Journal of Psychology and Theology Copyright 2005 by Rosemead School of Psychology

2005, Vol. 33, No. 2, 113-121 Biola University, 0091-6471/410-730

INTERVENTIONS THAT APPLY SCRIPTURE

IN PSYCHOTHERAPY

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Christian therapists are sometimes challenged in

their work with appropriately religious clients to

develop treatment components that incorporate the

Bible. Utilizing a case study format, this article

describes various intervention strategies available for

the clinician to consider. Psychodynamic, psychoeducational,

theoeducational, cognitive, behavioral, and

affective experiential therapeutic examples are presented.

As long as sound ethical and religio-cultural

assessment guidelines are followed, Scripture

remains a rich resource for clinicians in their work.

For the word of God is living and active and

sharper than any two-edged sword, and piercing

as far as the division of soul and spirit, of both

joints and marrow, and able to judge the

thoughts and intentions of the heart. Heb. 4:12

(NASB)

He sent forth his word and healed them… Ps.

107:20 (NIV)

... in humility receive the word implanted, which

is able to save your souls. James 1:21b (NASB)

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he Bible, as seen from the passages above,

makes no apologies for the potency of its

message to heal. Accordingly, whatever our

approaches to Christian therapy, we are challenged

to discern how the Bible’s message applies to our

work. Christian counseling is a tremendously diverse

profession (Johnson & Jones, 2000; McMinn &

Phillips, 2001). Within this diversity exists a wide

variety of perspectives on if, when, and how to use

Scripture in psychological treatment. Some

approaches might eschew overt strategies incorporating

Scripture in treatment, others mandate such

usage as the only true way to do Christian therapy

A version of this article was presented for the Scripture and the

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(e.g., Adams, 1970), while others take a situation-

specific, client-specific stance.

This article uses the case of George (a fictional

amalgam composed from several different clients) to

provide examples of various intervention strategies.

The article is not an exhaustive literature review of

all interventions that might incorporate Scripture as

a resource; rather, the aim is twofold: first, to

increase Christian therapists’ awareness of the variety

of types of Scripture interventions available, and,

second, to stimulate “divinely inspired creativity” in

the further development of strategies to incorporate

the living Word of God in Christian psychotherapy.

THE CASE OF GEORGE

George is a 30-year old single Caucasian male

construction worker who presented for psychotherapy

with chief concerns of depressed mood, low self

esteem, suicidal thoughts, and trouble sleeping. He

describes these symptoms as occurring “on and off”

over the last 10 years. George has no plans or intentions

of acting on his suicidal thoughts and agreed to

a contract with me to monitor these thoughts. He

commonly makes statements like “I’ll never amount

to anything “ and “I’m a loser.” He also displays a

constricted expression of affect.

Currently, George is most depressed about his

lack of progress in any career. He’s been working

construction or other odd jobs since he graduated

from high school twelve years ago. George would

really like to be a pilot, but he has not taken any

steps in that direction. “They’d see right through

me,” he laments. He also has a tendency to take on

too many overtime projects, leading to another

comment, “I get anxious when I think about saying

‘no’ to offered work.”

Prior to his current treatment, George has never

seen a therapist. He reports suicidal thoughts as an

adolescent but reports never making an attempt. “I

came close a couple of times, but never did anything”

he notes.

113

SCRIPTURE INTERVENTIONS

George says his father periodically ended up in

alcohol treatment centers before dying 3 years ago

of cirrhosis of the liver. His mother suffered from

occasional bouts of depression and was periodically

on antidepressants. George didn’t know of any other

history of mental illness in his family, and no abnormalities

were noted in George’s medical history.

Aside from typical childhood illnesses, no major

accidents or illnesses occurred. While he’s been in

occasional fights in his life, he does not recall any

head injuries that resulted in unconsciousness. His

developmental history also appeared normal.

Partly due to his father’s history, George has

avoided alcohol and drugs throughout his life. “I’ll

never do what he did to us [the family],” he reports.

His father worked as a plummer and his mother

was a nurse’s aid in a local hospital. A Vietnam war

veteran, George’s father had resorted to drinking to

cope with the scars of war. It didn’t work. Instead,

his father displaced his frustrations and anger onto

his wife and George when he was born. Verbal and

physical abuse were common for both George and

his mother. Indeed, it appeared the harsh comments

during the abuse were most stinging. “You’re a no

good &\*!@$ loser George. You stay in line or I’ll

send you back to your creator.”

George played a variety of sports growing up and

had some friends. However, these friendships were

not very deep and focused primarily on the common

sporting interactions. George started dating when he

was 16. Sadly, his relationships from then until now

have all been short-lived (1 week to 4 months at the

most). As George describes it, women have “felt

sorry for me ... They date me to help cheer me up ...

and then they leave when they see it hasn’t helped.”

George was sexually active until he became a Christian

two years ago.

Growing up, George’s family rarely went to

church. He became a Christian two years ago

through a construction worker friend who had gotten

saved and took him to a revival meeting. Since

then, he’s attended a local Baptist church. He finds

support there, but also feels uncomfortable, believing

that one day they’ll discover, like others in his

life, just what “a loser” he really is. “I know God loves

me, but I still feel good for nothing,” he laments.

George’s new found Christian faith has given him

added incentive to keep from making any suicide

attempts despite the recurrent depressions.

Diagnostically, George is experiencing a chronic

depression, apparently trauma-induced from a child

hood relationship with an abusive alcoholic father

suffering from Post Traumatic Stress Disorder.

George has developed an underlying core belief

(schema) that he’s worthless, which helps maintain

his depression. It’s likely also that internalized anger

towards his father is also present. He is motivated

for therapy but also feeling hopeless that anything

can be done (Again, partly maintained by maladaptive

worthlessness cognitions). It is encouraging that

he does have a goal (becoming a pilot). He longs for

the strength and courage it takes to “risk” enrolling

in pilot school.

As treatment begins, individual psychotherapy

will be implemented. If George’s symptoms continue

at high levels after a month of treatment, a referral

for antidepressant evaluation will also occur.

Finally, George’s religious resources will be explored

as potential assets in his treatment. George agreed

with this treatment plan.

ETHICAL, CULTURAL, & ASSESSMENT

ISSUES WHEN CONSIDERING SCRIPTURE

INTERVENTIONS

Much has been written on the ethical usage of

spiritual interventions in psychotherapy (Richards &

Bergin, 1997; McMinn, 1996; Anderson, Zuehlke, &

Zuehlke, 2000; Tan, 2003). Common ethical areas to

consider in this pertinent literature concern dual relationships

(religious and professional), imposing religious

values on clients, violating work-setting

(church-state) boundaries, informed consent issues,

and clinician competency issues. Clinical applications

of Scripture should therefore include good client religio-

cultural assessment, a solid therapeutic alliance,

clear informed consent procedures, avoidance of the

imposition of religious values on the client, and the

maintenance of intervention flexibility versus rigidly

applying Scripture interventions to all Christian

clients (Tan, 2003; Richards & Bergin, 1997).

For the clinician, values often play a large part in

how overtly they utilize religious resources such as

the Word of God. Richards & Bergin (1997)

describe three guiding values important when considering

such religious interventions: (a) respect for

the client’s autonomy/freedom, (b) sensitivity to and

empathy for the client’s religious and spiritual

beliefs, and (c) flexibility and responsiveness to the

client’s religious and spiritual beliefs.

While most Christian therapists would agree in

principle to the above, a visceral reaction often takes

FERNANDO GARZON

place (positive or negative) when a discussion of

Scripture techniques occurs. This is informative as an

indicator of potential countertransference that can

block the effective adoption of the above values, particularly

in the area of flexibility and responsiveness.

For example, those with a positive initial reaction

may be prone to incorporate overt interventions utilizing

Scripture while neglecting a client’s misgivings

about such interventions. Has George experienced a

legalistic and judgmental church environment for

the last two years and does he see the Bible as a book

full of condemning passages? If so, guilt and shame

might be his primary affects in reaction to an intervention

utilizing Scripture. Such interventions may

be contraindicated, at least early in treatment, until a

supportive therapeutic alliance has been developed

(and perhaps throughout). Negative countertransferences

likewise can have perilous dangers in this

regards. George may be having a positive experience

in his church environment and look upon the Bible

as his sacred source of primary aid, but the therapist

might have had painful experiences in a church that

utilized Scripture in a heavy-handed legalistic or judgmental

fashion. The therapist’s own emotional reactions

might be erroneously presumed to lie in the

client as well, preventing the ability to see the Bible

as a valuable coping resource for the client when it

actually is. Thus, both positive and negative Scripture

countertransference may lead to subtle or not-sosubtle

impasses in treatment.

In summary, clients will have a mixture of experiences

with the Bible based on their particular religiocultural

background. This background needs to be

assessed carefully, and any Biblical interventions

incorporated into treatment should be done in a

highly ethical manner. In addition to considering the

ethical, cultural, and assessment issues involved in

incorporating Scripture in treatment, clarifying one’s

own countertransference reactions to the possibility

of utilizing Scripture will enhance the ability to accurately

assess an intervention’s appropriateness in the

individual client’s care.

POTENTIAL SCRIPTURE INTERVENTIONS

FOR GEORGE’S TREATMENT

Careful assessment of George revealed a man utilizing

his Christian faith as a main support in his life.

He was very open to discussing spiritual issues and

having spiritual techniques incorporated as a part of

his care. He had a positive view on the inclusion of

the Bible as a part of his treatment, so some interventions

applying this resource were used. Intervention

samples described in George’s care below came

from a variety of theoretical orientations. These

interventions serve only as samples that can be

found in a potentially broad literature.

Implicit Scripture Intervention

Psychodynamic and psychoanalytic Christian

therapists sometimes emphasize an incarnational

perspective on spiritual interventions such as utilizing

the Bible in treatment (White, 1984; Benner,

1983). In George’s care, for example, they might

emphasize the therapist’s empathic stance towards

George as the key mode of integrating the Bible.

Such an empathic stance models the character of

Christ as seen in the Bible when He ministered to

wounded people. Quiet and non-overt strategies,

such as praying for George outside of sessions and

perhaps quietly during sessions, complement this

approach. Tan (1996a) describes these interventions

as types of implicit integration. Other aspects of

implicit integration include the personal spiritual life

and development of the counselor. Tan contrasts

such an approach with explicit integration, which

more systematically incorporates spiritual resources,

such as the Word of God, purposefully in treatment.

It is important to note that implicit and explicit Biblical

strategies are not mutually exclusive and exist on

a continuum. Each client’s individual diagnosis,

symptom severity, and presenting problems can lead

to different levels of implicit/explicit integration.

Indeed, implicit and explicit integration strategies

are closely linked in client care. The therapist’s

own implicit spiritual growth, development, and

quiet prayer for George may still have a direct impact

on the quality of care and a client’s treatment outcome,

even with varying levels of explicit integration.

However, this linkage is not complete, as research

suggests that explicit spiritual interventions strategies

can sometimes be used by non-Christians with

Christian clients to great effect (e.g., Propst,

Ostrom, Watkins, Dean, & Mashburn, 1992). This

perhaps surprising preliminary finding appears quite

consistent with Scripture (e.g., Matt. 7:22-23).

Psychoeducational

George may need education around the appropriateness

of experiencing his emotions, as well as a framework

for understanding the place of assertiveness and

SCRIPTURE INTERVENTIONS

limit-setting around declining requests to work

overtime. In discussing these areas with him, it

appeared he felt men should not have much affective

awareness and that declining the extra work

would be unchristian. The Bible contains many pertinent

passages that might be appropriate to discuss

with George in session and/or to assign to him as

homework.

For example, in regards to men and emotions,

many of the Psalms reflect great affective awareness

in David’s on-going conversation with God (e.g., Ps.

3, 4, 7, 23, 35, 139, etc.). Examining passages pertaining

to Jesus that are reflective of his emotional

awareness, such as His weeping over Jerusalem

(Luke 19:41-42), his anger in the temple (Matt. 21:1213),

and his struggle in Gethsemane (Matt. 26:36-46)

might help George be more accepting of his emotional

side. For other clients who are defended

against their normal grief process, the book of Job

might also be very helpful.

George’s tendency to view all assertiveness negatively

reflects an inaccurate understanding of Biblical

principles of stewardship and calling. Several books

have been written amplifying on these Biblical

themes. For example, Boundaries (Cloud &

Townsend, 1992) is a commonly recommended book

by many Christian professionals (Johnson & Johnson,

1998). This book and in-session discussion with

George might help him understand Biblical assertiveness

and help him distinguish this from an unbiblical

self-sufficiency and disregard for others’ needs.

Theoeducational

Some of George’s comments during the early sessions

suggested that he may suffer from “worm theology,”

a view that overemphasizes one’s sinfulness,

the fallen nature, and God’s judgment while minimizing

God’s love, acceptance, and the reality of

George’s new position in Christ as a Christian.

Assessment of George’s condition suggested that

part of this theology may be based on his early experiences

with an abusive father. I also assessed the theology

promoted through George’s church, both in

conversations with him and in conversations with

other persons I knew who went to his church.

As work continued on his relationship with his

father, he became more open to input in regards to

his theological stance. Homework assignments

around passages of Scripture emphasizing God’s caring

nature and acceptance of George and bibliother

apy (e.g., Anderson, 2000) were fruitful in readjusting

his perspective.

Behavioral

Assertiveness was briefly addressed above.

George also suffered from anxiety symptoms as seen

in his difficulty falling asleep. Benson (1996)

described a deep-breathing relaxation technique

which he adapted for religious individuals to

increase compliance, motivation, and efficacy. In

applying this technique to George, I explained to

him the rationale behind deep breathing relaxation

and asked him if there were a Scripture or supportive

phrase he would like to use as he exhaled during

each repetition of the exercise. George readily

responded, “Psalm 23, ‘The Lord is my shepherd.’”

He was then trained to inhale deeply, holding to a

count of five, and to exhale slowly repeating this

comforting line of Scripture. After a few repetitions,

regular breathing followed, and then another set of

deep breathing. George felt this technique was helpful,

so he was encouraged to try it as an aid in falling

asleep at night.

Cognitive

Much has been written on applying the Scriptures

from cognitive perspectives emphasizing Rational

Emotive Behavior Therapy styles (e.g., Nielsen, Johnson,

& Ellis, 2001; Johnson, 2001; Backus, 1985;

Johnson, Devries, Ridley, Pettorini, & Peterson,

1994; Pecheur & Edwards, 1984), as well as styles

resembling the work of Aaron Beck (e.g., Propst,

1988; Hawkins, Tan, & Turk, 1999; Tan & Ortberg,

1995). The brevity of this article will lead to a focus

on one sample intervention from each major cognitive

therapy “camp.”

REBT utilizes reason and logic as primary tactics

to change core irrational beliefs (Ellis, 2000), while

cognitive therapy emphasizes idiosyncratic or individualized

dysfunctional perception styles and a

more experimental, empirical modality to alter these

misperceptions (Beck & Weishaar, 2000). George

experienced one episode during treatment that will

highlight the two strategies.

Around eight sessions of treatment, George

decided to apply to take flying lessons at a local

small airport. The pilot instructor said he would

review the application and get back to George within

two weeks. George hadn’t heard from him at this

time, so I encouraged him to call and ask what had

FERNANDO GARZON

Figure 1. Sample REBT Intervention

Activating

Event

Irrational

Belief

Consequent

Emotions

Disputations of

belief

Ratings of

original belief

following disputation

Pilot instructor “He knows what Discouragement, This instructor has only 35% belief in

hadn’t reviewed a loser I am” [rated sadness, met me briefly & hasn’t original thought.

application as 90% believed] depression talked with me for over

3 minutes. He couldn’t

possibly know me enough

to make a judgment!

God’s Word says “I can do

all things through Christ

who strengthens me”

(Phil. 4:13) and “Beloved,

now I am a child of God”

(I Jn 3:2), so I’m not a loser,

no matter what the instructor

might think anyway! I am

pleasing to God.

happened. The instructor apologized and said he

hadn’t gotten around to it since he was very busy.

George felt discouraged and believed the instructor

was “stalling because he knows what a loser I am.”

Figure One highlights a common REBT written exercise

that might be helpful in addressing George’s

irrational belief. In the technique, he describes the

incident, his belief, and then disputes the belief.

Afterwards he rates his endorsement of the original

maladaptive thought. This activity often is done originally

in-session with the therapist.

As can be implied from the above, the clinician

may need to educate George on promises found in

the Bible to counteract his negative belief if George

does not know these from his past two years as a

Christian. Many times, a more Beckian approach is

equally suitable to address what happened to George.

The Seven column technique developed by

Greenberger and Padesky (1995) reflects such a perspective.

This technique applies an inductive, Socratic

strategy for exploring the evidence both for and

against the key maladaptive cognitions George has in

an effort to help him develop more balanced

thoughts. Care is taken to empathize with George’s

experience before asking him inductive questions to

find evidence against his belief. Figure Two depicts

the seven column technique altered to include questions

in column five that facilitate the utilization of

Scripture in generating contradicting evidence.

Several thought records over several different situations

may be needed to substantially reduce

George’s belief in his maladaptive thought and

increase his belief in the more balanced thoughts.

Many other REBT and Beckian cognitive techniques

exist and can be adapted for addressing George’s

condition.

Affective Experiential

Affective experiential approaches normally seek

to activate the client's cognitive/emotional matrix

related to a core issue (like George’s belief that he is

a loser) and to bring these minimally processed or

“nonmetabolized” feelings into the here and now

with the clinician so that the emotions can be identified

and processed (Magnavita & Carlson, 2003).

Strategies utilizing the Bible may have a similar goal,

except that the desire is to bring these core issues

and connected emotions “into the living presence of

God” for processing, as well as for processing with

the therapist. One biblical intervention seeking to

facilitate resolution of core affective issues is inner

healing prayer.

Inner healing prayer consists of “a range of ‘journey

back’ methodologies that seek under the Holy

Spirit’s leading to uncover personal, familial, and

ancestral experiences that are thought to contribute

to the troubled present” (Hurding, 1995, p. 297).

Many of these approaches focus on helping the

SCRIPTURE INTERVENTIONS

Figure Two.

Seven Column Technique with Scripture-Focused Questions in Column Five

Situation

Feelings

&Beliefs

Evidence

for

beliefs

Evidence

against

beliefs

Alternative

Beliefs

&Ratings

of

ratings of

Beliefs & rating

Feelings

intensity (0-100,

of believability

after exercise

100 highest ever)

Pilot instructor

Discouragement (90%),

“He knows

hadn’t reviewed

sadness (80%),

what a loser

application

depression (85%)

I am”

, [believed

90%at beginning]

He didn’t process

[Empathy and support prior

to

The instructor is

Discouragementmy application. He’s had

questions below to generate

busy and focused

decreased to

enough time to process it.

contradictory evidence]

on other things.

30%, sadness to

Other people have seen

He could only

25%, depressionI’m a loser in the past.

What might your best friend

have an initial

5%

point out in this situation that

impression of me.

you have underemphasized?

Some people see[& other standard questions]

me as competentand some don’t.

What Scriptures come to mind

God knows me

that suggest you are not

a loser?

fully, loves me fullyand has empoweredWhat promises are there

in the Bible

me to do all things.

that might encourage you here?

I’m learning patiencehere. [65%]

Whom might your pastor/goodChristian friend bring to your mindthat doesn’t see you as a loser yetknows you well?What persons

in the Bible

had todisplay patience and wait beforethey “

obtained the promise”? Werethese people losers?

FERNANDO GARZON

client process affectively painful memories through

vividly recalling them and asking for the healing presence

of Christ to resolve the pain. This prayer form

was carefully used to help George process affectively

laden memories that reinforced his perception that

he was a loser (See Garzon & Burkett, 2002, for a

description of a variety of approaches).

In inner healing prayer, the counselor’s knowledge

of Scripture is used as the backdrop or grid

through which to interpret what occurs as the

client’s describes the experience of inviting Christ to

come into the memory. Perceived occurrences out of

line with Jesus’ character are quickly addressed.

Sides (2002) recommends that appropriate Biblical

passages should be assigned following a successful

implementation of this prayer form to ground the

experience in the Word of God and continue the

healing process. Overt incorporation of the Word of

God following the prayer helps maintain a balance

between affective experience and continuing growth

from that experience through its interpretation via

the Bible. This was done in the case of George.

While some question the legal and ethical ability to

use some forms of inner healing prayer in psychotherapy

(e.g., Entwistle, 2004), others believe

they can be used in a clinically sensitive manner as a

part of treatment (Tan, 1996a; Garzon, in press).

The historical Christian contemplative prayer

tradition also contains affective experiential strategies

that utilize Scripture to seek spiritual resolution

of core emotional conflicts. The client’s awareness

of the pertinence of Scripture to his or her condition

is deepened through the experiential impact of

God’s Living Word and through discussion of the

experience with the therapist. More than being just

projective or assessment measures, these interventions

seek to facilitate the treatment of core issues.

The ultimate goal is attaining more Christlikeness,

with increased emotional well-being often flowing

out of this improved relationship. As can be seen

from this description, the intersection between

Christian counseling and spiritual direction

becomes apparent. Current explorations of the

commonalities, differences, and the ethical application

of spiritual direction-like techniques are occurring

in the literature (Benner, 2002, 1998; Tan,

2003, 1996a, 1996b). The writings of Madame

Guyon (1975) and Saint Ignatius of Loyola provide

creative starting points for the application of these

rich historical resources. One example from this tradition

will be given.

St. Ignatius of Loyola, founder of the Jesuit order

of Catholic priests in the 16th century, developed

the contemplative practice of “Living Scriptures” as

a component of his spiritual development practices

(Endean, 1990; Lonsdale, 1990). In the therapy context,

the strategy sometimes may be described as follows.

The client and therapist together read through

a carefully selected Biblical passage (a story from

one of the Gospels, for example, or a parable). The

client is then asked to take the part of one of the

characters in the story, and with “the sanctified

imagination” (Foster, 1998, pp. 25-26) relive the

Gospel story with as much sensory experience as

possible. The client is encouraged to “imagine seeing,

hearing, smelling, and physically feeling or

touching all that is going on in the Scriptural scene”

(Cook, 2004, p. 177).

Prayer is recommended at the beginning of the

exercise asking for the Lord’s covering and protection

over the entire process. In the psychotherapy

context, the therapist sometimes facilitates Living

Scriptures through verbal descriptions of scenes in

the story. At the end of this “experiential Gospel

episode,” the client is asked to talk with the Lord

(silently or out loud) about what transpired and anything

discovered in the process. The therapist then

explores with the client the experience of the intervention,

connecting what happened with the client’s

treatment as appropriate.

In working with George, I selected Luke 13:10-17,

the story of the woman in the synagogue who was

“bent double and could not straighten up at all”

(Luke 13:11b, NASB). The purpose was to help

address his core schema, “I’m a loser.” Given

George’s gender, we changed the main character of

the Gospel story to be a man with this condition.

George closed his eyes and I then used the following

dialogue, proceeding slowly and monitoring his non-

verbals, to facilitate George’s experience.

“It’s a hot desert day ... the Sabbath. You are led

from the sandy street into the synagogue but immediately

pushed towards the back. You are unclean

with this heavy burden you carry, which slumps you

over, so you cannot come towards the front . . .

“You wait for the teaching to begin. The smell of

sweat fills the air, and your eyes can only see the dirt

floor, sand, and people’s feet . . . It’s the same as

always, your view for the last eighteen years of your

stooped-over-existence ... You are a loser in the people’s

eyes, condemned to an existence of staring at

the desert ground ...

SCRIPTURE INTERVENTIONS

“You hear a man start to teach. He’s different

than the other rabbis you’ve heard. His words are

like no other ... He pauses in his sermon ... ‘Why?’

You wonder . . .

“People are whispering. He speaks, ‘You, come

up here.’ He’s noticed you . . . He tells them to bring

you forward. A mass of feet now crowd around you.

You struggle to walk his way, trying to avoid the converging

mass of legs, dirt, and sand that stand in your

way ...

“Finally, there is only one pair of sandy feet

before you . . .

“‘Son, you are freed from your sickness.’ The

weight of ‘I’m a loser’ falls off your back . . . He

stoops down and places His hands on you, helping

you straighten up. For the first time in many years,

you are standing straight up, seeing someone face-toface,

your healer, Jesus.

“Others try to object to what has occurred, but He

is stern. ‘And this man, this son of Abraham, whom

Satan has bound for eighteen long years, should he

not have been released from this bondage on the Sabbath

day?’ . . . He defends you. The entire crowd

rejoices at this great miracle. You are healed . . .”

Tears streaming down his face, George is clearly

moved by this experience. I invite him to have an intimate

conversation with Jesus about what had

occurred, quietly in silence or out loud as he preferred.

He whispers thanks and praise. He pours out

his heart and worships the King. After waiting for

this holy encounter to cease, I process with George

this exercise. He notes that he feels like the charge,

“I’m a loser,” had symbolically fallen off his back.

It should be noted that some Christians have

great concerns about using imagery in their experience

of the Scripture. Foster (1998) notes

Jesus himself taught in this manner, making constant appeal to

the imagination ... There is good reason for concern [about

using the imagination though], for the imagination, like all our

faculties, has participated in the Fall. But just as we can believe

that God can take our reason (fallen as it is) and sanctify it and

use it for his good purposes, so we believe he can sanctify the

imagination and use it for his good purposes. (pp. 25-26)

One might also point out the rich usages of imagery

seen in the psalms (Psalm 23, for example) and highlight

our regular usage of imagery in our daily functioning.

While some people don’t have the capacity

to imagine visual images, for most the skill is readily

apparent. When one thinks of a red car, for example,

a mental image often accompanies the words “red

car.” In another example, the command “don’t think

of a pink elephant” leads automatically to an image

of a pink elephant. Foster’s comment, the biblical

application of imagery in many passages, and our

daily experiences with imagery suggest an alternative

position to the “never use imagery” view, one emphasizing

the importance of submitting this ability into

the hands of God for His guidance and control. As

always, the client ultimately chooses which view he

or she will ultimately adopt.

CONCLUSIONS

“Spirituality” has become a popular topic in both

secular and Christian environments. With appropriately

religious Christian clients who desire the integration

of spiritual resources into their treatment,

therapists are sometimes challenged to find meaningful

ways to incorporate the Word of God effectively

into clinical care. George’s case highlights just

a few of the myriad ways Scripture can be used as an

intervention. Perhaps the sample techniques

described in his care have served as a catalyst to stimulate

deeper reflection about how the Bible can be

applied in typical therapeutic modalities. When

appropriate ethical and religio-cultural assessment

guidelines are followed, the Word of God demonstrates

itself a living, powerful resource to be humbly

handled by clinicians in their work.

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