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**CHRISTIANITY AND PSYCHOTHERAPY:
CLINICAL IMPLICATIONS FROM A SEVENTH-
DAY ADVENTIST BIBLICAL ANTHROPOLOGY**

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Introduction

When asked to participate in an interfaith panel on psychotherapy and religion at the Fourth World Psychotherapy Congress in Buenos Aires, Argentina, I felt challenged to reflect on the impact of my spiritual heritage on the clinical work and teaching I am engaged in daily. It was fascinating to read an essay by Ana-Maria Rizzuto (2004) that did something like that – how her experiences of faith shaped her work as a psychoanalyst. Her description is not quite the same as what the proponents of the integration of Psychology and Christianity tend to pursue. By en large, the integration literature selects a topic in psychology (i.e. depression) followed by a discussion from a Christian perspective (i.e. Christian Cognitive Behavioral Therapy for depression). Roberts (1999) captured in words the approach that I am taking : “We are unabashed about bringing theology right into the heart of psychological reflection and research, not as an afterthought, to be ‘integrated’, but as a basic guiding commitment; and not merely as supplying ‘control beliefs’ that set limits to what we can accept from twentieth-century psychology, but as contributing substantively to our conceptualization of the human person” (Roberts, 1997; p.8)

It is in the context of reflecting about my spiritual journey that various anthropological dimensions emerged: how a biblical view on human nature influences the manner in which I conduct psychotherapy. Does a biblical anthropology make a difference on what technique is selected? Does it matter at the moment of selecting goals for treatment? Does it influence that which is affirmed or discouraged in a given session? My focus is not in the development of a grand or unique theory of psychotherapy, but on the nitty-gritty of the conversations I have with those that honor me with their trust regarding their darkest secrets and most painful experiences. In doing so, could I find ideas and research findings congruent with these anthropological dimensions?

Nancey Murphy (2005) makes a compelling argument for Psychology’s inherent limitations when it comes to considerations regarding human nature. Although comprehensive psychological theories are bound to incorporate notions of ultimate reality, ethics, human flourishing and derailment and what constitutes the ultimate good for humankind, this is clearly beyond the spectrum of its self-imposed methodology. Murphy (2005) provides an interesting discussion as to how Theology can organize psychological theory from an Anabaptist tradition and states the obvious: various Christian theologies will result in diverse, and at times unique results.

The anthropological dimensions included in this paper are not meant to be exhaustive nor exclusive. They come from a practicing psychologist without formal theological or philosophical training (which surely will become apparent!), thus, it does not follow the traditional categories of Systematic Theology (Veloso, 1991). A point that Murphy (2005) seems to find advantageous for this endeavor. The categories are not exclusive as other Christians and non-Christians may resonate with them as well, although the language and concepts are informed by my views as an Adventist Christian.

Before proceeding to describe each anthropological dimension, a brief historical overview of the tension between Psychotherapy and Christianity will follow. Given that Psychotherapy is arguably the child of western civilization, it is notable that Judeo-Christian views on human nature have had such a limited impact. The history appears to show that the anti-Christian biases of the founding fathers have had a pervasive influence.

Brief Historical Overview

Sigmund Freud is universally recognized as the founding father of modern psychotherapy. His negative bias is apparent in various essays such as Totem and Taboo (Freud, 1913), The Future of an Illusion (Freud, 1914) and through his private correspondence (Nicholi, 2003). Freud's negativity seems to go beyond the mere disagreement on philosophical grounds but reflects a deep personal rejection. Armand Nicholi (2003) wonders "for someone who did not believe in the existence of God: **who** was Freud so angry with?"

Freud's influence on generations of psychotherapists is undeniable. Sorenson (2004) has quantified Freud's negative bias by tabulating the type of references to religion in psychoanalytic journals between 1920 and 2000. He concludes that "the proportion of articles that consider religion as "pathological" has decreased considerably since Freud's death, in comparison to a more balanced perspective that has emerged since".

Those who have seen the practice of psychotherapy as a threat to a believer's faith, have found Carl Jung's (1960) statement a source of comfort. He said: "Among all my patients in the second half of life... There has not been one worse problem in the last resort that was not of finding a religious outlook on life... None of them has been really healed who did not regain his religious outlook". What Jung had in mind was a godless spirituality arising from archetypes in the collective unconscious. A couple of quotations might suffice: "The Christian Church has failed to stand the baptism by fire – the test of reality" (1933, p.200). Even though Jung claimed to limit his analysis to the intrapsychic world, he suggested that religious figures such as Christ "do not exist outside the psyche" (Fuller, 1994, p.111)

Cognitive therapists have not been kinder. Albert Ellis (1980) made this observation: "devout and orthodox religiosity is in many respects equivalent to irrational thinking and emotional disturbance... the elegant therapeutic solution to emotional problems is to be quite unreligious..."

Humanistic and Transpersonal psychotherapists seem more tolerant, but not necessarily in regards to Christianity as they clearly identify with Eastern philosophies (Miller. 1999). For instance, Carl Rogers (1961) attended Union Theological Seminary but explicitly rejected the Christian beliefs of his parents. He could not train in a field that would require him to "believe in some specified religious doctrine". Furthermore, he

states that “neither the Bible or the prophets –nor Freud or research- nor the revelation of God or man can have precedence over my own experience”.

Contemporary developments are clearly encouraging. In 1996 the American Psychological Association published “Religion and the Clinical Practice of Psychology” (Shafranske), the first of a series of books (Richards and Bergin, 1997, 2000, 2005; Sorenson, 2004; Miller, 1999; Miller and Delany, 2004) that take Christianity and other religious expressions as rightful cultural expressions and not merely as indications of psychopathology.

Despite the progress made, there are three observations that indicate that a measure of bias persists: There is a cultural gap between the beliefs and values of the American people (including psychiatric populations), and that of psychotherapists. Second, there is a culture that approves what is “spiritual” and denigrates what is “religious”. Finally, there is more comfort with Eastern religious experience than with Western manifestations (American Psychological Association, 1999, 2003).

In all fairness, psychotherapists that value religious and spiritual issues in their clinical work, have failed to produce a body of empirical evidence that would support their claim, with few exceptions (e.g. Propst, 1992), whereas Eastern based strategies have a robust research-based foundation (e.g. Linehan, 1993).

Psychotherapy and Christian Anthropology: One Adventist’s Perspective

Browning (1987) argues in a most compelling way, that every theory of psychotherapy has an inherent Philosophical Anthropology, ethical parameters and a view about the meaning of life. In Murphy’s (2005) words: “Comprehensive psychological theories are bound to incorporate some assumptions about *ultimate reality* One’s vision of the ultimate good has implications for what one judges to be normal versus abnormal; for what one perceives as progress, development and maturation; and for what counts as the greatest threats to human flourishing”.

For example, Sigmund Freud’s view on human nature is that there is constant conflict between psychobiological (instinctual) forces and cultural forces. That religion (and therefore the “spiritual dimension”) is an illusion – another cultural attempt to tame instinctual forces. And, on the meaning of life he said: “If I had known the limited happiness left at 60 years old, it is very likely that I would not have enjoyed it when I was one year old. At best, it would have been a melancholic celebration” (Freud, cited in Nicholi, 2003). A perspective reflected in his psychotherapeutic technique and theory of personality to some extent.

Murphy (2005) also points out, that there is no single Christian account of what constitutes human nature. What follows are the dimensions that I have found significant in my clinical work and that flow from my spiritual heritage as an Adventist. The dimensions are not meant to be exhaustive nor theologically sophisticated. For each

dimension, a brief overview of some of the relevant research will be presented, and some of the implications for psychotherapeutic practice mentioned.

Here are the dimensions:

- Spirituality as a Core Component of Being
- Holistic Concept of the Person
- Intrinsic Relational Motivation
- Love as an Organizer of Psychological Experience
- Values and Imago Dei
- Agency
- Internal Conflict
- Temporality
- Transformation

1. Spirituality as a Core Component of Being

Christianity assumes that human beings are created to relate to God (Nehemiah 9:6; Colossians 1:16). The Psalmist sees it as need as basic as thirst: Psalm 42: 1 “As the deer longs for flowing streams of water, so my soul longs for you, O God. 2 My soul thirsts for God, for the living God”. Psalm 16:11 “You show me the path of life; in your presence there is fullness of joy...” Saint Augustine echoes this sentiment in this way: “You arouse in us to take joy in praising you, for you have made us for yourself, and our heart is restless until it rests in you” (Confessions, p.43, 1961)).

Both, the Psalmist and Augustine suggest that spirituality is a basic motivational force with clear psychological implications. They also reflect a spirituality that is not only relational, but has anthropomorphic elements. We are wired to thirst for God as a person, and God (our heavenly Father) is always ready to respond. This view is in sharp contrast with those that embrace an amorphous spirituality or consider religion no more than a cultural narrative (Joseph, 2003).

a. Basic and Applied Research

Contemporary developments in Jungian Psychology articulate some of these ideas. “The psyche, or consciousness is permeated with, and organized by, spiritual principles Jung referred as Archetypes... Today they are thought as a priori fields, patterns of information that are not dependent on any learned or environmental factors... The Archetype is the capacity to form an image, not the image itself... Religious tradition clothes the experience with a variety of God-images we see in the creeds” (Corbett & Stein, 2005).

It is my (speculative) contention (Fayard and Trammel, 2005) that these “a priori fields” can be found in brain structures that are sensitive to an anthropomorphic spirituality and that a failure of integration in the way it is designed to be, has negative implications in relational and emotional functioning. With a different emphasis, but articulating this idea the distinguished neurobiologist Jaak Panksepp

(2005) states: “how subjective experiences arise from brain dynamics remains a great mystery... a variety of basic emotional systems exist in mammalian brains that help generate instinctual emotional behaviors and the corresponding core affective states. These birthrights allow organisms to survive and to reproduce navigating the complexities of the world with intrinsic survival values in mind. Affects, as instinctual action dynamics, provide heuristic neuropsychological codes that allow organisms to automatically instantiate, and thereby anticipate, major survival concerns”

The neurobiological processes that can contribute to the development of the *experience of God* could include:

- The neurobiology of basic motivational systems (the “seeking” system, Kilts, et al. 2004) may generate an undefined sense of longing (St. Augustine). “These circuits appear to be major contributors to our feelings of engagement and excitement as we seek the material resources needed for bodily survival, and also when we pursue the cognitive interests that bring positive existential meaning into our lives” (Paknsepp, 1998)
- The neurobiology of attachment development (Schoore, 2003) may generate the blueprint for the emotional connection to an Other (loving another, relating to, and feeling loved by our Heavenly Father, Rizzuto, 1979)
- The neurobiology of the transitional space (Winnicott, 1971) where symbols acquire a powerful emotional status. It may well be that what is currently known as the neurobiology of “theory of mind” (Abu-Akel, 2003) may provide some direction in this regard
- The neurobiology of cognitive and emotional processes that support the development of beliefs, mental representations, moral codes and even numinous experiences (D’Aquilli and Newberg, 1999)

b. Clinical Implications

- Spirituality will be present in explicit (i.e. “God talk”) or implicit ways (Tan, 1996) in all clinical situations
- Spirituality should be a part of the formal evaluation
- Spirituality may be crucial for healing (e.g. addictions, May, 1992)
- The development and maintenance of an anthropomorphic spirituality can be crucial for the development and maintenance of basic mental health processes (self-worth)
- The loss of an anthropomorphic spirituality can have very negative consequences (i.e. deconversion, Exline and Rose, 2005)

2. Holistic Concept of the Person

“May God himself, the God of peace, sanctify you through and through. May your whole spirit, soul and body be kept blameless at the coming of our Lord Jesus Christ”
(1 Thessalonians 5:23)

“The ancient Hebrews’ concept of ruach and the Pauline use of the Greek word *pneuma* represent this subtle synthesis of nature and spirit. Both terms include the psychological dimensions called soul but preserve an understanding of spirit which is distinguishable from soul; spirit is capable of both relating to God and relating back to oneself in self-reflection and self-objectification. Soul and spirit can be distinguished but not separated, and the spirit is the principle of soul. In addition, both soul and spirit can be distinguished but not separated from the body” (Browning, 1987, p.22).

Ellen White (1905) applies it to a clinical context this way: “Many illnesses that affect humanity have their origin in the mind and only can be cured when the mind is cured”. “The body is a very important mean through which the soul and the mind contribute to character development”. “The condition of the mind has a greater impact than it was believed. Many illnesses are the result of depression. Sadness, anxiety, frustration, remorse, guilt and distrust undermine vital forces and result in weakness and death... Courage, faith, hope, trust and love promote health and prolong life. A happy and satisfied spirit bring health to the body and strength to the soul”.

a. Basic and Applied Research

Few areas have received as much attention in recent times as research showing the correlations between religious practice and health, including the Adventist Health studies (e.g. Jacobsen et al., 1999; Lemon et al., 1964, 1966; Miller and Thoresen, 2003). Richards and Bergin (1997) have summarized the research on religious practice and beliefs and mental health. Religiosity is correlated with lower indices of suicide, depression, addictions and frequency of criminal activities. It also correlates with higher levels of life satisfaction in general and marital satisfaction in particular. Religious couples have lower indices of divorce.

There is a “complex or ambiguous” correlation between religiosity and psychosis, anxiety, self-worth and sexual disorders. Finally, higher levels of religiosity correlate with higher levels of dogmatism, authoritarianism, dependency and suggestibility.

A study in preparation (Fayard, Austin and Ramirez, 2004) found that a positive view of God correlates with a more positive internal object world, and with higher levels of quality of life in breast cancer patients.

Pargament (2001) raises a most appropriate cautionary note to those of us that view faith as important in the lives of our patients. Not all religiosity (Christian or otherwise) is an asset that promotes mental health and social adjustment. For instance, frequent church attendance has been identified as a powerful predictor of health status in the elderly population. Pargament (2001)

found that the emotional climate of the church and the perception of God make a crucial difference. A negative climate and a negative perception of God correlate with poorer health indices.

b. Clinical Implications

- Every clinical assessment must include psychological, physical and spiritual parameters
- Psychological distress can result not only from emotional conflict but from physical and spiritual sources
- Psychotherapeutic interventions can enhance not only emotional, but physical and spiritual well being
- Spiritual interventions can enhance emotional and physical well being
- Treatment is most effective when psychological, physical and emotional aspects are addressed

3. Intrinsic Relational Motivation

The Bible uses multiple metaphors to describe the relational drive inherent to being human. It refers to God as Father and Mother, the creatures as children, and the relationship between Jesus and the Church as a marriage. The Genesis narrative tells us that Man was alone, even though he was in a pre-fall perfect world and had immediate access to God. "It is not good for man to be alone... The man said: This is now bone of my bones and flesh of my flesh" (Genesis 2: 18, 23). The relational motive also includes a vertical dimension "that all of them may be one, Father, just as you are in me and I am in you... I in them and you in me. May they be brought to complete unity" (John 17: 21, 23)

a. Basic and Applied Research

John Bowlby's (1990) seminal work on attachment theory, the research of Mary Ainsworth (1978) and her students, and the neuroaffective developmental work of Alan Schore (2003) have demonstrated that the relational drive is a motivational system in its own right.

Shore (1996) describes it in this way: "the developmental organization of the Self in the brain takes place in the context of the interaction with the Self of another, that is with the brain activity of an other". The longitudinal research conducted by Waters (Waters, Merrick, Trboux, Crowell y Albersheim, 2000) and Sroufe (Collins y Sroufe, 1999) shows that the attachment classification of a mother during the third trimester of pregnancy predicts the attachment classification of that baby at 12 months of age. This, in turn, predicts with about 75 to 78% accuracy the attachment classification of that child at age 16 to 20.

The type of relational pattern established early on, literally sculpts the brain (Schore, 2003, Rizzolatti and Craighero, 2004) and generates implicit expectations about the Self, others and how relationships unfold. The pattern can be transmitted from one generation to the next.

b. Clinical Implications

- The centrality of the therapeutic relationship and the therapeutic alliance is one of the more consistent findings in psychotherapy research (Hubble, Duncan and Miller, 1999)
- Attachment theory provides a fruitful set of interventions to restore relational breakdown (e.g. Johnson, 2004)
- Relationships are crucial for the formation and maintenance of emotional maladjustment (Stolorow et al., 1984)
- A spiritual relationship is crucial but insufficient for emotional well being
- Interpersonal relationships are crucial but insufficient for emotional well being

4. Love as an Organizer of Psychological Experience

“Teacher, which is the greatest commandment in the Law? Jesus replied: Love the Lord your God with all your heart and with all your soul and with all your mind. This is the first and greatest commandment. And the second is like it: Love your neighbor as yourself” (Mathew 22).

The Bible states that “God is love”. The character, the motivation, the essence of the Divine is love. Paul indicates that *any* experience devoid of love is meaningless (1 Corinthians 13). “Nature and revelation alike testify of God’s love. Our Father in heaven is the source of life, of wisdom, and of joy... ‘God is love’, is written upon every opening bud, upon every spire of springing grass... This is His glory: ‘The Lord, The Lord God, merciful and gracious, long suffering, and abundant in goodness’... The Son of Man came from heaven to make manifest the Father: ‘Whoever has seen me, has seen the Father’... The more we study the divine character in the light of the cross, the more we see mercy, tenderness, and forgiveness blended with equity and justice “(Ellen White, 1892; Exodus 33:18, John 1:18).

Love is also seen from an ethical and interpersonal perspective. “A new command I give you: Love one another. As I have loved you, so you must love one another. By this all men will know that you are my disciples, if you love one another.” (John 13: 34, 35).

Love appears to be the organizing principle of divine activity and I suggest, it is an optimal organizer of human activity. The research to be briefly reviewed highlights the impact of feeling loved (or its absence) on neurobiological development. Furthermore, some of the findings correlating intrinsic religiosity (“loving God with all your heart”) and depression are also reviewed.

a. Basic and Applied Research

I. The Psychological Impact of Feeling Loved

Early brain development, particularly during the first three years of life, is heavily dependent upon the nature of the environment. Only by late adolescence there is a consolidation of synaptic pathways, the neurobiological architecture that will support cognitive and affective experience.

The absence, intermittence or unpredictability of the experience of feeling loved can cause significant neurobiological dysfunction. For instance, the brain of neglected children show smaller overall brain size, decreased growth of the corpus callosum, impaired growth of the GABA (gamma amino butyric acid, an inhibitory neurotransmitter) fibers from the cerebellum that serve to calm the excitable emotional limbic structures and probably as a result of excessive amount of stress hormones released during traumatic events which is toxic to neurons, can impair growth or kill existing cells (Schore, 2003).

Van der Kolk (2005) summarizes the impact of interpersonal trauma that results in insecure attachment patterns, neurobiological dysregulation, affective dysregulation, dissociation, impulse control failures, cognitive deficits and a distorted sense of Self.

II. Intrinsic Religiosity and Depression

Social psychologists de-constructed Jesus' dictum to "Love the Lord your God with all your heart and with all your soul and with all your mind" (Mathew 22:37) into an operational construct – intrinsic religiousness. Allport and Ross (1967) defined intrinsic religiosity as a faith that is personal, internalized, has integrity and is not motivated by power, control or tradition. By contrast, they defined extrinsic religiosity as an adherence to the formal aspects of religion with a focus on the personal gains that can be derived from belonging to an organization.

A series of studies conducted by Koenig (1988a, b; Mathews et al. 1998; Koenig et al. 1998, 2001) documented the correlations present between intrinsic religiosity and depression in a large sample of hospitalized elderly individuals. He found that increased church attendance and reliance on religious coping was associated with lower levels of depression. Intrinsic religiosity was associated with less hospitalization days and improved remission rates from depression.

b. Clinical Implications

The world of psychotherapy is currently dominated by either the empirically supported protocols from Cognitive-Behavioral Therapy, or by Eastern informed humanistic strategies. In this context, the promotion of contexts of being loved *as well as* loving is significant. The Cognitivists tend to overemphasize a rationalist perspective whereas the humanists tend to focus on a self-referenced ethic.

- There is a critical role for the intersubjective field of psychotherapy as a "holding environment" (Winnicott, 1971)
- Accessing primary emotions produces significant shifts in the therapeutic process (Greenberg, 1998; Greenberg et al., 1997, 2006)
- Self worth can be restored "through the loving eyes of another" (God – in my clinical experience, Psalm 139:14 can be very helpful in this regard; significant others)
- The restoration of emotional bonds should be the goal of psychotherapy whenever feasible (e.g. forgiveness interventions)

- Susan Johnson (2004) highlights the relevance of primary emotions of affiliation in the restoration of marital relationships
- Facilitate processes that can promote or restore a sense of “loving God with all your heart” (e.g. spiritual disciplines)

4. Values and Imago Dei

“Values are an inevitable and almost omnipresent part of the therapeutic process” (Bergin, 1980). Research has provided evidence that therapist’s values influence every phase of psychotherapy, including the theories of personality and therapeutic change, assessment strategies, goals of treatment, the design and selection of interventions, and evaluations of therapy outcome. Patients are influenced by therapist’s values, often adopting their health, moral, and religious values (Miller, 1999).

Although it is not widely debated in the world of psychotherapy (Tjeltveit, 1999), a multicultural world begs that these questions be addressed: which values? The patient’s? The therapist’s? Mainstream values? The values embedded in the philosophical anthropology found in any given system of psychotherapy? (Browning, 1987)

Christianity assumes a moral order that reflects the image of the Creator in the creature. Exodus 20 is the expression of values that generate boundaries – internal differentiation and the regulation of interpersonal social adjustment that flow from a personal and collective ethic informed by love. Galatians 5:22-25 reflects the virtues at the core of Christian values (love, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control) and embodied in the person and life of Jesus Christ.

More importantly, Christianity assumes that the fullness of Imago Dei can only be the result of spiritual processes. The founder of modern Adventism puts it this way: “Education, culture, the exercise of the will, human effort, all have their proper sphere, but here they are powerless. They may produce an outward correctness of behavior, but they cannot change the heart... That power is Christ” (White, 1892, p. 11). In other words, the affirmation of values can only go so far without a proper understanding of grace as a foundation.

Christian psychotherapists must remain faithful to the values of the patient, yet they (as everybody else) should acknowledge the moral implications of behaviors and relationships. Most psychotherapists would agree with the virtues expressed as fruits of the Spirit. In fact, Positive Psychology (Peterson and Seligman, 2004) provides a similar listing. Doherty (1996) has challenged the profession to take moral challenges seriously. I suggest that Exodus 20 provides an important compass in this regard.

a. Basic and Applied Research

Since Psychotherapy can not claim value neutrality, the question of *which* values are to be considered important remains and *which* values are to be considered negative remains open from a scientific perspective. Positive Psychology (Peterson and Seligman, 2004) has developed a set of “character virtues” that are the focus of current research and may provide a needed direction in this regard. Notice the echoes of the Fruits of the Spirit in at least some of the virtues described:

- **Wisdom and Knowledge:** Cognitive strength involved in the acquisition and utilization of knowledge.
- **Courage:** Emotional strength involved in the pursuit of goals despite internal and/or external opposition
- **Love:** Interpersonal strength that promotes mutual caring
- **Justice:** Strength for community living
- **Temperance:** Prevents excess
- **Transcendence:** Connectedness with the universe and development of a sense of meaning.

Just as a point of interest, notice the similarities with the wording Ellen White (1905) utilizes in her classical statement: “The condition of the mind has a greater impact than it was believed. Many illnesses are the result of depression. Sadness, anxiety, frustration, remorse, guilt and distrust undermine vital forces and result in weakness and death... *Courage, faith, hope, trust and love* promote health and prolong life. A happy and satisfied spirit bring health to the body and strength to the soul”.

Recent research (Moll et al., 2002) has shown that there is a distinction between unpleasant emotions and emotions informed by moral challenges. Failing to recognize this difference in the context of psychotherapy could have important implications, in that areas of the brain that need to be addressed can be ignored only to the patient’s peril.

Perhaps one of the best examples on the religious values influence of the therapist on the patient comes from Sorenson’s (2004) research. He asked for narratives by Clinical Psychology students about:

- Their idea of God as emerging from family of origin contexts
- Their experience as to how religious issues were dealt with in their own therapy
- How they worked with religious issues in their own clinical practice

He also looked at the experience of these students in their own experience as patients. Their therapists were classified as:

- Therapist accepted the transcendent as real v. “illusion”
- Therapist was comfortable with religious issues v. conflicted
- Active exploration of religious issues v passive

When the participating students had a therapist who viewed religion as a resource as opposed to pathological, a legitimate issue to be explored as opposed to a passive “waiting until something relevant comes up”, showed openness to the mystery of spirituality as opposed to antipathy, they (the students) in turn, dealt with religious issues as therapists in a more respectful and skilled manner. But not only that, he also found that the influence of the therapist on the spiritual development of the students was larger than that resulting from the family of origin. Students also reported a deeper spiritual walk when they were in this type of therapeutic context.

b. Clinical Implications

Doherty (1996) suggests that only once the therapist has listened, reflected and affirmed the patient, she can proceed with moral observations in this way:

- The therapist may describe as a personal opinion, the moral views emerging from a specific situation
- Sharing the moral concerns that emerge from the consequence of the patient's actions
- Making a clear statement regarding actions or behaviors that can not be supported, providing the rationale for it, and if needed, transferring the case
- Validate the patient's language that denotes moral concern
- Introduce language that makes explicit the moral contours in the patient's presentation
- Ask questions that can clarify the patient's perception in regards to the consequences of his/her actions on others and explore the personal, family and cultural sources of his/her moral views
- Educate the patient regarding the known research findings or therapeutic knowledge regarding the consequence of certain actions

It could also be added that:

- Moral values organize psychological experience (e.g. moral teaching on suicide). Confusing unpleasant emotions with moral emotions will result in inadequate therapeutic work
- The salience of explicit values as boundaries and the relevance of virtues for a healthy experience of self and others (i.e. positive psychology) can inform the therapeutic process
- Implicit moral assumptions are a part of the therapeutic process
- The psychotherapist has a role (whether acknowledged or not) in the religious world of the patient
- The psychotherapist's ethics and values need close self-examination, whether the therapist is a Christian or not
- Ethical mandate to remain centered on the values of the patient
- Therapists should examine their values driven and religious countertransference reactions
- Active utilization of patient-congruent values for the achievement of healthy behavior and the elimination of unhealthy ones (e.g. suicide) may be relevant

6. Agency

“By the exercise of the willpower in placing themselves in right relation to life, patients can do much to cooperate with the physician’s efforts for their recovery” (E.G. White, 1905). Among the various points of tension between the fields of psychotherapy and Christianity is the one regarding the role of the will. Psychotherapy, a child of the scientific tradition, has highlighted the deterministic role of environmental forces (e.g. experiences of victimization) and internal processes (e.g. unconscious over determination; bio-genetic factors). Ellen White assumes that there is a capacity for choice, and that it can be harnessed in the healing process.

a. Basic and Applied Research

Recent developments in neuropsychology (i.e. Arnsten and Li, 2005) have shown the vital role played by the brain’s executive functions. These include: self-regulation, self-determination, self-control, self-management, self-direction and maturation. Interestingly, executive functions which organize action, thought and emotion are not determined by immediate environmental factors, not determined by body states or immediate impulse, nor determined by the control of others. They are directed toward personal goals while taking into account the goals and intentions of others.

Studies in computational neuroscience (Makeig, 2005) are tracking how decisions happen in the brain. Brain imaging studies with clinical populations diagnosed with Obsessive-Compulsive Disorder or Attention-Deficit Hyperactivity Disorder show abnormal activity in the brain’s pre-frontal region. These disorders exemplify the failure of executive function and its impact on behavioral functioning, therefore highlighting its relevance.

b. Clinical Implications

Understandably, the professional literature is filled with strategies to decrease the emotional slavery brought about by various psychiatric and relational challenges. Interestingly, almost no attention is given to the role of “will power” in the healing process. I should say that no positive attention is given, as the literature is replete of negative observations in this regard. The consensus is that this is a concept riddled with judgmental overtones and should not be emphasized.

Sherwin Nuland (2005), a retired Yale surgeon and award winning writer, told an audience of several hundred therapists his own journey from severe depression to full remission. He highlighted the role of electro-convulsive therapy and psychotherapy in his own healing. He somewhat shocked his audience when he also said that he found it essential in the course of therapy to enlist his own will to abandon symptoms and choose health. He described it in a context of “faith” on the part of the therapist that the patient has the strength and the courage to move in a different direction. The power to choose is essential to any change, psychological or spiritual.

Freud’s old concept “where Id was, Ego must be” implies an element of choice becoming possible when the unconscious dynamics guiding old and repetitive behavioral patterns are revealed. Choices are not made in a social vacuum but are informed by values. Values inform decision-making, provide direction for conflict-resolution and

frame the parameters for social accountability. For some patients, the concept of human choice may lead to a necessary confrontation with his or her own responsibility.

Finally, it is obvious that any substance that decreases neurobehavioral integrity needs to be addressed. As those who work in the addictions field know well, alcoholism and drug addiction is the one illness you can only start healing by *choosing* sobriety.

7. Inner Conflict

The Apostle Paul in Romans 7:15-25 states that “I do not understand what I do. For what I want to do I do not do, but what I hate I do. 16And if I do what I do not want to do, I agree that the law is good. 17As it is, it is no longer I myself who do it, but it is sin living in me. 18I know that nothing good lives in me, that is, in my sinful nature. For I have the desire to do what is good, but I cannot carry it out. 19For what I do is not the good I want to do; no, the evil I do not want to do—this I keep on doing. 20Now if I do what I do not want to do, it is no longer I who do it, but it is sin living in me that does it. 21So I find this law at work: When I want to do good, evil is right there with me. 22For in my inner being I delight in God's law; 23but I see another law at work in the members of my body, waging war against the law of my mind and making me a prisoner of the law of sin at work within my members. 24What a wretched man I am! Who will rescue me from this body of death? 25Thanks be to God—through Jesus Christ our Lord!

The Scripture provides a sharp contrast regarding human nature to what humanistic psychologies embrace. The Bible resonates with the wise words of Aleksandr Solzhenitsyn: “The difference between good and evil lies in the center of the human heart”. The apostle Paul seems to be talking not just about sin, but evil.

Gerald May (1982) and Phillip Zimbardo (2004) provide a useful contrast between the notions of sin and evil. Sin may be seen as a condition, the way we tend to approach life. It is a complex of inclinations, attitudes, and behaviors that arise from self-importance and attachment. Its recognition may bring one to an awareness of fallibility and subsequent repentance

Evil has a more basic quality: it appears as a force that impels or compels away – it fragments within and without, eroding the human heart from longing. Acts that arise from revenge, envy or other purely destructive motivations are evil. Human history is littered with the results of senseless violence. The quote attributed to Plato summarizes it well: “Only the dead have seen the end of war”.

a. Basic and Applied Research

Sigmund Freud’s (1962) gloomy assessment of human nature is probably closer to its biblical portrayal than that of contemporary theorists. He believed that the unconscious mental system is a reservoir not only of fear, but of selfish motives, shameful experiences, violent wishes, unacceptable sexual desires, immoral urges, and irrational wishes. Freud attributed unconscious motives to evolutionary psychobiological forces constantly at war with the forces of civilization. Freudian psychoanalysis saw that emotional cure necessitated the facing of these forces, ownership of these motives, and contrary to popular belief, a harmonious integration with other areas of psychological functioning.

In a related but distinct direction, Carl Jung wrote about the “shadow” as the negative side of personality that without correction, may burst into consciousness with untoward consequences. Jung also felt that unconscious processes were at work but conceived its roots not as instinctual forces, but as connected to the “collective unconscious”.

One of the most striking research examples regarding the dark side of humanity was conducted by Zimbardo (2004) at the basement of Stanford University’s Psychology Department. He recruited and screened Stanford students that were randomly assigned roles of either prisoners or guards. After only a couple of days, guards showed increasing levels of cruelty and prisoners become dehumanized and passive. Within days, a few prisoners had to be released due to the development of symptoms of depression and psychosis. The experiment was prematurely aborted because the brutality of the guards was deemed too harmful to the prisoners (e.g. solitary confinement for minor “offenses”, denial of access to a toilet, removal of food, clothes and bed).

While Zimbardo (2004) stressed the role played by social variables, Bandura (1991) has systematized what he calls the selective disengagement of moral controls, which in the scientific tradition highlights measurable factors and therefore tends to undervalue the “inherent evil” implications described by the apostle Paul and Freud.

The criminal populations (Hare, 1999) provide ample evidence that there are segments of the population that can act out in evil ways without remorse. Differential personality profiles have been described for a long time. The use of brain imaging techniques reveals unique features that have generated controversy in the legal arena related to criminal responsibility.

The Stanford prison experiment suggests that healthy individuals can turn evil in a short period of time. The literature on psychopathy reflects how evil is found in a segment of the population. The apostle Paul also highlights not only the human tendency to evil, but also to “enmity with God”. In this regard, the research of Exline and Rose (2005) can be very instructive. Out of a large sample (n=5,472) of elderly individuals, they found that 25% had significant conflict with God. In fact, “anger with God” predicted higher mortality rates in medically ill elderly patients at 2 years follow up and was linked to poorer recovery in medical rehabilitation after social, psychological and physical factors were controlled. Prolonged anger with God was linked to low self esteem, depression, anxiety, trait anger, insecure attachment, was facilitated by a narcissistic sense of entitlement.

b. Clinical Implications

The limitations in psychotherapeutic approaches to treat the psychopath are well known. What follows, is directed at the need to pay attention to and address the elements of inner conflict found in the individuals seeking psychotherapeutic help. Many of Doherty’s (1996) recommendations are applicable here as well. More specifically a psychotherapist could:

- Turn into Ego-dystonic that which is perceived (rationalized) as Ego-syntonic

- Have the patient visualize the same negative action being committed by their significant other (e.g. marital unfaithfulness)
- Interpret the negative behavior as emerging from the patient's own desire (a la Freud)
- Interpret the negative motive as a split off part of the Self that tells something about the patient's character
- Affirm that conflict is an unavoidable component of human nature
- Utilize elements from the Twelve Steps
 1. Admit powerlessness over negative behavior
 2. Belief in a "power greater than ourselves"
 3. Turn will over to the care of God "as we understood Him"
 4. Take a moral inventory
 5. Admit to God, to ourselves, and to another human being the exact nature of our wrongs
 6. Ready to have God remove all these defects of character
 7. Ask Him to remove our shortcomings
 8. Make a list of all persons harmed and became willing to make amends to them all
 9. Make direct amends wherever possible
 10. Ongoing personal inventory and promptly admitted when we were wrong
 11. Through prayer and meditation improve our conscious contact with God, 'as we understood Him'
 12. "Having had a spiritual awakening as the result of these steps, we tried to carry this message to others, and to practice these principles in all our affairs"

8. Time Consciousness

"There is time for everything, and a season for every activity under heaven:

- A time to be born and a time to die, a time to plant and a time to uproot
- A time to kill and a time to heal, a time to tear down and a time to build
- A time to weep and a time to laugh, a time to mourn and a time to dance,
- A time to scatter stones and a time to gather them, a time to embrace and a time to refrain
- A time to search and a time to give up, a time to be silent and a time to speak,

- A time to love and a time to hate, a time for war and a time for peace” (Ecclesiastes 3:1-8)

Time consciousness is at the heart of Adventist identity: the Seventh-Day Sabbath and the anticipation of the Advent in the near future. The Bible links the hope of the advent with the psychological state of those awaiting it. “Why are you downcast, O my soul? Why so disturbed within me? Put your hope in God, for I will yet praise him, my Savior and my God” (Psalm 43:5). Hope is a key word in the Adventist psyche. “While we wait for the blessed hope—the glorious appearing of our great God and Savior, Jesus Christ” (Titus 2:13).

Whereas hope anchors our sight in the future transforming the present, the Sabbath transforms the present by facilitating an encounter with the sacred and provides a glimpse of the future. The Sabbath connects the present moment with eternity, the mundane with the sacred.

This section will utilize some of the ideas emerging from phenomenologist Edmund Husserl who considered temporality (temporal consciousness) a foundational form of mental activity, (all other forms depend upon it), and from one of the most influential contemporary psychotherapists, Daniel Stern (2004) who just wrote a book about time consciousness in the psychotherapeutic context. The focus will be first on hope, and secondly on the Sabbath.

a. Basic and Applied Research

Stern (2004) explores the notion of time consciousness from the perspective of the present moment or *kairos*: the passing moment in which something happens as time unfolds as the defining moment for psychotherapy. It is the coming into being of a new state of things, and it happens in a moment of awareness. It is the moment of opportunity, propitious for action. During these moments of real experience, the “now” when jointly lived, it is grasped without having to be verbalized. It is like an existential affect.

The past can eclipse the present by casting so strong a shadow on it that the present can only confirm what was already known. The future can also annihilate the present by reorganizing it so much and so fast that the present becomes ephemeral and almost passes out of existence.

Eugene Minkowski (1970) expanded on some of Husserl’s ideas for Psychiatry. He postulates that desire and hope go beyond the present. Desire seeks that which I do not have at the present time, it stretches beyond complacency. Hope looks beyond the immediate future, it is free to look to a horizon filled with promise and removes the person from the present context freeing humans from passive waiting.

1. Hope

Snyder (1994) conducted research on hope and found that individuals high in hope have:

- a. A greater number of goals
- b. Have more difficult goals
- c. Have greater happiness and less distress

- d. Have superior coping skills
- e. Recover better from physical injury
- f. Report less burnout at work

Hope has long been recognized as a vital element in healing and has been known by many other names, including optimism, the placebo effect, remembered wellness and positive expectancies (Yahne and Miller, 1999).

Optimism is the ability to psychologically distance oneself from negative outcomes. Hope, by contrast, is the ability to set goals, find paths to those goals, and motivate oneself to use those paths. Religious beliefs often provide a worldview that is both optimistic and hopeful, infusing difficult or traumatic life events with purpose and meaning. Research on hope and religiousness found a significant correlation – out of 14 studies, 12 showed this association (Koenig, 2002).

The so called “placebo effect” (Lambert, 1999) or remembered wellness (Benson, 1997) has an impact of approximately 30% on any treatment. When both patient and doctor believe that the treatment is efficacious it can raise up to 60% (Roberts, 1993). Benson (Benson and Friedman, 1996) sees that a sense of mutual faith and hope about the outcome of treatment is what accounts for the “placebo effect”. Lambert estimates that the placebo effect accounts for about 15% of the change in psychotherapy.

2. The Future is Here: The Day of Rest

According to Minkowski (1970) death is the most distant horizon where hope is challenged. As death looms threatening, notions of ultimacy and meaning are developed in the human mind. Minkowski (1970) sees supplication or prayer as the existential position where the most distant future moves to the present. Rest, meditation and prayer bring glimpses of eternity to the present moment and transform it, and challenge the power of death.

The Scriptures exhort us to “Remember the Sabbath day by keeping it holy. Six days you shall labor and do all your work, but the seventh day is a Sabbath to the Lord your God “ (Exodus 20:8-10). The dimensions of Sabbath rest involve the following dimensions:

- Physical rest: Shabbat: “to pause, cease activities”
- Mental rest: Nuach: “state of rest and peace” (Gen. 2)
- Emotional rest: restoration of energy (Ex. 31)
- Time to celebrate (not just observe) Ex. 31:16)
- Sacred time: time to have an encounter with God (Gen. 2)

Rest, prayer and meditation are among the spiritual practices (Foster, 1984) that bring glimpses of the future and eternity to the present time and transform the experience of it. Time turned sacred by divine command opens the door of eternity to a present that is renewed every week on the Sabbath day.

D’Aquilli and Newberg (1999) have documented changes in brain activity during meditation and prayer which correlate with subjective reports of increased well-

being and sense of unity with a reality larger than one's own. From a spiritual perspective, it could be said that glimpses of eternity are being experienced in the present. The recurrent cycle of work and rest, and the potential to experience sacredness in the midst of ordinary lives provides the opportunity for a renewal of this experience.

Although Eastern forms of meditation are widely used in clinical contexts (e.g. Kabat-Zinn, 1990), the utilization of Christian based meditative practice applied to medicine or psychotherapy await the test of research.

b. Clinical Implications

Attention to time consciousness in the context of therapy is important. The present moment in psychotherapy is a moment of intersubjective contact: "I feel that you feel that I feel". Patients want to be known and to share what it feels to be like them (Stern, 2004) The mind then, is intersubjectively open as postulated by basic interpersonal processes such as what is captured by mirror neurons at a neurobiological level, and attunement and empathy at an emotional level.

The therapeutic action of the present on the past is that as each new present moment takes form, it rewires the actual neural recording of the past, rewrites the possible memories of the past and opens up a new future.

A strong therapeutic relationship (warmth, friendliness, interest supportiveness, empathy, credibility, and a positive attitude towards the patient) have been correlated with evoking hopefulness in patients. Furthermore, hope is elicited when new expectations of help and recovery are inspired in the patient. Hope is strengthened when new learning experiences that enhance self mastery and opportunities for rehearsal and practice are provided.

Finally, meditative practices deepen the experience of the present moment and provide a foretaste of the most distant existential horizon, thus promoting hopefulness. Meditative practices that highlight an intersubjective space or holding environment enhance healing, thus promoting wholeness.

9. Transformation

"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" (Romans 12:2). Paul's encouragement to be transformed is embraced by most Bible believing Christians and seen with caution and suspiciousness by many in the psychotherapeutic community.

Psychotherapy is usually understood to yield gradual change, in relatively small steps of over periods of time. However, dramatic and sweeping transformation of a person has been reported, yielding highly stable changes.

a. Basic and Applied Research

Miller and C'de Baca (2001) synthesized 55 such narratives they described as quantum change. Among the 55, the most common immediate antecedent to transformation was an ardent prayer for God's help, often the person's first prayer ever, or in many years. Nicholi (2002) reports his research with Harvard students on "religious conversion" in the American Journal of Psychiatry:

- A marked improvement in ego functioning
- A radical change y lifestyle with an abrupt halt in the use of drugs, alcohol., and cigarettes
- Improved impulse control
- Improved academic performance
- Enhanced self-image and greater access to inner feelings
- An increased capacity for establishing close relationships
- Improved communication with parents, though most parents were alarmed at first about the change
- A positive change of affect
- A decrease in preoccupation with the passage of time and apprehension over death

b. Clinical Implications

Two years ago I was asked to evaluate and provide recommendations for a member of the clergy who had been arrested twice for indecent exposure and had carried a twenty-year affair unbeknownst to both his wife and religious organization. My report reflected the seriousness of the situation and the recommendations commensurate with the findings. His supervisor called me and challenged me with his pastoral perspective. He said, “Dr. Fayard, don’t you believe that people can change”. After continuous and difficult work with him and his wife, they are doing significantly better. His marriage has not only been salvaged but significantly improved, and he is progressively returning to active ministry. Change IS possible. There is hope for everyone. People are redeemable.

The goal of psychotherapy from a Christian perspective goes beyond Freud’s modest hope for an improved capacity to “love and work”. Jesus said: “I have come that they may have life, and have it to the full” (John 10:10).

Conclusion

Good ideas, even the correct ideas, however helpful are insufficient. A Christian psychotherapist, in my view, ought to have a “Spirit friendly” approach. That is, one that is open to the direction of the Spirit of God during the conduct of psychotherapy and that is friendly to the voice of the Spirit as it might be perceived by the patient. Moreover, a Christian psychotherapist should conduct psychotherapy from a perspective of “informed compassion”, thus reflecting the heart of God.

Ellen White describes this ideal as a “ministry of healing”. Excerpts from Chapter 1 from her book capture what I am trying to convey. “Our Lord Jesus Christ came to this world as the unwearied servant of man’s necessity. He “took our infirmities, and bare our sicknesses,” that He might minister to every need of humanity. Matthew 8:17. The burden of *disease* and *wretchedness* and *sin* He came to remove. It was His

mission to bring to men *complete restoration*; He came to give them *health and peace and perfection of character.*”

“During His ministry, Jesus devoted more time to healing the sick than to preaching... The Saviour made each work of healing an occasion for implanting divine principles in the mind and soul. This was the purpose of His work. He imparted earthly blessings, that He might incline the hearts of men to receive the gospel of His grace. By methods peculiarly His own, He helped all who were in sorrow and affliction. Gracious, tenderhearted, pitiful, He went about lifting up the bowed-down and comforting the sorrowful. Wherever He went, He carried blessing. Christ recognized no distinction of nationality or rank or creed... He passed by no human being as worthless, but sought to apply the healing remedy to every soul”.

In summary, a “Spirit friendly, informed and compassionate” psychotherapist will have as a goal complete restoration (physical, psychological, social and spiritual). Will spend more time devoted to healing than to preaching, and will show the true compassion and radical acceptance embodied by Christ.

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