tasks:

- The descriptive empirical task: "What is going on?"
- The interpretive task: "Why is it going on?"
- The normative task: "What ought to be going on?"
- The pragmatic task: "How might we respond?"

6.2 Conclusions

6.2.1 Descriptive empirical task (cf. Chapter 2) conclusion

By use of the descriptive task, this chapter set out to answer the question of "What is going on?" (Osmer, 2008:4) in the Church, or if there is an unaddressed need for Church ministers to provide mental health solutions to those struggling with their mental health within Christ's Church. The researcher showed in chapter 2 that an unaddressed need for mental health solutions exists for the following reasons:

- **The breadth and depth of mental illness in the local church.**
  Simpson and Shelley (2013:52-55), found a considerable number of church leaders are aware of mental health disorders in their churches; such as: 84% are aware of anxiety disorders, 91% are aware of disorders such as depression, and 37% recognized that at least one congregant struggled with psychoticism.

In addition, Lifeway (2014:13) reported at least 20% of pastors struggled with their mental health. Accordingly, with the prevalence of mental health within the church, it is not inconceivable that the impact on congregants is considerable as well, as reported by Rogers *et al*. (2010), thus affecting one's spiritual growth (Pirutinsky *et al*., 2011).

- **The normative ministerial response to assist those with mental illness in the local church.**

  The researcher found the normative ministerial response to assist those with mental illness in the local church reveals a need for mental health solutions within the Church. The researcher found in the research adaptive responses to mental health awareness in the Church, such as clergy recognizing the need for empirically based solutions (Standford & McAlister, 2008:145), along with a growth trend in mental health services in the U.K. (Ryan, 2018). By contrast, some research suggests maladaptive responses which in turn creates a need for improvement when addressing mental health within the Church. For instance, Farrell and Goebert (2008) report a need for more mental health care training among clergy and professionals; Horton (2014) found an influence of over-spiritualizing when assessing mental health issues; Bussema and Bussema, (2000) reveal there is a stigma on mental health within the Church, and (Koenig, 2009) shows the effectiveness and thus need for more studies in religious counseling.

- **Global evangelical potential to address mental health issues beyond the Christian community.**

  Subsequently, while recognizing that Christians are called to minister to the global needs of the Church (Matt. 28:19-20; MacArthur, 2005), with the breadth, impact, and room for improvement for mental health solutions within the Church, it is understandable this creates a global evangelical potential to address mental health not only within the Church, but to the world's vast mental health needs (WHO, 2001) outside the Christian community.

6.2.2 The interpretive task (cf. Chapter 3) conclusion

To show the necessity for the pastoral and ministerial care model addressed by CAMH, the researcher conducted a literature review to answer the question according to Osmer's (2008:4) interpretive task: "Why is this going on?" The literature study was undertaken to answer the question to elucidate on what Christian Apologetics and Cognitive Behavioral Therapy provide in the understanding and explanation of the current situation of common obstacles in the gap between willing Church ministers and those struggling with mental health challenges. By this, the study revealed what the researcher suggests are common obstacles in the gap between willing church ministers and those struggling with mental health challenges as proposed by the following:

- Blind-spots. The researcher contends, blind-spots, characterized as "deficits in self-knowledge" (Vazire & Wilson, 2012), need to be considered and explored as an obstacle to mental health solutions within the Church. As shown in Chapter 3 and summarized here, this claim rests on the data supporting the limited current response by the Church, and arguably a response still outstanding from close to a century ago (Jung cited in Adler *et al*., 2014:344):
    - A "nearly invisible" awareness of the mental health needs within the Church (Rogers, *et al*., 2010).
    - A slow adaptation to assist more with severe mental illness in the Church (LifeWay Research 2014:8).
    - More transparent dialogues about mental health in the Church (Simpson, 2013:142-143).
    - Theological misconceptions, such as a "fragmented" use between the nature of the body and soul. (Horton, 2014).
    - A narrow use of general revelation with special revelation that leads to a limited use of integrative counseling that optimizes Scripture and good psychology (English, 1990).
    - Limited emphasis and utilization of multi-trained counselors proficient in psychology, theology, and spirituality (McMinn, 1996).

6.2.3 The Normative task (cf. Chapter 4) conclusion

The researcher approached the normative task that asks the question, “What ought to be going on?” (Osmer, 2008:4) to “give an answer” (1 Peter 3:15) to those struggling with mental health challenges within Christ’s Church by creating the pastoral model CAMH. Chapter 4 answered the normative task by establishing a broader use of the known data found in special revelation (Bible) and general revelation (nature/creation) to create a synthesis between the praxis parallels in Christian Apologetics and CBT to establish the pastoral model CAMH. CAMH systematically integrates philosophy, Christian theology, Apologetics, and clinical psychology, and formulates the model with these following building blocks:

- The call to minister to the sick (Matt. 9:35-6; Ps. 147:3; Gal. 6:2).
- The call to teach and defend the truth (Eph. 4:12-13; 1 Pet. 3:15; Phil. 1:7; Phil. 1:15-16; Jude 3).
- A Christian Apologetic history of “correcting error” (Craig, 2010:13; Sproul, 2009:14-15) with proven efficacy (Acts 17:2-4, Acts 17:34).
- The integrative counseling use of special revelation and general revelation (Moreland, 2019:29).
- The use of scientific psychology (Worthington, 2010), with efficacious interventions or praxis as found in CBT (Beck, 2011:4-5) that does not compromise the use of Scripture (Johnson, 2010; Habermas, 2013; Pearce, 2016).

6.2.4 Pragmatic task (cf. Chapter 5) conclusion

Lastly, the final outcome of this work established the pragmatic task (Osmer, 2008:4), “How might we respond?” to mental health challenges within Christ’s Church. The pragmatic task was forged by coalescing or marrying Classical Christian Apologetics theory and praxis with Cognitive Behavioral Therapy praxis into Christian Apologetics for Mental Health Promotion. The researcher unpacked the agreements and differences between CAMH and CBT while concluding with a demonstration of an annotated model case to show the interplay between the cognitive model triangle to catch, check, and change (3 Cs) misbeliefs and maladaptive behaviors against the

truth of ultimate reality to more reflect the mental health sufferers desired values and/or, to God's Biblical precepts.

6.3 Final conclusion

At the heart of the CAMH model, is the synthesis between the theoretical framing of the Christian worldview, and the praxis parallels between Apologetics and CBT to minister to mental health sufferers.

The findings of this research demonstrated a model that is theoretically systematic and objective with the use of complimentary applications between both Apologetics and CBT. Notably, both Apologetics and CBT apply major interventions, such as questioning the evidence', 'rational responding', 'examining the options', 'direct disputation', and 'labeling the distortion', with the goal of *catching, checking, and changing* a mental health sufferer's misbelief to live a life more reflective of Christ-like living.

6.4 Possible limitations of the study

The researcher maintains, the glaring limitation for the CAMH model is one of scope. While CAMH is a transferable model, learners must operate within ministerial boundaries and pastoral guidelines toward mental health promotion while avoiding professional therapeutic applications such as assessments, diagnosis, and ethical or legal judgements. This limitation is primarily a function of training, in that, psychotherapeutics services are performed by professional providers with professional training (American Psychological Association (2012:474), while ministers, even with their training in pastoral care have limited training in counseling and psychotherapy (Aten *et al.,* 2013:290). Therefore, a significant objective when transferring CAMH to apologists and ministers in training settings, is to establish clear educational boundaries between the roles of the professional counseling and ministerial or pastor.

6.5 Recommendations for further research

Moving forward, the researcher suggests exploring the following subjects as the way forward towards future research.

- Broaden the awareness of the extent, effects, and needs of mental illness in the Church.
- Emphasize the call of the Church.
- Emphasize the call of the Church (Matthew 28:19-20), and the global evangelism potential to address mental health issues beyond the Christian community.
- Explore and emphasize the role of the Church to minister, care, and counsel those with mental illness within the Church.
- Broaden the scope of the Apologetic mandate to defend against the obstacles interfering with spiritual formation.
- Research the distinctions driving the imbalances between secular and spiritual counseling.
- Address the distinctions between psychological accommodation, organic mental health etiology, and hyper-spiritualism toward mental health promotion.
- De-compartmentalize the roles between empirically supported counseling and pastoral care practices.
- Research and broaden the scope toward mental health promotion that optimizes Scripture and “good” psychology.
- Explore and broaden the awareness of spiritual/religious interventions and research.
- Broaden the emphasis towards the multi-tasking counselor by supporting ministerial training in psychology, theology, and spirituality.
- Establish pastoral guidelines to negotiate a code of conduct procedure between pastoral care and professional counseling.

Lastly, since CBT is a testable counseling modality that has been subjected to quantitative studies, the researcher contends that the CAMH model could be applied to a small sample size quatitative study to explore the efficacy of CAMH by training Apologists and ministers to apply the model to mental health sufferers in their congregations.

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APPENDIX A: LIFEWAY RESEARCH, THE STUDY OF ACUTE MENTAL ILLNESS AND CHRISTIAN FAITH (2014): METHODOLOGY

The Study of Acute Mental Illness and Christian Faith was conducted by LifeWay Research. Its objectives were: 1) to equip family members and churches to care for loved ones suffering from acute mental illness, by expanding the understanding of what these persons experience, applying what Scripture says about essentials of faith, and sharing positive contributions that can be made in these individual's spiritual lives; 2) to help family members and churches discern the spiritual state of loved ones suffering from mental illness.

Project sponsors were Focus on the Family and the family of a man who endured schizophrenia. The working review team that reviewed and approved the project direction and survey instruments were Jared Pingleton, Psy.D. Director counseling services Focus on the Family, David Murray D.Min. Professor of Old Testament and practical theology Puritan Reformed Theological Seminary, Kelly Rosati, vice president community outreach Focus on the Family, and Briana Stensrud, director church & community Focus on the Family.

The quantitative survey of Protestant pastors was designed by LifeWay Research and reviewed by the working review team. LifeWay Research conducted 1,000 telephone surveys May 7-31, 2014. The calling list was randomly drawn from a list of all Protestant churches in three size categories. Up to ten calls were made to reach a sampled phone number. Each interview was conducted with the senior pastor, minister or priest of the Church called. Responses were weighted to reflect the size and geographic distribution of Protestant churches. The sample provides 95% confidence that the sampling error does not exceed ±3.1%. Margins of error are higher in sub-groups.

The quantitative survey of Protestant individuals who have been diagnosed with an acute mental illness was designed by LifeWay Research and reviewed by the working review team. LifeWay Research conducted 355 online surveys July 4-24, 2014. A large national panel prescreened over 800,000 adults to identify those who suffer from specific ailments or conditions. The prescreening found over 120,000 who suffer from depression, bipolar, or schizophrenia. Invitations were emailed to a random sample of

this prescreened group. LifeWay Research then screened respondents to identify Protestant adults who suffer from moderate depression, severe depression, bipolar, or schizophrenia. Quotas were used to ensure responses were received from a mix of illnesses, gender, age, region, and ethnic groups in the United States. The completed sample is 355 adults including 200 who have attended worship services at a Christian Church once a month or more as an adult.

The quantitative survey of Protestant family members of those with acute mental illness was designed by LifeWay Research and reviewed by the working review team. LifeWay Research conducted 207 online surveys July 4-20, 2014. A large national panel prescreened over 800,000 adults to identify those who have someone in their household who suffers from specific ailments or conditions. The prescreening found over 95,000 who suffer from depression, bipolar, or schizophrenia. Invitations were emailed to a random sample of this prescreened group. LifeWay Research then screened respondents to identify Protestant adults who attend religious services at a Christian Church on religious holidays or more often who have immediate family members in their household suffering from moderate depression, severe depression, bipolar, or schizophrenia. Quotas were used to ensure responses were received from a mix of illnesses, gender, age, region, and ethnic groups in the United States.

LifeWay Research conducted secondary research on specific theological questions on this topic. LifeWay Research searched published and historical writings that address what mental abilities are needed to have a saving relationship with Christ and whether the lack of these abilities precludes salvation. Relevant biblical passages were also explored in this summary.

LifeWay Research conducted qualitative research among mental health professionals whose practice includes regular treatment of those who have schizophrenia, severe depression, and bipolar disorders. LifeWay Research developed a topic guide for use in these in-depth interviews and submitted it to the working team for approval. The telephone interviews were approximately one hour in length. Interviews were recorded, transcribed, and then analyzed. The mental health professionals were recruited through a combination of networking, referrals, and directory lookups. Recruiting intentionally sought to include professionals experienced with schizophrenia.

15 Interviewees:

- Dr. Adrian Warnock, Jubilee Church, London
- Dr. Chuck DeGroat, Associate Professor of Pastoral Care and Counseling at Western Theological Seminary
- Dr. Chuck Hannaford, Executive Director of HeartLife Professional Soul-Care
- Dr. David Jenkins, Coordinator of Ph.D. Clinical Training, Liberty University
- Dr. David Powlison, Executive Director, The Christian Counseling & Education Foundation
- Dr. Eric Achtyes, President Michigan Psychiatric Society, Staff Psychiatrist and Research, Pine Rest Christian Mental Health Services
- Dr. Eric Johnson, Lawrence and Charlotte Hoover Professor of Pastoral Care, The Southern Baptist Theological Seminary
- Dr. Matthew Stanford, Professor of Psychology, Neuroscience and Biomedical Studies, Baylor University
- Dr. Michael Lyles, Lyles and Crawford Clinical Consulting
- Dr. Richard Winter, Professor of Practical Theology and Counseling, Covenant Theological Seminary
- Dr. Sam Williams, Professor of Counseling, Southeastern Baptist Theological Seminary
- Dr. Steve Runner, Licensed Psychologist, Pine Rest Christian Mental Health Services
- Dr. Tim Sisemore, Director of Research and Professor of Counseling and Psychology, Richmont Graduate University
- Dr. Todd Hall, Professor of Psychology, Rosemead School of Psychology, Biola University
- Dr. Warren Kinghorn, Assistant Professor of Psychiatry and Pastoral and Moral Theology, Duke Divinity School

APPENDIX B: STANDFORD AND MCALISTER (2008) METHODOLOGY

The results of a survey conducted among Christians by Standford and McAlister (2008) show that there is a tendency in the Church to over-spiritualize the causes of mental illness. The following question was posed to respondents:

Did anyone at your church ever suggest that your mental illness was a result of sin?

Responses: 63.5%: No

36.5%: Yes

Standford and McAlister (2008:148) state:

> Of the 85 study participants, 46% indicated that they had approached the church in relationship to their mental illness only once. The remaining 54% interacted with the church in relation to their mental illness on multiple occasions. The most common person contacted at the church was the senior pastor/priest. (55.3%) followed by a small group leader (34.1%), congregant/church member (32.9%), pastoral staff person (30.6%), lay counselor (11.8%), and elder/lay church leader (11.8%). When asked "What help or services were you hoping to get from the church in relationship to your mental illness?" most common answers were; guidance, counseling, support, and understanding. To the question, "In your specific case, how much has the church been involved with this problem?" most (57.6%), of the participants responded not at all, (18.8% a little, 17.6% somewhat, 5.9% a great deal). When asked, "How much more would you liked your church to be involved?" 36.5% responded a great deal more (17.6% somewhat more, 11.8% a little more). Satisfaction with the church's level of involvement was indicated by 22.4% of the participants, whereas 11.8% of the participants responded that they did not want the church more involved because they had made matters worse. A small majority (50.6%) of the participants felt that their family and friends (outside the church) were supportive of them in relation to their mental illness.

APPENDIX C: PEARCE'S TEN COMMON DISTORTED THINKING STYLES[47]

1. All-or-Nothing Thinking

You see things in black-and-white categories. For example, if your performance falls short of perfect, you see yourself as a total failure. This way of evaluating things is unrealistic because life is rarely completely one way or the other.

Theological reflection: Jesus told his followers that they are to hate evil; yet he also said that they should love and pray for their enemies, rather than judge or condemn them for doing wrong. Extending grace to others seems to mean seeing the world in shades of gray, rather than in strict black-and-white terms.

2. Overgeneralization

You see a single negative event as a never-ending pattern of defeat. For example, if you are turned down for a job, you tell yourself no one will ever hire you.

Theological reflection: In the Gospel of John, when Jesus was arrested, Peter denied ever knowing him. One might assume that Peter had failed as a friend and could never again consider himself worthy of friendship with Jesus. However, after the resurrection, Jesus engages with Peter in a loving manner and entrusts to him the sacred mission of sharing the gospel message with others. Peter openly proclaimed his love for Jesus for the rest of his life. One failure didn't mean a lifetime of failure for him.

3. Mental Filter

You pick out a single negative detail in a situation and focus exclusively on this. In doing so, you ignore or filter out any positive details or feedback.

Theological reflection: Scripture gives clear instructions on what to focus our thoughts on: "Whatever is true, or lovely, or gracious . . . think on that. If there is any excellence, if there is anything worthy of praise … think about that" (Philippians 4:8). To do this, we need to acknowledge and reflect on the positive things we have been given and

[47] Pearce, 2018:66-70.

accomplished and the positive feedback we have received; we are not to ignore or filter these things out.

4. Disqualifying the Positive

You disqualify positive experiences by insisting they “don’t count” for some reason. In this way you can maintain a negative belief that is contradicted by your everyday experiences. You don’t just ignore positive experiences as with the Mental Filter; you intentionally devalue them.

Theological reflection: When the Israelites experienced hardships in the wilderness on the way to the Promised Land, they decided that God had rescued them from slavery in Egypt only in order to kill them in the wilderness (Exodus 16:3). They disqualified God’s promises and the miracles he had done on their behalf to deliver them and to sustain them in the wilderness. As a result of disqualifying these positives, they made an inaccurate assessment of God’s character and his purpose for rescuing them from the Egyptians.

5. The Fortune-Telling Error

You jump to conclusions by anticipating that things will turn out badly. You feel convinced that your predictions are an already established fact even though no one can predict the future.

Theological reflection: Jesus told his followers not to be anxious about the future because he is in control and has promised to take care of them (Matthew 6:25–34). By worrying and imagining a negative future, not only do we not improve the situation, but we also act as if we do not trust God to keep his promises.

6. Catastrophizing

You inappropriately exaggerate the importance of things, such as thinking that a mistake you made was the worst possible outcome. By distorting reality, things appear worse than they are.

Theological reflection: After Judas betrayed Jesus, he felt so guilty that he saw no solution for his actions other than killing himself. Although his actions were certainly

grievous, Jesus had a history of demonstrating grace and forgiveness. Indeed, restoration of humankind's right relationship with God was the purpose of Jesus' death and resurrection. Judas's interpretation of his action was a distortion of reality, one that cost him his life.

7. Emotional Reasoning

You assume that your negative emotions necessarily reflect the way things really are: "I feel it. Therefore, it must be true." Our emotions are a reflection of our thoughts, beliefs, and physiology; they are not necessarily a reflection of the true state of affairs.

Theological reflection: Individuals in the Bible are described as having times of dryness and darkness, times when they yearned for God, but did not feel his presence. However, not feeling God's presence did not mean he was absent, because God says he will never leave or abandon us. Their feelings of being alone were not a true reflection of the situation. We are asked to put our faith in God's promises, not in our feelings.

8. Should Statements

You try to motivate yourself with should(s) and shouldn't(s), as if this is the only way you can get yourself to do something. When you don't do something you think you should have done, you feel guilty. When you direct should statements toward others, you feel anger, frustration, and resentment.

Theological reflection: One of the central themes of the New Testament is that Christ has accepted us, forgiven us, and given us a spirit of freedom. As such, there is no need to condemn ourselves if we do not perform the way we or others think we should have performed (Romans 8:31). If we make a mistake, the Bible says that we are to confess our sin to God and that He immediately forgives us and puts that sin as far away as the East is from the West. His love is a gift of grace, not a result of us earning or deserving it.

9. Labeling

This is an extreme form of overgeneralization. Instead of describing your error or behavior (e.g., I failed the exam), you attach a negative label to yourself (e.g., I'm a failure). When someone else's behavior bothers you, you attach a negative label to that person (e.g., he is a jerk), rather than describing the behavior.

Theological reflection: God loves us unconditionally and rejoices in us even when our behavior is not pleasing to him. For example, in the parable of the Prodigal Son (Luke 5:1–24), the father eagerly welcomes the son back home even though the son has squandered his inheritance and disgraced his family. This parable—a story meant to teach us about God's relationship with humankind—demonstrates that the son's identity and worth were not based on his behavior, but simply on being his father's son. Likewise, our identity and worth are not based on what we do or don't do, but simply on the fact that we are God's children.

10. Personalization

You see yourself as the cause of some negative external event for which you are not responsible. While we have some influence over people, what they do is ultimately their decision and responsibility, not ours.

Theological reflection: God has control over the events that happen in the world. We, for the most part, do not. We should not presume to be God or try to fill his shoes, especially when negative events happen to us. There are many things we will not understand in this life and many things over which we have no control. In these situations, the scripture says we are to "be still, and know that I am God" (Psalm 46:10).

APPENDIX D: DEFENSE MECHANISMS

Gladding (2007:193) maintains, psychologically, that the primary defense mechanisms are the following:

- *Repression*: This is one of the most challenging of all defense mechanisms. It is said to be present when a person represses unconscious painful thoughts and memories—i.e., childhood abuse that they have difficulty recalling.
- *Denial:* This is a pervasive defense mechanism, a term used even by lay folk. Here a person refuses to see or accept a problem about themselves, i.e., an alcoholic does not recognize excessive drinking.
- *Regression*: This defense mechanism often manifests itself under heavy stress, arising when a person returns to a childlike way of behaving, i.e., an adult having a tantrum when not getting their way.
- *Projection*: This defense mechanism is often unconscious and places personal perceived inadequacies onto another person, i.e., a socially insecure person speaking out about something about another person, but it is something that they actually do not like in themselves.
- *Rationalization:* This is another defense mechanism used by lay folk. It involves defensively providing an intellectualized answer to justify a particular action, i.e., a spouse in a broken marriage stating, “We do not need counseling. There is nothing wrong with our relationship; it is fine; we have just been under too much stress lately.”
- *Reaction formation:* When a person speaks out against the very thing they are freely acting out in their personal life, i.e., a politician speaking out against a moral or political cause while practicing in their private life the very thing they are denouncing.
- *Displacement*: This defense mechanism redirects an emotional response onto a harmless outlet, i.e., when a husband gets yelled at by his boss at work, he displaces his anger by taking it out on his family.

APPENDIX E: DRILL-DOWN OR VERTICAL ARROW TECHNIQUE

The drill-down or vertical arrow technique, popularized by Burns (2012:269-270), is an intervention used to uncover one's internal, often subconscious, beliefs and emotions. Like peeling off the layer of an onion, the counselor drills down on the counselee's beliefs to get to the core belief underlying and supporting all the building layers of beliefs. The counselor repeats the same question, such as, "If that were true, then what?" or "If that were true, why would it upset me?" so each prior belief or layer is revealed until the counselor reaches the end where the core or root belief is brought to light. By uncovering or catching the root belief, one is able to check if the ultimate core belief is accurate, and if not, the belief can be changed to a more adaptive belief. Consequently, by drilling down and changing the misbelief, it can influence more positively a mental health sufferer's emotions and behavior.

Here is an annotated example of the drill-down or vertical arrow technique that demonstrates the use and effectiveness of one question: "If that were true, what would it mean to you?"; followed by the vertical arrow, to uncover the root and driver belief forming the layers of negative beliefs:

Counselor: "You report that you feel anxiety when you think about having an interview with your boss for a job promotion within your company this week?

Counselee: "Yes, if I go to the interview, I might have anxiety.

Counselor: "If that were true, what would it mean to you?"



Counselee: "If I have anxiety, I will look odd, like I'm not professional, to my boss, and it will lead to a bad interview."

Counselor: "If that were true, what would it mean to you?"



Counselee: "Then my boss would think something is wrong with me."

Counselor: “If that were true, what would it mean to you?”



Counselee: “Well, I would not get the job, but worse, everyone in the company would be talking about me and think there is something wrong with me.”

Counselor: “If that were true, what would it mean to you?”



Counselee: “No one would want to be around me.”

Counselor: “If that were true, what would it mean to you?”



Counselee: “If no one wants to be around me, I will be alone.”

Counselor: “If that were true, what would it mean to you?”



Counselee: “I am insignificant, unworthy of value and even love from others.”

Counselor: “If that were true, what would it mean to you?”



Counselee: “That would be extremely painful, I would have to leave the company because I would feel rejected by my peers. Ultimately, I would be so depressed, it would be hard to get out of bed each day.”

As the reader can see, after drilling down to the root or core belief, not only is the counselee placing a lot of weight on the interview, but it is also easy to understand what is causing the anxiety. The anxiety or symptom is driven by the layers of beliefs, the core (cause) of which is the silent belief that “If I have a bad interview, I am unworthy of love from others, I would have to leave my job, and be left with depression.”

Note that the outcome in this example of the drill-down or vertical arrow technique to get to the core beliefs, as covered in section 4.5.2.2, is in line with what Beck (2011:228) identifies in the three categories for negative core beliefs: helplessness, lovability, and worthlessness.

APPENDIX F: SOCRATIC QUESTIONS

Beck (2011:171-172) lists the benefits of applying Socratic questions to the counselee's thinking:

- Examine the validity of the automatic thought.
- Explore the possibility of other interpretations or viewpoints.
- Decatastrophize the problematic situation.
- Recognize the impact of believing the automatic thought.
- Gain distance from the thought.
- Take steps to solve the problem.

Likewise, below is a sample list of suggested Socratic questions that Beck (2011:171-172) considers can assist counselees to examine their thoughts:

1. What is the evidence that supports this idea?
2. What is the evidence against this idea?
3. Is there an alternative explanation or viewpoint?
4. What is the worst that could happen (if I'm not already thinking the worst)? If it happened, how could I cope? What is the best that could happen? What is the most realistic outcome?
5. What is the effect of my believing the automatic thought? What could be the effect of changing my thinking?
6. What would I tell [a specific friend or family member] if he or she were in the same situation?
7. What should I do?

APPENDIX G: BECK'S TESTING YOUR THINKING WORKSHEET

Name: _____ Date: _____

This worksheet is an easier version of the Dysfunctional Thought Record and should be used in place of, not in addition to, the DTR, for certain clients, such as adolescents.

What is the situation? _____

What am I thinking or imagining? _____

How does that make me feel? mad sad nervous other: _____

What makes me think the thought is true? _____

_____

What makes me think the thought is not true or not completely true? _____

_____

What's another way to look at this? _____

_____

What's the worst that could happen? What could I do then? _____

_____

What's the best that could happen? _____

_____

What will probably happen? _____

_____

What could happen if I changed my thinking? _____

What would I tell my friend [think of a specific person] _____

if this happened to him or her? _____

_____

_____

What should I do now? _____

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APPENDIX H: BECK'S THOUGHT RECORD WORKSHEET

Date/time	Situation	Automatic Thought(s)	Emotion(s)	Adaptive Response	Outcome
	1. What event (external or internal) is associated with the unpleasant emotion? Or what unhelpful behavior did you engage in?	1. What thought(s) and/or image(s) went through your mind (before, during or after the event or unhelpful behavior)? 2. How much did you believe the thought(s)?	1. What emotion(s) (sad/ anxious/ angry/ etc.) did you feel (before, during or after the event or unhelpful behavior)? 2. How intense (0–100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions below to compose a response to the automatic thought(s). Indicate how much you believe each response.	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0–100%) is the emotion? 3. What would be good to do?
Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) If the worst happened, how could I cope? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking? (5) If [person's name] was in this situation and had this thought, what would I tell them? (6) What would be good to do?					

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