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ESSAYS

Clinical Christian Psychotherapy

In the first part of this presentation I summarized some of the important concepts of the metaphysical anthropology on which I based Christian psychiatry. I noted that the current scientific view of the nature of mankind and the structure of his mind does not include a spiritual dimension, and observed that when spirit is included it becomes necessary to formulate a new theory of personality development. At the same time, if the spirit is included as a dimension of the nature of mankind, we, as Christians, must also subscribe to a dualist view of the mind and brain. I then briefly conceptualized the system that we call the mind and included the spirit as its driving force. I also pointed out that the natural, or unregenerate state can end with salvation, an event that results in a dramatic and radical change for the better in the personality. I ended by describing the spiritual development of regenerate persons. I would now like to turn to the problem of spiritual disease and the interventions that are available to bring about healing.

SPIRITUAL DISEASE

In the foregoing we have described two states of spiritual existence. The natural one we have called the unregenerate state. In this state our will is directed to the satiation of our appetites, and toward the control of our environment so that we and those closest to us can survive. The second state of existence is a supernatural one. We called it the regenerate state. In this state we live in a supernatural condition because of the dramatic alteration of our mind by the Holy Spirit. The Spirit has given us new power and direction. We still desire to live as we did in the unregenerate state, but we have now added a higher good to our desires for living that supercedes the others. We want to do everything we do for the glory of God.

Disease is usually considered to be an impairment due to a disturbance of function in some vital part or system of an organism. We must conclude, then,

that the natural state of man's existence described earlier, is diseased because it is incomplete and can not function as it should. In the regenerate state there can also be malfunctioning when some controlling mechanism causes the person to behave in a maladaptive way. Let us now inquire into these two conditions.

Toksosz Karasu (1977) has observed that a psychiatrist's approach to therapy is determined by his view of human nature. Since scientific humanism does not admit to the existence of either the human spirit or a supernatural spirit, it can only consider the unregenerate state as normal. To explain away the regenerate state it has to believe it to be the result of psychopathological disturbances, or to recognize the phenomenon of regeneration and then to ignore it as some psychological artifact that is unexplainable. Having lived in both states, Christians know experientially that there is a marked difference. Christians regard the unregenerate state as diseased. We do, therefore, begin our classification of spiritual disease by designating the unregenerate state as <u>the</u> primary spiritual disease.

There are three stages of disease in the unregenerate state. The first of these the Bible calls "lost" in sin. In this state, so graphically described in the first chapter of the letter to the Romans (Rom. 1:18-32), the person has no cognizance of disease. Pain is considered a normal part of existence, and there is neither the possibility of escaping it nor any comfort to ease it. Usually they hope that some of the "worldly pursuits" mentioned in our first essay will bring some happiness. If they do not, then the problem exists within the person so that they must work harder at getting more gusto out of life. But even when they have done this, the world's pleasures, no matter how hard they are pursued, fail to bring sustained happiness. At some point despair develops. Despair is the second state of primary spiritual disease.

Since despair has an affective component that is painful, most persons seek to ascertain the cause of their problem. As they search, they find that something is wrong with the ideology that they live by, so they try new ones. If they were reared in a Christian environment, they usually ignore Christianity because they have already developed a defense mechanism against it. Instead they may seek some of the world's other answers and try psychotherapy, materialism, status, eastern religions, or support "noble causes". If they were reared as an agnostic or atheist, they may even try Christianity. This third stage is called the searching stage.

If the message of salvation is available they can turn to Christianity, for they see and hear that it makes a favorable difference when it is appropriated. They are now under conviction. All that is left to bring about healing is surrender and salvation.

Stage two and three of this diseased state are symptomatically existential depression, a type of depression that sometimes is indistinguishable from other

dysthymic disorders. The symptoms may be mild to severe. It is described with such mood statements as sad, empty, melancholy, despairing or depressed. Occasionally the person will say that they are angry, afraid or anxious. They often have biological concomitants such as insomnia, anorexia, loss of libido and changes in psychomotor activity. Thinking is ruminative and obsessional, and its content is usually expressed as needing to find the meaning of life, finding some way to control their biological drives, or finding some meaning in death. Persons with existential despair do commit suicide.

In the regenerate state, it is also possible to develop spiritual disease. Its cause is sin. Sin is a moral problem that exists as a result of the rejection of God's sovereignty over a person's life (Schoonenberg, 1965; Moxon, 1922). In the unregenerate state they reject Him because they have not heard the message that salvation is possible, or they reject Him out of a desire to retain control over their lives. In the regenerate state, God is rejected because persons still have the tendency to want to control their own lives. They are created with free will, they can make choices. The greatest number of potentially conflictual choices that they make are almost always in their relationships with other persons. This is true because humankind was created to live in relationships, and must sustain them by putting the best interests and welfare of others above their own. They do not, however, do this readily so guidelines or laws develop out of a need to regulate these relationships. Except in the case of the Hebrews, laws have evolved out of the secular history of a society. Hebrew law, and subsequently our law, was uniquely given by God and does, therefore, have greater authority because it was formulated by the creator of the universe who is omniscient. His complete understanding of human nature allowed him to create a system of laws that are uniquely suited to the needs of His creation. He then made it possible for his creation to live with this system of laws by providing him the power to do so. Only when they live in union with God can humans live as they are created to live--normally (Weiss and English, 1957, p.37). They are to live in love, for God's commandments are summed up in the one word--LOVE.

Love makes simple demands. It asks that all persons love God who is the author of love and the source of the power of love. It demands that everyone love his or her neighbor. If its demands are ignored, then sin is a consequence. Sin is, therefore, denial of that which is rightfully God's--His sovereignty over a person's life.

M. H. Spero (1978) has recently examined the concept of sin as neurosis and neurosis as sin. He concluded that although not all sin is neurosis, all neurosis is sin. Sin gives rise to dynamic conflict, conflict with God, self and others. The concomitant of conflict is emotion, usually anger, shame, fear or sorrow, although other painful emotions can be experienced. The intrapsychic conflict and the emotions experienced give rise to moral paralysis (MacKay, 1918, p. 18), as well as alienation from God, man and society. The alienation occurs because the

painful emotions mentioned above always move us away from others, and we suffer from the loss.

Neurosis is sin, for it places the sufferer at the center of their own universe. They focus on themselves, and seek nothing more than to have their problems resolved and their symptoms relieved. Nothing else matters--God, other persons, and the world is of no importance.

Unfortunately, the ideas outlined above present us with a dilemma, for with this definition of neurosis we are in danger of being reductionists who can, in turn, believe that we must attack all neurotic problems from a strictly spiritual viewpoint. Jay Adams (1971) leaned very strongly in this direction in his writings. We cannot accept a reductionist approach since we have observed the harm that can be done when such an approach has been used. How, then, are we to resolve our problems? Our answer to this question can be found in Dwight Pentecost's (1965) definition of depravity. He observed that we are not as bad as we can be, but instead we are as bad off as we can be. It is not our proclivity to sin that is the problem, but our failure, and at times, our refusal to stop sinning. I believe as does William Glasser (1965), that the truly neurotic patient, and here we use the term in its broadest definition, is responsible for getting out of their predicament. If they refuse to do so, they are sinning.

There are, then, two states where sin becomes disease. In the first state, the person willfully rejects God's laws and develops neurotic symptoms. The second occurs when a person develops neurosis because of unavoidable events in their lives and then sins when they persist in rejecting healing. In the latter neurosis, the person still has the responsibility of not only dealing with the neurosis, but also with sin.

Space does not allow us to discuss the effects of physical and other emotional diseases on the human nature. These effects do cause secondary spiritual complications that must be treated. All we can do here is mention their occurrence..

EVALUATION OF SPIRITUAL MATURITY AND DISEASE

When I was a medical student we were taught in detail how to examine a patient's body and soul, but as for his spirit we only learned to determine the patient's church affiliation and activities. Quite obviously this information is inadequate for us to determine the spiritual status of the patient, so we must improve on it. I use the following approach in my standard examination of the patient.

After I have obtained a chief complaint and a history of the development of their illness, a family, marital and sexual history, I end by inquiring into their developmental and personal history. It is at this point that I unobtrusively obtain

my spiritual history by asking all new patients what they do for fun. After I have determined the extent and nature of their recreational activities, I next ask them what their social life is like. If they do not include the church in their list of social activities, I ask them directly about their attendance. Persons who do not go to church are asked if they have ever attended, if so, why they no longer go, and whether they would be hostile to the idea of going back if their charges against the church could be refuted. If they go to church, I ask them what meaning church attendance provides in their life. If I get an answer that indicates that it is very important to them, I ask them why. All patients are asked if they have ever had an experience where they felt close to God, but if they have volunteered the information that they have a personal relationship with Him, they are asked if they are born again or have committed their lives to Christ. One has to be careful in asking about being born again, since some people believe that only Baptists get “born again” and may be offended by such an inquiry.

Once I have established the patient’s relationship to the Lord, I next want to know if they have been discipled. The questions that one asks are obvious. Do you pray? How often? For what? With whom? Etc. Do you study the Bible? How often? How do you go about it? With whom? etc. Do you know and do God’s will? Since the answer to this is almost universally no, we usually do not need to ask other questions, but if we do their content can be derived from our earlier discussion. Next, I ask if they have any knowledge of the Holy Spirit and how he works in their life. Again I usually get a negative response. Finally I ask them if they have put feet on their faith. As this usually produces a look of bewilderment on their faces, I hasten to explain that we are commanded by the Lord to go into the world to do the things that He asked us to do. I then list His action commandments to them. I usually get a negative reply to this question as well. Nevertheless, I have now established the level of spiritual development of the person and this provides me with an understanding of where the person “ is at” in their faith. Only then can I determine what spiritual interventions will be necessary before I can successfully integrate Christianity into my treatment.

SECULAR INTERVENTIONS

The ultimate goal of secular psychotherapy is to help the patient achieve normalcy. I use the definition of Weiss and English (1957, p. 37) which states that a person is normal when they are unhampered by mental conflicts, free of symptoms, have a satisfactory working capacity and are able to love someone other than themselves. The goal of Christian growth is exactly the same.

The only problem with secular psychotherapeutic systems is that when they are examined in the light of the scriptures, they are found to provide only partial answers to the problems faced by most persons. Many of them work only on a small part of the system that we call the mind. They can, however, be integrated into a more meaningful whole if they are applied using a Biblically ordered view

of the mind, and supplemented by the addition of spiritual interventions. Almost all of them can be used effectively at certain times to bring about healing.

The treatment approach that I have used has been called by Garfield (1980) "eclectic psychotherapy". All this means is that I have chosen concepts and interventions from various psychotherapies that I consider to be useful and are compatible with God's Word. This approach had its origins in the "distributive psychotherapy" of Adolph Meyer (1957). In the following paragraphs I will comment of some of the important ideas that I have incorporated into my approach.

Reality Therapy

To begin, I have made Glasser's (1965) reality therapy a cornerstone of my approach. A person must confront the reality of their life. They must face the fact that they are a person with problems, that they have not been able to resolve them, and that they must want to be helped. If they can accept these three basic requirements, they must then assume the responsibility to participate in the process of change. The presentation of these requirements and their acceptance may take place immediately after the evaluation, or much later in therapy, after the dynamics of the illness have been explored. This approach has scriptural confirmation found in the eighteenth chapter of Ezekiel and in the first twenty verses of the thirtieth chapter of Deuteronomy.

Cognitive Therapy

The next building block is cognitive therapy (Beck et al., 1979). It is absolutely necessary that the patient's erroneous cognitions of reality be determined and then restructured (Rom. 12:2). Of great importance is the concept of self. Karen Horney (Mullahy, 1952) made an important contribution to our understanding of neurosis when she observed that persons developed symptoms when their concept of the self, that she called the ideal self, and the objectively observed self, that she called the real self, were incongruent. Both of these selves have three parts. They are the physical, intellectual and social selves.

Contained within the concept of reality possessed by the patient are their views of their relationships with significant others, both living and dead. In what I consider to be their chronological order of importance are: (1) parents, (2) siblings, (3) extended family, (4) spouses, and (5) children. Biblically, these relationships are of great importance, for throughout both the Old and New Testaments there is a focus on relationships. We are ordered to love and honor our parents, siblings, neighbors, spouses, and children.

Of equal importance are our values. God has established absolute laws and commandments. They are to be established in the minds of our children and our children's children. Since these laws cannot be relativized without incurring pain,

it is necessary that we determine how a person's value system deviates from God's and then try to make them congruent.

Dynamic Therapy

The third building block used is what is usually referred to as dynamic or insight oriented psychotherapy (Malan, 1979, Mullahy, 1952). Here one must establish a positive transference relationship with the patient. This transference is facilitated by the Holy Spirit as He works to manifest and pass on God's love. This love is what really makes the difference in any type of therapy. Also from insight therapy comes the understanding that the genesis of the patient's problems lies in their past, and that by determining the significance of certain memories and their attached emotions, one can heal these memories and alter self concepts, values and relationships. The concepts of dynamic therapy are used to help the patient get in touch with their past.

Transactional Analysis and Gestalt Therapy

These are included because they contain useful linguistic concepts and techniques that help patients get in touch with their past (Harris, 1969, Perls, 1965).

Behavioral Therapy

Here it is necessary that we determine what destructive behaviors are present in the patient's behavioral repertoire. These have to be changed using behavioral modification techniques. Both aversive and operant conditioning are useful in bringing about change. The establishment of constructive behaviors is best accomplished using operant conditioning. This is Biblically adjured in the fourth chapter of Ephesians.

Existential Psychotherapy

In our earlier discussions, we established the occurrence of spiritual diseases that arose out of our existence (Yalom, 1980) and a wrong relationship with God. These are treated using the spiritual interventions that I will now explicate.

SPIRITUAL INTERVENTIONS

Evangelization

If we have chosen to integrate our faith into what we do, it is clear that we must evangelize all patients who do not have a personal relationship with God. Why is this so? The answer is that we have not only been ordered to do so (Matt. 28:16-20), but also are obligated to treat all the diseases that afflict our patients. To fail

to do so would be malpractice. We must, then, find a suitable way to evangelize without being offensive, while at the same time making sure that we do not take advantage of our patient's relationship with us to force our faith on them.

My solution to this problem has been to use the following technique. First of all, I try to determine what they know about me and why they chose me as their psychiatrist. If they have not heard that I am a Christian, I tell them that I am not a traditional psychiatrist and that I am a Christian, and that I integrate my faith into what I do. I further tell them that I believe that I will be handicapped in my treatment if I am not able to use all the interventions that I have in my armamentarium. This, I believe, is unfair to them and to me and if they wish, I will find them another psychiatrist, one who is traditional in his approach. I assure them that I will not be offended. In emergency situations and in ordinary consultations, I use the same approach as do most of my colleagues and no mention is made of Christianity. This is not to say that I do not pray silently for the patient as I examine them, nor do I fail to collect spiritual development data that can be used at a later date when appropriate or necessary.

If the patient is not a Christian and has no objections to my using Christian interventions, I move ahead with my work-up to determine the diagnosis, and to formulate a treatment plan. In almost every diagnostic group except schizophrenia, major affective disorder and organic brain disease, I include spiritual interventions in my treatment. If the patient is not a Christian, evangelization will be the first intervention.

I always wait until I have established a good relationship with the patient before I consider discussing their relationship with God. When this is established, I try to help them understand their position without and with Christ. Without Him they are lost, alienated, hopeless, and unable to control their human nature and are doomed to live eternally apart from God. With Him they will have love, joy, and peace, and all of the other things that are listed as the fruits of salvation. I also tell them that, if what I have to offer is a hoax, they have nothing to lose because I will still be doing the things that other psychiatrists will do, and if it is real, then they will have gained everything including eternal life.

When I exhort the patient, and by exhortation I mean encourage, I include appropriate scriptures to document my assertions. When I have finished my presentation, I ask the patient if they would like for me to pray with them to receive Christ as their Savior, Lord and Master. When I do this, I am always certain that <u>they</u> are inviting Him into their lives by their own free will. I tell them that they can say no, and be sure that this will not be held against them. If the patient seems at all uncomfortable during my exhortation, I ask them to think over what I have said and let me know when they have made up their mind. It must be emphasized that I discover that some persons who thought that they were making a decision of faith had not really committed their lives because unconscious mechanisms prevented them from doing so, and others who

accepted Christ as Savior, but not as Lord, later had to rededicate themselves in absolute surrender in order to grow further.

Discipleship

Since I have already detailed the content of discipleship, I will only speak to the means by which it is accomplished.

There are many times in the treatment of the patient that it is necessary that their education be accomplished as quickly as possible. He or she needs to learn the principles and the techniques of utilizing the means of grace as quickly as possible in order that they can be used in therapy. One cannot rely on the institutional church to teach them so it becomes the responsibility of the evangel to do it. Because it is a tedious and time consuming task, I have chosen to put the essential information on audio tapes, which I then give or loan to the patient. After they have listened to them several times and taken notes on them, I answer any questions that they may have. This saves me many hours of time and is as effective as is my own personal teaching. Since most of the basic principles are used in therapy, the patient gets practical demonstrations as well. I most often have the patient listening and learning during the time that I am working out the dynamics of the psychological aspects of their illness.

I learned that one could be discipled in this way when I was discipled by the Holy Spirit. He led me to tapes prepared by Campus Crusade for Christ, Stuart Briscoe, and others.

Tapes are not the only way that a patient can be discipled. One can refer them to mature laypersons who have a desire to be in some kind of helping ministry. In my job as a teacher, I have used medical students and nurses who were working with me on an elective. These students found the experience most enlightening and rewarding.

Confession, Repentance and Forgiveness

Sin, as we have noted, is the result of the rejection of God's sovereignty over one's life, and it must be dealt with if the person is to be healed. The world is full of sin-sick souls such as another young woman who was brought to me because she wanted to commit suicide. In her short life she had never dated a boy or man with whom she had not had sexual relations by the third date. As she confessed these relations and the two abortions that she had when her promiscuity resulted in a pregnancy, she said over and over, "Why did I do what I did? I felt so guilty! I would swear that I would never do it again and then I would! I couldn't help myself! I felt so dirty and soiled!"

In time, we were able to heal the memories of these events because she was repentant. Nevertheless, she could not stop being promiscuous until she

understood how the subtle rejection of her mother and father had driven her to find love the only way she knew how, to give her body away. She did not know that she had anything else to give. It was not until the Holy Spirit was able to teach her that she was loved for herself that she was able to cease her sexual activity and accept God's forgiveness.

Confession is the necessary condition for receiving forgiveness. It is said "But if we confess our sins to God, he will keep his promise and do what is right: he will forgive us our sins and purify us from our wrongdoing" (1 John 1:9). Confession is, then, a necessary part of being healed of the guilt and shame, the anger, the hate, the hurt, the fear, or the sorrow that we may carry around as a result of our actions, or the actions of others that have affected us. Confession is an important prerequisite to becoming repentant, for in our confession we are acknowledging our wrongdoing before man and against God (Luke 15:21). Confession can be private, but usually should be to oneself, to God and to one other person. If we have hurt someone by our actions, we should confess our wrongdoing to that person and ask for forgiveness. If we are repentant, then that person must forgive us (Matt. 18:22). Public confession is necessary only if the person has sinned against a group of persons. Again the person must be repentant.

Repentance is a term that in the minds of most persons has religious implications. To the person with no religious commitment, the concept of repentance is expressed in a kind of contrition that is designed to lessen the likelihood of retaliation or rejection, if the act has caused the offended person pain. When a person has disobeyed the law, its aim is to lessen the likelihood or the severity of punishment. In any case repentance, in the unregenerate man, is not likely to result in any profound change in his behavior. To say "I'm sorry" is often a social convention., even though there is a meaningful use of the term "I'm sorry" when unintentional or accidental slights or hurts have occurred and man wishes to acknowledge his empathetic response to the pain that he has inflicted.

In contrast, Christian repentance is defined in the New Bible Dictionary (1978) as a radical change in thought outlook and direction. It is "turning from sin unto God and his service." There is greater depth to the meaning of repentance for the Christian. We do, therefore, expect the psychological consequences of Christian repentance to be greater. Why this is so is not clear except that there can be a greater emotional release, if the repentance has been the result of the work of the Holy Spirit. I am convinced that real life changing results of confession can only occur if there is a godly sorrow and a deep desire to amend one's behavior. Only with confession and repentance is the will redirected. This is a must if the person's behavior is to change radically.

Forgiveness of sin is one of the concepts that is unique to Christianity, yet the church has almost forgotten that it was the primary reason that our Lord came (Matt. 1:21). None of us is without sin (Rom. 3:10-20), and as a result we cannot

avoid the judgment that Jesus referred to when he was describing one of the works of the Holy Spirit (John 16: 8-11). Because we sin and because judgment is certain, it is imperative that our sins be forgiven. In the same way we must have the ability to forgive the sins of others if we are to be set free of the anger and hurt that we have accumulated when we are sinned against. Forgiveness is of God, for he is the final judge and only he can provide the forgiveness that will heal the consequences of sin. He forgives us because of his loving kindness, and not because of anything that we have done. The only prerequisite is that we confess our sins, be repentant, and accept his forgiveness. The refusal to accept forgiveness is as much an obstacle to healing as is the refusal to repent, and may require considerable exhortation.

Bibliotherapy

Christians are not to be conformed to the world but to be transformed by a complete change of their mind (Rom. 12:2). This can only take place if the person has his mind cognitively restructured (Beck et al, 1979). It is the responsibility of the therapist to bring this about. To begin the process, the wrong thinking of the patient must be identified. This is done by carefully evaluating the reality of the patient's life and identifying the maladaptive thinking that has resulted in their predicament. The primary areas that we inquire into are: (1) their self concept and self esteem, (2) their view of God, (3) their value system, and (4) the nature of the relationships that they have with significant others in their lives. Once sufficient information is collected, we begin the process of helping the patient restructure their thinking and their relationships using cognitive therapeutic techniques. Much of this is done in a one to one relationship using the Bible as our primary authority. In using this technique, we make every effort to find scriptures that address their erroneous thinking. A secondary source of instructional materials are tapes, books, and some written materials that we have prepared for topical Bible studies that address some of the common problems with which we have to deal.

Inner Healing

Agnes Sanford described the technique of inner healing in her epochal book The Healing Light (1947, also Sandford and Sandford, 1982). Basically this is a type of prayer imaging, or prayer fantasy, in which the person relives traumatic events in their lives and restructures them so they can release the damaging emotions that have been cathected to the memory. Memory healing does, however, go beyond that, for it also cathects God's love to the memory and thus prevents it from having further influence on the patient's present, or their anticipation of the future. The use of imaging by the Christian is far more effective than the same technique used by a secular therapist, since it has the Holy Spirit's power to facilitate the decathexis and cathexis of the emotions.

Behavior Therapy

Behavior therapy (Wolpe, 1969) is also necessary if the patient is to be healed. The integration of the individual into a fellowship greatly facilitates behavioral change. This occurs because there is modeling, encouragement, and reward for right behaviors. Change is facilitated because the acceptance of the group provides loving relationships that the patient may not have had before. The thought of losing them reinforces the desire to change. We also use role play and assertiveness training to facilitate behavioral change.

Prayer

There is not enough time to say all about prayer that I would like to say, but I know that it is probably the single most unique and effective tool that the Christian psychiatrist possesses. Prayer is helpful in uncovering unconscious mechanisms, in redirecting will, in motivating change, in healing memories, in facilitating cathexis and decathesix of love objects, and in healing and enhancing relationships with persons and with God. It is necessary to initiate and continue the process of salvation (Phil. 2:12). One cannot know God's will for their lives if they do not let God reveal it in prayer. I could go on, but time does not allow anything more than an abbreviated listing of its uses, so I will stop here.

CONCLUSIONS

In these two essays, I have attempted to provide an overview of the integration of our Christian faith into the practice of psychiatry. I have focused on counseling since that is the place where it is of greatest use. There was no way that I could get into all of the areas where Christian principles and activities can be applied and have therapeutic effect in the space allotted to me. Nevertheless, I hope that I have helped you to develop an understanding of how it can be of help, and that our faith is a healing faith. God has given us the wisdom and the techniques and we are remiss if we do not use them.

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