1

Introduction

Topics in Chapter 1

- A historical view of spirituality, religion and psychotherapy
- The development and dominance of cognitive therapy as a psychotherapy
- The importance of Christianity in the West
- The appreciation of the role of non-specific factors in psychotherapy
- Interest in the Buddhist technique of 'mindfulness'
- Findings relating religious adherence to positive mental and physical health
- The growing respect for cultural and individual differences
- The decline of logical positivism and the rise of postmodernism and social constructionist theory
- The question of a logical connection between cognitive therapy and the teachings of Jesus
- A general outline of the book

A historical view of spirituality, religion and psychotherapy

Psychotherapy, a form of treatment for people suffering from emotional and behavioural disorders such as anxiety disorders, had its major period of development during the twentieth century. With rare exceptions, for most of this time there was seen to be little connection between the conduct of psychotherapy on the one hand, and spirituality and the practice of religion on the other. Two very significant figures in the development of psychotherapy, Sigmund Freud and Albert Ellis, have taken an essentially negative view of religion. Freud saw it as an illusion and the result of wish fulfilment in terms of longing for the father (Wulff, 1996). Ellis (1980) contended that all forms

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of religious belief were pathological and lead to neurosis. For much of the twentieth century the view prevailed that values, including religious values, could be kept out of psychological theory, research and practice (Patterson, 1958, cited in Bergin, Payne & Richards, 1996).

Developments in general psychology for most of the twentieth century were also antagonistic to the exploration of the relevance of religion to psychotherapy. In the economic crisis after World War I the United States of America shifted to a preoccupation with scientific progress and economic success. Within psychology this was parallelled by the 'spectacular success of behaviourism and its ideal of an objective and mechanistic science' (Wulff, 1996, p. 45).

At the beginning of the twenty-first century it is appropriate to reconsider the issue. The divorce of psychotherapy from religion may never have been logical nor appropriate, and there have been developments that make it timely to consider the potential for integration of religion and psychotherapy. Some of these developments are: the development and dominance of cognitive therapy as a psychotherapy; the appreciation of the role of non-specific factors in psychotherapy, including the role of values; the interest in the Buddhist technique of 'mindfulness' by a number of respected authors within the cognitive therapy tradition; the finding that 'intrinsic' religiousness is positively related to mental health; the growing respect for cultural and individual differences; the decline of logical positivism and the scientific worldview and the rise of postmodernism and social constructionist theory; and cultural changes in Western society.

The development and dominance of cognitive therapy as a psychotherapy

Cognitive therapy is a psychotherapy that aims to assist people with emotional disorders such as the anxiety disorders, and depression. It has also been used with a wide variety of other disorders, including chronic pain, eating disorders and personality disorders. Cognitive therapy considers that emotional disorders, such as depression, are caused and/or maintained by faulty thinking. It works by the therapist using a variety of verbal and intellectual techniques to assist the patient to identify and change the dysfunctional beliefs and thought processes. Cognitive therapy (CT) was developed by Aaron T. (Tim) Beck in a series of books and papers in the 1960s and 70s, most notably Beck (1976) and Beck, Rush, Shaw and Emery (1979). CT continues to be refined by Beck and others (e.g. J. S. Beck, 1995). It is aligned with other therapies with a similar view of psychopathology and focus of treatment, including cognitive behaviour therapy (e.g. O'Donohue & Fisher, 2012); cognitive restructuring therapy (e.g. McMullin,

2000); rational emotive therapy/rational emotive behavior therapy (e.g. Ellis & Harper 1975; Ellis & Grieger 1977); acceptance and commitment therapy (e.g. Hayes, Strosahl & Wilson, 1999); and mindfulness based cognitive therapy (e.g. Segal, Williams & Teasdale, 2002).

Cognitive therapy is accepted by the American Psychological Association as a 'well-established' treatment for depression, a very common mental health problem, and is a component in about half of the psychological therapies considered to be well-established treatments by the clinical psychology division of the American Psychological Association (Chambless, et al., 1996, 1998; Task Force on promotion and dissemination of empirically validated psychological treatments, 1995), The relationship between cognitive therapy and cognitive behaviour therapy is complex and has been subject to misunderstandings and, in some cases, mislabelling of a particular therapy. Cognitive behavioural therapy was originally the integration of cognitive phenomena into traditional behaviour therapy, but in popular understanding it has come to mean the reverse. The following is a representative definition:

> **Cognitive therapy** is a psychosocial (both psychological and social) therapy that assumes that faulty thought patterns (called cognitive patterns) cause maladaptive behavior and emotional responses. The treatment focuses on changing thoughts in order to solve psychological and personality problems. **Behavior therapy** is also a goal-oriented, therapeutic approach, and it treats emotional and behavioral disorders as maladaptive learned responses that can be replaced by healthier ones with appropriate training. **Cognitive-behavioral therapy (CBT)** integrates features of behavior modification into the traditional cognitive restructuring approach. (Encyclopedia of Mental Disorders, n.d.)

Arden and Linford (2009, p. 55) define 'Pure CBT' as follows:

> Pure CBT – as opposed to the elements of it many of us employ in our practices – has five components
> 1. Psychoeducation
> 2. Breathing retraining
> 3. Cognitive restructuring
> 4. Exposure
> 5. Relapse prevention

The situation is further complicated in that Beck's original 'Cognitive Therapy of Depression' (Beck et al., 1979) included a large behavioural assignment component. Thus both 'cognitive therapy' and 'cognitive behaviour therapy' include attempts to change both thoughts and behaviour directly.

It is this set of components that has been very successful in achieving outcomes for people with emotional and behavioural disorders by assisting people to change their thinking and their behaviour without recourse to attempts to change anatomy or physiology. The CT-CBT approach has outperformed other non-physiological/non anatomical approaches. It has also largely been a 'Western' phenomenon. It is therefore appropriate to consider the relationship of CT-CBT with the dominant religion of the West: Christianity.

The importance of Christianity in the West

The teachings of Jesus, a first-century Palestinian Jew from Nazareth, a small town in the north of Israel, are important to a very large number of people. Christianity, the religion based on those teachings, is unarguably the world's most popular religion with two billion adherents. The point prevalence for depression in adults ranges from 2–3 per cent for men and 5–9 per cent for women (American Psychiatric Association, 2000). Therefore between 40 and 180 million people with an adherence to Christianity are likely to be suffering from depression at any point in time, not to mention at least the same number who suffer from one of the many other disorders, including anxiety disorders, that benefit from cognitive therapy.

Many people with depression and other emotional disorders will (or should) receive CT as a component in their treatment. Many of these people, particularly in the West, will be practising Christians. If there are connections between the teachings of Jesus and CT, and if the teachings of Jesus can then be integrated positively with CT, clearly it could be very beneficial for people receiving CT who have Christian beliefs.

The appreciation of the role of non-specific factors in psychotherapy

Since the discovery in the mid 1980s that all psychological theories appear to have about the same positive effect on symptoms of disorders such as depression, interest has developed in the so-called non-specific effects of therapy. These are factors that are not necessarily derived from the theory the therapy is based on, but which affect therapy, or occur in the context of therapy. They have included the therapeutic alliance, and client factors such as motivation for therapy and expectancy of success in therapy. A non-specific

factor explored explicitly in the context of psychotherapy is the role of both the therapist's and the client's values in therapy. Bergin, Payne and Richards (1996, p. 301) claim that 'Experiencing empathy for clients, knowing something of their struggle and identifying with their dilemmas depends upon comprehending their beliefs, their moral framework, and their assumptive world'. These authors believe that helping people clarify their own values may be the most important aspect of therapy (1996, p. 302). An implication of this work is that the compatibility of the therapy with the client's values and expectations may enhance the effectiveness or the acceptability of psychotherapy, either directly or by enhancement of a known non-specific factor such as the therapeutic alliance. Values are often considered to be important aspects of a person's religion, so it follows that being able to engage with the source of a person's values in psychotherapy will enhance the efficacy of therapy.

Interest in the Buddhist technique of 'mindfulness'

Mindfulness trains people in 'non-judgemental awareness' of bodily sensations, thoughts, and feelings. These thoughts and feelings are viewed as passing events in the mind. The technique was introduced to clinical psychology by Marsha Linehan (1993) as part of her 'dialectical behavior therapy' (DBT), a form of cognitive behaviour therapy developed for people with borderline personality disorder. It has since been applied in the treatment of a number of disorders and problems. Furthermore, Teasdale and Barnard (1993) have seen mindfulness as fitting with their interacting cognitive subsystems model of depression, and, with other colleagues, Teasdale has developed a mindfulness based programme of therapy to prevent relapse in persons with depression (Segal et al., 2002).

Mindfulness was explicitly derived by Linehan from 'Eastern spiritual practices' (1993, p. 144), notably Zen Buddhism. Linehan introduced Segal, Williams and Teasdale to the work of Jon Kabat-Zinn in Worcester, Massachusetts. Kabat-Zinn had developed 'mindfulness-based stress reduction' (MBSR) and had been using it with large numbers of people, including in groups of up to 30 at a time, for over ten years at that time. Segal and colleagues comment: 'The accounts of what his patients were getting out of his program bore a striking similarity to what we were beginning to see as the central change process in cognitive therapy' (2002, p. 41). If it is reasonable to incorporate Zen Buddhist practices into cognitive (behaviour) therapy, then it is also reasonable to consider the teachings of Jesus in the context of cognitive therapy.

Findings relating religious adherence to positive mental and physical health

The relationship between various aspects of religion, including intrinsic and extrinsic religiosity, spirituality and religious adherence, is a complex one (Gartner, 1996; Wiggins Frame, 2003). For example, Gordon Allport the great social psychologist in his seminal 1950 publication differentiated between extrinsic and intrinsic religiousness. Intrinsic religiousness was characterised by church attendance, reading the scriptures and other devotional literature, engaging in private prayer and meditation and living out religious beliefs in everyday life (Wulff, 1996). Determining the relationship between these aspects of the human experience and mental health/illness is even more complex. For the purposes of this book religious adherence and spirituality will be treated as a unitary phenomenon.

In a classic early meta-analytic study in the area, Bergin (Bergin, Masters & Richards, 1987) found that when religion was correlated with measures of mental health, 23 per cent of the studies revealed a negative relationship, 30 per cent found no relationship and 47 per cent found a positive relationship. Larson and Larson (2003) reviewed the relevance of spirituality/religious adherence to physical and emotional health. They found:

- Religious participation has been consistently linked with increased chances of living longer in a large number of large community samples.
- Although religious coping was not associated with longer life in acutely ill people, it was associated with better mental health status and social support.
- Contrariwise, in a study of over 600 people over 55 suffering from physical illness, those who were also suffering from religious distress had a greater chance of dying.
- Four studies with moderate to large sample sizes reported that people with persistent mental illness reported significant assistance from their religious beliefs.
- Religious participation reduces risk of suicide. In 68 studies, 84 per cent found lower rates of suicide or more negative attitudes towards suicide.
- Religion and spirituality are also associated with lower rates of depression. A review of over 100 studies found that religious and spiritual factors are consistently associated with lower rates of depression.
- Therapy is slightly more effective when it is oriented to people's religious beliefs. This is especially the case when the therapy is conducted by a therapist who does not have personal religious adherence.

- Spiritual/religious involvement is associated with lowered risk of alcohol and drug dependence, and is a component of the 12-step programmes which are some of the most respected treatments for substance abuse and dependence.
- Spiritual and religious factors contribute to successful outcomes of surgery and chronic medical illness.

This evidence of positive benefits of spirituality and religion upon physical and mental health, and especially in the domains in which cognitive therapy operates, suggests that there may be benefits in combining religion/spirituality and cognitive therapy. It also raises questions about the mechanisms of action of CT versus religion.

The growing respect for cultural and individual differences

Principle E of the APA Code of Ethics, Respect for People's Rights and Dignity states:

> Psychologists respect the dignity and worth of all people… *Psychologists are aware of and respect cultural, individual, and role differences, including* those based on age, gender, gender identity, race, ethnicity, culture, national origin, *religion*, sexual orientation, disability, language, and socio-economic status and *consider these factors when working with members of such groups.* Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (my emphasis)

This supports the recognition of, and sensitivity to, 'differences' in provision of psychological services (which includes psychotherapy). Whether or not practising Christians are becoming a minority in Western countries, that religious allegiance certainly constitutes a 'difference' from non-Christians that is important to the people concerned, and that ethical guidelines, such as those of the APA, are exhorting psychologists to consider.

The decline of logical positivism and the rise of postmodernism and social constructionist theory

Jones (1996, p. 118) has written 'The traditional or positivistic view of science has been eroding since the late 1950s'. It has become accepted that theory is value laden. Postmodern thinkers have promoted the idea that all

reality is socially constructed (Wiggins Frame, 2003); therefore the door is opened for religious and spiritual phenomena to be the object of scientific investigation. While that is not a primary aim of this book, an investigation of the relationship between the teachings of Jesus and cognitive therapy may throw up aspects of both that could be the focus of scientific investigation.

Thus there are a number of powerful reasons why we should consider the potential for integration of cognitive therapy with the teachings of Jesus. To summarise:

- Both CT/CBT and Christianity are important in contemporary Western society. Lots of people are suffering from the disorders that CT/CBT has been shown to be effective in treating. It follows that many of these will have some degree of allegiance to the Christian religion.
- Positive spirituality and religious practice are associated with positive mental health outcomes.
- Ethical guidelines encourage psychologists to consider the differences (or, better, the distinctivenesses) of their clients. This includes the degree and nature of the clients' religious adherence.
- The process may generate some questions for scientific analysis.

This book will consider the integration of the teachings of Jesus into cognitive therapy. For there to be benefit from such an exercise there would need to be logical connection between the two, significant cross-contribution and sufficient compatibility in content. It would not be appropriate to attempt two fields of endeavour with no logical connection.

The question of a logical connection between cognitive therapy and the teachings of Jesus

Cognitive therapy is a psychotherapy, and the teachings of Jesus are the teachings of an itinerant Jewish teacher and healer who lived in the first century of the Common Era (CE) that have been recorded and serve as the basis for the Christian religion. Although one is something that is primarily done with individuals, and the other with assembled groups of community members, there are a number of points of similarity: the main ones being that both are verbal, both are concerned with beliefs and both are concerned with improving the functioning of the hearers. It would seem at first blush that practice both of the Christian religion and CT have similar domains of operation.

A general outline of the book

The aim of this book is to provide a vehicle to allow therapists to engage with aspects of the Christian religion whilst doing cognitive therapy with their clients. Those aspects that can be engaged with include the beliefs, values and practices that are associated with the Christian religion. The first question is whether those beliefs, values and practices are (sufficiently) compatible for the exercise to be worthwhile. The first part of the book considers this issue. Here we consider:

- the core tenets of cognitive therapy
- the core tenets of Christianity. This will include an attempt to distinguish between the teachings of the historical Jesus of Nazareth and the teachings of the church as they have developed. This will involve a sojourn into twentieth-century Biblical scholarship, and into the social and political environment of the Eastern Mediterranean in the first century CE
- the degree and nature of compatibilities and incompatibilities between the two. It will be shown that there are a number of core compatibilities.

In the second part the compatibilities are addressed in detail and in the third therapeutic approaches are presented that integrate important aspects of the teachings of Jesus into cognitive therapy, both in terms of general approach, and in specific techniques and therapeutic strategies:

- Chapter 7 describes a general model for assessing people for cognitive behavioural therapy, and notes the most common areas in which Christian people may have cognitive difficulties that may be associated with their Christian faith.
- Chapter 8 discusses preliminary and general considerations when doing cognitive therapy with Christian people, including using logic as Jesus did.
- Chapter 9 introduces content based interventions and provides a general method for working with the clients' negative thinking from a Christian perspective.
- Chapter 10 considers the value of people in the teachings of Jesus and presents guidelines for applying them to attitudes to oneself and others.
- Chapter 11 considers Jesus' teaching about the relationship of the individual to God and presents guidelines for using that with clients.
- Chapter 12 considers the behaviour that Jesus prescribed for his followers.
- Chapter 13 integrates the preceding three chapters as a series of dialectics that lead to a way of thinking and behaving in which a Christian person can blend the teachings of Jesus with cognitive (and behavioural) therapy.